DOCUMENT RESUME

ED 266 199 UD 024 683

AUTHOR	Owan, Tom Choken, Ed.
TITLE	Southeast Asian Mental Health: Treatment, Prevention, Services, Training and Research.
INSTITUTION	National Inst. of Mental Health (DHHS), Rockville, Md.; Office of Refugee Resettlement (DHHS), Washington, D.C.
REPORT NO	ADM-85-1399
PUB DATE	85
NOTE	557p.; Metrotec, Inc. also participated in the substantive development of this publication.
PUB TYPE	Books (010) -- Collected Works - General (020)
EDRS PRICE	MF02/PC23 Plus Postage.
DESCRIPTORS	Acculturation; *Asian Americans; Ethnic Groups; Immigrants; *Indochinese; *Mental Health; Mental Health Programs; *Psychological Needs; *Psychological Services; *Refugees
IDENTIFIERS	*Southeast Asians

ABSTRACT

This sourcebook contains 19 papers which discuss the mental health service needs of Southeast Asian refugees in the United States. The volume is divided into five sections: Treatment; Prevention; Services; Training; and Research. The papers (and their authors) are: (1) "Psychiatric Care for Southeast Asians: How Different Is Different?" (Tran Minh Tung); (2) "The Role of Culture in the Mental Health Treatment of Indochinese Refugees" (Hideki A. Ishisaka, Quynh T. Nguyen, and Joseph T. Okimoto); (3) "Mental Health of Southeast Asian Refugees: Observations Over Two Decades From Laos and the United States" (Joseph Westermeyer); (4) "Mental Health Treatment Issues for Southeast Asian Refugee Children" (Jean E. Carlin and Burton Z. Sokoloff); (5) "Overview of Clinical Issues in the Treatment of Southeast Asian Refugees" (J. David Kinzie); (6) "Southeast Asian Mental Health: Transition From Treatment Services to Prevention--A New Direction" (Tom Choken Owan); (7) "Preventive Intervention Research: A New Beginning" (Morton M. Silverman); (8) "Mental Health and Prevention Activities Targeted to Southeast Asian Refugees" (Bruce Thowpaou Bliatout, Rath Ben, Vinh The Do, Kham One Keopraseuth, Hollis Yap Bliatout, and David Tsanh-Tsing Lee); (9) "Southeast Asian Mutual Assistance Associations: An Approach for Community Development" (Le Xuan Khoa and Diana D. Bui); (10) "Alternative Mental Health Services Models in Asian/Pacific Communities" (Kenji Murase, Janey Egawa, and Nathaniel Tashima); (11) "Mental Health Services for Refugees and Immigrants in Canada" (San Duy Nguyen); (12) "A Community-Based Mental Health Service to Southeast Asian Refugees" (Rodger G. Lum); (13) "Inpatient Psychiatric Services for Southeast Asian Refugees" (Evelyn Lee); (14) "An Indochinese Mental Health Service Model in San Francisco" (Reiko Homma True); (15) "Training for Mental Health Service Providers to Southeast Asian Refugees: Models, Strategies, and Curricula" (Herbert Z. Wong); (16) "Mental Health and Refugee Youths: A Model for Diagnostic Training" (Jeanne F. Nidorf); (17) "Mental Health and the Refugee Experience: A Comparative Study of Southeast Asian Refugees" (Ruben G. Rumbaut); (19) "Research Concerns Associated with the Study of Southeast Asian Refugees" (William T. Liu and Freda Cheung); and (19) "Studying Vietnamese Refugees: Methodological Lessons in Transcultural Research" (Elena S. H. Yu). Supplementary statistical tables are included in an appendix. (KH)

National Institute of Mental Health in collaboration with Office of Refugee Resettlement

SOUTHEAST ASIAN MENTAL HEALTH:

Treatment, Prevention, Services, Training, and Research

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE • Public Health Service • Alcohol, Drug Abuse, and Mental Health Administration

COVER ILLUSTRATION

Two significant themes are portrayed in the cover design: (1) the distinctive landscape of Southeast Asia—the bamboo, water buffalo, the farmer—and (2) the ancient Yang and Yin symbol (**A**), which together symbolize the omnipresent danger in the refugees' transition from a rural environment to a highly urbanized setting. The concept of Yang (good, strong, highest) and Yin (bad, weak, lowest), developed in the eighth century B.C., signifies the duality which Chinese philosophers see in all things. For this publication, the Yang and Yin symbol was purposely distorted and interposed with the Chinese word "Wei Chi" (**B**), meaning crisis, to illuminate the increasing mental health concerns of the Southeast Asian refugees. It is intriguing to note that in coining the word "Wei Chi" the Chinese scholars gave it a dual meaning—danger (**C**) and opportunity (**D**)—when the characters are interpreted separately.

T. Owan

A. 

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B. 危
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D. 機

SOUTHEAST ASIAN MENTAL HEALTH:

Treatment, Prevention, Services, Training, and Research

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in collaboration with
Office of Refugee Resettlement
Social Security Administration

This publication was partially developed under professional services contracts from the National Institute of Mental Health. METROTEC, Inc., also participated in the substantive development of this publication (NIMH contract no. 84 MO 295 06301D).

Library of Congress Catalog Card Number: 85-600553

DHHS Publication No. (ADM) 85-1399
Printed 1985

FOREWORD

During the past decade, one of the urgent problems that has confronted the mental health field is the need for better mental health care for Southeast Asian refugees. Uprooted from their culture with iittle or no preparation for a vastly different lifestyle in the United States, many of the victims of this forced migration developed severe adjustment problems, sharply limiting their progress into the mainstream of our society. The mental health system in this country is beginning to recognize the problem of providing mental health services for Southeast Asian refugees and to seek ways of initiating appropriate services.

Presently there are few publications that deal with Southeast Asian mental health concerns, and that also encompass the broad perspectives of treatment, prevention, services, training, and research. This sourcebook provides current information about each area and suggests new techniques and models to improve mental health services for Southeast Asian refugees.

The contributions to this volume were furnished by distinguished mental health professionals and researchers who are also astute and sensitive observers of the people who make up this American subculture. These special skills are not learned easily. To obtain them requires exceptional interest, dedication, experience, and an understanding of the diverse cultural heritage that Southeast Asians have brought to America.

While this book is specifically intended for mental health professionals and students, I believe it also may be a valuable reference for the many people who are working in related health care disciplines.

This sourcebook represents an important initiative in fostering greater attention to the mental health needs of Southeast Asian refugees. We have a long way to go. At this point, perhaps it is fitting to quote Carl Gustav Jung who said, "And yet each of us can carry the torch of knowledge but a part of the way, until another takes it from him."

Shervert H. Frazier, M.D.
Director
National Institute of Mental Health

PREFACE

Since 1975, nearly 1 million refugees have resettled throughout the United States. Approximately 700,000 of these refugees have come from Southeast Asia.[1] They have been dispersed to places where unemployment, social isolation, family estrangement, a new language, racial tension, and other barriers to their leading a normal life are commonplace. The majority of this new American population have overcome the traumatic experiences caused by their forced separation from a familiar culture and lifestyle and their being thrust into a radically different way of life in a new home. A growing number, however--inevitably and understandably--have developed serious adjustment problems.

Various mental health practitioners, including those in State and local governments, have expressed the urgent need for technical assistance in planning and implementing appropriate services for the Southeast Asian refugees. This sourcebook has been developed in response to that need.

This volume is divided into five sections: Treatment, Prevention, Services, Training, and Research. It attempts to build a new direction in mental health care by describing how to (1) modify health services by providing eclectic treatment approaches to fit the needs of groups whose beliefs are deeply rooted in their ethnicity, (2) develop primary prevention efforts to

[1] See the appendix for detailed demographic data.

forestall psychological problems, and (3) conduct preventive intervention research.

The contributors are pioneers in the development of culturally relevant mental health services, not only for Southeast Asian refugees but also for Asian/Pacific Islander Americans who share similar problems and needs. The authors offer innovative ideas about the need for more basic sociocultural research, development of social support systems, mental health services more closely tailored to non-English-speaking and limited-English-speaking populations, and sustained assistance for those considered most in need of mental health services.

Thomas Choken Owan
Editor

ACKNOWLEDGMENTS

Through their active assistance and collaboration, numerous individuals greatly enriched this publication. They provided helpful suggestions, timely observations, and data bearing on the complex scientific, clinical, and societal issues that are explored in this sourcebook. The editor especially wishes to express his gratitude for contributions made by:

- Larry B. Silver, M.D., Deputy Director for Special Projects, NIMH, who played a pivotal role in launching the project in collaboration with the Office of Refugee Resettlement, Social Security Administration, with support from the Office of Refugee Health, Office of the Assistant Secretary for Health.

- The concerned individuals from across the United States who participated in the series of regional conferences that preceded the development of this volume.

- The members of the Publication Advisory Committee composed of the five associate editors, listed on the title page; Sharon Fujii, Ph.D., Regional Director, Office of Refugee Resettlement; Nguyen Kimchi, Program Specialist, Office of Refugee Resettlement; Taoru Ishiyama, Ph.D., Coordinator, Special Projects, Department of Mental Health, State of Ohio; and Regina el Arculli, Program Officer, Office of Refugee Health.

- The 30 authors who expertly prepared the chapters of this sourcebook.

- The following NIMH staff members who provided professional advice on development of the publication and consultation and review at many stages: Juan Ramos, Ph.D., Director, Division of Prevention and Special Mental Health Programs; Morton M. Silverman, M.D., Chief, Center for Prevention Research; and Delores L. Parron, Ph.D., Associate Director for Special Populations.

CONTENTS

TREATMENT

While each of the authors in this section addresses treatment issues from an individual perspective and experience, three major themes emerge that provide new knowledge to enhance the current state-of-the-art in the treatment of the Southeast Asian refugee.

The first major theme is that service providers and the therapeutic team must be acutely sensitive to the Southeast Asian client's cultural and life experiences. The Southeast Asian "culture" is, in fact, a multivaried

set of cultures. Yet within that framework there is a common thread of perspectives that cuts across mental health issues. Tung points out that feelings and emotional problems are rarely considered proper reasons for seeking professional assistance and that psychological reasons are not easily accepted. Psychiatric diseases are often seen by Southeast Asians as extraordinary, supernatural, or magical phenomena. For those reasons, the Southeast Asian people often turn to their families, friends, community leaders, priests, and shamans for assistance and rarely seek professional psychiatric services. Consequently, Southeast Asian refugees are reluctant to engage the American system of professional mental health services and seek assistance only when problems seem overwhelming. The engagement of the Southeast Asian client in the American mental health system has been shaped to a great extent by the client's culturally determined perspective about his or her relationship with any social system. According to Ishisaka et al., the client's cultural code of conduct as defined, for example, by the social distance between persons, has great impact on the interactions between the client and the service provider. Tung points out that Southeast Asian clients tend to understate problems, rarely express feelings, and are modest and discreet. Therefore, they are reluctant to open up, preferring most often to focus on factual difficulties and physical discomforts (Tung).

The concerns that emerge from the experiences of mental health treatment services with Southeast Asian refugees are not unique to that group. Westermeyer argues that the current Southeast Asian refugee's experience has much in common with other refugees and minority groups, and thus there are lessons to be learned from history. The use of refined, cross-cultural clinical applications, techniques, and data from other refugee groups must be encouraged. Realizing that adjustment to a new culture and establishment of appropriate and acceptable treatment techniques is a long and difficult process, at best, a vast array of information, knowledge, and sensitivities utilizing many disciplines is necessary (Westermeyer; Kinzie).

The second major theme is that culturally relevant mental health intervention must be researched, identified,

and made operational. These processes require patience, flexibility, and an understanding of cultural taboos, analogs, symbols, and codes of conduct (Ishisaka et al.; Tung; Westermeyer). Ishisaka and his colleagues provide a well-organized outline of client engagement, role induction, and effective interventions. The concepts of universalization--the notion that symptoms are shared by many people; obligatory motivation--obligation to others; and normalization--encouraging the understanding of the connection between abnormal levels of stress and emotional reactions--provide intriguing suggestions for therapeutic interventions.

The Southeast Asian client's propensity to focus on physical discomforts and to attribute difficulties to physical antecedents makes a medical approach highly relevant and effective (Kinzie; Carlin and Sokoloff). Kinzie has found psychotropic medicine to be very useful in treating Southeast Asians; the dose of antipsychotic medications tends to be lower than for Caucasians. The Carlin and Sokoloff chapter on treatment for Southeast Asian children is consistent in its concerns for language and cultural factors. At the same time, children's issues tend to be more future oriented than issues for adult refugees.

The third and final theme in this section is the need for competent, well-trained service providers. Most authors in this section suggest that mental health specialists who come from similar cultural backgrounds and who share the personal experiences of their clients are needed to assure effective treatment services. There is a caveat, however, as Tung points out. Some Southeast Asian clients prefer non-Southeast Asian counselors for fear that their personal problems will become known in their community if they have Southeast Asian counselors. Ishisaka et al. also suggest that the use of a Southeast Asian interpreter/translator in counseling may present some difficult problems, since three people become involved instead of two, i.e., the therapist, the interpreter/translator, and the client. Westermeyer and Kinzie suggest that cultural and language sensitivites are not enough and that simply being from Asia does not always impute effectiveness. Well-trained psychiatric personnel, knowledgeable and expert in interviewing and counseling, are deemed more essential.

Southeast Asian Mental Health: Treatment, Prevention, Services, Training, and Research. T. C. Owan, editor. National Institute of Mental Health, 1985.

PSYCHIATRIC CARE FOR SOUTHEAST ASIANS: HOW DIFFERENT IS DIFFERENT?

