FindArticles > Human Organization > Summer 2004 > Article > Print friendly

Training Refugee Mental Health Providers: Ethnography as a Bridge to Multicultural Practice

Gozdziak, Elzbieta M

As the number of forced migrants increases, so does the number of programs established to provide psychological help to refugees and victims of wartime violence. The expansion of such programs both in the West and in nonwestern countries indicates the prominence of mental health professionals in the refugee field. There is a widespread assumption that armed conflict and civil strife constitute mental health emergencies and all refugees and victims of wartime violence need to have an immediate access to psychological counseling and trauma programs. The role of mental health interventions in addressing refugee suffering begs the question whether existing training programs adequately prepare mental health professionals to serve diverse refugee populations. This article attempts to answer this question by analyzing the tenets of Western training programs for the helping professions. It also explores the contributions that anthropology can make to the field of refugee mental health.

Key words: refugees, mental health, biomedical training

As the number of refugees and internally displaced continues to increase, so does the number of programs established to provide psychological help for refugees and victims of wartime violence (Bracken, Giller, and Summerfield 1997). The expansion of such programs in the West and the considerable zeal with which they are exported to nonwestern countries indicate the prominence of mental health professionals in the refugee field. This prominence is based on the premise that ethnic cleansing, war, and civil strife constitute mental health emergencies. The ever-increasing role of mental health interventions in addressing refugee suffering begs the question whether mental health professionals are adequately prepared to serve ethnically, culturally, and religiously heterogeneous refugee populations. I attempt to answer this question by critiquing the growing importance of psychological trauma programs and counseling services in refugee relief operations and resettlement programs; by discussing the tenets of Western training programs for the helping professions, based primarily upon a biomedical model and Western diagnostic categories; and by exploring the contributions that anthropology can make to the field of refugee mental health.

The Growing Prominence of Refugee Mental Health Programs

Recent years have seen a tremendous increase in the number of programs addressing "post-traumatic stress" and providing counseling services to refugees (Bracken, Giller, and Summerfield 1997; Summerfield 1999). Indeed, trauma projects are becoming progressively more attractive for Western donors.

In February 1995 the European Community Humanitarian Office (ECHO) was providing financial support to 15 international NGOs from six European Union member states for psychological work in former Yugoslavia. A European Community Task Force (ECTF) review noted 185 such projects being implemented by 117 organizations. There were 10 times more projects in Croatia than in Bosnia-Herzegovina, the reason given being the state of the war. 63% of projects were offering direct psychological services and 54% ran psychologically oriented groups, mostly self-help. 33% ran psychiatric services and 63% had staff training programmes including topics like war trauma (Summerfield 1999:1452).

The expansion of such programs in the West-as documented by van Ewijk and Grifhorst (1997) in the Netherlands, Muecke (1992) in the United States, and Watters (2001) in Britain-and their export to nonwestern countries-as shown by Foster and Skinner (1990) in South Africa, Gibbs (1994) in Mozambique, and Boyden and Gibbs (1996) in Cambodia-are directly related to what Kleinman (1997) calls "medicalization of human suffering" and Hughes (1994) labels "culture of victimhood." Bracken and colleagues relate the proliferation of specialized centers for the care of refugees and torture victims to the "modernist responsibility to act" and "control the disorder provoked by suffering and loss through instituting programs of analysis and therapy" (Bracken, Giller, and Summerfield 1997:434) "that may eschew critical analysis in favor of pragmatism that proliferates, and adds credence, to bio-medical taxonomies" (Watters 2001:1710).

They argue that the tendency to establish such centers and programs results from the "spectacular growth within Western culture in the power of medical and psychological explanations for the world, and in the pronouncements of mental health professionals" (Bracken, Giller, and Summerfield 1997:436-437).

Undeniably, mental health professionals and trauma programs have acquired a new prominence in the refugee field. Shortly after the genocide in Rwanda in 1994: "there was a stampede by humanitarian agencies in the region. The first flows of destitute Tutsi refugees had scarcely abated when from afar a surprising number of agencies, many with little knowledge of the country, mobilized projects to address what they saw as mass traumatization" (Summerfield 1999:1452). In the mid-1990s, the United Nations Children's Fund (UNICEF) established a National Trauma Program in Rwanda (UNICEF 1996). The National Trauma Center, headquartered in Kigali, provided intensive therapy to traumatized children and their families. By 1996, more than 6,000 "trauma advisors" had been trained in basic trauma alleviation methods. They reportedly assisted approximately 144,000 children (Summerfield 1999:1451). Similar efforts to train mental health staff were undertaken by the United Nations High Commissioner for Refugees (UNHCR) and the World Health Organization (WHO) in Bosnia and Croatia (Summerfield 1999).

