Primary Care Needs of Cambodian Refugees

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Cambodian refugees who endured the Pol Pot regime experienced a horrendous assault on their physical and mental health. The complaints and diagnoses of 168 Cambodian refugees who presented to a family medicine primary care clinic between 1985 and 1987 were examined. Fourteen of these patients were visited in their homes to obtain in-depth perspectives of their health beliefs and needs. The results support the growing awareness that Cambodian refugees require sensitive and sophisticated approaches to dealing with widespread emotional and physical dysfunction. **J Fam Pract 1990; 30:565-568.**

Since 1975 over 800,000 refugees from Southeast Asia have immigrated to the United States. The largest number of these have settled in California. Initial health care focused on infectious disease considerations of hepatitis, on parasites, and on diseases endemic in the third world. Assessments of refugees' adaptation to the United States in the first few years seemed to indicate remarkably high levels of function and a less than expected incidence of mental health problems.[1–4] Further evaluation revealed a significant difference between the better educated, more highly skilled refugees in the first wave of immigration from 1975 to 1978 and the second wave of war refugees in 1978 and 1979. Different investigators also began to appreciate some of the cultural characteristics of these refugees and how standard tools for assessing adaptation and mental well-being in westernized populations might not be appropriate for these refugees.[5–8]

Researchers at several mental health clinics focusing on refugee psychiatric problems have begun to document the previously undetected extent of significant psychological problems in this population. Mollica et al[9] in Boston, Westermeyer et al [10–12] in Minnesota, and Kinzie and Fleck[13] in Portland, Oregon, have documented the extent and severity of depression and post-traumatic stress disorder in Southeast Asian refugees, particularly those in the second wave of immigration. Cambodian refugees who suffered from the atrocities of the Pol Pot regime appear to be the most severely compromised.

A consistent pattern of somatization in Southeast Asian refugees and cultural inhibition in identifying mental health problems have been described. Kinzie[14] discusses the approach in his clinic of adopting a medical model that would be less threatening to the patients. This model minimizes the distinction between physical and mental health care problems and emphasizes the patients' adaptational issues to family and community. Several of the authors stressed the need to approach these problems from a chronic perspective and to investigate the natural history of adaptational problems and the post-traumatic stress disorder.

The study reported here was designed to explore health problems brought to a family medical center at the University of California, San Diego (UCSD) School of Medicine by Cambodian refugees. The study sought to discover any common symptom patterns associated with common biomedical and psychosocial problems among these refugees. Because of the Cambodians' previously documented tendency to somatize psychosocial problems, it was hypothesized that the patients may be at risk for polypharmacy and drug interactions that could result from frequent visits for somatic complaints. For over 8 years the Family Medical Center at UCSD School of Medicine has included didactic and clinical consultations in cross-cultural health care in the Family Practice Residency Program. The Family Medical Center has been an important site for the care of Southeast Asian refugees in metropolitan San Diego including Cambodian, Vietnamese, and Laotian. Psychologists, social workers, and

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translators experienced in cross-cultural health care are available to the residents when seeing patients.

METHODS

Chart Audits

Medical charts of Cambodian patients seen at the Family Medical Center during the years 1985 to 1987 were audited. The patients were identified by a computer printout of all patients seen at the center self-identified as Asian. The list of patients was then reviewed by Cambodian and Laotian translators, who identified the nationality of the patients by surnames. Of 252 charts selected, 168 patients were identified to be of Cambodian ethnicity and over 15 years of age. A medical student (S.W.) was trained to audit the charts for demographics, diagnoses, and symptoms documented on the problem lists or in the progress notes. Data on prescribed medications were collected and reviewed.

Home Visits

A team composed of a faculty nurse practitioner, a clinical psychology graduate student, and a Cambodian translator conducted 3- to 4-hour in-home interviews on 14 (8.3%) of these patients. Patients were selected randomly, and the first 14 consenting patients contacted by telephone were selected. The nurse practitioner interviewed patients regarding health beliefs and practices using open-ended interviews. The Hopkins Symptom Checklist-25[15] and a questionnaire of symptoms suggestive of post-traumatic stress disorder were administered by a clinical psychology graduate student. Reliability of both scales was estimated by their internal consistency utilizing Cronbach's alpha (α).

