

## Assessment and Diagnostic Issues in the Psychiatric Care of Refugee Patients

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Despite substantial progress in recent years, the assessment and diagnosis of mental disorders in general continue to be plagued by a significant degree of ambiguity and uncertainty (Akiskal, 1989; Fabrega, 1987). These difficulties are further accentuated when refugee patients are being evaluated (Westermeyer, 1985). This is not only because the life experiences of refugee patients often fall outside of the grasp of the evaluator/diagnostician but also because refugees come from divergent cultural backgrounds and their encounters with mental health clinicians are inevitably cross-cultural in nature. As has been amply documented in the literature, cultural factors often complicate psychiatric evaluation (Tseng & McDermott, 1981). As a consequence, high prevalence of inappropriate assessment and misdiagnosis of cross-cultural patients have been repeatedly reported (Adebimpe, 1981; Mukherjee, Shukla, Woodle, Rosen, & Olarte, 1983).

Fortunately, considerable recent advances in cross-cultural psychiatry, cultural anthropology, and refugee research have converged to make the task of psychiatric assessment of refugee patients less formidable. At a practical level, factual information accumulated over these years regarding refugee patients' cultural values and practices, as well as the history and process of their escape and resettlement, have been helpful for clinicians in understanding refugee patients' behavior and psychopathology (Owan, Biatout, Lin, Liu, Nguyen, & Wong, 1985; Williams & Westermeyer, 1986). At a more theoretical level, insights and knowledge derived from these areas of research also provide valuable general guidelines enabling clinicians to approach their refugee patients in a more systematic and organized manner.

Issues relevant to the evaluation of refugee patients will be highlighted and briefly discussed in the following section. This discussion will be divided into (1) conceptual issues; (2) assessment issues; and (3) diagnostic issues.

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### Conceptual Issues

Knowledge and interests in cross-cultural psychiatry and refugee research are crucial for clinicians who wish to provide systematic and rational assessment of refugees with psychiatric problems. Key concepts derived from these two research fields that are particularly relevant will be briefly discussed below.

The concepts of *psychic unity* (the universality of human nature) and *cultural relativism*, both derived from the tradition of cultural anthropology (Fabrega, 1989; Honigman, 1976), are seemingly diametrically opposed to each other, yet equally indispensable for cross-cultural understanding and assessment. A firm conviction in the universality of human behavior and sufferings is needed before we can apply psychiatric theories and techniques developed in one cultural setting to patients immersed in another (Leff, 1981; Murphy, 1982; Tseng & McDermott, 1981; Wittkower & Prince, 1974). At the same time, the neglect or minimization of cultural differences will lead to psychiatric practices that are inappropriate or even harmful (Favazza, 1985; Gaw, 1982). In order to avoid "over-diagnosis" (i.e., misinterpreting culturally sanctioned behavior as pathological) and "under-diagnosis" (i.e., attributing psychiatric symptoms to cultural differences), clinicians evaluating and treating refugee patients should simultaneously keep both concepts in mind at all times.

Culturally shaped *health belief systems* have clearly been shown by Kleinman and others (Kleinman, 1976; Kleinman, Eisenberg, & Good, 1978) to be of central importance in determining not only the interpretation and communication but also the experiencing and perception of symptoms and disabilities manifest by patients. Further, these beliefs and the behavior determined by them should be evaluated in the context of the patient's cultural background. Innovative concepts developed by prominent medical anthropologists and psychiatrists in recent years, such as the distinction between "disease" and "illness," the routine and systematic elicitation of patients' "explanatory models," and a negotiated approach to medical care, could be very useful for clinicians treating refugee patients (Kleinman, Eisenberg, & Good, 1978; Lazare, 1979; Tseng & McDermott, 1981).

**Cultural sensitivity vs. stereotyping.** While clinicians should strive to be sensitive to cultural differences, they should at the same time be aware of the danger of over-generalization of cultural or group characteristics (McGoldrick, Pearce, & Giordano, 1982). The neglect of individual and subgroup variations could lead to damaging stereotyping and erroneous conclusions in patient evaluation.