The prominence of mental health professionals in refugee camps, resettlement programs, and detention centers seems to be directly related to the "spectacular" rise in the diagnosis of post-traumatic stress disorder (PTSD) that is considered by many mental health experts a "hidden epidemic" and the most important public health problem in recent war-torn countries such as Kosovo, Bosnia-Herzegovina, Croatia, and Rwanda (Agger 1995). These assertions often influence international organizations and governments. Their mental health consultants-psychiatrists Inger Agger and Jardanka Mimica (Agger 1995 and Agger and Mimica 1996)-told the WHO and the UNHCR that some 700,000 people in Bosnia and Croatia suffered from severe trauma and were in need of urgent treatment and that local providers are able to address fewer than 1 percent of these cases. UNICEF claims that "10 million children have been psychologically traumatized by war in the past 10 years and that psycho-social trauma programs must be a cornerstone of their rehabilitation" (Bracken, Giller, and Summerfield 1997:439). I have seen similar efforts during Operation Provide Refuge, a resettlement program for Kosovar Albanians operated by the United States government in 1999 at Fort Dix, New Jersey. I have discussed the challenge to integrate indigenous coping strategies, including religious and spiritual beliefs, into the organizational response to the Kosovars' suffering elsewhere (Gozdziak and Tuskan 2000; Gozdziak 2002).

The Paucity of Forced Migration Content in University Training

The prominence of mental health interventions in addressing refugee suffering begs the question whether mental health professionals are adequately prepared to serve ethnically, culturally, and religiously heterogeneous populations. There is a consensus in mental health literature that "efficient and professional work with refugees requires professionals with special skills not normally present in community health programs, including bicultural knowledge and bilingual abilities" (Streuwe 1994:312) and that "mental health professionals need specialized training for effective service delivery to ethnically and culturally diverse consumers" (Yutrzenka 1995 in Ridley, Chih, and Olivera 2000:65). But is such training available and appropriate?

In the mid-1990s when I was on the faculty of Howard University, I managed a special initiative to enhance professional education on displaced populations, a project supported by the Fund for the Improvement of Post-Secondary Education (FIPSE) of the U.S. Department of Education. As part of that project, I conducted a national survey of approximately 1,300 departments and schools, including social work, psychology, public health, medicine, nursing, sociology, anthropology, international studies, political science, and law to identify existing courses and teaching experiences on refugees, immigrants, and international migrants. Fifty-eight percent (or 130 schools and departments) of the 224 institutions that completed the survey offered courses on refugee and immigration issues. The largest proportion of courses was offered by law schools (39 schools, 81%), followed by social work (17 schools, 33%), anthropology (15 departments, 65%), and international relations (11 departments, 79%). However, while 81 percent of participating law schools offered immigration or human rights coursework, only 30 percent of respondents representing institutions training health and mental health professionals indicated inclusion of displaced populations content in their curricula. Only one department of psychology offered a course on refugee issues and none provided internship opportunities to work with displaced populations. One

school of nursing, four schools of medicine, and seven schools of public health included forced migration content in their curricula.

With few exceptions, most courses were taught by ad junct faculty, which indicated lack of institutional commitment to these issues. Most did not offer professional degrees or certificates. Many did not have adequate financial support, thus their permanency in the academic landscape was questionable. Stellar programs in refugee studies existed at the time of the survey, including Oxford University's Refugee Studies Programme (RSP). Established in the early 1980s, it was the first academic program for professionals interested in refugee and humanitarian crises. Additional ones have been established since, including training programs at York, Tufts, Sussex, Columbia, Witwatersrand, Georgetown, and Johns Hopkins. However, with the exception of the Columbia and Johns Hopkins Schools of Public Health, none of these programs were specifically designed to train health and mental health professionals.

Ruth Krulfeld (2000:62) in a correspondence to the Anthropology Newsletter wrote about a continued need to "promote adding permanent courses on refugees and immigrants, transnationalism, and cultures of resettlement" to curricula in anthropology. I would add that there is a great need to promote refugee studies, taught from an anthropological or interdisciplinary perspective, in professional schools, particularly schools of medicine, nursing, and social work.

The Biomedical Focus of Mental Health Training

The paucity of forced migration content in university curricula is not the only, and not necessarily the greatest, problem associated with training mental health professionals. Even more disturbing is the cultural and philosophical gap between Western training programs for the helping professions, based on a biomedical model and Western diagnostic categories, and the indigenous forms of expression and classification of distress found in refugees' native cultures. Contemporary training programs for health and mental health professionals are a result of 20th century Western European and American culture (Streuwe 1994). The prevailing tenets of these programs are the individualistic framework of Western psychiatry and psychology and a worldview that privileges biology over culture. Since the biomedical model is at the core of research and training in medicine and mental health (Freidson in Kleinman 1995; Good 1994), let us look briefly at how students are initiated into this scientific paradigm and the major theoretical underpinnings of this training.

