

FROM POST-TRAUMATIC STRESS DISORDER TO CULTURAL BEREAVEMENT: DIAGNOSIS OF SOUTHEAST ASIAN REFUGEES

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Abstract-There are pitfalls in the singular application of western categories in diagnosing psychiatric disorders and distress among refugees. Based on my research with Cambodian refugees I argue that cultural bereavement, by mapping the subjective experience of refugees, gives meaning to the refugee's distress, clarifies the 'structure' of the person's reactions to loss, frames psychiatric disorder in some refugees, and complements the psychiatric diagnostic categories: Cultural bereavement includes the refugees' picture of what the trauma meant to them; their cultural recipes for signalling their distress; and their cultural strategies for overcoming it-and the cultural interpretation of symptoms commonly found among refugees that resemble post-traumatic stress disorder. Cultural bereavement may identify those people who have post-traumatic stress disorder on the Diagnostic and Statistical Manual (DSM) criteria but whose 'condition' is a sign of normal, even constructive, rehabilitation from devastatingly traumatic experiences. Cultural bereavement should be given appropriate status in the nosology.

Key words: cultural bereavement, DSM, post-traumatic stress disorder (PTSD), refugees.

INTRODUCTION

Clinical work with refugees poses a special challenge because the usual difficulties in making a diagnosis with any people of a different cultural background are compounded when they have suffered massive trauma in the wake of war.

Most refugee research is generated in the United States, and DSM, the American Psychiatric Association's *Diagnostic and Statistical Manual*, is becoming the standard reference not only for North America but also for other European and English-speaking countries. The diagnosis of post-traumatic stress disorder in this nosology is increasingly applied to refugees (1).

This diagnosis, which is a convenient one for mental health workers, picks up many people who have gross reactions that impair their social and psychological functioning (2). It offers a checklist of criteria, many of which have to do with physical changes in the person's body that are easy to elicit and are presumed to occur as a universal physiological reaction to stress; the nature of the stressor or the cultural background makes no difference. And it is based on a cultural view of health that prescribes how people should adjust or acculturate after immigration, how they should express their distress, how their disorders should be classified, and how the distress should be remedied. It seems to offer a universalist solution to a relativist problem. But health and ill-health are defined by the culture and a psychiatric taxonomy should allow for variations in cultural background and the circumstances surrounding the trauma.

Eugene Brody in his critique of psychiatric 'biologism' notes that official diagnostic systems contribute to a worldview that privileges biology over culture: "One reflection of the tendency to regard behaviours in question as innately determined is the absence of

the term 'culture' in the *Diagnostic and Statistical Manual* (DSM-III) of the American Psychiatric Association and its mention only in passing in the revised version (DSM-III-R)." Brody says that North American psychiatry is much more eclectic than these diagnostic systems might suggest (3). The literature on post-traumatic stress disorder pays some attention to social factors (4) and Parson, for example, points out the ethnic variations in post-traumatic stress reactions (5). In the case of refugees who must draw upon cosmologies different from those used in the western countries to explain their experiences of extreme trauma, there is room for the taxonomy to be sensitive to those systems favored by them.

Clinical experience in many western countries suggests that, even after an initial period of increased well-being, some refugees seem to become alienated from the host society, and either retreat into a troubled private world or show antisocial behavior. Their experience of their illness is culturally determined, but their illness may not necessarily be a disease. How should their condition be dealt with in a psychiatric taxonomy?

The response of western health professionals to refugee sickness has been varied. Sometimes, workers have attempted to identify and treat refugees using western definitions (6). Some workers, for example, use DSM categories to diagnose refugee distress, which may be a normal, even constructive, existential response rather than a psychiatric illness, and treat it with western medicine. But this may mean treatment (and creation) of an illness the refugee does not have and confusion in the mind of the refugee about what this medical encounter means. Such a misunderstanding of the refugees' needs could be avoided if more emphasis were placed on the integrity of the information gathered from the refugee, regardless of how bizarre it may seem.

In earlier papers I proposed cultural bereavement (7) and reported the development of the cultural bereavement interview (8) and the empirical comparison of cultural bereavement among Cambodian unaccompanied children in the United States and Australia. In this paper, I set out the concept of cultural bereavement and illustrate how the antidotes to it can be understood through the refugee's cosmology. I illustrate through case material how cultural bereavement can be used to improve the diagnosis and management of refugees, and to refine psychiatric diagnoses such as post-traumatic stress disorder.