RESULTS

Table 1 presents the most commonly documented diagnoses from the problem lists and progress notes. The mean age of the patients was 43 years with a range of 17 to 78 years; 67.3% were female and 32.7% male. One half (48.2%) were married, 10.1% single, 13.7% widowed, 2.4% separated, and 1.2% divorced. For 24.4%, the marital status could not be determined from the chart. The number of years patients had resided in the United States averaged 5.7 years (ranging from 2 to 10 years), and the mean length of time they had been followed in the Family Medical Center was 4.14 years, with a mean number of visits being 10.9 (ranging from 1 to 91).

TABLE 1. CHARTED DIAGNOSES OF CAMBODIAN REFUGEES IN A FAMILY MEDICAL CENTER (N = 168)

Diagnosis	Number	Percent
Depression	61	36.3
Post-traumatic stress disorder	8	4.8
Psychosis	6	3.6
Anxiety disorders	4	2.4
Manic-depressive illness	0	0
Situational adjustment reaction	3	1.8
Abdominal pain (nonspecific)	50	29.8
Abdominal pain (specific diagnoses*)	15	9.0
Joint pain (nonspecific)	28	16.7
Joint pain (specific diagnoses†)	19	11.3
Back pain	31	18.5
Headache (tension or nonspecific)	76	45.2
Migraine	3	1.8
Chest pain (nonspecific)	13	7.7
Fatigue	53	31.5
Dizziness (nonspecific)	40	23.8
Asthma	5	3.0
Hypertension	13	7.7
Anemia	18	10.7
Coronary artery disease	1	0.6

**Peptic ulcer, cholelithiasis, esophagitis, irritable bowel syndrome.*
†Rheumatoid arthritis, osteoarthritis, acute sprain.

Somatic complaints with or without psychiatric diagnoses were analyzed. Eighty percent of the 61 patients with the diagnosis of depression also reported at least two nonspecific complaints as follows: headache, abdominal pain, backache, joint pain, chest pain, dizziness, or fatigue. The difference in number of depressed patients with two or more somatic complaints compared with the nondepressed patients was statistically significant ($t = -5.45$; $P = .000$). When individual somatic symptoms were examined (Table 2), the depressed patients had significantly more headache, fatigue, dizziness, and weight loss. Other significant mean differences of the depressed group included more prescriptions for chronic medications (4.7 to 1.2) and more frequent office visits (almost twice as fre-

TABLE 2. COMPARISON OF DOCUMENTED SYMPTOMS IN DEPRESSED (N = 61) VS NONDEPRESSED (N = 107) CAMBODIAN PATIENTS

Symptom	Depressed Patients No. (%)	Nondepressed Patients No. (%)	*t* Value	*P* Value
Abdominal pain	19 (31)	31 (29)	−.29	.770
Joint pain	12 (20)	16 (15)	−.76	.448
Back pain	13 (21)	18 (17)	−.70	.485
Headache	42 (69)	34 (32)	−4.95	.000
Chest pain	6 (10)	7 (7)	−.73	.469
Fatigue	30 (48)	24 (22)	−3.30	.001
Dizziness	21 (34)	19 (18)	−2.33	.022
Weight loss	17 (28)	9 (8)	−3.05	.003

quent). The depressed patients began receiving health care at the Family Medical Center more recently than the nondepressed patients.

Of the patients with a diagnosis of depression, 74% had been prescribed tricyclic antidepressants, 16% antipsychotic medications, 8% benzodiazepines, and 13% hypnotics. Sixty-one percent had been prescribed nonsteroidal anti-inflammatory analgesics. Despite the higher number of medications prescribed for chronic conditions over the years to this group, when the charts were reviewed case by case for medications prescribed during any particular time, no significant mean difference in risk for drug interactions could be detected.

Men were as likely to be depressed as women. No significant difference between the depressed and the nondepressed patients in terms of how many years they had been in the United States was found. If patients had three or more somatic complaints without specific biomedical diagnoses, then almost all were diagnosed with depression (four were not). Of those with two somatic complaints, 42% were not diagnosed with depression.

Some of the more conventional symptoms of depression were either not found or simply not documented for these patients. The symptoms of insomnia, anhedonia, and anorexia were each identified only once. Crying spells and nightmares were documented in nine patients' charts.