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Most observers and practitioners who work with Southeast Asian refugees seem to agree on most of the following statements about Indochinese mental health problems and service needs: 1) This is a population definitely at risk, beset with a variety of stresses and problems due to sudden uprooting and forced expatriation as well as to the necessity of adjusting to a new milieu (Chu 1972; Pedersen 1949; Rumbaut and Rumbaut 1976; Tyhurst 1951; Zwingmann et al. 1973). 2) They are in dire need of assistance; their condition cries out for help, for prevention, and for treatment, both for their own good and for the welfare of the community in general (Aylesworth et al. 1980; Lin et al. 1979; Liu et al. 1979; Pennsylvania Department of Public Welfare 1979; Tung 1975, 1979a; Yoshioka et al. 1981). 3) These needs are not always being met, since the services that are available are not always appropriate or even acceptable to this population. 4) The main reason for this state of affairs is that Southeast Asians are different, and this is not always sufficiently taken into account when such services are offered (Le 1977; Nguyen 1982b; Wong 1977).

The consensus, however, is not as general or as complete on the subject of solutions or remedies. The reason for this, in part, is that not everybody has agreed on what constitutes the differences between

the newcomers and the rest of the American population and how these variations demand the fine tuning necessary to make our standard service model more suitable for this new clientele (Egawa and Tashima 1982; Friedman et al. 1981; Lee 1979; Tung 1978d, 1981b). This paper has been written in the hope of providing some answers by presenting the essential information one might obtain by asking the question, "How different is different?" at each critical point in the therapeutic process for Southeast Asians. By pinpointing the main characteristics that set this group of newcomers apart from the mainstream, we will also have a better idea of the effects of these characteristics on the nature, form, and content of psychological care given to Indochinese patients. Consequently, we will be better able to define the adjustment that will make our services more useful and usable.

Our presentation will try to follow what usually happens in real life with a non-American patient. We shall look at the most conspicuous factor that makes our patient different; i.e., being a foreigner who speaks little or no English. Then, as the patient proceeds along the road of psychiatric service, we shall observe behavior and study problems at different stages of the journey: when the patient enters the system, submits to diagnosis, then undergoes therapy.

THE NEWCOMERS: A DIFFERENT CLIENTELE

The fact that Southeast Asians have problems because they are foreigners, newly arrived in this country, and that they speak little or no English, requires no special acumen to recognize. One does need, however, to point out some of the ramifications of these problems, which are more complex than is usually suspected.

In the first place, very few aliens are aware of the resources available in their community, nor do they know where to get such information. And if they did, most services would still be out of reach because transportation, communication, formalities, paperwork, etc., are formidable obstacles to newcomers unfamiliar with them (Tung 1980d); hence, mass media approaches to keep the public informed about the availability of services become very important.

Without the access to information, refugees usually have to depend on others for their needs. Sponsors, friends, compatriots, volunteers, and workers from resettlement agencies make most referrals to mental health services. Thus, they should be included in the planning and operation of any refugee mental health program, the success of which depends in great part upon the cooperation of these people (Moon and Tashima1982).

LANGUAGE

Language difference is the second big problem, and a major obstacle to services in more than one way.

There are, in the first place, those refugees who neither speak nor understand English. Their numbers are considerable. In 1980, a special report to the Secretary of Health, Education, and Welfare (now, Health and Human Services) stated: "Most refugees cannot communicate in English. Only one-third of all the refugees interviewed can be understood by the survey team. Almost half of the old wave of refugees have difficulty communicating, and 25 percent could not communicate without an interpreter. . . ." (HEW 1980). Remembering that traditional psychiatry relies on verbal skills, it can be understood that language is a problem for an even greater number of Indochinese who don't have the language proficiency necessary to take full advantage of these services.

There are also those who think they cannot speak English, at least not well enough to allow them to use some of the services they may need. Many Indochinese, therefore, who may feel inclined to seek help outside their circle of compatriots, often stop short at initiating the necessary contact when faced with the prospect of having to use their laborious and imperfect English to deal with what is almost a matter of life and death (Tung 1980b, 1983b).

If, somehow, they are able to overcome this initial hesitation, they will be facing more problems, whether they work directly with an English-speaking professional or through an interpreter. In either case, this is definitely a stressful situation for them as well as for the

therapist. These patients are certainly on edge, straining to understand, apprehensive about being misunderstood, constantly and painfully aware of the distance between them and their interlocutors. The American practitioner may not be as anxious but is far from being comfortable, with little of the self-confidence that comes from working on more familiar terrain. Frustration, fatigue, and sometimes guilt or anger set in; relationships are often tense and uneasy, and both parties are usually content to cut it short and let it die at the first opportunity.

With an interpreter, communication may be quicker and less laborious but not necessarily more accurate or satisfactory. As a general rule, the presence of a third person in a therapeutic situation brings in a foreign element, the effects of which are not always clear or easy to distinguish (Baker 1981; Baker and Briggs 1975; Bang and Finlay 1982; Tung 1983a). In my experience, there is an aggravating circumstance in the fact that very few Southeast Asian auxiliaries offer the transparency that professional translators must attain to avoid interposing themselves in the dialog they are helping to carry out. If anything, the majority of these improvised interpreters feel very involved and almost compelled to make their unsolicited contributions to the transaction. Generally, their motives are generous, and the "little" changes and embellishments that they bring into the translation are made with the most laudable intent: to explain or interpret the patient's statement, which may be too obscure or too confused for their taste, or, more often, to try to present a better case for their compatriot. Egotistical reasons are also quite frequent, often existing outside of the interpreter's awareness and varying from a desire to project a better image of themselves and of their group to deeper reactions of transference and identification--quite common in a situation in which both patient and interpreter are sharing the same or comparable experience. At any rate, the patient is often quite conscious--and none too glad--of such interference but is unable or too intimidated to raise an objection. The therapist may not be as inhibited, but the task is certainly made more complex, since he or she has to handle both interpreter and patient at the same time. The relationship, instead of being of a

singular, one-on-one type, becomes triangular, with three dyads and complex, simultaneous interactions in which any change in one of the three couples will affect the other two.

One frequent and preferred solution to this problem is to use bilingual, bicultural workers, generally Indochinese refugees themselves, to serve as mental health assistants to help bridge the gap with Indochinese patients. Very few such assistants are fully qualified professionals who are able to function on their own. The majority are recruited for temporary positions and briefly trained to work under supervision. The role of such auxiliaries is unique, and their contribution is invaluable, but their function is often complicated by problems that have not been sufficiently noticed (Lique 1982; Tung 1983b; Tung et al. 1978; Weiss and Parish 1981). What is being asked of them would be a tall order for any seasoned professional: to straddle two different cultures, to assess the discrepancies between them, and to serve as arbiters to explain and reconcile the differences. Yet these tasks are being entrusted to people whose training has been brief and scanty and who are themselves wrestling with the same problems they are supposed to help in others. Not only are knowledge and tact necessary, but also insight and an appreciable degree of detachment, neither of which is easily obtainable in matters that are so sensitive in their proximity to one's inner self.

MODE OF ENTRY

In the next stage of the treatment process, differences are not so obvious but are still quite noticeable. This is when the patient comes into actual contact with the system, and mental health services begin. For Southeast Asians, a few characteristics of the entry process are worth emphasizing.

VOLUNTARY ADMISSIONS

To begin with, voluntary admissions are infrequent, and most Indochinese arrive at the mental health facility because of someone else's decision rather than their

own. There may have been an explicit obligation to seek psychiatric service, for example, from a court order. Or it may have been a mere suggestion, combined with some form of friendly persuasion, as in the case of referrals by the school system or social services. In other instances, the initiative may have come from a voluntary agency or a sponsor who also took the necessary steps to secure the consultation, including transporting the patient to the consultation. At any rate, very few of the subjects really agree to or even fully comprehend what has been decided for them, but even fewer resist or refuse to comply with the suggestion, either for fear of retribution or simply out of complacency.

The result, predictably, is not always most propitious for the relationship that is to follow. In the most benign circumstances, the patient-to-be is bewildered, confused, and fearful; having no idea of what is happening, what to expect, what the potential benefits are, and his or her rights and responsibilities. In the worst cases, annoyance turns to anger, ignorance fosters suspicion; the involuntary client becomes more or less convinced that he or she is being singled out for harassment or persecution. The patient, therefore, cooperates only minimally and, if not already antagonistic, will remain reserved and expectant, refusing to commit to the therapeutic venture to any appreciable degree.

This is not to say that the only Indochinese we therapists will see are those who have been taken forcibly, by coercion, to our offices. Many do come on their own, in the most positive state of mind. But, if we are looking for differences, let us note that there are certain kinds of problems for which Indochinese will not seek help.

FEELINGS AND EMOTIONAL PROBLEMS

Feelings and emotional problems per se are rarely, if ever, considered to be a proper reason for seeking professional assistance (Khoa et al. 1981; Tung 1979a, 1979b, 1980c, 1983a). Depression, regrets, guilt, shame, or similar preoccupying sentiments may weigh heavily on a Southeast Asian's mind and life, yet these

are still perceived as essentially private concerns, and to talk about them would be about as discrete and commendable as parading in the nude in public. And because hardships and suffering are considered as the givens of life and the lot of every living creature, it serves no purpose to complain: lamenting is simply a sign of weakness and denotes a lack of character. If, however, relief must be sought because the pain is too much to bear, one should look for solace from parents, siblings, or friends because they are the most likely to understand and sympathize with you. It is almost unthinkable to call on a stranger or a professional for such a purpose. In these people's countries, there exists no profession dedicated to helping with mental distress or unhappiness in general, the way the American public expects psychiatrists, psychologists, and social workers, for example, to help in similar circumstances.

SUICIDE

Suicide is another problem for which the Indochinese will rarely expect any outside intervention (Alley 1982; Tung 1980a). The American intense concern and constant preoccupation with "helping" in cases of suicidality are rarely comprehensible for a Southeast Asian, to whom suicide represents a personal decision based on various "normal" motives and is not always considered pathological or reprehensible. One may kill oneself on behalf of the family or the group, to publicize a position or a sentiment that is impossible to express otherwise, or as an honorable way out of a moral dilemma. An outsider has no way of knowing about this, has no right to pass judgment, and generally has no business interfering. Friends or family may intervene to stop the attempt, but society has no responsibility in the matter, except maybe to prevent such acts from being committed in public. Suicide, in any case, would never be considered a proper object for professional concern or medical attention (unless the suicidal person has reached the emergency room, and then only because of the physical symptoms of the suicide attempt).

On the other hand, what Indochinese patients come to a mental health consultation for is also remarkably different. In the first place, such patients often arrive with special agendas that do not always fit with what we know of an American mental health center (Aylesworth et al. 1980).

GRIEVANCES

Their grievances, for example, are mainly about a factual difficulty: the rebellious teenage son, the philandering husband, or the pressures from work, etc. And the questions they have for the therapist are most practical: What shall they do? What could others, including the therapist, do to help resolve the situation? The expectation is that the therapist will do something immediately to help with the problem. Many times, this simply means a concrete action such as signing an official document or intervening in an administrative procedure. But it could also be a more complex behavior such as playing the role of an ally, a patron, or an intercessor or mediator. At the least, the hope is that the consultation will result in some detailed and practical advice about what the patient should do to dispose of the problem.

MEDICAL SYMPTOMS

In quite a few cases, the patient brings in issues related to medical symptoms (Kinzie et al. 1980; Kinzie and Manson 1983; Lin et al. 1979). The major complaints are about headache, insomnia, fatigue, or poor appetite, but loss of memory and poor concentration are also often mentioned by many patients who are alarmed by the condition of their minds, which seem to be "slipping away." The consultation will then focus on the physical discomfort, for which it is hoped medical care, i.e., medication, injections, and other physical manipulations, will bring relief. Here again, some patients may eventually acknowledge their emotional distress and talk about their psychological problems, if enough trust has been established with the therapist. Such information, however, will be presented as an ancillary

issue of secondary importance, for which they see little or no relevance to their actual preoccupations.

PSYCHOSES, NEUROSES, AND FAMILY PROBLEMS

Finally, Indochinese patients may come in with the usual crop of problems commonly seen in an American mental health center: psychoses, neuroses, and family problems. The difference here is that the number of such problems is minimal, and most patients arrive at an advanced stage of their evolution. The reason for the small number is to be found in these patients' very narrow definition of mental illness, meant to cover only those conditions that are so disruptive that they derange the social order and disturb or endanger others in the community. Psychoses generally fit the bill, but neuroses and other nonpsychotic disorders would be considered as diseases only if their repercussions were unpleasantly felt by others and created trouble for the community. As a rule, psychological distress per se is not a disease and does not justify medical intervention. Family problems are strictly the clan's affairs but may be brought to an outsider's attention if the outsider is seen as a possible ally and likely to help by putting some pressure on the patient.

In most circumstances, the patient will probably arrive after a long delay with very advanced symptoms. The reasons for this may be involuntary and outside of the patient's and family's intentions, but more often, the lateness will have derived from the stigma attached to mental illness, as well as from the cultural stance that advocates patience, resignation, and stoicism in the face of adversity, and allows calling for help only as a last resort.

A DIFFERENT PERSPECTIVE

The distinctive way the Indochinese explain their diseases, visualize the help they would like to get, and conceive of their own responsibility and that of the therapist represent important elements that require careful consideration in the therapeutic sessions.

Because of their special, and often bizarre, manifestations, psychiatric diseases have always been set apart from other illnesses. Psychoses especially are more likely to be viewed by Indochinese as extraordinary phenomena of a supernatural nature and the effects of magical forces such as demonic possession, a voodoo curse, or retribution for a sin or a fault (Tung 1980a; Westermeyer and Winthrop 1979a, 1979b). For more benign, nonpsychotic disorders, medical explanations are often favored, and one speaks of a deranged nervous system; of a "weak" liver or, in a more sophisticated system, of an imbalance between the yin and yang ,or "cold" and "hot" principles. Circumstantial explanations are often invoked as well, and psychiatric disorders are frequently blamed on the stresses coming from dramatic events and changes such as losses, failures, deaths, separations, and life's downturns and misfortunes in general. Unsatisfactory relationships in the family or in society are also high on the list of causes of "unhappiness." As is often the case with commonsense psychology, the role of psychological factors is limited to the rare circumstances in which the stress is of an extraordinary magnitude, while the subterranean workings of affects and sentiments in their subtler shades are often ignored or overlooked.

On the othe hand, the role of willpower is emphasized and considered essential in every facet of life, in health and in disease. With willpower, everybody should be able to keep out of trouble, and willpower should be enough to get people out of trouble, if they simply maintain constant control over their behavior and emotions.

