
Refugee Health Care and the Problem of Suffering

by Judith Shepherd and Shotsy Faust

Post-Traumatic Stress Disorder (PTSD) is a disabling psychiatric condition which affects health and functional ability. Most medical interventions lack effectiveness so the sufferer may continue to complain of symptoms such as pain, intrusive thoughts or nightmares relating to the traumatic experience. A support group for Cambodian women with PTSD was started in 1991 at the Refugee Clinic at San Francisco General Hospital. The structured group format of concentration building, English language lessons, and relaxation/stress reduction exercises proved effective in relieving symptoms for most participants. We were able to help those who continued to suffer by addressing issues of unresolved grief and unmourned death through culturally appropriate religious ceremonies.

Caring for Cambodian Refugees

Between 1975 and 1979 Cambodia experienced a sociopolitical upheaval that resulted in the deaths of several million people (Boehnlein 1987). Educated Cambodians were among the first to be executed by Pol Pot's army, the Khmer Rouge. Buddhist monks were systematically killed because of their social status, educational background and Pol Pot's desire to create a new society. Those who died were not the only victims. Many of the survivors of the Pol Pot regime were damaged by torture, starvation, forced labor and separation from family and community.

That Cambodian refugees are among the most severely traumatized of all recent refugee populations has been suggested by several studies of refugee mental health (Baughan et. al. 1990; Mollica 1987; Meinhart et. al. 1986; Rozee and Van Boemal 1990). These researchers have also noted that Cambodians are at extreme risk for health and mental problems, especially Post-Traumatic Stress Disorder (PTSD). Mollica (1987) found that the Cambodian population in his Boston clinic had poorer health status than other refugee groups. He states that 95 percent of Cambodian women seen in therapy at the Indochinese Psychiatry Clinic had been raped and that most women did not discuss these sexual assaults until three years into therapy. A study by Rozee and Van Boemal links suffering under the Pol Pot regime in Cambodia and life in Thai border camps to psychogenic blindness of 30 Cambodian middle-aged women who sought treatment in a southern California medical clinic. We have corroborated the occurrence of psychogenic blindness in traumatized Cambodian women patients in the San Francisco General Hospital (SFGH) Refugee Clinic.

Cambodian and other Southeast Asian refugees began arriving in San Francisco in 1979. At that time, the Refugee Clinic opened to provide federally mandated health screening services to new arrivals. In 1982 the clinic became part of the Family Health Center at San Francisco General Hospital. The clinic has expanded over the years into a family practice center that also serves monolingual, indigent refugees and immigrants from the former Soviet Union, Ethiopia, Eritrea, Cuba, Tibet, Haiti and the Middle East as well as Southeast Asia. We have been able to serve such a diverse community because our staff of multilingual, bicultural health workers/interpreters speaks approximately 12 languages and dialects.

The clinic's interpreters provide more than standard translation services for physicians and nurses. They also interpret cultural concepts and behaviors, making them, in effect, culture brokers working between Western health care and the patient's health belief system. This unique collaboration with our multilingual staff has enabled us to realize that providing health care to refugees who have been tortured and weakened by war is no easy task. In fact, our experience in providing health care services to refugees who have suffered extensive torture, such as Cambodians, illustrates that medical care alone is insufficient to positively affect overall health.

Typically, the Cambodian patients we see seek relief for severe headache, back pain, abdominal pain

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and malaise. Tests are ordered to rule out underlying pathology that might be responsible for the pain. In most instances the results are negative, indicating possible psychological dysfunction rather than physical disease. The health care provider may not give the patient the support, recognition or relief of suffering that is needed, driving the patient to seek care from an indigenous healer (*Kru Khmer*) in the community while continuing to seek help at the clinic.

Such dual use of medical healing systems is common, as patients adapt to a Western health care system and other facets of American life. Since our patients are desperate to find relief from their suffering, treatments from the "old country" are combined with those of Western medicine, known for its powerful medications. This pattern of help-seeking for persistent pain may continue indefinitely, and some patients have been seen for years without change. With experience, our clinic staff began to realize that our system of health care had not relieved our patients' suffering. Chart reviews revealed that after the diagnostic work-up was com-

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plete, we were often no closer to knowing what was wrong than when we started: we only knew what was not wrong. For patients, the suffering was sometimes intensified by intrusive medical testing. We began to wonder if patients were suffering from culture-bound illnesses with which we were unfamiliar, but when we discussed this with our staff we were told that the somatic complaints had no special significance, but seemed to occur more frequently after arrival in the United States.