The strategy of teaching in medical schools is "to deconstruct a health problem by projecting a hierarchy of images from epidemiological slides of population-based data, through slides of individual patients, to slides at even lower levels of the biological order of pathology" (Kleinman 1995:244). Medical education commences with anatomy: "enter the human body" (Good 1994:72). In medical laboratories students "make over the body as they have known and lived it into a medical object" and are learning "a new way of seeing: along tissue planes, through gross dissection, under the microscope in finer and finer detail. Learning medicine is learning to reconstruct the world anew, medically" (Kleinman 1995:243). Students at Harvard Medical School tell how they "first learned about schizophrenia as behavior, then about genetics, and thereby came to see it as a disordered protein, still unknown, but lurking in nature as the 'concrete' locus of the affliction" (Kleinman 1995:244). For medical students, this biological reductionism is not an epistemological commitment. It is an active process of ontological genesis (objectification) of medical objects out of human problems. Writing and speaking before a clinical audience, students convert pathos into pathology and construct a person as a patient, a document, and a project (Good 1994:77). But what is suffering? And what does it mean to medicalize human suffering?

What Is Suffering?

In Writing at the Margin: Discourse Between Anthropology and Medicine, Arthur Kleinman (1995:101) defines suffering as "a universal aspect of human experience in which individuals and groups have to undergo or bear certain burdens, troubles and serious wounds to the body and spirit." Gordon W. Allport, in a forward to Victor Frankl's Man's Search for Meaning (1985:11), puts it even more succinctly: "to live is to suffer, to survive is to find meaning in the suffering." Different populations may elaborate on the cultural meaning of suffering in different ways, but suffering itself is a defining characteristic of the human condition in all societies. In most major religions, including Christianity, Judaism, Islam, Hinduism, and Buddhism, the experience of human misery, from sickness, natural disasters, accidents, violent death, and atrocity, is taken to be a vital condition of people's existential plight (Bowker 1970).

Moreover, suffering is inextricably embedded in social contexts. "No matter how true it is that there must be an individual locus of suffering, the meaning of suffering arises out of the relations of individuals together in the society, so that in consequence the social fact of suffering is more than the sum of its parts" (Bowker 1997:363).

Allen Young (1997:245) emphasizes the social dimension of suffering in the sense that it is "understood locally, by identifiable groups and communities, in the context of ideas about redemption, merit, responsibility, justice, innocence, expiation" and is "based on social codes (which include moral and religious codes)." John Bowker, author of Problems of Suffering in Religions of the World (1910) and The Meaning of Death (1991), emphasizes the contribution religions make to the definition of social suffering. He writes: "while some items of suffering can indeed be isolated and treated in abstraction, this should not distract us from remaining alert to the far wider networks of constraints that contribute causatively to human suffering" (Bowker 1997:380). Lawrence Langer (1997), writing about the Holocaust, "finds attempts to explain extreme atrocity naive, as he does the understandable but, to his way of thinking, misguided efforts to cure survivors of their trauma" (Kleinman, Das, and Lock 1997:xvii). Despite the different perspectives from which these authors approach the concept of suffering, they all return to the primacy of the phenomenological domain of experiences of suffering in a broad social context.

Suffering certainly has been an inseparable element of the experiences of refugees and "includes a range of traumas: pain, anguish, fear, loss, grief, and the destruction of coherent and meaningful reality" (Kleinman 1995:174). According to different accounts, the suffering-physical, emotional, psychological, and spiritual-of the people of Rwanda, Bosnia, and Kosovo, to name just a few, was undeniable (Malkii 1995; Gozdziak and Tuskan 2000; Gozdziak 2002). They experienced individual torture, mass violence, and human rights abuses, and endured physical and emotional wounds, pain, anguish, sorrow, distress, and anxiety. However, most of them neither appeared nor considered themselves helpless and hopeless victims.

The Kosovars I worked with at Fort Dix framed their suffering in a political and religious context. Being a refugee, a torture or rape survivor with its connotation of victimhood and powerlessness and loss of agency, did not figure in their conceptualization of themselves (Trix 2000). The Kosovars' self-identity was anchored more to who they were (Kosovar Liberation Army [KLA] fighters, political dissidents, and Muslims whose right to practice religion was violated) than to what they became in the eyes of the Western mental health providers (traumatized refugees, torture and rape victims). They sought understanding of their situation and solace for their plight in Islam and Islamic ritual (Gozdziak and Tuskan 2000; Gozdziak 2002). Their conceptualization of their own suffering and their response to the resulting trauma stood in sharp contrast to the Western propensity to medicalize human suffering.

Medicalization of Human Suffering

Medicalization is a widespread tendency to expand the meaning of medical diagnosis and the relevance of medical care. Instead of seeing itself as one element of contemporary life, medicalization of human suffering is becoming a unilaterally dominating force (Illich 1976). Medicalization refers to the way in which medical jurisdiction now encompasses many problems previously not defined as medical issues (Williams and Calnan 1996:1609). As a result of medicalization, suffering, an inherently moral category, is transformed into a psychiatric condition. An existential experience of tragedy and loss is converted into technical problems that transmogrify its existential roots (Kleinman 1995:34).