As for the refugees, their views of the problems, which may take them or their loved ones to a psychiatrist, are even simpler and are derived from their actual and very vivid experiences as exiles and displaced persons. Characteristically, they put the blame for almost every difficulty on the multiple stresses and hardships they know so much about: the quest for subsistence, the preoccupation about job and career, the new poverty and social demotion, feeling and being lonely and different, the changing relationships with their immediate entourage, etc. The accent is usually on the environmental problems, the solutions for which,

they believe, would bring their misery to an end. For a deteriorating family relationship, for example, help is often sought to find a new lodging or a better paying job, with the assumption that conflict and unhappiness have come almost solely from poor living conditions or "too much worry." Emotional distress, again, might be mentioned, often as an afterthought and in personal confidence, but it rarely constitutes the major problem for which the patient seeks assistance.

In such a context, and with very precise ideas about what is ailing them, Indochinese patients have definite expectations about what they should do or what kind of help they would like to receive should they get sick.

For themselves, the expectation is that they will maintain control over their own sentiments and do their utmost to help themselves at the outset. Self-control works for prevention and for treatment, since willpower may keep "superior persons" from becoming prey to the dark forces of inappropriate emotions or may help them to get "back in the saddle" if they have already succumbed to the violence of their own emotions. At the least, willpower will enable them to sail through the vicissitudes of life with equanimity, to endure the pains and miseries of existence with dignity, and, it is hoped, to find within themselves the resources to overcome actual difficulties (Tung 1979b).

If, however, the burden has become too much to bear alone, the next recourse is to those who are the most ready and the best placed to help: family and, also, friends, who are almost brothers and sisters in spirit. One can confide in these people and ask for help without having to feel ashamed or be afraid the plea will be denied. The help requested may be material, monetary, or simply of a moral kind. It will generally be provided without question or criticism, but with the assumption that should the need arise, reciprocal help would be given to similar calls for help from friends or relatives (Tung 1972a).

Other kinds of assistance may be sought afterward as each case warrants and for a specific purpose; for example, a priest to help with prayers or exorcism, a

physician for a physical ailment, or a social worker for a welfare assistance problem. But no professional is known to have the interest or qualifications to intervene in the domain of "sentimental" problems.

It is quite easy to see the quandary for Western psychiatry and its agents in attempts to help these people whose host country is alien to them. In practice, and because the Indochinese have tried to fit this novel entity into their universe, mental health services tend to be assimilated in a way that approximates the few types of helping professions familiar to Southeast Asians. Medicine, of course, is the best known of such prototypes, but also included are various categories of "charitable people" who give a helping hand to people in distress, mainly on a voluntary basis out of kindness rather than because it is their profession.

Whatever model is chosen, the view is that such persons occupy prominent social positions, wield much power and authority, and are endowed with knowledge, experience, and wisdom (Tung 1972b, 1980a). They can help, but they can also withhold their aid and deprive one of what one needs. If, however, they are really good, the help that they offer will be given generously and wholeheartediy, without reservation, hesitation, or limitation, and with no questions asked. In return, these "charitable people" demand respect for their authority and deference for their decisions as they literally take charge and assume the direction of their proteges' lives. If all goes well, they are owed gratitude for a great favor, while any mishaps are simply accidents and the effects of fate, not the results of any mistakes of theirs. They can choose to be compassionate and warm, but no one would dare to criticize if they were to act distant or haughty, because aloofness is but an attribute of authority.

DIAGNOSIS

All these cultural differences affect the task of diagnosing and treating the Indochinese in various ways and at different points. Diagnostic work in general will be more tedious and delicate because of the language difference and because Indochinese patients are

not used to detailed historytaking, accustomed as they are to relying on the divinatory power of their physicians. It takes time, also, to win a patient's trust and confidence (Chin 1983). Making a diagnosis presents some special problems, of which one should be aware:

1. Always expect understatement whenever the patient talks about his or her emotional condition, especially if this is of a negative nature. Grief and depression, for example, often come out in a muted form, with great economy and very little emotional expression. Anger, in particular, is generally presented in an oblique and indirect fashion, with hints and allusions or a touch of bitterness or irony, but seldom directly, with threats or imprecations, for example. Any such outburst, if witnessed, may indicate either extreme anger or an appreciable degree of disorganization of the personality, and, in either case, a rather severe degree of pathology. More discretion is expected, as a rule, from males than from females, and a certain degree of emotion is tolerated in females.

2. Many patients may seem unusually modest and discrete: this has less to do with their true character than with their culture. The self-deprecating comments that they make are what their culture demands and do not necessarily indicate that they have a low opinion of themselves. By the same token, they rarely volunteer details about themselves, even if these will put them in a good light, because they do not want to look boastful. On the other hand, they will keep silent about nearly everything that may reflect unfavorably on themselves, their family, or their community. An astute interviewer, therefore, will do better to have a few leads before sitting down with such clients; pointed questions sometimes may ease a patient's inhibition by showing that he or she will not be divulging any secret by giving out information already known to the interviewer.

3. Expect even more discretion about the patient's family. Factual information is often complex and confused because family matters are complex and

confused. A description of the relationships and emotional interplay between family members is even more difficult to obtain because the family members feel protective of each other and of the clan and will readily censor any public revelation that could cast a bad light upon the group. Some patients may not succeed totally in suppressing their discontent or unhappiness, but direct accusations or harsh or hostile comments about parents or elders are exceptionai.

4. Expect difficulty in obtaining information about sex life and sexual problems. The subject is practically taboo for women, although female patients may be a bit more candid when talking to a female therapist. Males may be more open if they are seeking help for specific problems, such as a loss of sexual potency. Usually, allusions and circumlocutions will be used to elude inquiries--if such inquiries have not already scared the patient away and made him or her "clam up" for the rest of the interview.

5. Physical symptoms and bodily discomfort are a more acceptable topic for discussion and a suitable introduction to an inquiry into the patient's condition, even if the interviewer is not a medical person. The patient's description is often couched in the traditional medical terminology of the patient's homeland, such as having a "hot" liver or a "weak" kidney, etc. (Chueng et al. 1980; Tung 1980a).

   The problem often is to separate these bizarre-sounding symptoms into those that reflect a physiological problem and those that are expressions of anxiety or depression. A medical workup may be necessary, but a problem sometimes occurs when a medical specialist persists in using every available diagnostic tool, up to the most arcane techniques, and ends up creating an iatrogenic hypochondriacal anxiety in the patient.

6. All symptoms should be examined for cultural relevance and meaning. A patient who talks about seeing or conversing with a dead parent, for example, is not necessarily psychotic: such beliefs

are almost normal for people who live very closely with the supernatural (Yamamoto et al. 1968).

ANXIETY AND DEPRESSION

Anxiety and depression are the most frequent nonpsychotic conditions for which Indochinese patients will seek help most readily. The typical symptomatology, which is readily acknowledged by the patient, includes a rich variety of complaints: headache, tension in the neck and the back, thoracic oppression, palpitations, dizziness, flatulence, poor appetite, lassitude, fatigue, aches and pains in the limbs, and sleep disorders (Kinzie and Manson 1983; Kleinman 1977; Lin et al. 1979; Nguyen 1982b; Tseng and MacDermott 1975; Tung 1980a). A most frequent complaint, one often encountered in East Asian patients, is the fear of cold ("frigophobia") (Tseng 1975; Yap 1951). It is described as a feeling of constant chill, which causes the patient to dress more heavily than others, and it is often self-diagnosed as flu or malaria. Most Indochinese consequently treat it by "rubbing out the wind," which leaves red or purple longitudinal bruise marks on forehead, temples, or neck and chest. Another frequent complaint is the difficulty of studying English and "not being able to remember." The new "forgetfulness" is recent, as is poor concentration, and these are often perceived as an indication of the decline of their intellectual capabilities and a most terrifying sign of old age (Tung 1978a).

Anxiety is well recognized, and its diagnosis is accepted without too much question by most patients, who feel that they have good reason to be worried. Depression, on the other hand, is less readily acknowledged because of the traditional oriental view of life, which regards sadness as a normal, everyday condition and a natural reaction to adversity and misfortune, rather than as a sign of pathology. Predictably, in the majority of cases, depression and anxiety are part of an adjustment disorder and result from the refugees' stressful experiences. The prognosis is usually good and the condition transitory, with most patients recovering on their own or with minimal outside assistance as circumstances

evolve, generally for the better, and the subjects themselves come to terms with most of the changes.

PSYCHOSIS

Psychosis may take all the forms commonly found in the Western world. In our experience, however, it seems that schizophrenic disorders are more prevalent than affective disorders and that depressive syndromes are less frequent--or perhaps their symptoms less often brought to the clinicians' attention--than are manic forms of disease. One type of psychotic reaction that is of particular interest involves a systematized paranoid delusion that affects an individual who has had no symptoms until some time after he or she arrives in a new country. The patient is very fearful of foreigners and feels persecuted because he or she is different. The reaction is acute and in most cases short-lived, responding favorably to medication and the reassuring presence of compatriots and a familiar environment. The syndrome has been described in many ethnic groups, and because there seems to be a common denominator in the fact that the subjects are newcomers living in a foreign country, it has been individualized as a distinct entity and dubbed "aliens' paranoid psychosis" (Kino 1951).

SEX AND FAMILY

As has been explained previously, because of a cultural bias against discussing sex and family troubles with strangers, it takes extraordinary circumstances--and external intervention--to see these issues brought to the attention of the mental health professional (Tung 1979a). The occasion is usually some entanglement with the law or a public disturbance that could no longer be contained or tolerated by the family or the community. In any event, the discussion of the case is strictly limited to the identified patient or the specific trouble that caused the turmoil, and exploration of any other subject is carefully avoided.

ALCOHOLISM, SUBSTANCE ABUSE, AND GAMBLING

Alcoholism is sometimes a problem for the male Indochinese adult population but is definitely a rarity for females. In a culture in which drinking is usually communal, that limits to certain social occasions the opportunity for using alcohol, lone drinking should be considered pathological. Most Southeast Asians are quite aware of this distinction, evidenced by the fact that problem drinkers often rationalize their habits by protesting that they drink in company more often than they nurse the bottle all by themselves.

Substance abuse is rare in Indochina, and even here, after 9 years of contact with the American culture, few Southeast Asians are substance abusers. The only exception seems to be a small number of young Laotians who grew up in areas in which the use of opium is traditional and have simply switched to other substances to obtain the kick they used to get from the poppy extract.

Gambling, on the other hand, is a big problem that brings misery to innumerable individuals and causes many families to break up. It is rarely, if ever, reason for a request for a mental health consultation. However, the problem is so prevalent in most Southeast Asian communities that it pays to remember to inquire about it in cases of marital discord or a family problem or with male adults who seem prone to acting out.

THERAPY

Cultural idiosyncrasies are numerous in the therapy relationship, and one is hard pressed to say which is most important. Following are some comments on a few of them.

PUNCTUALITY AND FLEXIBILITY

Punctuality is relative with Southeast Asians, whose notion of time is very elastic. An Indochinese patient is usually on time for the first appointment but cannot

be expected to continue such a performance for long. "No shows" are frequent, as are "walk in" patients who have no appointment or have made no prior contact, by phone or otherwise. Many times, this simply reflects the real difficulty some patients have in securing transportation or using the telephone. It may also denote a casual attitude toward time and timeliness and, in a more general fashion, the traditional desire always to keep one's options open and flexible enough to make the most of changing circumstances.

The understanding by the patient also is that he or she is expected to be flexible enough, if necessary, to rearrange his or her time to suit the therapist's needs and concerns. Schedules can be shifted or juggled around, sessions can be shortened or prolonged, without formality and without much objection from the patient. So in return, the patient believes that the therapist should also do his or her utmost to accommodate variations, even if this means skimping on other activities or staying after hours for an unannounced visit, instead of scheduling an appointment for another day.

Flexibility--which generally means adaptability--has a different meaning for the Southeast Asian; an Indochinese patient's agreement to a therapeutic contract should be understood as temporary and conditional, with an unstated clause: to reserve the decision to continue or terminate therapy depending on the perceived results of the treatment. Appointments for followup may be made but are not really considered binding: the patient will wait to see benefits from the first encounter before deciding to come back for a second. With a therapist who has been firm and positive, the patient may feel obliged to return, but not without ambivalence, feeling shame or guilt for being "weak," and also feeling anxiety about the gravity of the problem. He or she may also wonder why the practitioner had made the treatment "drag on" for so long. Therapy usually proceeds by fits and starts on an as-necessary basis. The patient often drops out of sight without any forewarning as soon as he or she thinks the problem is on the mend and reappears when the symptoms start up again. A patient may not continue therapy for more than three or four sessions but may come back some months or a year later if there

is a problem, whether or not it is similar to that experienced before. Such a pattern of attendance is comparable to what has been observed in most minority groups, including Asians, Hispanics, and blacks (Hatanaka 1975; Ramirez 1980; Sue and McKinney 1975; Sue and Sue 1974; Task Panel 1978; Yoshioka et al. 1981).

CONFIDENTIALITY

The issue of confidentiality is often raised by Indochinese patients but in a very distinct perspective. As much as their American counterparts, Indochinese patients are concerned about keeping their problems out of public scrutiny. On the other hand, they also live in a culture in which privacy is often limited, in practice, by the usual communal living arrangement and, psychologically, by the dominance over the individual of certain social units, such as the family, clan, or group, all of which claim the right to know. Discretion, rather than confidentiality, is expected from the professional, and it is up to the patient to exact a promise to this effect and to specify the extent of the secrecy required. Because of such concerns, Indochinese patients have been known to ask for a non-Indochinese therapist, fearing that their secrets would not be safe if they were to work with a compatriot, especially in localities where the refugee community is relatively small and almost everyone knows everyone else. This has sometimes stopped some Indochinese from seeking help in agencies where they could be recognized. In my experience, one may as well go along with the patient's desire and assign the case to a non-Indochinese worker but also explain about confidentiality and point out that the option of working with a compatriot remains open should the patient have a change of mind. Of course, confidentiality as a professional and legal obligation should be stressed with the Indochinese workers and strictly enforced if credibility is to be kept intact.