During and after the diagnostic work-up we often try a variety of interventions to help with symptomatic relief. These may involve use of over-the-counter medications, which may be unavailable to patients who cannot read or speak English. We also try analgesics, vitamins, antacids and, at times, antidepressants. Traditional healers in the community may give our patients herbal remedies or other culturally appropriate treatments such as coin rubbing, the practice of rubbing a coin along the acupuncture meridians on the trunk and arms; moxibustion, the therapeutic burning of small bits of bark or vegetable fiber above or on the skin; or cupping, placing a lit candle with a glass or cup on it over the forehead or abdomen thereby forming a

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vacuum to pull toxins or negative energy out of or away from the body. Frequently our patients appear in the clinic with the stigmata of these treatments. We recognize that patients believe in the benefit of folk treatments, and since they cause no harm we do not discourage their use. In fact, we often encourage such practices in an effort to support the patient's cultural values while introducing Western concepts of health and treatment. We also recognize that many patients are clinically depressed, perhaps in addition to having other health problems. Rozee and Van Boemel found that Cambodian patients may somatize some of their illnesses and also have concurrent organically-based disorders such as hypertension, diabetes and arthritis. In our experience, many of the somatic complaints voiced by the Cambodian population are the likely outcome of psychiatric or psychological problems resulting from trauma.

Recent literature on refugee mental health has documented PTSD as a recognizable syndrome in those who have experienced severe trauma (Carlson and Rosser-Hogan 1991; Kinzie and Boehnlein 1990). The symptoms include intrusive thoughts, flashbacks, sleep disturbances and emotional numbing. We explain the symptoms of PTSD to our Cambodian patients by saying that "pain in the life often leads to pain in the body." However, even the most successful psychiatric interventions, which include anxiolytics and antidepressants, fail to provide lasting relief. It took time and experience for us to recognize that our treatment approach had to be less disease focused and less ethnocentric in order to address the underlying needs of this group.

Therapeutic Support Groups: A Means of Rebuilding Culture and Promoting Healing

Several instruments for measuring PTSD and depression have recently become available in Cambodian and Vietnamese languages (Mollica 1987, 1992). The Harvard Trauma Scale and the Hopkins Symptom Inventory were selected for assessing PTSD and depression in our adult female Cambodian population because they were valid and reliable in translating difficult concepts across linguistic and cultural barriers. Patients who scored high

on these screening tools were referred to a weekly support group led by a social worker and a Cambodian health worker.

The overall goal of our support group was to reduce the social isolation and emotional numbing that had plagued our patients for over ten years. We wanted to reduce depression and rebuild a sense of community among Cambodian women so they would be able to heal themselves through mutual support that might carry over to their daily lives. We also wanted to teach patients how to gain some control over their PTSD symptoms such as intrusive

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thoughts, poor concentration, irritability and sleep disturbances. With these skills patients would not always depend on the clinic or be at the mercy of their own symptoms. To this end, we designed three activities—crocheting, English as a second language, and relaxation exercises—to be implemented over a two hour period each week.

The first activity involved a craft, crocheting. Initially, concentration was poor and individuals so depressed that little was accomplished. The patients complained of headache and said they were unable to create anything of beauty. However, with coaxing and support, they slowly improved their ability to concentrate and began to focus for short periods on work and discussion with each other.

The second portion of the group focused on the interaction among several volunteer English as a second language teachers and patients. Participating in songs, pantomimes and games in English did much to build concentration, self-esteem, and good will. Perhaps the laughter and camaraderie that developed during this time was the most important factor in blocking intrusive thoughts of war trauma that constantly plagued our patients and caused somatic symptoms.

The third activity was the most difficult to introduce to the group. In the last thirty minutes of the session, we taught the women visualization and breathing techniques to reduce stress and replace negative stimuli such as intrusive thoughts with positive imagery. This behavioral approach to relaxation resulted in problems for some patients at the beginning. Flashbacks were triggered by the 20 minute audiotape of water sounds for several patients who had experienced their trauma in an environ-

ment reminiscent of these sounds. However, with practice in the safe setting of the clinic and practice at home, even these patients were eventually able to use the tape to fall into a state of deep relaxation, or sleep.

Through such activities the clinic mediated the suffering of most of our support group members, some of whom we had treated medically for ten years with little relief. The support groups also demonstrated how some patients' somatic complaints would temporarily decrease and then recur, when a new trauma such as a death in the family, an accident or news of conflict in Cambodia was experienced. New or recent trauma could also trigger unresolved grief.