Furthermore, medicalization not only reconstructs human experiences, but also, as Illich (1976), Pupovac (2002) and Summerfield (1999) have argued, the exaltation of biomedicine may actually diminish the capacity of human beings to deal with anxiety and suffering, deny their resilience, render them incapacitated by their trauma and indefinitely dependent on external actors for their psychosocial survival. When suffering is defined as a medical problem, it is removed from a public realm and is no longer within the purview or power of ordinary people; rather it is raised to a plane where only professionals-medical or mental health care providers-can analyze and discuss it. Moreover, when refugees suffer as a result of political dissidence or generalized political violence, medicalizing their experiences removes the matter from the political and social context that produced their anguish and loss (Wellman 2000:28).

Medicalization of human suffering has resulted in the "trauma model" and the diagnostic category of post-traumatic stress

disorder. While the philosophical assumptions and concepts of the "trauma model" are rooted in Western science and psychology, the trauma model is assumed to be relevant to the needs of all societies (Pupovac 2002) and as such constitutes "an unwitting perpetuation of the colonial status of the non-Western mind" (Summerfield 2000:422). The trauma model is dominated by a value system of humanistic psychology that promotes self-assertion, autonomy, and relativity in values and situational ethics (Bergin 1980). These values are very different from the values of many refugees, political dissidents, and torture survivors, who stress interdependence and deference to authority in social relationships. Even when mental health professionals acknowledge cultural differences in the response to adversity, they still assume that refugees, torture, and mass violence survivors must be traumatized (Pupovac 2002) and in need of urgent professional assistance without which they will be unable to recover (Summerfield 1999). Additionally, in contemporary Anglo American culture, trauma confirms suffering and confers moral status and the basis for legal rights, so there is readiness for individuals to identify themselves as traumatized (Brown 1995). It is in this context that PTSD has become an attractive diagnosis (Dean 1997; Summerfield 2001).

In other societies where trauma does not grant the same status, individuals do not like to identify themselves as traumatized and tend to exhibit stoicism. As indicated above, in most major religions, suffering is taken to be a vital condition of people's existential plight (Bowker 1970). The Buddhist influenced worldview, for example, teaches that hardship and suffering are a given in life and that complaints are a sign of weakness and lack of character. Thus, suppression is the usual way of coping with trauma (Morris and Silove 1992).

The dichotomy in the conceptualization of human suffering suggests two basic responses to refugees' suffering: 1) an approach based on the adaptation of Western psychiatric diagnostic categories; and 2) a strategy based on the exploration of indigenous forms of expression and classification of distress. However, it is the first approach that is almost exclusively taught in medical schools and psychology departments. Almost all theories and data of contemporary psychiatry and psychology come from Western populations (e.g., Europeans, Americans of European ancestry, and Australians), yet 70 percent of humans live in nonwestern societies (Triandis 1995). In addition, most psychiatric studies are carried out on clinical populations and thus ignore the social processes that select patients appropriate for Western treatment. Also, such studies do not include forms of distress that lie outside the range of questions and observations dictated by interview schedules based on the Western classification of distress (Kirmayer 1989).

And yet American medical schools and residency programs, as well as social work and psychology programs, routinely expect students to pass examinations based on the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association 1994). Many mental health workers use DSM categories to diagnose refugee distress. For example, the diagnosis of PTSD in this nosology is increasingly applied to refugees despite the fact that refugees' distress may be a normal, even constructive, existential response to their suffering (Eisenbruch 1991). For refugees who draw upon cosmologies different from those used in the West to explain their suffering, there is little room for a taxonomy that until very recently has been void of the term "culture" (Briody in Eisenbruch 1991).

Additionally, few mental health professionals are trained either to understand religious belief or to treat it sympathetically (Post 1990). Spiritual and theological precepts are conspicuously absent in psychiatric training (Eng 1998). Furthermore, it was only with the publication of the fourth edition of the DSM that the negative bias and stereotypes of religious persons were removed from official psychiatric nomenclature (Post 1992; Lukoff, Lu and Turner 1998). Despite the fact that religion is one of the strongest components of culture and helps people adapt to and manage extreme stress and traumatic events, individualization-the main axiom of Western psychiatry-theoretically explains many components of religion-based behavioral differences as repressive and undesirable.

Ethnography as a Bridge to Refugee Mental Health Practice

I could go on citing additional arguments why Western psychiatry and psychology are ill equipped to serve refugees, but let me turn to more important questions instead: What can be done to remedy the existing situation in academic mental health training? Can anthropology help? How can we best contribute to the field of refugee mental health?