MEDICATION

Medication is an important issue with the Indochinese. Because in their world medication is the epitome of

medical service, no medical consultation would be complete without the prescription or administration of medication. The patients who come to a mental health consultation, therefore, have the same expectation as when they come to see a doctor and hope to have something--a shot, some pills--to show for their effort. On the other hand, their conviction is also that, although Western medicines are effective, they may be too potent and not always suitable for an oriental constitution, which is either more fragile or simply different. Vietnamese and Chinese in particular believe that Western medications are generally "hot," and for that reason should be used with caution: at a low dosage and never for too long, lest they cause a disequilibrium in the hot-cold balance of the body. Most patients therefore would feel cheated if they were not prescribed some medication, or, even better, several kinds of medications, after the visit to a doctor. Yet once they get back home, a great many will either reduce the dosage, change the schedule of administration, stop taking the medication after a few days, or cut down on the amount of medicine that they use, without telling the physician about their decision.

Medicines "for the nerves" are deeply respected by patients because of their effect on the mind and because of the fear that they may allow someone to take control of their minds and enslave them. For these reasons, they are handled with apprehension and caution. Valium and Librium, which are quite popular in Indochina because of their effectiveness and are usually available over the counter, have rarely produced any severe addiction problem thanks to this salutary wariness that keeps most people from abusing them. However, this attitude sometimes stands in the way of any long-term therapeutic regimen involving, for example, neuroleptic agents, since most patients and their families object to prolonged use of medication owing to the fear of intoxication and dependency.

It should be noted that in many cases Southeast Asians' perception of Western medicines as being "too powerful" are quite valid (Collard 1962; Blackwell 1977). The sensitivity of Asians to different psychotropic agents (neuroleptics, in particular) is well known, if not well documented. Quicker therapeutic responses and more

frequent and intense side effects are found in Indochinese patients at dosages lower than those used for Caucasian patients. Antidepressants are poorly tolerated by most Indochinese patients except in major affective disorders, which limits their use in treating moderate, reactive depressions. Antianxiety agents, on the other hand, are less a problem, though as a rule most patients will do well on one-half to two-thirds of the usual dose recommended by the literature.

PSYCHOTHERAPY

Psychotherapy, as a specific technique for helping with emotional problems, is properly a product of Western culture and, as noted by different authors, cannot be transplanted to other cultures without some significant transformation (Chang and Kim 1973; Hsu and Tseng 1972; Lambo 1974; Neki 1975; Pande 1968; Torrey 1972; Tseng and McDermott 1975). Such adaptation requires that any psychological intervention, to be acceptable and effective for the Southeast Asian population, should probably be:

- Of short duration, since such patients would rarely dream of "imposing" upon strangers, i.e., not friends or relatives, for too long.
- Limited in scope to the problem brought forth by the patient and to the person identified as being in trouble.
- Directed toward a goal that is predefined by the patient and generally limited to the relief of symptoms or the resolution of the crisis.
- Active, in that the therapist should be the one who initiates all the actions that are supposed to remedy or improve the situation; the patient simply waits for the bonanza that will follow compliance with the therapist's orders.
- Directive, with the therapist in charge and the patient simply following instructions. Role modeling, persuasion, pressure, and counsel will be the mainstays of the therapeutic arsenal.

- Assorted, with some concrete expression of the therapist's concern and tangible manifestations of power, from a symbolic imposing of hand under the form of somatic therapy and/or medication, with or without the use of placebo effect, to various kinds of environmental manipulation: intervention, advocacy, material assistance, which may also help by alleviating or dispelling some of the external stressing factors.

- Supportive, striving to bolster the patient's ego at the conscious level, with reassurance, encouragement, and also providing opportunities for emotional catharsis and desensitization (Wolberg 1977).

- Focused on the present and the immediate future, with little or no concern for the remote, historical past.

"Classical" Western psychotherapy that is psychoanalytically oriented or has reeducative or reconstructive goals may stand some chance for success if the patient is Westernized and is also young, intelligent, articulate, sophisticated, and middle class, like the preferred patients of most Western psychotherapists (Pedersen 1981). This confirms what we have long suspected: that the level of acculturation is the common denominator that cuts across most cultures to determine a person's medical behavior.

The content of therapy should also strive to conform to the patient's value system, which is rarely similar to the therapist's own. With such concerns in mind, the therapist should remember:

- That most values held by these patients (Parsons et al. 1968) are those of a rural, gregarious society of a preindustrial era, not so different from the United States of yesteryear. These include order, authority, family, respectability, industriousness, achievement, and a Victorian attitude toward sex.

- That in the Southeast Asian there is a constant quest for peace and harmony with others and with the world in general; this leads to accommodation rather than confrontation and to appeasement,

submission, and acceptance rather than aggression, impatience, and rebellion.

- That the whole system is not static and has evolved and is still evolving with time and with contact with Western civilization. The result is a complex and composite picture of a culture that is not quite what we read about in books, nor is it the copy of Western culture it may sometimes seem.

In practice, if we, as therapists, have any doubt about where such a patient stands, the best bet is to be conservative and assume that he or she still thinks and acts in the traditional way. If we are wrong and the patient is more sophisticated and Westernized than we thought, there is not much harm done, as the patient will understand what we are talking about on the basis of past experience. Any rectification needed will be much easier than if we had assumed a "radical" position, which would have alienated a traditionally minded patient and sabotaged the therapeutic relationship beyond salvaging.

FAMILY THERAPY

Since Southeast Asians are family centered and take a family approach to most problems, including mental illness (Tung 1972a), it seems natural to think that family therapy could be a good way to give help. This is not entirely true, however, for while most Southeast Asian families are prompt to assist any member who is in trouble, they are rarely agreeable to the suggestion that the problem is family related. Family therapy sessions are not as informative and productive as we would like them to be, as almost everyone is trying to protect the image of the family as a whole. Parents will abstain from disclosing their feelings in front of the children. Children refrain from saying anything negative about their parents. And all resent a therapist who wants to suggest that the problem is the group's instead of the identified patient's. In our experience, better results would come, for instance, from staging separate, consecutive meetings with the parents rather than with the children and scheduling a "joint" session for the entire family only after

obtaining everyone's agreement on one or two issues, which could then serve as the starting point for reaching a compromise.

GROUP THERAPY

Group therapy is also generally difficult to implement with a population that is formalistic and whose members frown on talking about themselves publicly, so to speak. Therapeutic groups may have a chance to succeed only if:

- The participants are allowed to speak their native language, to diminish any inhibition or reluctance that they may feel about a situation that may be somewhat intimidating and foreign to their traditions.

- The group composition is homogeneous, with members of the same sex, of same profession or corporation, of a similar social background, or with the same interests or problems.

- The session is goal-oriented and focused on a specific problem in which everyone has a stake. A process-oriented, free-form meeting would in most cases be too fluid, uncomfortable, and incomprehensible for most Indochinese, who are accustomed to more structured situations and who expect immediate benefit from their participation.

- There is a visible leader who directs the discussion, serves as facilitator and mediator, and also hands out opinions and judgments, and closes the discussion. The best choice of a person for that role would be someone with maturity, experience, and prestige or social position.

Finally, working with Indochinese patients in the present circumstances also means that we have to make the maximum use of the resources in their communities.

RELIGION

Religion occupies a privileged position in the life of many refugees. The kind of help that a patient can get from such a source, however, is very limited. Most Indochinese go to the priests or bonzes or the few mediums or clairvoyants in their community only for services considered to be their "speciality": prayers, incantations, sacrifices, exorcism, expiatory ceremonies, divination, and other magical interventions of this sort (Egawa and Tashima 1982). A few may ask for guidance and counseling, but any such help is provided as a favor, coming from a person of good counsel with experience and wisdom to spare, and not because it is in any way a part of the professional calling. In practice, the religious leaders do contribute greatly to mental health, through the consolation and appeasement that religion brings to a distressed person and by referring or motivating patients to come to therapy or reinforcing the therapist's explanations and instructions. It helps, therefore, to keep in touch with the community religious establishment, if only to insure their goodwill toward the mental health facility and to prepare for their eventual cooperation in future cases.

Other resources in the refugees' own community are generally scarce and poorly organized and inventoried, but if and when they are available, they are valuable because they provide assistance that is immediately usable and acceptable (Khoa 1980). Among such resources, the most significant is the circle of friends and immediate intimates who often stand in as a family for the refugees who have no relatives in the United States. The care and support of patients can often be entrusted to these informal support systems with surprisingly good results, although, of course, there will always be some limitations inherent in such an arrangement.

Most voluntary, benevolent refugee associations (mutual assistance associations) are still in their infancy and can help only in very general tasks such as public information or health education. The presence of the Indochinese community in general, however, is in itself a big asset to mental health. The availability of a

congenial milieu, the possibility of social interaction, the promise of a meaningful relationship with companions from the same background and culture are, without doubt, the best remedy to depression and a source of moral support that helps counterbalance the stress of living in a foreign country. Such a therapeutic tool should be fully exploited for patients who may be feeling doubly alienated, both by their illness and by their foreignness.

IN SPITE OF THE DIFFERENCES

It has been 9 years since the first contingent of refugees arrived in the United States from Indochina. Now numbering almost 700,000, they form a good-sized group, though still a minority among minorities. With time, and often without being aware of it, a great many have gone a long way toward integrating themselves into the host society and becoming a working part of the American community, not only sharing in but also contributing to its activities and resources. In a few fields, however--and mental health is one of the most notable examples--the "mainstreaming" process has never been complete enough to permit an Indochinese patient to be treated the way an American is or to receive the same benefits.

The refugees' problems also have become more complex and intricate; they may not be as acute, but they certainly are not less severe or less numerous. They no longer involve survival and subsistence but concern issues that are more elusive, often intangible, but no less real than those that were experienced before. Conflicts; discord between spouses, parents, and children; cultural identity crises; or difficulties in relationships with one's own people or with the host community are not merely words but represent sleepless nights, sorrow, headaches, and often blood and tears for many Indochinese. They need answers and solutions, and most have tried to find these on their own, without even thinking of seeking help. Some among them, however, did arrive at institutions and receive services. Were they helped? How much did they appreciate the services? Some apparently did, as many are coming back, and perhaps in time, many more will come, with

more questions and more problems. What is available from our establishment at the present time, though not luxurious, is generally sufficient in most cases. It may not always be appropriate and adequate for every Southeast Asian, however, because of the gap between value systems, customs, and traditions.

One could think of two ways to narrow such a gap. Either patients can change and learn to adjust to the norms established by the majority or the services can be modified to fit the patients' needs and demands. There is no doubt that Indochinese Americans have changed and will continue to evolve toward more Americanized behavior. If, however, the history of Asian/Pacific Islander Americans is of any predictive value regarding the shape of things to come, such evolution will probably stop short of complete assimilation, and many generations later there will still be a need for a different kind of psychological care for Indochinese Americans.

This means that we cannot simply sit still and wait for the patients to be sufficiently acculturated to take advantage of our services. In the meantime, the acute and pressing needs of the present generation of Southeast Asians in the United States give one more reason to try to find, right now, some way to tailor our services to benefit this new clientele. The problem is difficult but not insoluble, requiring time and patience as well as an earnest desire to help. From the official establishment, must come a sense of purpose, along with tangible commitments in terms of research and active programs; from the practitioners, tolerance, perserverance, and concern for the special ordeal this group of patients has undergone. Some authors have described "cultural empathy" as being that special sense that allows a therapist to feel along with a patient from a different cultural background (Hsu and Tseng 1972; Kinzie 1978). Empathy is perhaps the greatest gift a clinician can possess: that great human quality that causes us to stand by our patients, to see their foreignness among their problems and, by fully accepting the implications, to make this foreignness an integral part of the solution. Coupled with compassion, which makes us take that extra step to help, empathy should be enough to make us open and

flexible and ready to help in spite of cultural differences.

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THE ROLE OF CULTURE IN THE MENTAL HEALTH TREATMENT OF INDOCHINESE REFUGEES

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INTRODUCTION

Over the past two decades, there has been increasing recognition of the vital role played by culture in both the manifestation of behavioral dysfunction and its treatment. Yet responsible use of cultural knowledge in clinical work continues to be problematic. Beyond recognition of an individual as a member of a given group due to name, common characteristics, general appearance, or other discriminating features, few if

any meaningful inferences can be drawn regarding an individual's functioning (Levine 1973, pp. 27-28). While it is essential that all those providing mental health services to Indochinese refugees be well versed in cultural knowledge regarding the several societies that constitute Indochina, it is also true that such cultural knowledge may not be predictive of the behavior of individuals. The importance of ethnicity and cultural variables for understanding an individual is a matter of culturally sensitive assessment in which the therapists' (psychiatrist, psychologist, social worker) store of cultural knowledge serves as a general field against which the individual or client group may be assessed.

Regrettably, mental health services and practitioners seem to have moved from an era of disregard for cultural variables to a time of excessive reliance on simple models of cultural determinism. Such reductionism is exemplified by trait approaches to analyzing cultural differences; i.e., enumerating the characteristics whereby one cultural group might be seen as different from another (Green 1982, p. 9). While useful as a means of recognizing differences between groups, such an analysis is inadequate for the needs of clinicians whose principal responsibilities and interests involve the individual or small-group functioning. Because of the problems of generalizing from a group level to that of an individual, the transactional approach set forth by Barth (1969, p. 11) appears to be more appropriate for clinical work. Within the transactional framework of culture, the role of culture in influencing behavior is assumed to be variable. The therapist using the transactional framework is operating as a participant observer identifying relevant cultural factors as manifested by the individual client or client unit in interactions with others and the environment. To identify relevant factors, the clinician must possess adequate information about cultural values, norms of conduct (both prescriptive and proscriptive), language patterns, nonverbal behavior patterns, and so forth. Most critical to the transactional model of clinical practice in cross-cultural mental health settings is the recognition of immense variability of behavior across cultures, within cultures, between individuals, and across time and situations. Recognition of such variability includes

awareness that each individual will manifest a unique cultural and developmental synthesis in his or her behavior; this uniqueness cannot be adequately predicted by knowledge of the behavior patterns of the client's cultural group (Green 1982, p. 52). Failure to recognize these essential elements of cross-cultural practice results in a form of benign ethnic stereotyping that can be extremely destructive in our work. Knowledge that the client is Vietnamese, for example, suggests certain values and behavior patterns for which we must be watchful (Ishisaka and Takagi 1982, p. 148). Other factors that must be considered are age at time of arrival, traditionality of developmental experience, rural or urban background, socioeconomic class background, education, religion, and relative acculturation to American lifestyles. While hardly an exhaustive list, these dimensions illustrate the types of assessment variables necessary to identify the specific effect of cultural membership on an individual client.