The complex relationship of grief and mourning to PTSD was especially brought to our attention by T., one of the women in the support group. Through T. we began to see the need for occasional consultation with the Cambodian religious community about prescribed rituals for bereavement.

The Case of T.

T. was born 38 years ago in a rural province in Cambodia. During the Pol Pot regime, her first husband and her older brother were killed by the Khmer Rouge. She was separated from her children when she was sent to forced labor camp. During her escape she witnessed her sister-in-law being dismembered and burned to death by soldiers. T. left behind a sister, uncles, nieces and nephews to come to the United States under the sponsorship of one of her sisters who had immigrated earlier. T. had to spend 10 years in a Thai refugee camp before gaining asylum. She arrived in the U.S. several years ago.

T. used the clinic frequently for multiple somatic complaints, including headache, low back pain, anxiety and sleep disturbances, but her diagnostic work-up revealed no underlying organic disease. She had been treated with analgesics, anxiolytics and antidepressants with minimal relief, and was also evaluated by a psychiatrist.

After 10 months of participating in the support group, T. became involved in a conflict between two other women in the group, one of whom had allegedly been raped publicly, at a party in the other woman's apartment. Shortly after hospital staff tried to help these two women overcome the effects of the alleged rape, T. appeared at the Refugee Clinic. The social worker who directed the support group was called in to see her. The social worker and the health worker/interpreter spoke with T. and were told the following: Witnessing the

rape of her friend had triggered an emotional landslide for T., back to visceral memories of what occurred when she was sent to a forced labor camp on a small island during the Pol Pot regime in Cambodia.

T. survived on the island by sleeping in trees at night and scrounging for food in the forest when she wasn't working. She was forced by threat of death to submit to Khmer Rouge soldiers, who repeatedly raped her. Her shame was so great that she told no one about these events. The significance of her silence became more apparent as her story unfolded. As she revealed more details of her sexual assault, she began to regain emotional equilibrium. Suddenly, she became highly agitated. Her agitation was punctuated by sobbing and disjointed recounting of details about all her relatives who had died in Cambodia. It became clear that loss and separation from her loved ones were as distressing as the sexual assault.

Although T. regressed to past levels of emotional suffering when she thought of her friend's and her own sexual assault, the memory of the assault was only partially responsible for her emotional collapse. An element of unresolved grief began to emerge as the overriding factor for T.'s suffering. After further questioning, it became clear that T. did not have an opportunity to mourn the death of her family members in ways appropriate to Cambodian religion and culture.

Eisenbruch (1991) and Boehnlein (1987) argue that the diagnosis and treatment of PTSD in Cambodian refugees is confounded when the bereavement process is ignored. The case of T. demonstrates that for patients whose underlying PTSD symptomatology may be exacerbated by unresolved grief, there is clinical relevance in helping them begin the mourning process in a culturally sanctioned way, no matter how long ago the deaths occurred. We gain further insight into the Cambodian refugee community's dilemma when we examine some of the community's spiritual or religious beliefs.

Spiritual vs. Material Explanation for Disease and Suffering

In our experience, Cambodians tend to view their physical problems through the symptoms of their suffering, while Western practice usually explains illness in terms of pathology or disease. Although organic causes are accepted explanations for disease in Cambodia, illness is frequently viewed as the result of karma on an individual or collective basis, or as an imbalance in the world of nature or

spirits, community and family (Aronson 1987). Abatement of suffering and resolution of disease can occur only if balance is restored in some or all of these areas, or by bearing one's suffering as fate.

The physical model of medicine might cause us to overlook one of the fundamental differences between the Cambodian and Western view of suffering. Classically, Western medicine focuses on the pathology that causes the symptoms of suffering, and attempts to treat that pathology. Suffering is viewed as a side-effect of disease, but not the root cause. Psychiatry and the integration of psychological principles into primary care and family practice have changed this somewhat, but often the pure biomedical model persists.

Historically, nursing has focused on the patient's response to disease or suffering, not just physiologically but psychologically and in the context of family and society. The emergence of nursing into the arena of primary care through the work of nurse practitioners and midwives allows for a more holistic approach in the clinical setting. Cross-cultural sensitivity is of primary importance since the patient's complaint may not be related to disease or pathology alone but to the symptoms or somatics of suffering.

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Cambodian religion—Theravada Buddhist, Hindu and animist—emphasizes karmic rebirth as well as the notion that events in both past and present lives can significantly alter the quality of future lives (Aronson 1987; Eisenbruch 1991). Religious upbringing may also cause patients to believe they will suffer emotionally if they are unable to participate in appropriate religious rites for ensuring the proper transmigration of relatives' souls from this world to the next.