One thing is clear to me: anthropology has much to offer the world of biomedical training and research. But out of a vast

array of anthropological knowledge and skills, what can we offer students of psychiatry, psychology, or social work? After two decades of experience as a practicing anthropologist in the area of international migration, I have come to the conclusion that many of the substantive studies of the traditional targets of anthropological research are woefully out of date and of limited utility. For example, the relationship of Evans-Pritchard's work to our understanding of the psychosocial well-being of Nuer refugees resettled in Minnesota or lingering in refugee camps in Africa is much as de Toucqeville's writing was to all of us following the last presidential election's recounts in Florida. While both may provide interesting insights, the outdated ethnographic detail neither makes mental health professionals culturally competent nor did it speed the recount. Merely imparting information on different cultures has been found to insufficiently prepare medical or social work students for cross-cultural practice (Thornton and Garret 1995). There are too many diverse refugee groups to provide meaningful information on even the largest ones. Moreover, students presented with lists of cultural characteristics of specific refugee populations "may develop stereotyped views and assumptions that will not serve them well in dealing with individuals" (Thornton Garret 1995:67). Reliance on normative data may lead to what Ridley, Chih, and Olivera (2000) call "unintentional racism."

Some utility may be derived from "ethnographies that canvassed concepts of coping styles, and ideas about and reactions to illness generally and mental illness in particular" as well as studies of "cultural beliefs about depression, bereavement, anxiety, and cultural influences on the ways emotions and mental disorders are experienced, including responses to psychiatric treatment" (Kleinman 1988a:148). However, the real contributions that anthropology can make to refugee mental health are its methods and underlying epistemology. In my opinion, ethnography is the real bridge to multicultural mental health practice with refugees.

"Ethnography is the work of describing a culture" (Spradley 1979:3). According to Spradley (ibid.), the goal of ethnography is to "understand another way of life from the native point of view" or, as Malinowski put it, "to grasp the native's point of view, his relation to life, to realize his vision of his world" (Malinowski 1922:25, emphasis in original). "Rather than studying people, ethnography means learning from people" (Spradley 1979:3, emphasis in original). Ethnography "offers health professionals the opportunity of seeing health and diseases through the eyes of patients from a myriad of cultures" (Spradley 1979: iv). In psychiatric practice, ethnographic methods, including ethnographic interviewing, participant observation, and domain, structural, and taxonomic analyses, can be used to "elicit ethnopsychiatric beliefs of patients and families" and "evaluate the influence of cultural rules on abnormal behavior," as well as to "improve cross-cultural and cross-ethnic communication in the clinical interaction" (Kleinman 1988a:149).

There has been much discussion about the utility of ethnographic methods and theory to the study of refugee mental health, as evidenced by a recent volume on Psychosocial Wellness of Refugees: Issues in Qualitative and Quantitative Research, edited by Frederick Ahearn (2000). The volume includes articles by noted researchers who discuss technical issues-such as sample selection, measurement, reliability and validity, refugee narratives, and the ability to generalize findings-involved in researching the emotional and social impact of forced migration on refugees from Afghanistan, Cambodia, Vietnam, Palestine, Cuba, Nicaragua, Haiti, Bosnia, and Chile.

Patricia Omidian (2000) debates the advantages of ethnographic investigation, with particular focus on issues of sampling, reliability, and validity, in the context of her research on health issues among Afghan refugees resettled in California. In a rare self-analysis, Joseph Westermayer (2000) assesses the interplay between qualitative (including ethnography) and quantitative methods in his own research among Hmong refugees, as well as the influence of several anthropologist-mentors on the development of his research agenda. Marita Eastmond (2000) discusses the usefulness of an ethnographic method of inquiry in exploring the suffering and illness of refugees from Chile, Bosnia, and Guatemala. She argues that "Anthropology's ethnographic approach situates health and illness, as a system of knowledge and practice and as lived experience, in the contexts of the local social world of the people concerned" (Eastmond 2000:68). Eastmond further contends that anthropological methods and theory allow mental health providers to move "beyond a narrow medical or psychiatric focus" and explore "suffering and illness as socially and culturally mediated phenomena" (ibid.:83). According to Eastmond (2000:68), "Such a contextualized approach may provide a vital contribution of knowledge to the clinical encounter, and in cross-cultural context of research in particular, this kind of qualitative enquiry may generate knowledge about indigenous understandings and management of ill health as a vital basis for subsequent epidemiological

and other quantitative investigations."

There is also a growing discourse on the role of ethnography in clinical practice, including clinical encounters with refugees. Eastmond (2000:84-85) emphasizes that "An ethnographic approach can also be a vital tool in clinical assessments of treatment, expanding the restricted context of the clinical encounter as well as the bases of the clinician's understanding, thus bridging anthropological and clinical traditions." Given the dynamics of refugee lives, she points out the usefulness of narratives and life stories to elicit "narrativex of suffering" (Eastmond 2000:76, emphasis in original). Herbst and Robin (1992), Lifton (1993), and Woodcock (1997) have also discussed how narratives can be used as therapeutic tools.