The following sections present key clinical issues that have been identified over the course of 9 years of providing mental health services for Indochinese refugees at the Asian Counseling and Referral Services, Inc. The clinical approaches addressed are provided to assist clinicians serving Indochinese clients in handling potential issues in treatment. The use of the recommended approaches relies on a thorough assessment that seeks to identify the relative contribution of traditional culture to client functioning. For example, younger Indochinese refugees who are fluent in English and who have adopted many of the mannerisms of American culture may not benefit from the formal introduction to the practitioners suggested in the following section. Similarly, an appeal to an individual's sense of obligation to others may be inappropriate for many whose behavior is guided by Western norms of conduct. On the other hand, a practice approach such as normalization has been found to be useful with the majority of clients because of widespread unfamiliarity with the use of American mental health services. It should be emphasized that these approaches must be individualized in their use in any given case and should not be viewed as applying across the board.

INTERPRETATION AND CULTURAL CONSULTATION

Because of the paucity of trained bilingual and bicultural Indochinese mental health providers, services to the growing number of Indochinese needing mental health services must rely on a variety of personnel available to act as interpreters and cultural consultants. Due to their importance, we view such individuals as mental health assistants upon whom our work depends and who must assume a role equal to that of the therapist if work is to proceed effectively. Although others have reported little or no difficulty with the use of mental health assistants (Kinzie 1981), our experience has demonstrated that there are several areas of potential difficulty that, if unanticipated, will simply undo all of our efforts to assist Indochinese refugees (Marcos 1979). Therapists need to be aware that the cultural factors described in this chapter are operating between therapist and mental health assistant, between mental health assistant and client, and between the therapist and the client. Thus, an interaction that typically involves two actors when a language and culture are shared becomes an interactional process involving three distinct subsystems. The bilingual mental health assistant may be unwilling to divulge certain clinical features that he or she may feel will show the client's community in an unfavorable light. Such censorship, however well intended, is an important problem given the need for accurate information on which to base our assessment work and treatment efforts. A bilingual mental health assistant may find it extremely difficult to communicate client complaints to the therapist that might be construed as being disrespectful of the therapist in his or her authority role (Muecke 1983a). A client may be unwilling to disclose important aspects of the clinical situation to the bilingual coclinician due to anxiety about how it will be received or because of personal shame. Overall, the traditional value placed on conflict-avoiding behavior requires the most emphasis. Therapists should be aware that, in many instances, a mental health assistant, client, or consultant may choose to deny or suppress information that is perceived as threatening to harmonious role relationships between the actors involved. Therapists need to be aware of these issues and their cultural origins

and to develop sensitivity to the myriad ways such factors can influence the therapeutic process and anticipate their influence in the interview. If the therapist can sense that some information is being withheld or that a possible controversial issue is being avoided, it is useful to raise the issue and, by example, seek to obtain better information. It is critical that therapists unfamiliar with the cultural systems of Indochina not misunderstand the motives for the behavior patterns described. The intent is not to deceive or somehow estrange the therapist. Rather, the force of traditional values is so strong that from the coclinician's perspective the option taken is the lesser of two problematic courses.

Because of these difficulties in language access and cultural differences, it is always preferable for mental health services to be provided by bilingual, bicultural specialists. Due to differing linguistic and cultural histories (Spradley 1979, p. 17), interpretation poses several serious problems in the provision of mental health services to Indochinese refugees, in addition to those previously discussed.

Perhaps most important, the languages of Indochina are vastly different in internal structure from English. Constructions that appear simple in English may have no direct correspondence in another tongue. Similarly, a construction from Cambodian may have no directly corresponding translation into English. Therapists need to be aware of such differences and to recognize that the interpreter should play an important adjunctive role as a cultural consultant for effective work with Indochinese clients. The interpreter must be invited to provide us with information about the client's nonverbal behavior that is understandable only in its own cultural context, as well as information about the type of honorific words employed by the client, cultural norms being represented by the client, and the like. In clinical work, the interpreter must assist in far more than interpreting words. The interpreter must assume the hugely important role of translating meanings across what is often a vast cultural and personal distance. In this context, there are several suggestions that have proven to be helpful.

It is extremely helpful to have an opportunity to review with the interpreter the nature of the interview, special content areas that the therapist is interested in pursuing, and technical issues that might have to be covered. This allows the interpreter to provide feedback to the therapist about potentially sensitive areas and alternative ways to obtain information, to become prepared by identifying the points of greatest correspondence possible between the two languages, and to identify any role induction work that may need to be done to prepare the client. Similarly, it is beneficial to reserve time to discuss with the interpreter any observations he or she might have made during the interview. It is also helpful for the therapist to speak directly to the client and to avoid unnecessary gestures. Often when communication is difficult, there is a tendency to increase nonverbal behavior: it should be noted that nonverbal behavior by the therapist is simply more "noise" in the information system and will serve to detract from communication. It is helpful to employ an interpreter to review the therapist's statements and questions for unnecessary use of technical jargon. As therapists, we should attempt to keep our statements as simple as possible and avoid using technical terms that might be better translated by staying with the behavioral referents of the concept. For example, "depression" does not translate directly into any of the Indochinese languages, and it is far easier for the interpreter and client if the therapist uses the symptom pattern in his or her attempt to diagnose the clinical entity. Of special importance is the need to avoid using idioms or other confusing phrases in working through an interpreter.

In certain areas of clinical process, there are specific difficulties that may arise in working through an interpreter. For example, some of the questions involved in a mental status examination may need to be changed to avoid cultural/linguistic confusion. It may be useful to have the interpreter use a culturally appropriate proverb to gage abstract thinking ability and to use appropriate sites and the like to test storage of information. What is needed in those instances in which bilingual, bicultural therapists are not available is a pool of interpreters who are trained in mental health

issues, diagnosis, and treatment and who have developed a working relationship with providers in an area.

CLIENT ENGAGEMENT

For a variety of reasons detailed elsewhere (Lin et al. 1982), refugee clients may be extremely reluctant to seek out or accept mental health treatment. The concepts of mental health and mental illness as used in the United States are likely to be alien to many Indochinese refugees (Moon and Tashima 1982, p. 27). Moreover, mental health and mental illness may be viewed as interchangeable terms, with traditionally felt stigmas attached to both (Muecke 1983b). Because of unfamiliarity with Western mental health practices, reluctance to use such services may be compounded by fear of the unknown. Another key potential problem is that there is no traditional role among the Indochinese cultures for a person who provides mental health services. Thus, for persons raised in societies that maintain an elaborate interpersonal code governing relationships between individuals, the lack of a suitable role to assign to the mental health practitioners evokes anxiety about acceptable conduct. Moreover, Indochinese clients may not be familiar with, and thus will not share, certain assumptions about mental health practice that are common in the United States. An example is confidentiality. While the majority of individuals may assume confidentiality and have a working knowledge of its practice, Indochinese refugee clients must often be taught about confidentiality and its use in mental health settings. In Indochina, since there are no comparable mental health systems, there are no clear laws about confidentiality known to the general public. In Vietnam, for example, people believed that if one agency knew something, the whole government knew; or if one American knew, then every American in Vietnam knew. Such beliefs can interfere with the divulging of information critical to client engagement as well as to accurate assessment and treatment.

Because of the complexities involved, it is helpful during the engagement phase of work with Indochinese refugees to be mindful of the particular sources of anxiety experienced by the client. The following

sections review several of the most important clinical issues.

THE INITIAL ENCOUNTER

It is important to recognize that all the Indochinese cultures have developed complex codes of conduct that may be seen in the verbal and nonverbal behavior of individuals. An example is the honorific systems in the languages of Indochina, wherein it is possible to represent in speech an individual's awareness of relative social distance between speaker and listener. Relative social distance can include language forms indicative of sex, age, education, and socioeconomic class. Formal introduction, preferably through a third party, can be extremely useful in providing enough information about the client and practitioner to permit interaction respectful of the client's sense of interpersonal propriety The therapist's education, experience, etc., should be a part of the introduction to permit the client to gage what form of honorific to employ if speaking his or her native language, or to gage nonverbal behavior toward the clinician if the interview is taking place in English. If using an interpreter, the interpreter may be the most appropriate person to provide the introduction.

The therapist should be aware that it is considered ill mannered for an individual to sound boastful about his or her own accomplishments. Individuals who do so lose the respect of others. Therefore, if no third party is available to make a formal introduction, the therapist can simply introduce himself or herself by title and specialization. This amount of information helps the client to determine the proper mode of address and personal conduct toward the interpreter and helps allay anxiety about the therapist's competence and experience. Whenever possible, it is desirable for the therapist to make contact with the client through a trusted relative or friend of the client. This approach is supportive of traditional culture and can play an important role in subsequent networking as part of the treatment plan.

As Muecke points out (1983a, p. 433), the therapist's presentation of self is important to consider. The therapist should appear calm, quiet, and unhurried, thus conveying the impression of maturity, wisdom, and dignity. The therapist can also express awareness of the client's code of conduct by inquiring about the appropriate form of address.

In the initial sessions of work with Indochinese clients, it may prove helpful not to take notes. Notetaking, unless carefully explained, will tend to reduce openness by the client because of fear of what purposes the recorded information will serve. This caution does not pertain to demographic information that might be required for agency intake or to establish eligibility.

Some Indochinese may tend to talk in generalities in the early phase of work with a therapist. It is important to assume that the client is resistant or evincing problems in getting to the point. The general picture provided by the client will supply an important background for further inquiry into areas of detail left unclarified by the client. Like notetaking before the client learns to trust the therapist, premature pressures on the client to go into detail may result in the client's being less inclined to share information.

NORMALIZATION

An important aspect of engagement-phase work with Indochinese clients involves education of clients in a framework of understanding of distress that makes clear the connection between abnormal levels of stress and emotional reactions. Although it is helpful to avoid the use of psychiatric or mental health labels that might reinforce traditional negative connotations about manifestations of personal distress, it is also useful to develop a subframework in which commonly encountered symptoms of distress are tied to high and chronic stress levels and in which the appearance of symptoms is considered normal. Such an approach has permitted therapists to emphasize clients' strengths and coping skills that continue to work, while deemphasizing explanations that focus on individual or family pathology. As suggested in Bridging Cultures (Morales 1981,

p. 256), it is helpful to avoid terms that are threatening to the client's view of self. Thus, however innocently intended, the designation psychosis, unless handled extremely carefully, implies "crazy" to the Indochinese client and may result in clinical problems that might otherwise be avoided. Normalization involves helping a client to change expectations surrounding symptoms and the relationship of the symptoms to overall functioning. In our practice, we have seen many times that it is helpful to suggest that, given the stress levels and worries with which the client has been dealing, it is to their credit that symptoms have taken so long to appear. Again, the major effect of normalization is in reducing anxiety by helping the client to reformulate what was once unpredictable, and, hence, anxiety arousing, into a set of expectations that provide the basis for treatment.

HISTORYTAKING AS PART OF THE ENGAGEMENT PROCESS

Historytaking has been demonstrated to be a key element in appropriate assessment and treatment of Indochinese clients (Kinzie 1981). In addition to providing the therapist invaluable information regarding the client's past, historytaking also permits an opportunity for the therapist to become aware of cultural factors that need to be considered in further assessment and treatment. For example, a Cambodian client who is encouraged to talk about the experience of becoming a refugee and losing family members will be providing the therapist with information about his or her views of family life, loss of status and mobility, religious values, and so forth. But most important, historytaking during the engagement phase indicates to the client awareness of the importance of the client's life and demonstrates interest in and sympathy regarding the events that have shaped the refugee's current situation. The transactional framework of cross-cultural mental health work requires that the therapist provide opportunities for clients to manifest their unique perspectives and values in the context of life experience.

Areas for historytaking include:

1. Family life and experiences during childhood

2. Life experiences prior to becoming a refugee

3. Reasons for escaping, the escape process, losses, and expectations

4. Life in the camps, attitudes about camp life, problems of sustenance

5. Sponsorship to the United States, expectations of life in the new land, experiences with culture conflict, survival problems, coping strategies

6. Family life adjustments, if the family has been in residence for several years

7. Current concerns and expectations for the future

8. Client's current understanding of adjustment difficulties

ROLE INDUCTION

As described by Goldstein (1973, p. 25), role induction has proven to be invaluable in "realigning discrepant patient-therapist role expectations." Role induction involves carefully describing clinical processes and their rationale to clients. While a flexible approach to mental health work is a must for those involved in providing services to Indochinese clients, there are certain therapeutic tasks that we feel are essential. It is extremely important to assist any newcomer to American culture to understand what is involved in getting help and why certain approaches, activities, and interviewing protocols (e.g., the mental status exam) are employed. The types of services we are prepared to offer are often at considerable variance with what Indochinese clients may expect. Role induction can help clarify client expectations as well as indicate what to expect in mental health treatment. In addition, role induction may be a critical factor in continuity of treatment (Tseng and McDermott 1975); that is, role

induction can assist persons needing treatment to stay in care despite differing expectations and unfamiliarity with Western practices. Similarly, role induction is helpful in our work with family members and others involved in the client's life. Often family members and others are just as nonplussed as the client about the need for therapeutic assistance and just as confused about the forms such assistance may take.