CULTURAL BEREAVEMENT

Uprooted people have always suffered from homesickness, but the increasing number of uprooted peoples might support the resurrection of a 'forgotten' category of the sort used before World War I (9j). Refugees cannot return to their homeland at will, but they cannot leave it completely behind either. Nostalgia has been described widely among immigrants (10) and specifically among refugees and exiles (11). Mess. sive social loss, such as that caused by uprooting, produces grief. Marris, who studied the effects of widowhood in the East End of London, slum clearance in Nigeria and America, and colonization in Kenya, noticed that each transition involved the anxieties of change centered on the struggle to defend to recover a meaningful pattern of relationship (42j). Muñoz describes anxiety, guilt, and depression the thought of contamination by the values of the host society in Chilean refugees in England (13j).

In 1983 I worked with an Indo-Chinese children's mental health service in Boston. The Cambodians proved to be appropriate for study because they had suffered a traumatic loss of society and culture and were obliged to adapt rapidly to a new country; they could also be seen as representing other displaced people. The Cambodians showed features of distress that were culturally determined, such as *sramay*, in which the past came to them as visual and other perceptions during sleep but continued unabated in the waking state. It seemed to me as a participant observer in the community that these features amounted to a clinical complex that could be translated into western psychiatric terms. Using a combination of clinical and ethnographic work, I identified what in 1984 I termed cultural grief but later refined to cultural bereavement (14). I defined cultural bereavement as the experience of the uprooted person or group—resulting from loss of social structures, cultural values and self-identity: the person or group continues to live in the past. It is visited by supernatural forces in the past while asleep or awake, suffers feelings of guilt over abandoning culture and homeland, feels that memories of the past begin to fade, but finds constant images of the past (including traumatic images) intruding into daily life, yearns to complete obligations to the dead and feels stricken by anxieties, morbid thoughts, and anger that mar the ability to get on with daily life. It is not of itself a disease but an understandable response to the catastrophic loss of social structure and culture. To measure cultural bereavement, I developed a semi-structured interview that—moves

through a sequence of complaints identified in my fieldwork as troubling the resettled Cambodians—memories of family in homeland; continuing experiences from the past; visitations from ghosts or spirits; dreams; guilt, clarity with which appearance or relations is recalled; the structuring of the past to the homeland; Personal experience of death, funerals and graves; anxieties, morbid thoughts, and anger in response to separation from the homeland—and adds two that are perceived to be antidotes to the person's cultural bereavement: comfort derived from religious belief and comfort from participation in religious gatherings (18).

In an empirical study I examined the differences in cultural bereavement between two groups of unaccompanied and detached refugee adolescents (mean age 15 years) fostered in Cambodian group care in Australia and in foster families in the U.S. I studied two groups, 47 fostered in Cambodian group care in Australia and 32 placed in foster families (24 with Americans, 8 with Cambodians) in the U.S. The children in Australia had been resettled for an average of 28 months; those in the U.S. for an average of 16. I interviewed the children in Khmer. I found that the cultural bereavement among those in the United States was significantly greater than that found among their counterparts in Australia, where there was somewhat less pressure to leave the old culture behind, and where the children were encouraged to participate in traditional ceremonies (14).

Sometimes the children fostered with American families saw little of their fellow Cambodians and had little or no access to Cambodian culture. These children continued to be immersed in the past, thinking often about their families and more preoccupied than they had been at the time of arrival. They had sustained feelings of regret over leaving the homeland, coupled with a wish to go back. Very powerful bad memories of atrocities during the *Poi Pot* times lingered, with a recollection of anger and regret at the time of leaving the homeland.

The children seemed to feel that their painful feelings could be combated by traditional religious beliefs and access to ritual. Sometimes the importance of these feelings is ignored by policy-makers and care-givers, who feel that rapid integration into western thought, behaviour and religion is better for the children, especially as they are young! The fieldwork showed that much good could be done by promoting access of the refugee children to Buddhist monks and Cambodian *kruu kmae* (traditional healers). It was striking how often my young Cambodian informants expressed their yearning to participate in traditional Buddhist ceremonies. They wanted to learn how to chant with the monk and the older participants, and how to 'make merit' for their dead or lost parents and ancestors for a better life in the next incarnation and to protect themselves from vengeful spirits. They were helped to make sense of their feelings when the monk explained *sansaa* (samsara or the inevitable cycle of rebirths) and *tanhaa* (excessive desire or craving). A child fostered into a middle class American family said to me:

When I go to the ceremonies, the whole thing keeps me from forgetting. I used to participate in these ceremonies with my father and mother.