**Commonalities of the refugee experiences.** Refugee groups differ drastically in many ways, including their cultural backgrounds, educational levels, and degree of modernization. Interestingly, despite these apparent differences, many important "commonalities" also have been consistently observed (Lin, 1986; Tyhurst, 1977). These include the process of uprooting and readjustment, the impact these experiences exert on their mental health, the psychological symptoms they are likely to develop, and the tasks they have to go through to re-establish a new life in their new homeland. An adequate understanding of these common themes will facilitate the clinician's ability to assess accurately the psychiatric status of refugee patients and to apply their experiences with one refugee group to those coming from a different group.

### Assessment Issues

As has been thoroughly reviewed by Westermeyer (1989b), skills that are required for successful assessment of refugee patients as well as patients with different cultural backgrounds are not different from those needed for the evaluation of any patient. In other words, in order to perform adequate cross-cultural interviews, one has to be first a well trained clinician. However, in addition to good clinical skills and at least some understanding of the patient's cultural background, there are also specific issues that deserve special attention. These will be briefly summarized.

**The establishment of rapport.** As the crucial first step for successful clinical interviews, this task is particularly important in cross-cultural situations. As has been discussed above, clinicians with good clinical skills and adequate understanding of cross-cultural and refugee mental health issues will have a much better chance of developing and maintaining good rapport with their refugee patients. In addition, there are other issues that also deserve special attention in this regard. For example, historical reasons, such as the existence of animosity and political friction between the cultural/ethnic groups represented by the patient and the clinician, potentially could interfere with the development of trust between the two. Unless these hidden agenda items are explored and brought into the open, they could seriously compromise the communication and the sharing of information. Conflicts and misconceptions in the role expectations between the patient and the clinician often also exist. Most refugees are unfamiliar with the role of mental health professionals and as a rule regard contact with them as potentially stigmatizing. Their encounters with psychiatric clinicians are thus potentially anxiety laden, traumatizing, and inhibitive. In order to minimize

these role conflicts, experts have suggested that clinicians identify themselves with indigenous helping agents who are more congruent with the patient's expectations and thus less threatening. A practical way for psychiatric clinicians to establish credibility with their refugee patients would be to emphasize their role as physicians or their close connection with modern medical sciences (Kinzie, 1981, 1985).

In general, clinicians should be prepared to spend more time with their refugee patients. This is necessary for several reasons: (a) many refugee patients are not fluent in English, their narratives may be slow and require frequent clarification, and the use of a translator/interpreter can further slow down the process; (b) cultural materials also will need to be explored as they come up; and (c) a systematic, longitudinal understanding of the refugee experiences is crucial and should be included as part of the initial assessment of all refugee patients. History taking should include information regarding life in the homeland (pre-refugee stage), the escape process (refugee stage), life in the refugee camp, and adjustment since resettlement (post-refugee stage). In general, it is particularly important when conducting cross-cultural evaluation to ensure that both the informant gathering and the diagnostic formulation be thorough and systematic (Kinzie, Tran, Breckenridge, & Bloom, 1980; Westermeyer, 1989b).

In terms of the interview skills, it is suggested that facilitation and clarification should be used to maximize the information flow and data gathering, but interpretation should be used with extreme care, if at all. Initially, questions that are less threatening, such as the nature and severity of various physical and behavior symptoms, might result in more productive interactions and a greater level of trust. After the clinical condition has been clarified, it usually becomes easier to bring up personal and psychosocial problems. Even in cases with severe language barriers, the careful observation of appearance, behavior, dress and grooming can yield important data. Tests of orientation, memory, fund of knowledge, and abstracting ability also can provide meaningful data if performed in a culturally appropriate manner. Finally, physical examination also can be an important source of clinical information (Westermeyer, 1989b).

Conscious efforts should be made to routinely include family members in the evaluation process. This is so not only because they often can provide additional, vital information regarding the patient's psychiatric condition and level of functioning, but even more importantly, because the meaning of family is often qualitatively different in the refugees' culture in contrast to that of contemporary Westerners. In most

traditional, non-Western societies, families rather than individuals are regarded as the basic units of the society (Lin, Masuda, & Tazuma, 1982; Lin, 1987). The sickness of a member of the family is regarded as a problem shared by all family members, rather than the individual. By excluding the family, as often is done in the Western setting, the clinician may inadvertently alienate those who are crucial to the emotional homeostasis of the patient and thus obtain only a highly skewed understanding of the nature of his or her problems.