CLIENT ASSESSMENT

Many of the tasks described as appropriate for the engagement phase may need to be continued into the assessment and treatment phases of mental health work with Indochinese clients. As new clinical content emerges, there will be a need for additional support and clarification to assuage anxiety. Beyond these considerations, assessment work with Indochinese clients may benefit from the therapist's awareness of several additional factors. For a variety of complex reasons, including different linguistic and cultural histories, the Indochinese languages do not possess an elaborate lexicon of terms to describe purely emotional states. This factor, in combination with widespread belief throughout the culture in stoicism, results in somatic complaints often representing stress-related disturbance (Ishisaka and Takagi 1982, p. 53). It is beneficial to consider somatic complaints to be indicative of unresolved stress or tension in the client's life and to provide symptomatic relief (Tung 1980). In many instances, such symptomatic relief is adequate for the client to feel marked improvement and may result in the client's discontinuing treatment (Kinzie 1981). In other instances, successful alleviation of symptoms by assisting a client through a crisis, providing psychotropic medications, or assisting in a family problem may result in the client seeking help for other issues. In any event, therapists must recognize that very few Indochinese clients will present dysfunction in the same terms or frameworks as majority clients or in ways we, as practitioners, expect. We have found that efforts on the resolution of concrete problems, following the client's lead, are most helpful and has led to a deemphasis on soliciting feeling statements. These comments are especially applicable to older, more

traditional clients, especially from backgrounds in which there was little contact with Western practices. For other, more acculturated individuals, there may be more congruity between the therapist's expectations and the clients' presentation of symptoms. Because of the cultural differences involved and the problems of accurate translation when an interpreter is used, it is desirable to keep the asssessment framework as simple as possible while producing the information needed for setting goals and planning treatment. The performance discrepancy assessment model appears to have cross-cultural utility and avoids conceptualization of client difficulties in a threatening manner (Gottman and Leiblum 1974, pp. 25-27). Basically, the performance discrepancy approach to assessment identifies those behaviors that are ego-syntonic and ego-dystonic and those behaviors that are reference-group approved and disapproved. The identification of behavior patterns that are reference-group dystonic is of particular value in our work with clients reared in societies in which group evaluation of individuals plays a strong role in ego identity and self-valuation.

Another critical aspect of cross-cultural practice is the need to be aware of the basic errors that can be made in assessment and problem identification across the boundaries of culture and therapist experience. Two basic potential errors merit discussion. First, caution is needed to ensure that normative cultural practices, behaviors, and beliefs are not confused with pathological processes. As stated earlier, a therapist must possess enough cultural knowledge to make these discriminations. For example, widespread belief in spirit possession (Chindarsi 1976, pp. 39-47) can be misconstrued as disturbed thought content; or relative selflessness in making personal choices can be mistaken for a problem of ego identity and personal boundaries. Second, it is equally necessary to ensure that we do not assume a pattern of behavior to be simply a normative cultural pattern because we are unfamiliar with it. In both instances, the client and/or significant others can serve as our best informant, if we assume a participant-observer stance. Others who may be more knowledgeable about prevailing cultural practices can also provide invaluable assistance in assessing client functioning. Because of the possibility

of cross-cultural error, it is desirable to seek as much information from as wide a range of informants as possible, should the client be willing. Family members and others can assist in determining what behaviors might be cultural in origin and which can be considered symptomatic of a disorder of functioning.

Throughout the assessment phase, it is important to seek to identify the client's statements regarding his or her own distress and its origins (Kleinman 1978). In doing so, the therapist can gain critical information needed to provide the client with an alternative explanation of his or her difficulties, if necessary, or, when possible, to treat the client within the context of his or her own understanding. The therapist should be aware that, in many instances, the interview in a participant-observer situation will be influenced by the client's sense of what constitutes proper behavior, and obtaining information may be problematic. Reared in traditions emphasizing interpersonal harmony and great deference to authority figures, many Indochinese clients may be reluctant to share information. It is therefore necessary to exercise patience, with the hope that information will be forthcoming in time as the client gains more confidence and trust in the therapist (Ishisaka and Takagi 1982, pp. 153-154). Moreover, it is important for the therapist to invite the client to share information by repeated role-induction efforts.

ATTRIBUTIONS

We have found it useful to share with a client a stress framework of disorder. Because the traditional explanations of emotional dysfunction involve shame to the client and family, an alternative no-fault explanation provides the client with a means of accepting the disorder without shame. We have found that the stress framework is readily understandable to the majority of Indochinese clients. Stresses uncovered over the course of taking a psychosocial history are especially important to incorporate into an explanation of the framework. It is helpful for clients to come to understand that emotional difficulties constitute a normal reaction to abnormal stressors. Providing alternative

explanations for dysfunction is essential to effective work with Indochinese refugee clients. Such alternative explanations are the foundations on which our practice can be built. In Indochina, there have been a wide variety of specialists who could assist persons who were experiencing life difficulties within the context of traditional explanations. Thus, folk healers, shamans, and others could provide appropriate treatment. In the United States, given the vagaries of the refugee process, such specialists are few in number. We have found that successful treatment requires an alternative explanation--one that is acceptable to the client and does not violate traditional beliefs or values. When possible, it is desirable to help clients seek forms of assistance consistent with traditional beliefs regarding dysfunction, as an adjunct to treatment provided by Western-trained mental health workers.

INTERVENTIONS

UNIVERSALIZATION

Perhaps because of the stigma attached to the more severe forms of behavioral dysfunction in Indochinese societies and the traditional ways of explaining such disorders, e.g., demonic possession, Indochinese clients may experience considerable anguish about the causes and perceived uniqueness of their adjustment problems or emotional disorders. As a means to alleviate anxiety, the technique of universalization has been used with Indochinese clients. Clients are informed that their symptoms are not unique but are shared by many people experiencing the adjustment stresses of refugee status. Clients are further informed about other persons who have been treated successfully for similar difficulties. We have found it useful to develop case anecdotes to share with clients, using precautions to ensure confidentiality. Universalization appears to help Indochinese clients to feel less alone in their distress, as well as to promote a sense of hope that effective help is possible. Many Indochinese clients do not seek professional help until symptoms reach crisis levels or until every other source of assistance has

been exhausted. Both the client and significant others are often extremely uncertain whether anything can be done to help. Examples of how others have been helped provides both an opportunity to relieve despair and an opportunity for the therapist to describe treatment practices to the client.

MOTIVATING THE INDOCHINESE CLIENT

Another aspect of traditional cultures that must be considered is the deep sense of obligation to others, especially family, among the Indochinese societies. Taught from childhood to construe "self" as an extension of a family group, many Indochinese may be said to have a collectivist, rather than an individualist, orientation (Matsushima and Tashima 1982, p. 43). Throughout life, the individual in Indochinese societies is expected to defer to group needs. The complex web of personal relationships forms the psychoemotional security for individuals. As can be expected, each of the Indochinese societies has evolved a rather complex interpersonal code to govern interactions between individuals in their various roles. The existence of such a code minimizes the possibility of conflict that might harm solidarity. However, many Indochinese clients experience severe role and status loss (Nguyen 1982) as part of the process of cultural transition. Individuals may be uncertain how to behave in situations of role loss. One approach that has been found to be useful involves the therapist's appealing to the client's sense of traditional obligations to others. Thus, a man may be motivated to renew coping efforts to fulfill the role obligations of fatherhood, or of being a son. Often queries made as to an individual's personal goals will go unanswered, while the individual may respond well to goals that can be derived from the individual's several roles. The counseling approach of identifying culturally syntonic role-related therapeutic goals allows individuals to direct energies in ways that have collective validity. Moreover, such an approach increases the likelihood that the individual's efforts will be met with positive reinforcement from the social environment.

The following case illustrates the use of culturally derived obligations to assist a client through a major problem of adjustment.

> The client, a 31-year-old man, was a major in the army of Vietnam. The client came to the United States in the first group of Vietnamese refugees to arrive in this country. Because of circumstances surrounding his escape, the client came to the United States alone. The client's two brothers were also in the Vietnamese army but had been captured and were in a prison camp in North Vietnam. The client was enrolled in an English-as-a-second-language class but complained that he could not concentrate during class. He had applied for several jobs but failed in the interview process. The client began to complain about difficulties in living in the United States and began to withdraw increasingly from his friends and his usual activities. The client received a letter from his sister-in-law that his brothers had died in prison camp. He also learned that both his sisters-in-law had attempted suicide. One sister-in-law succeeded, but the other was rescued and decided to stay alive to take care of the children of both families. The client learned of the deaths in his family while depressed, and the information exacerbated his mood disorder. With growing hopelessness, the client decided to commit suicide by hanging. He was found and hospitalized, during which time he made two more suicide attempts. During hospitalization, the client was not receptive to treatment attempts. Attempts at providing treatment having failed, the case was referred to Asian Counseling and Referral Services, Inc., in Seattle. A Vietnamese-speaking counselor was assigned to the case. After obtaining information from the hospital and from the client's friend (networking), the counselor decided to make his first hospital visit with the client's friend. It was felt that introduction of the counselor by the client's friend (formal introduction) would help to gain the client's confidence and trust. Moreover, the friend could introduce the counselor along the lines suggested earlier. Over the course of discussion between the client and his friend, the counselor could observe how traditional values were affecting

the client's attempts to cope (transactional assessment). The counselor participated in parts of the discussion, providing illustrations of other newly arrived Vietnamese refugees and their attempts to adjust to life in the United States, often with the added strains of devastating news from home about relatives and friends (universalization and role induction). The counselor was also able to instruct the client how others have been helped to cope with the grief of losing loved ones (normalization and attribution). The counselor acted in ways that would help the client to regain hope, to understand that help was possible and that in many instances the future could not be predicted from the client's present pain (motivating the client). As his work with the client continued, the counselor brought up the courage and sense of family which had caused his sister-in-law to choose life over death so that she could continue to care for her children and nephews and nieces. Using the sister-in-law as a model of how an individual can continue to honor her obligations during times of extreme hardship, the counselor was able to motivate the client to find meaning in his renewed attempts to help his surviving family in Vietnam. As the client's sense of meaning and purpose returned, the major symptoms of depression weakened. Over time, the client was helped to direct his energies toward finding work and establishing community ties. At this time, the client is employed and is supporting his family in Vietnam. He is an active member of the Vietnamese community. Throughout the counselor's efforts to assist the client, the client's friend continued to play an important role in treatment as the principal extra-therapeutic source of emotional support to the client.

MEDICATION

Symptom formation, while reflecting the individual's adaptive response to stress (as in posttraumatic stress disorder), can itself obstruct progress to optimal adaptation. For example, often seen in posttraumatic stress disorder is the exaggerated sympathetic response to sensory stimuli (startle response), the recurrent and intrusive recollection of traumatic events, palpitation,

anxiety, fear, sweating, mental confusion, difficulty with concentration and memory, irritability and anger, and avoidance behavior. As a result of these symptoms, an individual can become reclusive, with resultant interference with family and social relations and with the ability to function on a job. A refugee may lose his or her job as a result of these troubling symptoms and further aggravate the original stressful circumstances. Interruption of this cycle with psychotropic medication is an important component of the overall treatment strategy. Similar arguments can be made for symptom reduction in other diagnostic categories such as adjustment disorders, depression, and psychosis.

While explanations of illness may vary with the degree of cultural traditionality of an individual, many Indochinese refugees view Western medicine with some suspicion. A common beiief is that Western drugs are not suited to the Indochinese. This is particularly true when side effects occur with the use of psychotropic drugs, as is so often the case. Side effects such as constipation, dry mouth, and urinary retention are thought to indicate that the drugs create an imbalance of the "hot" elements, resulting in excessive "hot" energy within the body--an idea with roots in Chinese medicine and Taoist philosophy (Ishisaka and Takagi 1982, p. 151). Consequently, it is not unusual for the client to lower the dose or stop the drug altogether without communicating this to the counselor or psychiatrist (Muecke 1983). Medication noncompliance becomes a major obstacle to effective use of psychotropic medication and may require sustained educative efforts to overcome clients' misgivings.

Another important aspect of medication use with Indochinese refugees is the potential for misunderstanding side effects by the client or the misinterpretation of these symptoms and behaviors by the therapist. A case example illustrates this point.

An Asian Counseling and Referral Services counselor was called to assist in the treatment of a Vietnamese female who was involuntarily committed to treatment because of what was felt to be depression with suicidal ideation. The client had been seen a few days prior

to the commitment by a physician and started on an unknown drug. Soon she was unable to swallow or talk. She was quite fearful of these unexplained symptoms and thought "I am dying." The idea of death was misinterpreted by the Western therapists who concluded that the client was depressed and suicidal and prescribed an antipsychotic drug, which increased the symptoms. The counselor was able through detective work to discover that the client had been given on the first occasion an antipsychotic drug that produced a dystonic reaction in the tongue and throat muscles. The second antipsychotic drug only aggravated the dystonia. When this was discovered and an anti-Parkinsonism drug administered, the client improved and was able to leave the hospital.

This case report, as well as the problem of medication compliance referred to above, illustrates the need to inform the client of the benefits and side effects of psychotropic medication. We have found it necessary to approach this problem in several ways. First, the client is told by the bilingual, bicultural counselor about the condition and how the medication will affect the symptoms. This is generally couched in terms of the stress model of illness and the use of drugs to assist the client in stress reduction. The client is also told of the side effects and reassured that the appearance of any side effect is not cause for alarm. Further, the family may be informed so that they may watch for any occurrence of side effects and provide reassurance should they develop. Finally, the counselor monitors for side effects and therapeutic efficacy by telephone contact with the client. In these ways, noncompliance and the misinterpretation of drug side effects can be minimized.

Because multiple health care providers are frequently involved in the care of Indochinese refugees, there is often considerable confusion with regard to medication. While patients who are familiar with the health care system and are conversant with the language can negotiate the multiple-provider system without confusion, Indochinese refugees often are unfamiliar with the system and are not able to obtain information about medication prescribed by other physicians. A frequent occurrence is the prescribing of similar drugs by

different physicians who are unaware of other medications being taken by the patient. As a result, a patient may be taking two or three different antidepressants, with subsequent accumulation, side effects, and/or toxicity. It is often necessary to have the client bring in all medications for review so that the physician can prescribe drugs with knowledge. We generally confiscate drugs that are not indicated and communicate with other physicians about our treatment plans.