Diagnosis of Southeast Asian refugees

They took me to the pagoda. I had -anted to be a monk, to do -*uaa action* for my parents. *Vow* the ceremonies make me sad because they make me remember what I lost. If I do *loadacne*- then my mother *will* take care of me now. The religion *will* be useful for me after I have died ...

The unaccompanied children in Australia who had been placed in Cambodian group care eagerly awaited their first *pcunt-berr* (the annual ceremony held to venerate the souls of the dead and incorporate the survivors into their community). Before it started, they gathered, unrolling the *karneel* (mats) and preparing the ritual accoutrements such as the *purthea? rruup* (Buddha image). Some children anticipated that their families' *viririenna?khan* (sense, feeling) would descend from the 'other world' around Cambodia to rejoin them. Some expected to see or even touch them. During the ceremony, they were shown by the *doon cii* (nun) and the *look sail* (monk) how to join in *rhoo* (dharma) and *teehsnaa* (preaching the Buddhist sermon). The monk explained some relevant Buddhist cosmology, including the *sel* (Five Precepts to be followed by all Cambodian people) and the relationship between *sansaa* and *tanhaa*. Afterward, the children joked with the monk and said that they felt relieved to have understood more clearly who they were. The ceremony was a culturally coded 'corrective emotional experience,' and one that many children in need were denied. The formal religion was less helpful than the symbolic meaning of the ceremony as a way of bridging the past. as another child told me:

Cambodian Buddhism wants to help people not to do wrong things to one another. Buddhism helps you control your mind. If I can't control my mind, then I go crazy.

You know, I really miss *pcum-ben*. I enjoyed it in Cambodia. I really intended to go this year, but my foster parents didn't have the time to take me. They think I don't care about religion. But that's not the reason I need to go to *pcunt-ben*. On *pcunt-ben*, we believe that the spirits of the ancestors come back. I often reel like a baby chicken separated from its mother. It has just learned to walk. It feels sad all the time and scared because it *will* never become a big bird without its real mother. The baby chicken might starve to death.

One fifteen-year-old complained about not being allowed to continue his ceremonies:

We believe that on *pcunt-ben* the spirits of the dead come back, and we need to talk with them and comfort them. We draw a picture of the dead. If we don't go to the Buddhist ceremonies, they might end *up* in different hells. They might end *up* in boiling water. I wanted to go, but my foster parents took me to play soccer at ad ...

Right now, I live in Jesus' house live under my foster parents' rules, and under Jesus' rub. And so I am forced to go to church. I hate Jesus' matter what, a Christian minister is not the same as a Buddhist monk. My foster parents don't understand, but I just can't argue with them, because according to my culture I must respect them.

The ceremonies help the survivors to come to terms with these losses; make the world a safer place for them; reduce the tension between life in 'this-world' in the host society and the Khmer 'other-world', which is internalized in the person; and consolidate their sense of self. These ceremonies are antidotes to

daily and calendrical cultural myths and rituals of traditional Cambodian society.

POST-TRAUMATIC STRESS DISORDER AND CULTURAL BEREAVEMENT

Before post-traumatic stress disorder and cultural bereavement had been coined, Zwingmann's term 'nostalgic fixation' acknowledged aspects of posttraumatic stress disorder (withdrawal behavior) and of cultural bereavement (strong idealization of reference persons, objects and situations) and some that fitted both (psychogenic and psychosomatic difficulties). The beliefs and actions of patients with severe nostalgia may suggest to a western clinician that they are psychotic. It is not unusual to see, for example, a Cambodian patient who is possessed by spirits, troubled by visitations of ghosts from the homeland, hears voices commanding him or her to make merit to his ancestors, and feels that he or she is being punished for having survived. All these can occur as culturally normal signs of bereavement, and the patient often responds quickly to intervention by the Buddhist monk or the *kruukntae* (151 who can work as an ally of the clinician in clarifying the diagnosis).

The case of Ros illustrates how a refugee could think, real, and act in ways that express her cultural bereavement, but be misdiagnosed as having a psychosis or a post-traumatic stress disorder.

