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# Commentary

## Toward a Culturally Sensitive DSM: Cultural Bereavement in Cambodian Refugees and the Traditional Healer as Taxonomist

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Early editions of the DSM took each disorder as a psychological reaction, and etiology played a vital role; however, with DSM-III, etiology was deliberately stripped from the taxonomy in an effort to make it more standardized. Thus, in the United States, thousands of trainee psychiatrists from every ethnic or cultural background use the culture-free DSM-III and DSM-III-R as clinical templates, even when they work with patients from within their own ethnic communities. They surrender their insights from their own cultural backgrounds in the face of this monolithic yardstick. While "the new cross-cultural psychiatry" (Katon and Kleinman, 1981) has extended the thinking of many psychiatrists to allow for culturally based explanatory models of patient behavior, this thinking has had little impact on psychiatric taxonomies or on the spread of an often inappropriate biological determinism (Brody, 1990). According to Littlewood (1991), in Third World countries where funds for libraries are limited, the American Psychiatric Association standard has become, inappropriately, a virtual textbook. As such, the apparent order that it introduces into nosology is, in some important respects, illusory and damaging both to clinical practice and research. As Fabrega (1987) has pointed out, the DSM concept of psychiatric disorders as discrete real-world entities itself reflects a set of cultural assumptions. Kirmayer (1991) notes that the various forms of the Japanese diagnosis Taijin Kyofusho, viewed by Japanese psychiatrists as an extension of cultural concerns with the proper conduct of interpersonal relationships, do not constitute a single coherent syndrome for American clinicians. He makes the points that "the nature of self-consciousness, itself, is culturally shaped" (p. 24) and that for many syndromes "cultural beliefs or rules and patterns of interaction are constitutive of the disorder. In this case, there is no way to intelligibly describe the problem without invoking cultural particulars" (p. 26).

The argument for a culturally correct taxonomy has practical clinical implications. A taxonomy should have predictive validity, and it might be claimed that the DSM-III, with its culture-free bias, has it. But in the extensive DSM-III epidemiological and phenomenological field studies and questionnaire responses, it is not apparent that the data have been compared according to any criteria of patients' cultural, ethical, social, or religious backgrounds. A robust culture-free taxonomy must take shadings of culture into account. Kunitz (1987) cites the work of Faber, who pointed out that classifications of disease are not classifications of real entities and that the measure of their truth lies in their capacity to improve prognosis and therapy. Etiology was once an important classificatory principle, but, as Kunitz points out, it has receded in importance and nominalism has proliferated.

In these respects the clinical diagnosis of refugees poses a special challenge: The usual difficulties in making sense of the symptoms of people from different cultural backgrounds are compounded when they have also suffered massive trauma. Posttraumatic stress disorder (PTSD) is fast becoming the most popular DSM-III diagnosis for refugees from any cultural background. The diagnosis is often based on an ethnocentric view of health that prescribes how refugees should express their distress, how their disorders should be classified, and how the distress should be ameliorated. It offers a checklist of criteria, many of which are physical changes in the person's body that are easy to elicit and presumed to occur as a universal physiological reaction to stress, without regard to the nature of the stressor or the individual's cultural background. But as participants in the DSM-IV 1991 conference in Pittsburgh on cultural issues and psychiatric diagnosis pointed out, a psychiatric taxonomy should allow for variations in cultural background and the circumstances surrounding the trauma (Littlewood, 1991).

Physiological models of refugee reactions such as posttraumatic stress disorder (Mason, 1990) are attractive because they offer a biologically universal causal model for reactions to stress, regardless of its cultural background or nature. But not all patients from all cultures will respond similarly. A Cambodian refugee, for example, may regard his or her perceived abnormality in body or brain as caused by malevolent mystical or

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animistic forces in the new country, predestination, or deliberate interference by sorcerers and magicians, and will turn, if possible, to culturally prescribed antidotes. Illustrations come from clinical and ethnographic work with Cambodian refugee children in Boston, a group that had suffered a traumatic loss of society and culture, but seemed to have adapted rapidly. I found that they showed features of distress, not just reactions to difficulties in acculturation, that amounted to a culturally determined clinical complex that I identified as cultural bereavement. It is the experience of the uprooted person resulting from the loss of social structures, cultural values, and self-identity: The person continues to live in the past, is visited by supernatural forces while asleep or awake, suffers feelings of guilt, and feels pain if memories of the past fade, but finds constant images of the past 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 (Eisenbruch, 1984). Cultural bereavement under these circumstances may be a normal, even constructive, existential response, rather than a psychiatric illness.

Following Faber's (1930) dictum, recognizing cultural bereavement can minimize the likelihood of refugees being wrongly labeled as having psychiatric disorders. It can also detect disorder in refugees who exhibit no clinical symptoms in Western terms, shift the clinical focus from treatment to prevention, and improve the accuracy and predictive validity of diagnosis (Eisenbruch, 1991a, 1991b). It can help clinicians working with refugees to separate signs of pathology—reliving the past, for example—from signs of a consistent and culturally normal relationship between the person's past and present.

In practice, however, there are dilemmas in making a culturally relevant diagnosis when the clinical picture seems to form a "fuzzy set." Many Cambodian refugees, for example, describe themselves as having "Cambodian sickness," a constellation of chronic symptoms including lethargy, headaches, and worry about family members left behind in Cambodia. Patients may develop it in response to an anniversary, or a ceremony, or even the smell of the wind. It could be a mistake to interpret the "headache" as only another clinical symptom of a posttraumatic disorder; "headache" may be a signal for the whole complex of cultural bereavement. Western medical intervention may only compound the refugees' distress and inhibit the healthy aspects of cultural bereavement. Intervention by the Buddist monk or traditional healer, on the other hand, may successfully restore the patient's link with the past and help reintegration into the community. The traditional healer, understanding the patient's system of meaning and bearing the cultural recipes to treat him, provides the ritual antidote to cultural bereavement.