A brief word should be said about medication dosage in prescribing for Indochinese refugees. Kinzie (1981) comments on the sensitivity by Asians to psychotropic medication. Our experience is anecdotal, but it is consistent with the view that Asians require lower doses of medications. Our procedure is to start low and gradually titrate the individual dosage based on symptom reduction; for example, a tricylic antidepressant will often be started at 25mg/day and adjusted upward.

CONCLUSION

The foregoing sections reflect the accumulated experience of the authors over a 9-year period of providing services to Indochinese refugee clients. It is our hope that our suggestions and identification of issues in mental health work with Indochinese clients will benefit the many individuals attempting to provide important and needed services across the gulf of language, culture, and personal history. While reflecting direct experience with one-to-one mental health services to Indochinese refugees, staff consultations, and an informal review of agency archives, the recommendations made are not derived from empirical analyses or from hypotheses that have been formally tested. There is an enormous need for sustained research to provide guidelines for mental health practice with refugees from Indochina.

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MENTAL HEALTH OF SOUTHEAST ASIAN REFUGEES: OBSERVATIONS OVER TWO DECADES FROM LAOS AND THE UNITED STATES

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INTRODUCTION

BASIS OF OBSERVATIONS

From 1965 to 1967, I worked full time as a general physician among refugees in Laos. Eight months of this time were at a refugee hospital in northern Laos; 8 months were in rural areas with refugees, epidemics, and casualties of war and 8 months were devoted to various public health and administrative tasks (e.g., obtaining prostheses for amputees injured by land mines, working on a provincial hospital construction project, and teaching village health workers). During this time, I lived in the villages of refugees; shared their food; traveled the refugee trail with them; and experienced military attack, malaria, and dysentery along with them. Often I was away from anyone but refugees for weeks at a time, in the refugee settlements of Hmong, Lao, Thai Dam, Akha, Lu, Laven, Dyheun, Khamu, and Yao peoples. Usually I stayed in their

homes and shelters, and refugees also stayed in my home for various periods.

During the period from 1971 to 1975, I returned six times to Laos, for about 2 months on each visit. Four of these visits were consultations with the Ministry of Health and the Ministry of Social Welfare in Laos regarding refugee mental health issues, especially opium addiction. On two occasions, I returned on research grants to undertake psychiatric epidemiological studies on a variety of topics, including major mental illness, violence, assassinations, and drug dependence (Westermeyer 1971a,b, 1972, 1973a,b,c, 1974a,b, 1976a,b, 1978a,b, 1979a,b,c,d, 1980a,b,c,d, 1981a,b,c,; Westermeyer and Bourne 1977, 1978; Westermeyer and Hausman 1974a,b; Westermeyer and Kroll 1978; Westermeyer and Neider 1981; Westermeyer and Pattison 1981; Westermeyer and Peake 1983; Westermeyer and Peng 1977a,b). Between 1965 and 1975, 3 years were spent in Laos.

From 1977 to 1985, I returned to Thailand on seven occasions, once for the White House Office of Drug Abuse Programs and four times for consultations for the Drug Dependence Division of the World Health Organization. Although none of these visits formally involved refugees, I had numerous opportunities to observe and learn about refugees in Thailand from refugee relief workers in Thailand and from psychiatrists, other physicians, and relief workers who worked with the refugees. I obtained further information on refugee experiences in Thailand in the course of subsequent clinical and survey research with refugees in the United States.

My experience with refugees in the United States has been both social and professional. Many close friendships were forged with refugees in Laos at a time when we were working together, struggling together, living together, losing coworkers and friends (Laotian and American), and grieving together. These relationships have now been resumed in the United States. Professional experiences and research reports have been published elsewhere (Westermeyer et al. 1983a,b,c,; Williams and Westermeyer 1983).

LAOS

In the 1960s and early 1970s, refugees of all ethnic groups in Laos emigrated as intact villages and towns. Communities ranging from 50 people up to towns of 4,000 people moved between 50 and 200 kilometers with their populations largely intact (excluding those who died along the way, usually the very old, the very young, and those seriously ill). In the new locations, people reorganized themselves on the level of the mu ban, or collection of several houses, as well as on the level of the ban, or village. In towns, people further organized themselves as several ban into a taesseng, or into a larger mouang, or district. The general layout of a refugee village would essentially replicate the original village. During 1965 to 1967, I worked in communities that had moved two or three times in this fashion (some of them having originally moved out of North Vietnam).

Not only were geographic relationships maintained, but political relationships also persisted. The same extended family elders of the mu ban; the village chief, or nai ban; and the same taesseng or mouang leader continued to hold office as before. These leaders organized routes of flight and assigned defense and logistic tasks for the refugee move. Refugee relief workers from the Laotian Government, as well as refugee workers from international and national agencies (both private and public) worked with this indigenous political leadership. This was not only efficient, such recognition also enforced the legitimacy of indigenous leadership, accordingly it enhanced importance and strength.

Within this intact geographic and political organization, social roles and responsibilities persisted. Schoolteachers, midwives, merchants, herbal healers, spiritual healers, hunters, fishermen, gardeners, religious practitioners, and others continued their roles as before. Men were busy building new houses, clearing land for gardens and rice fields, fishing, and hunting. In many villages, men became members of a self-defense militia, with arms, training in military skills, and sometimes a uniform; these lent a sense of control and security in a context of recent loss of control and insecurity. Women were occupied with child care, cooking;

housekeeping; gathering tubers, roots, leaves, wild vegetables, and fruits; collecting firewood; preparing mats and decorative items for the new household; weaving bamboo matting for walls and floors; and tending gardens. Villagers remained involved with such tasks for at least 2 or 3 years after a move.

The decision to flee often occurred in the midst of fear and crisis. Typically it was made during or after a nighttime attack in which some local militia were killed. People took to the refugee trail with little more than the clothes on their back, a few days' rice rations, whatever gold or silver they possessed, a sleeping mat, and perhaps a cooking pot. They carried their young, their old, their ill, and their wounded on their backs. Depending on the duration and distance of the flight, mortality rates ranged from nil to 15 or 20 percent, although from 2 or 3 to 10 percent was a typical figure after a prolonged trek through the mountains over a few to several weeks. Medical problems among the refugees included respiratory infections; malaria (especially upon exposure to new strains different from those in their former locale); war-related injuries (shrapnel more than bullet wounds, and occasional phosphorous burns), diarrheas and dysenteries; and nutritional problems, including beriberi, pellagra (infrequent), and, especially in children, vitamin A deficiency keratitis, vitamin A-related bladder stones, and protein deficiency.

Despite the fear, the material losses, the personal and family losses, and the relocation, morale tended to be high. People had much to do: fields to prepare, homes to build, households to reestablish. They had maintained their social networks intact, as well as their political organization, not only within the village, but also with the district leadership and, indeed, even with the national leadership. They continued the social and occupational roles that provided them with identity, goals, and meaning. Any material help required once they reached safety tended to be modest (e.g., plastic for shelter, a blanket or two, rice, a cooking pot), and distribution was equal. Refugees were expected to build their own shelters, make their own clothes, and plant their own gardens and farms.

The American refugee relief workers in Laos (as well as those from other countries and organizations) were a skilled, experienced, and unusual group of people. Those leading the effort (e.g., heads of public health, education, and refugee relief organizations) were in their forties and fifties and had extensive cross-cultural experience. On a more junior level, virtually all of the workers had previous Peace Corps or other cross-cultural training and experience. These workers had some level of language capability in one or more local languages and had adjusted to the local culture. Those unable to adjust were repatriated to the United States or reassigned.[1] Promotion through the ranks usually depended upon demonstrated ability in Laos. Education and training were appropriate to the tasks assigned. These circumstances led to excellent cooperation between the refugees and those working with them. Refugees came to expect, and indeed received, both personal commitment and a high level of expertise from their foreign advisors and helpers.

Mental health problems did occur in Laos, but these varied greatly from those later observed in the United States. For example, one man who had lost his village twice, had lost one of his children, and then most recently had lost his wife through an illness, killed himself and his remaining children with a grenade as they sat around the evening fire (Westermeyer 1973a). Refugee opium addicts no longer able to grow their own opium or to raise crops for bartering with poppy farmers created family and social problems (Westermeyer 1983). One psychiatric "epidemic" (including the usual somatic and hysterical symptoms) occurred among a

[1]There was a relatively high rate of maladjustment among Americans in Laos. A significant minority of refugee workers had various mental health problems that forced their return to the United States or to other, less stressful, assignments. Those whom I knew included a physician, a few nurses, several refugee workers, support staff, and various family dependents. Diagnostic entities consisted of agoraphobia with panic, depression, schizophreniform psychosis, delirium tremens, chronic alcoholism, and opium dependence.

group of soldiers who had been isolated in a remote outpost for a number of years, but this was not observed among refugees. High stress, loss, and grief were omnipresent, but morale remained high; and the refugees were industrious and active in solving their own problems. Although epidemiological data are not available, major mental illness, widespread psychiatric disability, suicide, divorce, and social alienation, did not notably increase. The one major mental health problem, mentioned above, consisted of refugee opium addicts no longer able to raise or purchase their own opium.

THAILAND

The breakdown in this predominant pattern of total village migration began in 1975 following the change in the government. Especially in the larger towns such as Long Cheng, Ban Son, and the Mekong riverside towns, people departed as families from their communities and fled for the Thai border. Less often, there were larger movements, usually of the mu ban. A few Hmong ban fled as an intact community, as did some military units (with their families) and older schoolchildren. During the early days in the Thai refugee camps, there was a discontinuity of political and social organization. There was also a lack of food and material resources, and infectious disease spread due to the crowded conditions. Many children became mentally retarded as a result of nutritional deficiency, meningitis, encephalitis, prolonged high fever, or maternal malnutrition. The refugees were relatively powerless as foreigners in Thailand. The often unfriendly response they received in Thailand contrasted the usual friendly or at least neutral reception they had received in Laos. Extended families broke off from larger groups to husband food and resources for themselves. Even nuclear families sometimes broke off from extended families to provide for their own youth and elderly. Isolation, suspiciousness, and projection of hostile intent onto others began in this context.

Despite these tremendous changes in Thailand, there were also certain similarities. Topography, climate,

and food (when available) were familiar, as were Thai markets, the Buddhist religion, and music on the radio. The Thai language was readily learned by those who spoke Lao. Many missionaries and refugee workers whom the refugees knew from Laos again linked up with them in Thailand. Their customs remained largely intact, and they were exposed to relatively limited outside influence.[2]

UNITED STATES

It was a matter of some amazement to me to observe the Hmong and Lao people who came to Minnesota in 1976 and 1977. While there were only several score of them, they remained separated around the town. They did not reorganize as they had done repeatedly in Laos. There were expressions of suspicousness regarding their ethnic peers, not a little jealousy regarding what material resources this one or that one received from sponsors, and often considerable hostility regarding minor interpersonal issues that would have gone unnoticed back in Laos.

Environmental differences between Asia and the United States are marked; not only had topography, climate, language, and food changed, but the refugees were in the midst of a new and strange people. The American sponsors, social workers, and health workers seldom knew their history, language, or customs. Although homesick and often miserable in the new climate, they were typically expected to be grateful for the envied status of residing in the United States. Even simple tasks, such as shopping or travel, were unfamiliar. Due to the procedures used for resettling people, many individuals in extended families were separated from loved ones. Loneliness became even more acute than in the Thai camps. Those assigned by social, health, and educational agencies to work with

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[2]The differences were of course greater for the Vietnamese going to Thailand or to the Malay Archipelago, although the Cambodians fleeing to Thailand found much that was familiar (e.g., similar Buddhist religion, Pali script and words, food and topography, and housing styles and dress).

the refugees were mostly inexperienced in working with Southeast Asians; many were young and inexperienced even in their own professions. The refugees were well aware of the negative feelings by some Americans toward Indochina, their homeland. They also knew that many American minorities resented the special programs and resources directed toward them.

EARLY MENTAL HEALTH INTERVENTIONS IN THE UNITED STATES: AN OVERVIEW

The initial mental health assessments and interventions in the United States were conducted by military psychiatrists on National Guard or reserve status. A few military officers responsible for the refugees initiated consultation on their own. There were no reported initiatives from the State Department or the Department of Health, Education, and Welfare (now Health and Human Services). The psychiatrists, however, related that there appeared to be "few patients . . . with purely emotional complaints," while noting the frequency of somatic complaints. They reported that the refugees "seemed happy, . . . stoic, . . . clever, and energetic" (Mattson and Ky 1978).[3]

Another military consulting team indicated their lack of familiarity with Indochinese culture and their difficulty assessing psychiatric disorder across cultural boundaries (Looney and Harding, in press). They made a number of useful recommendations, some of which were followed. Other recommendations, such as those involving Indochinese adolescents, were ignored. In particular, the team suggested that extended families not be split up and that unaccompanied children and adolescents be placed with families from their same ethnic group. Neither recommendation was followed--the outcome of

[3]This points up the fallacy of relying on indigenous people, even well-trained professionals, to provide information regarding issues on which they might not be expert. Vietnamese or military psychiatrists might be fully competent in their respective clinical domains and still be quite naive regarding refugee mental health issues because of lack of prior experience and training with this unique problem.

which social and mental health professionals must still work with today. Looney and Harding indicate that, while volunteer organizations and the military complied with recommendations and were quite humanistic in their responses, the U.S. State Department and the U.S. Immigration Service tended to be less sensitive.

By the late 1970s, it was apparent that many of the Indochinese in the United States were experiencing adjustment problems, despite a report to the contrary by Vignes and Hall (1979). Lin et al. (1979) were the first to report a high symptom level among Vietnamese refugees. This was no surprise to those familiar with refugees or with the literature on refugee mental health, since refugees have inevitably shown considerably more mental health problems than general populations. This "rediscovery" resulted in a massive, short-term influx of funds on a State level for refugees. Unfortunately, in some States these funds were delegated by or to people with minimal knowledge or experience regarding refugees, mental health epidemiology, cultural psychiatry, mental health services, preventive services, or Indochinese people. In some instances, refugees themselves, although unfamiliar with the services (or sometimes even the concepts involved) were asked to design or choose their own services. There was considerable waste.