Since the birth of Cuk, her youngest child, Ros, a young Cambodian, had felt worried, depressed, and troubled by dreams in which she saw horrifying figures that told her to 'harm her son, and she was frightened when alone in her flat. She missed the family in Cambodia and had sarantay in which the cut cambu3 of the family visited her in Australia. (Each person has a cu3 cuanou3, derived from the mother and father, which protects them against danger but when provoked can cause harm.) She was observed to be crying and complained of blackouts, shortness of breath, and tingling extremities. The health team diagnosed post-traumatic stress disorder and post-natal depression with psychotic features, and it was thought that she might be a child abuser and that Ouk should be taken away from her.

I examined Ros, and we spoke in Khmer. Ros feared that because she had not made merit to her ancestors her parents' spirits would return to hurt her. She had been troubled by *priley*, *b3ysaac* and *neck raa* (a panoply of Cambodian spirits) coming through the ceiling of her fourth floor flat and worried that the flat was dangerous for her son because people would walk up and down on the fifth floor on top of his *khu3 kbaal* (brain) and damage his intellect. He was vulnerable, she thought, because his birth had been induced and his placenta thrown out by the obstetrician. The induction of labour meant that Ouk was born on the wrong day: "If they hadn't given me an injection, Ouk would have been born on the same day as me," Ros said.

Ros recalled how at the age of seven she had seen an *?dap* (a disembodied female skull with entrails dangling behind it) flying through the trees. Her father had told her that after childbirth the placenta must be buried to prevent the *?aap* from smelling the blood and swooping to devour it and kill the child and make the mother ill. After *Tbes* birth, Ros, sleeping on the balcony, had seen the bright green light of *. the laap* flying through the neighbourhood and had been overcome by an icy feeling.

The health center asked the housing agency to move her to the first floor. Ros really wanted to see a *kruu* to visit her-----

see one at his home. The *kruu* diagnosed the woman as suffering from prissy, *boysaac*, and *neck raa*. The *kruu*'s wife, knowledgeable in astrology, found that Ros's birth date and *rasi* (astrological cycle) were in decline. And the *cu3 cambu3* on her father's side was angry with her. The *kruu* treated Ros and *Ouk* with several ritual ceremonies: he performed *kieuna* (Sanskrit or *Pall Gata*) *d3ri krtmouc* (used the magic amulet to expel the *evil* spirits); and set up a *poatthea? ?aa* (a protective marker around her house) to repel further attacks. Ros's bad dreams stopped. she fell her home to be safer, and her physical symptoms

Ros's two older children were curious what had been bothering their mother. why she had gone to the *kruu* and how his treatment had helped her. Ros was reluctant to reply because she feared that since resettlement she had been cut off from her culture. I encouraged her to restore her childhood memories of participation in religious rituals and ceremonies of daily life until gradually she regained enough contact with her lost culture to tell her children what she knew. As Ros's children had lost touch with her, so she had lost touch with her childhood.

The most culturally sensitive clinical diagnostician, saddled with the DSM taxonomy, cannot avoid making this category, fallacy. The symptoms of posttraumatic stress disorder and postpartum depression seemed inevitable for Ros because western obstetric routine had been followed without allowing for her cultural needs. When the middle child had been born in Thailand, the placenta had been buried according to the custom and the child was protected against the *?yap*. No harm had come to Ros or the child. But in Australia Ros's labour had been induced, *Ouk* was born on the wrong day, and the placenta was discarded. Her cultural bereavement was verified by the *kruu*'s evaluation. He understood what she saw (what westerners might have diagnosed as visual hallucinations); and instead of trying to suppress her visions of her family at home and the associated vengeful spirits, he protected her from being harmed at their hands. The *kruu* turned an unhealthy contact with the past (borne out of her cultural bereavement) into a mastery of the separation from home, and the symptoms of post-traumatic stress disorder abated.

The diagnosis on referral of post-traumatic stress disorder and depression needed to be dismantled and then reassembled in the patient's terms, and a specialist opinion was sought from the *kruu*. The collaboration was instrumental in treating the patient's fundamental suffering rather than dealing only with the symptoms.

The DSM-111 lists 'uncomplicated' bereavement under a supplementary group of conditions not attributed to a mental disorder. According to Skodol and Spitzer (16) placing bereavement here reflects the belief that under normal circumstances a grief reaction is not pathological and may be adaptive. Since it is specified that an adjustment disorder has to be maladaptive, normal grief reactions are excluded. When the grief occurs in response to loss of culture—other words, the bereavement is no longer just personal but cultural—the cultural meaning of the loss cannot be dismissed as just another predisposing factor to the 'real' psychiatric illness.