With this understanding, we arranged to have a Buddhist ceremony conducted at a local temple to commemorate the dead in T.'s family. Several weeks later, support group members and priests joined in a ceremony called *Ban Skol* for T., the group members, and T.'s family and friends.

On the day of the ceremony, participants brought flowers and food to the temple. Three priests performed the ancient Theravada ceremony to ensure

peace in the life after for the souls of T.'s deceased family members who had been wandering since their deaths. The ceremony brought a sense of joy and relief to T. as well as to members of her family and the support group.

Conclusion

Our collaboration with the religious community is limited, but we hope our experiences at the Refugee Clinic will give clinicians who work cross-culturally the impetus and courage to look beyond the usual limits of clinical care. T.'s breakdown in the clinic over the recent alleged rape precipitated an emotional crisis that caused her to remember unresolved and unmourned loss and separation. We realized that suffering that results from severe trauma may not be managed successfully unless health care providers examine a patient's beliefs and values about dying and death and honor appropriate cultural and religious rituals. T.'s experience also demonstrated that support groups build a sense of trust and security that enable some patients to confront deeper levels of suffering. A support group format can foster partnership with the religious community to facilitate healing.

References

Aronson, L. "Traditional Cambodian Health Beliefs and Practices." *Rhode Island Medical Journal* 70 (1983) 73-78.

Baughan, D.M., et al. "Primary Care Needs of Cambodian Refugees." *The Journal of Family Practice* 30:5 (1990) 565-568.

Boehnlein, J.K. "Clinical Relevance of Grief and Mourning Among Cambodian Refugees." *Social Science and Medicine* 25:7 (1987) 773-781.

Carlson, E.B. and R. Rosser-Hogan. "Trauma Experiences, Post-Traumatic Stress, Dissociation and Depression in Cambodian Refugees." *American Journal of Psychiatry* 148 (1991) 1548-1551.

Eisenbruch, M. "From Post-traumatic Stress Disorder to Cultural Bereavement: Diagnosis of Southeast Asian Refugees." *Social Science and Medicine* 33:6 (1991) 673-680.

Kinzie, J.D. "Group Therapy with Southeast Asian Refugees." *Community Mental Health Journal* 24:2 (1988) 157-164.

Kinzie, J.D., J.K. Boehnlein and P.K. Leung, et al. "The Prevalence of Post-Traumatic Stress Disorder and Its Clinical Significance Among Southeast Asian Refugees." *American Journal of Psychiatry* 147 (1990) 913-917.

Lee E. and F. Lu. "Assessment and Treatment of Asian American Survivors of Mass Violence." *Journal of Traumatic Stress* 2:1 (1989) 93-120.

Meinhart, K., et al. "Southeast Asian Refugees in the 'Silicon Valley': The Asian Health Project." *Amerasia Journal* 12:2 (1986).

Mollica R.F., G. Wyshak, D. Marneffe, et al. "Indochinese Versions of the Hopkins Screening Instrument for the Psychiatric Care of Refugees." *American Journal of Psychiatry* 122:4 (1987) 497-500.

Mollica, R.F., Richard, Yael Caspi-Yavin and Paola Bollini. "The Harvard Trauma Questionnaire: Validating a Cross Cultural Instrument for Measuring Torture Trauma, and Posttraumatic Stress Disorder in Indochinese Refugees." *Journal of Nervous and Mental Disease* 180 (1992) 111-116.

Rozee, P.D. and G. Van Boemal. "The Psychological Effects of War Trauma and Abuse on Older Cambodian Women." *Women and Therapy* 8:4 (1990) 23-50.

Necessary Ignorance

by William G. Bartholome

I am frequently asked what is the most challenging aspect of playing the role of a "clinical ethicist." Although there is considerable controversy about this new role, I see the goal of my work as respecting and supporting the moral "agency" of health care providers, their patients (and patients' families) and the health care institution in which I work. How can a clinical ethicist support the moral development of individuals and institutions? By enhancing their ability to discharge ethical obligations and responsibilities. This work involves multiple tasks: (a) participating in a wide range of educational efforts for students and staff; (b) working with institutional forums such as ethics committees to develop guidelines and policies for addressing recurrent

ethical problems; (c) offering support to providers, patients and families in individual cases, often called "ethics consultation." In undertaking each of these tasks, I have encountered many challenges. However, the most intractable of these is what I call the problem of "acknowledging ignorance."

Although I have occasionally encountered this problem in patients or family members, it is endemic amongst health care professionals. Jay Katz has

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