The information obtained in the home visits verified not only the extent but also the severity of psychological distress. The Hopkins Symptom Checklist-25 rates anxiety and depressive symptoms on scales from 0 to 4.00. It has been validated in multiple studies of Southeast Asian groups to reliably reflect significant psychological distress with scores above 1.75.[15] All patients interviewed had scores on the anxiety scale over 1.75 (mean 3.22, SD = 0.70). Thirteen of 14 had depression scores over 1.75 (mean 3.17, SD = 0.69). Anxiety disorders were documented in the charts for only four (2%) patients, with another eight (5%) having a diagnosis of post-traumatic stress disorder.

The questionnaire addressing signs and symptoms of post-traumatic stress disorder was synthetically designed for this study, using the *Diagnostic and Statistical Manual of Mental Disorders,* 3rd Edition, Revised (DSM-III-R) criteria for post-traumatic stress disorder. There continues to be debate regarding the validity of the diagnosis. Even if the diagnosis is recognized, most authorities maintain it must be given only after an extensive psychiatric interview.[16–18] This scale must be considered exploratory, therefore, but the results were striking. Of the 14 patients interviewed, 13 (93%) responded with strongly affirmative answers that would fulfill all four criteria of the DSM-III-R criteria for post-traumatic stress disorder. The Cronbach α was computed (.97) for this scale, indicating excellent internal consistency.

The in-home visits also provided alternative perspectives on polypharmacy and the risks of drug interactions issues. The concept of taking medications on a long-term basis or of tolerating side effects was very foreign to the patients; therefore, many were not taking the prescribed medications. When the interview team reviewed the patients' medications, however, they discovered the Cambodian refugees were receiving prescription medications from health care providers other than those at the Family Medical Center.

The patients who were visited at home were a convenience sample. Time and financial constraints on this pilot project limited further data collection. Because of the sensitive nature of many of the patients' problems, it was felt to be inappropriate to press for reasons why some patients declined home interviews.

DISCUSSION

A focused effort to educate residents to the social, cultural, and psychological needs of Southeast Asian refugees has been a program goal of the UCSD Family Practice residency program for the past 8 years. The sensitivity to detecting psychiatric problems in refugees might therefore be higher in this clinic than in a typical community practice. Certainly the prevalence of depression as a documented diagnosis was significant, but the in-home visit data and the number of patients with multiple somatic complaints suggest that the true instance of depression may still be underdiagnosed. Of course, while continuing to be alert for psychological problems, the providers must also be alert to reviewing any progression or changes in the somatic symptoms in case a discrete medical diagnosis is in the process of evolution. The multiplicity of somatic complaints that do not progress may be the best clue to a clinician to reevaluate for a psychological problem. In this study, the most suggestive symptoms for depression were headache, fatigue, dizziness, and weight loss.

Perhaps the most provocative finding was the low incidence of chart-documented anxiety disorders or post-traumatic stress disorder compared with the findings of more systematic psychological evaluation in the home visits. There may be several reasons for this difference. First, the responses necessary to support the diagnosis of post-traumatic stress disorder are less frequently elicited during the routine of a normal office interview. Indeed, during the home visit the Cambodian translator found it necessary to rephrase some of the words in the DSM-III-R criteria for post-traumatic stress disorder. For example, patients would not say they had difficulty "loving" family and friends after the Pol Pot era, but they would

acknowledge that they had some or extreme difficulty in "opening their hearts" to family or friends. The patients' subjective experiences of anxiety were frequently interpreted as religious, mystical, or supernatural phenomena; unless the physicians phrased questions using those terms or were accepting of descriptions using those perspectives, they would not obtain the information necessary to diagnose anxiety disorders. The biochemical hypotheses for depression could be translated into the physical correlates of sadness and grief that were more culturally acceptable to the Cambodians. Perhaps depression was more likely to be diagnosed because there is a more clearly accepted pharmacologic intervention. There have been no intervention studies determining the best approach to chronic anxiety or post-traumatic stress disorder in refugee populations, so providers may less frequently explore and diagnose a problem if they do not know how to manage it. The details associated with many of the patients' histories may be deeply disturbing, indeed horrifying, to the providers, offering another reason for reluctance to pursue anxiety and post-traumatic stress disorder symptoms.