These classifications tend to focus on the responses of people precipitated largely in terms of the objective traumas they have come from (17). But sometimes the

incidence of post-traumatic stress disorder among survivors is lower than would be expected, and the somatic and psychosocial problems do not fit any diagnostic criteria [13]. Cultural bereavement in-, eludes their subjective picture—what the trauma meant to them, their cultural recipes for signalling their distress, and their cultural strategies for overcoming it.

The DSM evaluation requires that each case be assessed on five axes [19]. The first three carry the diagnosis, the others are supplementary. In post-traumatic stress disorder, for example, details of stress or culture are extraneous and at best relegated to a supplementary axis, at worst ignored (20). The manual states that the clinician should rate the stressor according to what an 'average' person in similar circumstances and with similar sociocultural values would experience from the particular stressor. Although the manual suggests, for example, that concentration camp experience is a catastrophic stress, there is nothing to show how an 'average' person should act in the circumstances, or how cultural theories of death or misfortune shape the person's response to disaster. And there is a strong assumption that the bigger the stressor the bigger the disorder. Post-traumatic stress disorder is the only condition in which a formal diagnosis is given to describe the post/traumatic reactions of patients.

There has, however been a growing recognition that the psychic reactions to stress need to consider the nature of the stressor. The latest revision of the manual, DSM-III-R, listed multiple items for reexperiencing, avoidant and arousal criteria but still assumed that all individuals responded in the same way despite the nature of the trauma (21). Again culture was not mentioned as a variable. There was a suggestion that the supplementary axis should contain a qualifier that would allow for conditions such as post-victimization syndrome (22). This has the merit of taking account of the biography of survivors but the disadvantage of ignoring cultural meanings—of loss, victimization, violation, and so on—and introducing another syndrome without cultural decoding.

The English-language classifications hint at the connection between the stressor and the reaction to gross insults such as war. The World Health Organisation classification (23) for example acknowledges the link between the disorder (adjustment reaction) and stressor (such as bereavement or migration) (24). The draft classification for DSM-IV recognizes that there is a range of disorders that follows a distressing event (25). One of its proposed classifications (26) allows for the refugee's explanation of the experience. But how can alterations in affect, consciousness, self-perception, perception of perpetrators, and (most of all) systems of meaning, such as loss of previously sustaining beliefs, be calibrated without correcting for culture?

The proposed revision offers a more compelling picture of what it must be to survive massive trauma. Although it focuses on symptoms and cultural bereavement focuses on meaning, there is some matching between the features of the two. Alterations in affect, such as over-expression of anger, behavior, such as risk-taking, thinking, such as persistent preoccupation with the perpetrator, inability to trust

others, and loss of previously sustaining beliefs (absent from the post-traumatic stress disorder), which are all described in the proposed classification, can be

explained as features of the refugee's cultural bereavement, which are not necessarily pathological. Alterations in affect may arise from an overflow of the refugee's revolutionary past into his or her daily life. Risk-taking may arise from a conviction that fate is dictated by karma or predestiny and that there is no special risk attached to flirting with situations reminiscent of carnage in the war zone. Persistent preoccupation with the perpetrator may arise from a culturally prescribed compulsion to relive even the grotesque past not just in dream but also in the transition to wakefulness. Inability to trust others and loss of previously sustaining beliefs may come from the seemingly senseless loss or old structures and meanings about life, suffering, and death. These 'symptoms' could be useful signs, as they perform a constructive function in bringing the person into a social system such as the Buddhist wax that restores morale and culture.

Physiological models of post-traumatic stress disorder, which use terms such as 'stress driven anxiety disorder' and 'dose response stress curves,' are attractive because they offer a biologically universal causal model for anybody's reactions to stress no matter what the cultural background or nature of the stress (27). But how does one know that all patients from all cultures are going to have the same physiological stress reactions such as hyperalertness or sleep disturbance? The psychiatrist trying to make sense of the patient's seemingly bizarre symptoms has nowhere to set other than with these presumed universal physiological responses. The insight-oriented therapist has nowhere to start other than with western concepts such as survivor guilt, which are taken to be universal. But the patient, a Cambodian refugee, for example, regards an abnormality in *sag say* (the axial tubules in the body) or in *khui kbaal* (the brain) as caused by action of a bad force in the new country, or sees the complaints as a result of *kam pail* (predestiny from action in a previous life) or the force of *la?so?ra?kaay* (malevolent supernatural mystical or animistic forces) or of *?ao~.*» (deliberate interference by others who have practised magic or sorcery to attack their minds) and turns or it is possible) to the culturally prescribed antidotes.