### Diagnostic Issues

Over the past several decades, clinicians and researchers working with divergent groups of refugees have consistently reported that refugees tend to be especially vulnerable to certain psychiatric conditions. These are briefly reviewed in the following.

**Depression and somatization.** Refugees suffer from multiple and significant losses during the process of escape and resettlement and thus are likely to experience varying degrees of depression and other dysphoric symptoms. The adverse effects of the refugee experiences on their mental health status appear to be of long duration, and it is not unusual for full blown major depressive episodes to re-emerge years or even decades after the initial migration (Lin, 1986; Rumbaut & Rumbaut, 1976). The diagnosis of depression among refugees may be difficult for several reasons. First, since feelings of nostalgia, homesickness, and helplessness are so prevalent among refugees, it may be difficult to differentiate those who are going through a relatively "normal" grief reaction from those suffering from pathological depression requiring psychiatric interventions. Second, most refugees continue to experience multiple and recurrent stressful life events originating both from environmental and intrapsychic sources, and their emotional reactions tend to be complex and multi-layered. Depressive symptoms are often intermingled with anxiety and anger, making accurate assessment of their mental status a more challenging task. Third, somatization is highly prevalent among refugees, especially those with non-Western cultural backgrounds (Lin, 1986; Tyhurst, 1981). Depressed refugee patients may focus primarily on the reporting of their somatic complaints. Clinicians not familiar with this mode of expression of distress may not be able to assess accurately the psychiatric status of these patients.

**Post-Traumatic Stress Disorder (PTSD).** Recent research findings have consistently demonstrated a high prevalence of PTSD among refugee populations (Kinzie, Fredrickson, Ben, Fleck, & Karls, 1984;

Kroll, Habenicht, Mackenzie, Yang, Chan, Vang, 1989; Mollica, Wyshak, & Lavell, 1987). This is especially true among refugee groups who have experienced multiple and prolonged traumatic events before and during their escape (for example, Cambodian and Central American refugees). PTSD patients have been observed frequently to be reluctant to describe their past traumatic experiences and to deny or minimize their suffering (Kinzie, Fredrickson, Ben, Fleck, & Karls, 1984). This tendency of denial and avoidance may be more prominent among refugee patients, because they are often unsure if their stories will be believed or accepted. In addition, clinicians unfamiliar with PTSD also may miss the clues for the syndrome, because they may not be familiar with the concept of the delayed-onset type of PTSD and may expect effects and reactions related to war-trauma to be time-limited.

**Reactive psychoses.** As a reaction to extreme environmental stresses, brief reactive psychoses are expected to occur more frequently among refugees as compared to the general population (Lin, 1986). It is important for clinicians to keep this possibility in mind when assessing refugee patients with acute onset psychotic conditions. Because of the cultural and experiential gaps between the clinicians and their refugee patients, the psychopathology of refugee patients may be exaggerated, and psychotic conditions of a reactive nature may be misinterpreted as signs of more severe conditions such as schizophrenia. Such labeling may have a significant stigmatizing and detrimental effect, leading to further deterioration of the patients' condition and unfavorable long-term outcome.

**Paranoid tendency and paranoid psychosis.** Deprived of familiar cultural cues, exposed frequently to mis-communication and ambiguity in personal transactions, and subjected to real or imagined slights and discrimination, refugees in the process of attempting to adapt to their new homeland are likely to become vigilant and suspicious (Lin, Masuda, & Tazuma, 1982; Tyhurst, 1977). At times these tendencies could evolve into full-blown paranoid psychoses. In addition to a number of anecdotal reports, recent epidemiological studies also have demonstrated that the prevalence rate of paranoid psychoses is indeed significantly higher among some refugee groups (Westermeyer, 1989a).