Arthur Kleinman, a Harvard psychiatrist and anthropologist, has been "writing at the margin" of anthropology and medicine for the past several decades. He has been exploring the many ways psychiatry could benefit from greater knowledge of the concepts and methods of anthropology and conveying the relevance of cultural perspective for psychiatric practitioners (Kleinman 1988a); arguing for an ethnographic approach to moral practice in medicine and providing a provocative analysis-using an anthropological perspective-to indicate how biomedical concepts fail to incorporate the social worlds of patients (Kleinman 1995); and using ethnography to reconstruct patients' "illness narratives" (Kleinman 1988b). In Rethinking Psychiatry: From Cultural Category to Personal Experience, Kleinman (1988a) goes even further. He not only discusses the application of anthropological methods (ethnographic techniques) in clinical settings and describes the place of anthropological concepts and perspectives in psychiatric education and practice; he also provides a blueprint for "teaching anthropology at different levels and in different contexts of psychiatry" (Kleinman 1988a:153). Kleinman's (1988a:153-159) scheme calls for inclusion of anthropological concepts and ethnographic methods at different levels of psychiatric training, including:

1. Introductory level, where psychiatric training should foster "attitudes that are sensitive to the importance of eliciting patient and family perspectives on the illness and treatment, and that are open to alternative points of view (religious, common-sense, etc.)."

2. Intermediate level, where "anthropology is most effectively taught in clinical settings, in the pragmatic context of patient care" and where residents are required "to make supervised home visits to their patients' communities so that they can have the experience of participant-observation, if ever so briefly, in the local cultural context." At this level residents can be trained in the "creation of mini-ethnography of the patient's experience of illness (that) is based on an interpretation of the patient's and family's narrative of the illness. Clinicians can use these mini-ethnographies "as the background against which to make sense of later experiences and especially problems in care. The report of the mini-ethnography is the appropriate material from which supervisors can assess the trainee's practice and particularly his skill in clinical interpretation." At the intermediate level, residents should also acquire skills in eliciting patient and family explanatory models of illness (Kleimnan 1980) and "learn to describe and conceptualize culturally based problems affecting the patient and his family's perception of symptoms and communication of distress and coping responses." This level is also an "appropriate setting to acquire competence in working through translators."

3. Advanced level, which will include "reading courses that support trainees' efforts to do small (archival or field) research projects that can be critically evaluated and written up for publication as research papers" and "focused ethnographies by advanced trainees of the local mental health system and the local social system within which its patients dwell (that) can complement critical reviews of the international literature in psychiatry to contribute to the building of such culturally appropriate psychiatry."

Kleinman's proposal stressing the interface between anthropology and psychiatry emphasizes the many contributions that anthropology can make to clinical practice with refugees, including: 1) the integration of emic (the insider's) and etic (the outsider's) perspectives to arrive at a complete understanding of refugees' suffering; 2) the importance of trauma narratives and the meaning of the illness experience; and 3) the importance of understanding and acting "on the social and political determinants of health and human suffering, while staying aware of the particular stakes and interests of a given perspective and of the great cultural diversity of individual and collective coping responses" (Pedersen 2002:188) found in refugee communities.

References Cited

Agger, Inger

1995 Theory and Practice of Psychosocial Projects under War Conditions in Bosnia Hercegovina and Croatia. Zagreb: European Commission Humanitarian Aid Office/European Commission on Tribal Filipinos.

Agger, Inger, and Jardanka Mimica

1996 Psycho-Social Assistance to Victims of War in BosniaHercegovina and Croatia: An Evaluation. Brussels: ECHO.

Aheam, Frederick L., ed.

2000 Psychosocial Wellness of Refugees. Issues in Qualitative and Quantitative Research. New York: Berghan Books.

American Psychiatric Association

1994 Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Washington, D.C.: American Psychiatric Association.

Bergin, Allen E.

1980 Psychotherapy and Religious Values. Journal of Consulting Psychology 48:95-105.

Bowker, John W.

1970 Problems of Suffering in Religions of the World. Cambridge: Cambridge University Press.

1991 The Meaning of Death. Cambridge: Cambridge University Press.

1997 Religion, Society, and Suffering. In Social Suffering. Arthur Kleinman, Veena Das, and Margaret Lock, eds. Pp. 359-381. Berkeley: University of California Press.

Boyden, Jo, and Sara Gibbs

1996 Vulnerability and Resilience: Perceptions and Responses to Psycho-Social Distresses in Cambodia. Oxford: Basil Blackwell.

Bracken, Patrick, Joan E. Giller, and Derek Summerfield

1995 Rethinking Mental Health Work with Survivors of Wartime Violence and Refugees. Journal of Refugee Studies 10:431-442.

Brown, Wendy

1995 States of Injury: Power and Freedom in Late Modernity. Princeton, N.J.: Princeton University Press.

Dean, Eric T.