Much of the existential pain of the refugees has to do with difficulties in recapturing the lost past and ultimately with the survival of their culture. An ethnocentric diagnostic system *will* further alienate survivors from their culture's view about suffering, and misfortune; could impose a worldview on health workers in non-English-speaking countries who deal with refugees; and may violate the cultural survival of the refugees.

Some people in any refugee community will suffer from major psychiatric disorders such as schizophrenia, some *will* suffer from post-traumatic stress disorder alone, and some *will* fulfil the diagnostic criteria for psychoses or post-traumatic stress disorder and show features of cultural bereavement; there may be co-morbidity between any of these three 1281.

DISCUSSION

Entrapped and suspended from their past, refugees can develop disabling symptoms that may mimic post-traumatic stress disorder but *will* not be ameliorated by western therapeutic methods along The clinical complex, cultural bereavement, which can be translated into western psychiatric terms, gives meaning to the distress of the refugee, frames psychiatric disorder in some refugees, and informs the diagnosis of post-traumatic stress disorder: The culturally bereft person may also have post-traumatic excess disorder and possibly another psychiatric disorder that may stem from cultural bereavement, or have clinical manifestations colored by it.

The numbed responsiveness described in post-traumatic stress disorder is attributed by cultural bereavement, at least for the Cambodians I studied, as a response to the structuring of the atrocities of the past, including experiences of death, which have been transposed into the present.

Disorders such as atypical grief reaction of refugees can declare themselves as somatic and other seemingly bizarre symptoms that health workers may fail to decode. There is a danger that, at least for some patients, crisp definitions such as post-traumatic stress disorder, post-victimization syndrome, or cultural bereavement could be artifacts. In the case of depressive disorder Kleinman identified the category fallacy as a cultural category constructed by psychiatrists to yield a homogeneous group of patients (29). Kleinman and others have shown that refugees commonly somatize (30). Indeed, several post-traumatic stress disorder criteria, such as somatization, are relatively common among Southeast Asian people. Others, such as guilt, may be relatively uncommon expressions of distress in the culture. Further research is needed to show how cultural bereavement can be used to show why some refugees psychologize or somatize and how these responses may be pathological to a cultural group.

Cultural bereavement can help clinicians working with refugees to separate signs of pathology -reliving of the past, for example-from signs of a consistent and culturally normal relationship between the person's past and present. But further research is needed to learn how the 'normative' cosmology of each immigrant group can be of use in combating the patient's reactions to uprooting and resettlement.

In practice there are dilemmas in making a culturally relevant diagnosis when the clinical picture seems to form a 'fuzzy set'. Many Cambodian patients, for example, describe themselves as having 'the Cambodian sickness', which in Khmer is described as ? or headache, but which refers to a constellation -of chronic symptoms including lethargy, headache and worrying about the family at home. These patients may develop clue *kbaal* when they are thinking of their homeland in response to an anniversary, or a ceremony, or even the smell of the wind. The *ch3u kbaal* may be heightened when they have had a *sramay*, in which their ancestors came from the dream into their daily life, and this may be worsened if they are denied the opportunity to transfer merit to their ancestors by participating in a Buddhist ritual, or by propitiating their ancestors. The *chou kbaal*

might be related to the reeling of anger at having left the homeland, coupled with survivor guilt and a confusion over the safety of the new society because of a transfer of danger from the traumatic past. It could be a mistake to interpret the 'headache' as only another clinical symptom of a post-traumatic disorder because the 'headache' may be a signal for that whole complex of cultural bereavement.