The study reported here presents evidence that Cambodian patients frequently present to primary care physicians with somatic complaints that may reflect psychological problems. The findings were compatible with other attempts to document the extent of psychological disturbance in Cambodian refugees. In the Indochinese Psychiatry Clinic in Boston, Mollica and his group determined in one study[9] that 50% of 52 Cambodian patients had post-traumatic stress disorder, and in another study[19] that 75% had a major affective disorder. In a community-based epidemiological study in California, Gong-Guy[20] reported that 36% of Cambodians surveyed had high scores on a depression scale, 96% were high on an anxiety scale, and 16.3% met the full criteria for post-traumatic stress disorder. She also documented the paucity of mental health resources available to deal with these problems.

Just as it took almost 40 years for survivors of the Nazi holocaust, and almost 20 years for Vietnam veterans, to fully appreciate the extent of psychological trauma, health care providers as well as patients may now be in a better position to address the problems of the survivors of the Pol Pot genocidal regime. More detailed studies and specific intervention approaches may reveal how to meet the biopsychosocial and spiritual needs of individual patients as well as their families and communities.

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References

1. Boehnlein JK: A review of mental health services for refugees between 1975 and 1985 and a proposal for future services. Hosp Community Psychiatry 1987; 38:764–768
2. Schultz SL: How Southeast Asian refugees in California adapt to unfamiliar health care practices. Health Soc Work 1982; 7(2):148–156
3. Muecke MA: In search of healers—Southeast Asian refugees in the American health care system. West J Med 1983; 139:835–840
4. Strand PJ, Jones W Jr: Health service utilization by Indochinese refugees. Med Care 1983; 21:1089–1098
5. Westermeyer J: Cultural factors in clinical assessment. J Consult Clin Psychol 1987; 55:471–478
6. Sue D, Sue S: Cultural factors in the clinical assessment of Asian Americans. J Consult Clin Psychol 1987; 55:479–487
7. Eyton J, Neuwirth G: Cross-cultural validity: Ethnocentrism in health studies with special reference to the Vietnamese. Soc Sci Med 1984; 18:447–453
8. Lin KM, Tazuma L, Masuda M: Adaptational problems of Vietnamese refugees. Arch Gen Psychiatry 1979; 36:955–961
9. Mollica RF, Wyshak G, Lavelle J: Psychosocial impact of war trauma and torture on Southeast Asian refugees. Am J Psychiatry 1987; 144:1567–1572
10. Westermeyer J: Clinical considerations in cross-cultural diagnosis. Hosp Community Psychiatry 1987; 38(2):160–165
11. Williams CL, Westermeyer J: Psychiatric problems among adolescent Southeast Asian refugees. J Nerv Ment Dis 1983; 171(2):79–85
12. Westermeyer J, Vang TF, Neider J: Refugees who do and do not seek psychiatric care. J Nerv Ment Dis 1983; 171(2):86–91
13. Kinzie JD, Fleck J: Psychotherapy with severely traumatized refugees. Am J Psychother 1987; 16(1):82–94
14. Kinzie JD: Evaluation and psychotherapy of Indochinese refugee patients. Am J Psychother 1981; 35(2):251–261
15. Mollica RF, Wyshak G, de Marneffe D, et al: Indochinese versions of the Hopkins Symptom Checklist-25: A screening instrument for the psychiatric care of refugees. Am J Psychiatry 1987; 144:497–500
16. Figley CR (ed): Trauma and Its Wake, vol II. New York, Brunner/Mazel, 1986
17. McFarlane AC: The phenomenology of post-traumatic stress disorders following a natural disaster. J Nerv Ment Dis 1988; 176(1): 22–29
18. Williams T (ed): Post-traumatic Stress Disorders: A Handbook for Clinicians. Cincinnati, Disabled American Veterans, 1987
19. Mollica RF, Wyshak G, Coelo R, Labelle J: The Southeast Asian psychiatry patient: A treatment outcome study. Washington, DC, US Office of Refugee Resettlement, 1985
20. Gong-Guy E: California Southeast Asian Mental Health Needs Assessment. Sacramento, Calif, State Department of Mental Health, 1987