1996 Shook Over Hell: Post-Traumatic Stress, Vietnam and Civil War. Cambridge, Mass.: Harvard University Press.

Eisenbruch, Maurice

1991 From Post-traumatic Stress Disorder to Cultural Bereavement: Diagnosis of Southeast Asian Refugees. Social Science & Medicine 33:673-680.

Eng, Alaine L.

1997 Faith and Psychology: Integration or Separation. Journal of Religion and Health 37:45-47.

Eastmond, Marita

2000 Refugees and Health: Ethnographic Approaches. In Psychosocial Wellness of Refugees. Issues in Qualitative and Quantitative Research. Frederick L. Aheam, ed. Pp. 67-87. New York: Berghan Books.

Ewijk, Mirjam Van, and Paul Grifhorst

1997 Controlling and Disciplining the Foreign Body: A Case Study of TB Treatment Among Asylum Seekers in the Netherlands. In The New Migration in Europe: Social Constructions and Social Realities. Khalid Koser and Helma Lutz, eds. Pp. 242-259. London: MacMillan.

Foster, Don, and Donald Skinner

1990 Detention and Violence: Beyond Victimology. In Political Violence and the Struggle in South Africa. N. Chabani Manganyi and Andre du Toit, eds. Pp. 205-233. London: McMillan.

Frankl, Victor E.

1985 Man's Search for Meaning. New York: Washington Square Press.

Freidson, Elliot

1986 Professional Powers. Chicago: University of Chicago Press.

Gibbs, Sara

1994 Post-War Reconstruction in Mozambique: Reframing Children's Experience of Trauma and Healing. Disasters 18:268-276.

Good, Byron J.

1994 Medicine, Rationality, and Experience: An Anthropological Perspective. Cambridge: Cambridge University Press.

Gozdziak, Elzbieta M.

2002 Spiritual Emergency Room: The Role of Spirituality and Religion in the Resettlement of Kosovar Albanians. Journal of Refugee Studies 15:136-152.

Gozdziak, Elzbieta M., and John J. Tuskan, Jr.

2000 Operation Provide Reuige: The Challenge of Integrating Behavioral Science and Indigenous Approaches to Human Suffering. In Rethinking Refuge and Displacement. Selected Papers on Refugees and Immigrants. Volume VIH. Elzbieta M. Gozdziak and Dianna J. Shandy, eds. Pp. 194-225. Fairfax, Va.: American Anthropological Association.

Herbst Robin, Patricia K.

1992 From Helpless Victim to Empowered Survivor: Oral History as a Treatment for Survivors of Torture. In Refugee Women and Their Mental Health: Shattered Societies, Shattered Lives. Ellen Cole, Olivia M. Espin, and Esther D. Rothblum, eds. Pp. 141-154. New York: Norwood.

Hughes, Robert

1994 The Culture of Complaint. Glasgow: Harper Collins.

Illich, Ivan

1976 Medical Nemesis: The Expropriation of Health. New York: Pantheon Books.

Kirmayer, Lawrence J.

1989 Cultural Variations in Response to Psychiatric Disorder and Emotional Distress. Social Science & Medicine 29:327-339.

Kleinman, Arthur

1980 Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry. Berkeley: University of California Press.

1988a Rethinking Psychiatry: From Cultural Category to Personal Experience. New York: Free Press.

1988b The Illness Narratives: Suffering, Healing and the Human Condition. New York: Basic Books.

1995 Writing at the Margin. Discourse Between Anthropology and Medicine. Berkeley: University of California Press.

Kteinman, Arthur, Veena Das, and Margaret Lock

1997 Social Suffering. Berkeley: University of California Press.

Krulfeld, Ruth

2000 From Ruth Krulfeld. Anthropology Newsletter, April:62.

Langer, Lawrence L.

1997 The Alarmed Vision: Social Suffering and Holocaust Atrocity. In Social Suffering. Arthur Kleinman, Veena Das, and Margaret Lock, eds. Pp. 47-65. Berkeley: University of California Press.

Lifton, Robert J.

1993 From Hiroshima to the Nazi Doctors: The Evolution of PsychoFormative Approaches to Understanding Traumatic Stress Syndromes. In International Handbook of Traumatic Stress Syndromes. J. P. Wilson and B. Raphael, eds. Pp. 11-24. New York: Plenum Books.

Lukoff, David, Francis Lu, and Robert Turner

1998 From Spiritual Emergency to Spiritual Problem: The Transpersonal Roots of the New DMS-IV Category. Journal of Humanistic Psychology 38(2):21-50.

Malkki, Liisa H.

1995 Purity and Exile. Violence, Memory and National Cosmology among Hutu Refugees in Tanzania. Chicago: University of Chicago Press.