Every practitioner—whether psychiatrist or traditional healer—must start with a taxonomy organizing the patient's disorder as a basis for decisions about treatment. Although bereavement is listed under a supplementary group of conditions not attributed to mental disorder, DSM-III has no central place for bereavement, let alone cultural bereavement. Even if the psychiatrist recognizes that the patient's clinical state reflects a profound sense of bereavement in response to cultural loss, this is given no credence in the taxonomy. The DSM-IV committee's dilemma is how to incorporate people's construction of psychiatric illness and reactions to stress into the taxonomy without having to make a new DSM for each cultural group. In the Cambodian case, the severity of this challenge becomes increasingly apparent as more is known of the Khmer classification of physical, mental, and spiritual phenomena and how the assumptions of the DSM violate the logic of that classification.

The multidisciplinary mental health worker of Cambodia is the traditional healer. He classifies *ckuɔt*, the term that encompasses mental illness, behavioral difficulties, and social and community disorders, and seems to apply a consistent template based firmly on Cambodian cosmology and drawing on its entire biological, psychological, social, and ecological canvas. Even though the healers are consistent in describing the characteristics of particular *ckuɔt*, it is false to see these as discrete diagnostic groups. The healer sees *ckuɔt* as arising from a disruption in the patient's world: his brain and body are out of balance; his relationships with past lives, destiny, and ancestors are blighted; his moral conduct and behavior are violated, leaving him vulnerable to brain collapse, ancestral vengeance, and interference from evil spirits or people. In this construction, there is a seamless connection across the supernatural, moral, and physical realms, and an underlying connection across the various diagnostic groups (Eisenbruch, 1991). This connection makes the apparently unclassifiable *ckuɔt* intelligible and permits application of traditional templates to the new clinical profiles that have appeared since the massive trauma of the Pol Pot regime. The healers comprehend that, whatever its features, people can become *ckuɔt* in the wake of separation, torture, death, bereavement, and uncertainty about their future in an environment of war. They appear to treat at least some of the spectrum of psychiatric disorders promptly and effectively. While there are no controlled population studies comparing the Western and indigenous taxonomies and the effectiveness of their treatments, the indigenous Cambodian categories may have at least as good predictive validity as the DSM taxonomy. In the Khmer mind, etiology and

phenomenology are inextricably woven, whereas in the DSM logic they are pulled apart so that phenomenology, without reference to etiology, becomes central.

Before asking if Cambodian traditional healers have concepts analogous to Western concepts of stress and posttraumatic stress disorder, we need to ask how they categorize psychiatric disorders. DSM adherents might feel that the elaborate indigenous view simply translates the comfortably crisp DSM categories into formidable obscurity. It could be argued that there is nothing to be gained from imposing an added complication to our presumably culture-free taxonomy (which is itself a cultural artifact). The Cambodian traditional healer as taxonomist reveals the internally consistent logic of the Cambodian mind as so different from the linear causal thought of Western taxonomists that diagnoses such as PTSD have little meaning for them. Instead of posing such questions as whether there is a Cambodian concept of a posttraumatic reaction to stress, or whether the traditional healers have always recognized the importance of catastrophic stress as inducing *ckuɔt*, we need to understand the logic by which Cambodians and other refugees categorize the world. If we discover that they have a concept like that of PTSD, then we will be in a position to ensure that the DSM-IV or DSM-V taxonomy does not violate its rules.

Part of the American rationale for the decision to rely on clinical features rather than on etiology was to achieve freedom from competing or incompatible theoretical explanatory systems, which in one sense means freedom from the requirements of competing clinical cultures (*e.g.*, psychoanalytic and psychopharmacological). But in so doing, it ignored what the patient had to say about his or her afflictions. If the patient's cultural background attributes more importance to etiology than to clinical features, the DSM diagnosis, which works the other way, violates the person's state of mind. Hunter Jenkins (1991) and van der Kolk and van der Hart (1989) remind us of Pierre Janet's 1889 work, in which trauma was said to produce a disintegrating effect of "vehement emotion" and a cognitive interpretation leading to dissociation of memory or identity processes. These reactions are missing from a diagnostic taxonomy that relies solely on clinical phenomenology.

Janet's insights illuminate diagnosis among Cambodians. The traditional healers' taxonomy for abnormal states of mind embraces Janet's span of vehement emotion and cognitive interpretation and identity dissociation: The healer makes the diagnosis not by grouping symptoms or, for that matter, other characteristics such as the organs affected, but by metaphorically entering the world of the patient's terror or distress, identifying the whole spiritual and somatic mechanisms by which the patients feel their afflictions, and dealing promptly with the cause. To do this, the healer links the properties of each *ckuɔt* with the intent attributed to it. Some mechanisms of treatment are used only for a specific type of invading spirit causing *ckuɔt*; others are used for several, and the treatment takes on its meaning according to the idea of the underlying spirit cause. If anything, it is a distraction to concentrate only on classifying the type of *ckuɔt* when for the Cambodian healer what is really at stake is the attribution of the cause and its effect on brain and body.

Like Kirmayer (1989) and Hunter Jenkins (1991), one is left with the feeling that the DSM categories minimize or ignore the refugees' suffering, their distress and its cultural context, and may even delegitimize the relation of suffering to disease. In the case of Southeast Asian refugees, the cultural meaning of their suffering must be incorporated into the diagnosis.

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