**Hysterical conversion, dissociation, and catatonic symptoms.** Although these modes of symptom expression have become relatively rare in urban Western societies in recent years, they still are frequently seen in less industrialized, non-Western settings, as well as among recent immigrants and refugees coming from these areas (Murphy, 1982). Clinicians working with refugee patients should be familiar with these

- Kinzie, J. D., Fredrickson, R. H., Ben, R., Fleck, J., & Karls, W. (1984). Post-Traumatic Stress Disorder among survivors of Cambodian concentration camps. *American Journal of Psychiatry*, *141*, 645-650.
- Kinzie, J. D., Tran, K. A., Breckenridge, A., & Bloom, J. D. (1980). An Indochinese refugee psychiatric clinic: Culturally accepted treatment approaches. *American Journal of Psychiatry*, *137*, 1429-1432.
- Kleinman, A. (1976). Depression, somatization and the "new cross-cultural psychiatry." *Social Science and Medicine*, *11*, 3-8.
- Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and cure. *Annals of Internal Medicine*, *88*, 251-258.
- Kroll, J., Habenicht, M., Mackenzie, T., Yang, M., Chan, S., Vang, T. (1989). Depression and Post-Traumatic Stress Disorder in Southeast Asian refugees. *American Journal of Psychiatry*, *146*, 1592-1597.
- Lazare, A. (1979). *Outpatient psychiatry: Diagnosis and treatment*. Baltimore: Williams & Wilkins.
- Leff, J. (1981). *Psychiatry around the globe: A transcultural view*. New York: Marcel Dekker, Inc.
- Lin, K. M. (1986). Psychopathology and social disruption in refugees. In C. L. Williams & J. Westermeyer (Eds.), *Refugee mental health in resettlement countries* (pp. 61-73). Washington, DC: Hemisphere Publishing Corporation.
- Lin, K. M. (1987). Experiences on inpatient wards: Taiwan vs. Los Angeles. *American Journal of Social Psychiatry*, *1*, 220-225.
- Lin, K. M., Masuda, M., & Tazuma, L. (1982). Adaptational problems of Vietnamese refugees. Part III: Case studies in clinic and field: Adaptive and maladaptive. *The Psychiatric Journal of the University of Ottawa*, *7*, 173-183.
- McGoldrick, M., Pearce, J. K., & Giordano, J. (1982). *Ethnicity and family therapy*. New York: Guilford Press.
- Molica, R. F., Wyshak, G., & Lavell, J. (1987). The psychosocial impact of war trauma and torture on Southeast Asian refugees. *American Journal of Psychiatry*, *144*, 1567-1572.
- Mukherjee, S., Shukla, S., Woodle, J., Rosen, A. M., and Olarte, S. (1983). Misdiagnosis of schizophrenia in bipolar patients: A multiethnic comparison. *American Journal of Psychiatry*, *140*, 1571-1574.
- Murphy, H. B. M. (1982). *Comparative psychiatry: The international and intercultural distribution of mental illness*. Berlin: Springer-Verlag.
- Owan, T., Biatout, B., Lin, K. M., Liu, W., Nguyen, T. D., & Wong, H. Z. (Eds.) (1985). *Southeast Asian mental health: Treatment, prevention, services, training, and research*. U.S. Department of Health and Human Services, DHHS Publication No. (ADM) 85-1399.
- Rumbaut, R. D., & Rumbaut, R. G. (1976). The family in exile: Cuban expatriots in the United States. *American Journal of Psychiatry*, *133*, 395-399.
- Teng, W. S., & McDermott, J. F., Jr. (1981). *Culture and therapy: An introduction to culture psychiatry*. New York: Brunner/Mazel Publishers.
- Tyhurst, L. (1977). Psychosocial first aid for refugees. *Mental Health and Society*, *4*, 319-343.
- Tyhurst, L. (1981). Coping with refugees, a Canadian experience: 1948-1981. Presented at the Seventh SIETAR Annual Conference, Vancouver, B.C., Canada.

"classic" psychiatric symptoms and be prepared to evaluate patients suffering from these conditions.

### Summary and Conclusion

In the past decade, we have witnessed substantial progress in the research and clinical care of refugee patients with mental health problems. It is critical that such information be disseminated to professionals working with refugee patients throughout the country, so these patients receive appropriate and effective care conducive to adaptation in their new homeland. At the same time, it should be pointed out that significant achievement notwithstanding, many important issues in the field are still awaiting clarification. For example, research on PTSD among refugees is still in the beginning phase of its development. Although we are beginning to realize the enormity and tenacity of the condition, we still know little about its natural course, its relationship with adaptation and disability, as well as the cultural influences on the manifestation and the nature of the syndrome. Professionals involved in the care of refugees have the opportunity to tackle these issues and to contribute significantly not only to the understanding and care of refugees, but also to the field of cross-cultural psychiatry, as well as the whole field of psychiatry in general.