Malinowski, Bronislaw

1922 Argonauts of the Western Pacific. London: Routledge.

Morris, Patrick, and Derrick M. Silove

1992 Cultural Influences in Psychotherapy with Refugee Survivors of Torture and Trauma. Hospital and Community Psychiatry 43:820-824.

Muecke, Marjorie A.

1992 New Paradigms For Refugee Health Problems. Social Science & Medicine 35:515-523.

Omidian, Patricia A.

2000 Qualitative Measures and Refugee Research: The Case of Afghan Refugees. In Psychosocial Wellness of Refugees. Issues in Qualitative and Quantitative Research. Frederick L. Ahearn, ed. Pp. 41-66. New York: Berghan Books.

Pendersen, Duncan

2001 Political Violence, Ethnic Conflict, and Contemporary Wars: Broad Implications for Health and Social Well-Being. Social Science & Medicine 55:175-190.

Post, Stephen E.

1992 DSM-III and Religion. Social Science & Medicine 35:81-90.

Pupovac, Vanessa

2002 Therapeutising Refugees, Pathologising Populations: International Psychological Programmes in Kosovo. New Issues in Refugee Research. Working Papers No. 59. Geneva: UNHCR.

Ridley, Charles R., David W. Chih, and Ronald J. Olivera

2000 Training in Cultural Schemas: An Antidote to Unintentional Racism in Clinical Practice. American Journal of Orthopsychiatry 70:65-72.

Spradley, James P.

1979 The Ethnographic Interview. New York: Holt, Rinehart and Winston.

Streuwe, Goran

1994 Training Health and Medical Professionals to Care for Refugees: Issues and Methods. In Amidst Peril and Pain. Anthony J. Marsella, Thomas Borneman, Solvig Ekblad, and John Orley, eds. Pp. 311-324.Washington, D.C.: American Psychological Association.

Summerneid, Derek

1999 A Critique of Seven Assumptions Behind Psychological Trauma Programmes in War-Affected Areas. Social Science & Medicine 48:1449-1462.

2000 Childhood, War, Refugeedom and "Trauma": Three Core Questions for Mental Health Professionals. Transcultural Psychiatry 37:417-433.

2001 The Invention of Post-Traumatic Stress Disorder and the Social Usefulness of a Psychiatric Category. British Medical Journal 322(7278):95-98.

Thornton, Serene, and Rendra J. Garret

1995 Ethnography as a Bridge to Multicultural Practice. Journal of Social Work Education 31:67-74.

Triandis, Harry C.

1995 Individualism and Collectivism. Boulder, Colo.: Westview Press.

Trix, Frances

2000 Reframing the Forced Migration and Rapid Return of Kosovar Albanians. In Rethinking Refuge and Displacement. Selected Papers on Refugees and Immigrants. Volume VIII. Elzbieta M. Gozdziak and Dianna J. Shandy, eds. Pp. 250-275. Fairfax, Va.: American Anthropological Association.

UNICEF

1996 UNICEF Survey Documents Horrors Experienced by Rwandan Children During 1994 Genocide. New York: UNICEF CF/DOI/PR/1996-08.

Watters, Charles

2001 Emerging Paradigms in the Mental Health Care of Refugees. Social Science & Medicine 52:1709-1718.

Wellman, David

2000 From Evilto Illness: Medicalizing Racism. American Journal of Orthopsychiatry 70:28-32.

Westermayer, Joseph

2000 Qualitative and Quantitative Research among Hmong Refugees: An Analysis. In Psychosocial Wellness of Refugees. Issues in Qualitative and Quantitative Research. Frederick L. Ahearn, ed. Pp. 208-233. New York: Berghan Books.

Williams, Simon J., and Michael Calnan

1996 The "Limits" of Medicalization?: Modern Medicine and the Lay Populace in "Late" Modernity. Social Science & Medicine 42:1609-1620.

Woodcock, Jeremy

1997 Group Work with Refugees and Asylum Seekers. In Race and Group Work. T. Mistry and A. Brown, eds. Pp. 254-277. London: Whiting and Birch.

Young, Allen

1997 Suffering and the Origins of Traumatic Memory. In Social Suffering. Arthur Kleinman, Veena Das, and Margaret Lock, eds. Pp. 245-260. Berkeley: University of California Press.

Yutrzenka, Barbara A.

1995 Making a Case for Training in Ethnic and Cultural Diversity in Increasing Treatment Efficacy. Journal of Consulting and Clinical Psychology 62:197-296.

Elzbieta M. Gozdziak is research director at the Institute for the Study of International Migration (ISIM) in the School of Foreign Service at Georgetown University in Washington, D.C. (e-mail: emg27@georgetown.edu). I am indebted to Dianna J. Shandy of Macalester College for organizing a session on Pedagogy, Publics, and Politicized Places for the 2000 annual meeting of the American Anthropological Association in San Francisco, where an earlier version of this paper was presented.

Copyright Society of Applied Anthropology Summer 2004
Provided by ProQuest Information and Learning Company. All rights Reserved