In my experience emblematic symptoms such as the *clu?* Kbaal seems to affect many in the neighborhood; it is common to find a small Cambodian community isolated as a group from the people., around them, the men struggling to find work or to manage two jobs and sometimes attending night school; an unknown number of 'widows' who can-- not or *will* not remarry, perhaps because they do not know where their husbands are, or because they' cannot let go of the past; adolescents struggling., over identity and belonging; many lonely elderly people facing the imminent end or this incarnation

and wanting to die on their home earth-and ail ina host society oblivious to their cultural bereave. ment. If some of the people in this community come to a mental health resource with complaints such as sleeplessness or flashbacks or some other hallmarks of post-traumatic stress disorder, how are we to really treat them? Treating the symptoms. can be counterproductive because the patient returns to a community that is itself in a state of collective grief and the patient becomes more estranged from the parent culture. Intrusive symptoms such as nightmares, sleep disorders, and startle reactions can be ameliorated with medication, but the persistence or other symptoms of post-traumatic stress disorder, such as avoidance behavior, shame, and decreased involvement with other people, suggests that another process is under way (31J. The result is to prolong the trauma

It makes sense that t many health workers anxious to help troubled refugees endorse the universalist understanding of post-traumatic stress disorder. But the hermeneutician would find that position problematic because such western diagnostic categories are devoid of cultural meaning. The clinician would find them attractive because they provide convergent and relevant categories into which a traumatized immigrant-of any stripe scan be funnelled. Despite some attempt at revision, the seminal diagnostic formulation of post-traumatic stress disorder was universalistic. Cultural bereavement, with its emphasis on cultural meaning, brings the relativist and universalist into greater balance.

From an understanding of the patient's cultural bereavement we overcome the tension between the hermeneutic/interpretive/nomothetic approach (which makes comparison difficult) and the ethnographic approach/ideographic (culturally based understanding) vs clinical approach (to some extent, to treat, one must categorize, abstract, and de-individualize). For Cambodian refugees, the *kruu* has the potential to act as hermeneutician and diagnostician; he is the decoder of the patient's cultural construction of illness; he can help the psychiatrist to treat the patient.

CONCLUSION

Cultural bereavement can refine our understanding of psychiatric disorder among refugees in several ways. It can minimize the likelihood of refugees being wrongly labeled as having psychiatric disorders when their 'symptoms' reflect a profound communal suffering, the experience, the meaning, and the expression of which are culturally determined. It can help to pin-point the problem for those refugees who do not appear to have an obvious and tangible stressor: it can detect disorder in refugees *who* exhibit no clinical symptoms in western terms. It can improve the detection of ca-mor'bid states, thereby enriching clinical management. It can shift the clinical focus from treatment to pre= vention by emphasizing the restoration of cultural meaning. (It is a false assumption that immigrants mourn in conformity with the norms of the host society (32J. It may be that refugees are unable to mourn because they are powerless to carry on their religious and cultural traditions.) It can contribute to proper outcome measures of refugee mental health. And it can improve the accuracy of a diagnosis where identification of a clear trauma may fail in cases where the refugee faced more subtle traumas (such as loss or self-identity) rasher than more obvious traumas (such as rape).

Although this paper has been derived from work with Cambodian refugees, each refugee group has suffered its own set of objective traumas; there is enormous inter-country variation in circumstances, such as not knowing the fate of relatives (33); and there are further differences in the cultural explanations for loss and death. The idea of cultural bereavement must be carefully cared in further clinical and ethnographic research. A range of ethnic and cultural groups needs to be compared, including groups who have experienced various stressors; refugees at each stage of the life-cycle; refugees in post-migration stages; those who have resettled in various countries with a range of resettlement policies; and those in refugee camps.

A comprehensive approach to the diagnosis of refugee mental health must be culturally relevant assume nothing about distress versus disorder, ands allow for the patient's cultural constructions oft mental health I propose that cultural bereavement could be used to refine the diagnosis of post-trau- stress disorder to allow for greater recog-, nition of the refugee's existential predicament Cultural bereavement may identify those people who have_ post-traumatic stress disorder but whose is a sign of normal, even constructive. rehabilitation from devastatingly traumatic experiences It should be given appropriate status in the nosology.

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1. Diagnosis is made if the person demonstrates (a) re-experiencing of the trauma as evidenced by at least one of the following: recollections of the event, recollections, recurrent dreams, or flashbacks; and (b) reduced involvement with the external world (diminished interest, detachment or estrangement, or constricted affect); and (c) at least two of a collection of symptoms: hyperalertness, sleep disturbance, survivor guilt, trouble concentrating, avoidance of activities that arouse recollection of the trauma, and intensification of symptoms by exposure to events that symbolize or resemble the traumatic event (American Psychiatric Association, 1980).
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