### References

- Adebimpe, V. R. (1981). Overview: White norms and psychiatric diagnosis of black patients. *American Journal of Psychiatry*, *138*, 279-285.
- Akiskal, H. S. (1989). The classification of mental disorders. In H. I. Kaplan & B. J. Sadock (Eds.), *Comprehensive textbook of psychiatry/V* (pp. 583-598). Baltimore: Williams & Wilkins.
- Fabrega, H., Jr. (1987). Psychiatric diagnosis: A cultural perspective. *Journal of Nervous and Mental Disease*, *175*, 383-394.
- Fabrega, H., Jr. (1989). Cultural relativism and psychiatric illness. *Journal of Nervous and Mental Disease*, *177*, 415-430.
- Favazza, A. R. (1985). Anthropology and psychiatry. In H. I. Kaplan & B. J. Sadock (Eds.), *Comprehensive textbook of psychiatry/V* (pp. 485-504). Baltimore: Williams & Wilkins.
- Gaw, A. (Ed.). (1982). *Cross-cultural psychiatry*. Boston: John Wright PSG Inc.
- Honigman, J. J. (1976). *The development of anthropological ideas*. Hornewood, IL: The Dorsey Press.
- Kinzie, J. D. (1981). Evaluation and psychotherapy of Indochinese refugee patients. *American Journal of Psychotherapy*, *35*, 251-261.
- Kinzie, J. D. (1985). Overview of clinical issues in the treatment of Southeast Asian refugees. In T. C. Owan (Ed.), *Southeast Asian mental health: Treatment, prevention, services, training, and research*. U.S. Department of Health and Human Services, DHHS Publication No. (ADM) 85-1399.

- Westermeyer, J. (1985). Psychiatric diagnosis across cultural boundaries. *American Journal of Psychiatry*, 142, 798-805.
- Westermeyer, J. (1989a). Paranoid symptoms and disorders among 100 Hmong refugees: A longitudinal study. *Acta Psychiatrica Scandinavica*, 80, 47-59.
- Westermeyer, J. (1989b). *Psychiatric care of migrants: A clinical guide*. Washington, DC: American Psychiatric Press.
- Williams, C. L., & Westermeyer, J. (Eds.). (1986). *Refugee mental health in resettlement countries*. Washington, DC: Hemisphere Publishing Corporation.
- Wittkower, E. D., & Prince, R. (1974). A review of transcultural psychiatry. In G. Caplan (Ed.), *Child and adolescent psychiatry, sociocultural and community psychiatry*. *American handbook of psychiatry*, Vol. II (pp. 535-550). New York: Basic Books.

## Mental Health Treatment of Refugees and Immigrants

by James M. Jaranson

To discuss the treatment of the mental health and adjustment problems of refugee and immigrant groups, one cannot avoid the overlapping issues in diagnosis and assessment as well as the use of bilingual/bicultural staff. Treatment is a most difficult subject to adequately cover briefly, not only because refugees and immigrants are so diverse, but because so much of what can be said about pharmacologic and counseling approaches is based upon assumption rather than on scientific evidence. This diversity is a critical point since selection of appropriate treatment is dependent upon demographic variables such as age, sex, and occupational or educational achievements as well as upon cultural differences, level of acculturation to the host country, degree of urbanization, history of trauma, and capacity to speak the new language. For example, groups currently entering the United States include those ranging from Vietnamese Amerasian youth and Vietnamese re-education camp survivors to larger numbers of presumably more westernized Jewish immigrants from Russia. If one looks at the first two Vietnamese groups, even though they have cultural background in common, there are still vast differences between their life experiences, strengths, weaknesses, available social support and many other factors. Not only is relatively little known about the problems of these populations, but they differ on many of the variables mentioned above. Treatment approaches should be tailored to their specific needs in order to be effective, and, in addition, the treatment we are able to offer also depends upon varying entitlements of legal status such as refugee, entrant, immigrant, or asylum-seeker.

This paper will delineate issues of importance in treating refugees and immigrants, review the types of treatment available, and ask some hopefully pertinent questions. Of necessity, general issues crossing cultural boundaries will be discussed primarily, while selecting only a few examples from specific cultures or groups.

Of primary public health importance in treating refugees and immigrants is determining selection factors for those who seek treatment in the Western systems. For example, is it only the very seriously ill who