Almost as abruptly as these services appeared, they were cut back in 1981. This came at a time when ineffective services were being eliminated and more effective services were being provided. Despite the lack of Federal leadership and the naivete of many grant recipients, useful services were being provided in many cases after a few years of frustration, learning, and development.

THE AUTHOR'S PROFESSIONAL EXPERIENCE WITH REFUGEES IN THE UNITED STATES

EARLY EFFORTS AND PROBLEMS

Soon after the arrival of Indochinese refugees in 1976 and 1977, I began receiving calls regarding mental

health problems among refugees. Early on, the psychiatric problems reaching me were mainly psychotic conditions, including schizophrenia, mania, depressive psychosis, and psychosis associated with organic brain syndrome. Kinzie (in press) has also described this phenomenon. Other referrals consisted of cases that had proven refractory to care by local health workers. Typical examples of the latter included an elderly Vietnamese man in opium withdrawal, a 13-year-old Hmong girl pregnant after a rape in Thailand (her family had refused medical care), an unaccompanied Lao teenager whose sexual behavior at school had alarmed school authorities, and a retarded Cambodian girl who was manifesting disturbing behavior at school. At that time, there were no translators, no health care system for managing these problems, and no recompense to my hospital or department for the provision of service to these refugees.

In 1976, I contacted officials of the U.S. Department of Health, Education, and Welfare, both in Washington, D.C., and at the regional office in Chicago. I was informed at both locations that Asian-American health professionals were being sought and consulted regarding the planning of mental health services for Indochinese patients, although few or none had any experience in Indochina. The services of American psychiatrists familiar with Indochina by virtue of having lived and worked there were not recruited. Given the cultural gap between other Asian Americans and the Indochinese and the traditional antipathy of many Southeast Asians toward other Asians, particularly Chinese and Japanese (whether American or not), this was a strange decision--somewhat akin to choosing only English American professionals to work with Irish refugees. Many Asian American professionals have continued to work with the Indochinese refugees and have been accepted despite initial negative transference issues.

Federal planners neglected the reports regarding mental health problems among refugees in Europe following World War II. None of the experts on those refugees was consulted, although several were alive and active. Neglect of these resources has been costly in both human and financial terms.

Data from Europe and North America following World War II showed increased rates of both minor and major mental health problems among refugees, even when the refugee's culture and the receiving culture were fairly similar (Eitenger 1959; Helwig-Larsen et al. 1952; Hoff 1957; Mezey 1960a,b; Murphy 1955; Pedersen 1949). These include increased rates of schizophrenia; affective disorder; and various forms of incapacitating neurosis, especially somatization, depression, and paranoid tendencies. These disorders have been associated with high incidence of marital and family problems, employment difficulties, and problems adjusting to the receiving culture. Prevention, early intervention, and treatment approaches have grown out of this extensive psychiatric experience with refugees (see Williams and Westermeyer, in press).

Cross-cultural clinical applications and techniques have been increasingly refined over the last decade. Butcher (1981) has developed standard methods for translating and "renorming" personality tests, and many of his colleagues and students around the world have elaborated on his work. Psychiatric approaches to cross-cultural diagnosis and treatment have also been developed (Abad and Boyce 1979; Cooper et al. 1969; Del Castillo 1970; Jeff 1974; Sabin 1975; Tsuang 1976; Westermeyer and Sines 1979; Westermeyer, in press a,b).

Over the last several years, certain interest groups have developed as a result of interest in cultural aspects of mental health and health services. The Society for the Study of Psychiatry and Culture has held informal meetings for a decade and has held regularly scheduled annual meetings over the last 5 years. It currently consists of 80 members, with a larger number of communicating members in training or in other fields besides psychiatry. There is also a psychiatric journal that focuses on cultural issues, Transcultural Psychiatric Research Reviews, published in Canada. The editor of the journal Culture, Psychiatry and Medicine is a psychiatrist, and many articles of cultural interest are published in such journals as the Journal of Nervous and Mental Disease, Journal of Operational Psychiatry, and Social Psychiatry. Favazza and coworkers (Favazza and Oman 1977; Favazza and Taheem 1982;

have prepared two annotated bibliographies containing thousands of cultural psychiatric references reviewing the last 55 years.

Cultural psychologists have also become increasingly active within the American Psychological Association. This has led to the establishment of the Journal of Cross-Cultural Psychology. As with the psychiatrists, they are a growing and active group. Many of the anthropologists now working with refugees tend to be more interested in sociocultural changes than in mental health issues. However, there are exceptions to this: Ness in Connecticut has studied mental health among Indochinese adolescents. In sum, the literature, expertise, and experience regarding refugee mental health that State and Federal planners have had available but not sufficiently utilized is considerable.

ESTABLISHING A MENTAL HEALTH SERVICE FOR INDOCHINESE REFUGEES

In mid-1977, a Hmong friend and research associate from Laos joined me as a junior scientist on a grant related to refugees. Tou Fu Vang and I were aware of the suspiciousness, depressive mood, high rates of psychophysiologic symptoms, family problems, and social withdrawal that prevailed among Hmong refugees. We had begun working together on an ad hoc basis with cases referred to me at University of Minnesota Hospitals. This led us to take a series of steps to deal with these clinical problems more systematically and to address the social disorganization, apathy, and inactivity that we observed among the Hmong refugees. Our initial interventions included the following:

1. We called a meeting of Hmong people in Minnesota at University of Minnesota Hospitals in the late summer of 1977, attended by about 60 out of 102 known refugees aged 16 and older. At that time, we suggested that the people organize themselves for their own benefit and progress to articulate their needs to majority institutions and agencies. This recommendation was accepted, and over the following several weeks, a constitution was adopted and officers were elected. This was the first

Statewide Hmong Association in the United States. Its name was subsequently changed to the Lao Family Association of Minnesota.

2. We sought means for the people to continue activities that were familiar to them in Laos. Some of these efforts worked out very well, such as obtaining city land for gardening purposes and orienting Hmong refugees to the use of city land for this purpose. Some efforts were unsuccessful, such as obtaining support of sportsmen's clubs to introduce the Hmong to hunting areas. We also attempted to have individual Hmong resume former roles such as fishing, healing, religious activities, sewing, carpentry and home repair, and leadership. This latter strategy was quite effective, especially among our patients with whom we were able to exert greater influence. Several of our patients become community leaders.

3. At the request of Hmong elders, a weekly psychiatric clinic was initiated at University of Minnesota Hospitals. They indicated that a regular clinic to which the Hmong people themselves might come without referral would be superior to the current situation in which clinic, hospital, and agency staff referred their major crisis problems to us.

INDOCHINESE CLINICS AT UNIVERSITY OF MINNESOTA HOSPITALS

We had not anticipated that the Hmong clinic would be as active as it turned out to be. The clinic began at 1:00 p.m. and usually ran overtime into the evening, at times until 9:00 p.m. We also began to receive an increased number of other Indochinese ethnic groups, including Vietnamese, Lao, Cambodians, and ethnic Chinese from Indochina.

Three notable events occurred after the start of this clinic. First, we began to receive a greater number of cases representing nonpsychotic diagnostic groups from among the Hmong people. These especially included major depression, with and without melancholia; adjustment reactions; learning problems; school crises;

and family difficulties. Second, the clinical problems of other Indochinese resembled those we had previously observed among the Hmong prior to having a Hmong translator-administrator-clinical assistant: the diagnostic entities were mostly major psychoses, as well as crises referred from social agencies and schools, but there were no self-referrals. Third, complaints flowed in from other non-Hmong Indochinese groups. One frequent complaint was that there were no translator-administrator-clinical assistants from their own ethnic groups in the clinic. The other regular complaint was that they did not want to come on the same day or at the same time that Hmong patients were coming. This led subsequently to a separate afternoon being established for the Lao and a third afternoon for the Vietnamese, Cambodian, and ethnic Chinese.

In mid-1978, since my research grant ran out, the regular Hmong and Indochinese clinics were discontinued. In 1979, the Minnesota Department of Public Welfare approached me with the idea of resuming the Hmong clinic, since by that time they had received Federal funds for mental health services. Several months later, the Department of Public Welfare also provided funds to hire a Lao translator-administrator-clinical assistant.

In late 1981 and 1982, our Indochinese clinics were gradually phased out due to lack of funding.

METHODS IN CROSS-CULTURAL DIAGNOSIS AND TREATMENT

Interviewing skills to cross-cultural boundaries are similar to interviewing skills in general but involve special techniques (Burton-Bradley 1970; Westermeyer and Walker 1982). More time is required to establish rapport and to set the context and purpose of the interview. Facilitation skills are similar, although difference in nonverbal communication across ethnic boundaries must be taken into consideration. Clarification is especially important in both directions to prevent misunderstandings and resolve lapses in communication. Probing must be undertaken with discretion until the patient's personal and cultural taboos are understood.

Confrontation across cultural barriers can readily be interpreted as rejection, although the establishment of rapport and working with the patient's family or social network can even permit this treatment approach. Interpretation relies heavily upon knowing the world view of the patient and thus being able to employ culturally relevant analogies and symbols. Use of appropriate idioms, symbols, myths, and proverbs can have salutary effects, while an inability to employ explanations and interpretations relevant to the patient's world view is a major limiting factor in undertaking psychodynamically oriented, or "insight" psychotherapy.

Choice of language is also important. Patients may show either more or less psychopathology in a second language, depending on the type of illness, severity of the disorder, and phase of recovery. Patients may be fluent in a language for business purposes but unable to adequately express feeling states. Some Indochinese patients have been able to describe an environmental event better in English, but they employ their native language again as they describe feelings and opinions. Differences in dialect within the same language can lead to misunderstanding (Peck 1974; Edgerton and Karno 1971; Marcos et al. 1973; Ruiz 1975; Marcos and Alpert 1976; Del Castillo 1976; Westermeyer, in press a,b).

Training in cultural psychiatry should be a prerequisite for those performing cross-cultural assessment and treatment. Clinicians should have some sense of the cultural spectrum in grooming, dress, speech, behavior, cognitions, and affect among their patients. The clinician working in such a setting must possess conceptual tools to help understand emic-etic[4] differences, varying world views among the various culture areas of the world, and the ways in which psychopathology manifests both similarities and differences from culture to culture (Favazza and Oman 1977). Methods for obtaining help from cultural consultants should be known. For cases

[4] "Emic" refers to intracultural and culture-unique definitions, explanations, or perspectives. "Etic" refers to cross-cultural or universal perspectives or interpretations.

in which communication may be difficult or even impossible, the clinician must know how to fall back on basic skills such as observation, physical examination, and screening laboratory tests. Experience working with translators with various degrees of training and skill is important. Appreciation of the pathoplasticity of disorders across cultural boundaries and of culture-bound syndromes is also critical (Schmidt 1965; Westermeyer, in press a).

COMMENT

LESSONS FROM THE INDOCHINESE EXPERIENCE

Stein (in press) has made the point that the lessons from each previous refugee experience tend to be lost during subsequent refugee movements, especially among those charged with implementing government policy toward refugees. The knowledge tends to be sequestered in academic centers and in the minds of "old refugee hands," who are usually not consulted during subsequent refugee crises. It is a timeworn process, and one that has occurred in the military psychiatric services, in which the hard-won lessons of World War I were largely forgotten until they were rediscovered (at great human and economic cost) halfway through World War II. This unfortunate situation persists with regard to Indochinese refugees at the present time. It seems likely that this situation will recur in the future. Perhaps current and future refugees can use such reports in their efforts to meet their own rehabilitative needs and goals.

CURRENT SITUATION

The refugees have lost a variety of social and cultural mechanisms for meeting adversity, including their social and geopolitical organizations and certain cultural mores that have mental health implications (such as polygamy among the Hmong as a means of solving the problems of solo-mother families). Resolution of these losses does not occur in 2 or 3 years but will continue over

at least two or three decades, perhaps even two or three generations.

There is a high prevalence of chronic depression and chronic psychosocial maladjustment among the refugees. It is associated with a variety of problems, including unemployment, illiteracy, cultural isolation, loss of religious practice and personal meaning in life, ignorance of American society, widowhood or singlehood, solo parenting, a generation gap, untreated major depression, and similar psychiatric and psychosocial ills. These problems prove costly to American society by 1) increasing the number of nonadapting disabled people who must be supported on public welfare and 2) increasing the medical and psychiatric caseload of American clinics, agencies, and hospitals lacking personnel skilled in coping with refugees and their problems. While these problems are not simple, they can be remedied. Programs, funding, commitment, and leadership--both from the refugees and from the receiving society--are needed to address them.

So long as mental health planning for refugees depends on the race of the providers, temporary employment on "soft" funds, and administrators not being totally informed of or experienced in refugee issues, such planning will reflect its thin origins. In addition to experience, a consortium of refugee leaders and professionals from a variety of disciplines. and evaluation of effort (not simply project reports) are needed.

RECOMMENDATIONS

There should be a national policy and national programs with regard to refugee mental health just as there are for physical health matters. This process should involve refugees themselves; local, State, and Federal planners and policy implementers; and experts in refugee mental health issues.

A distinction must be made between the increased psychological stress levels experienced by virtually all refugees and the incapacitating problems experienced by a smaller number. Policies or programs to remedy one of these problems may be detrimental to the other.

For example, our work (Westermeyer et al. 1983) suggests that certain factors increase psychological symptom levels over the short term for refugees but reduce psychiatric casualty rates and facilitate social adjustment over the long term.

Until adequate services are available to meet the resettlement needs of current refugees in the United States, more refugees should not be placed in local communities and States. Inadequate resources dilute programs and services for indigenous Americans, leading to resentment in the receiving communities.

Funding for refugee mental health programs should continue over two or three decades. In addition to mental health services, a refugee program should include primary and secondary preventive services. Training and research are also crucial, since it is likely that other refugees will continue to arrive here in future decades. Refugee resettlement policies and strategies shown to be effective in previous resettlements should be implemented unless demonstrated to be less effective than newer methods.

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MENTAL HEALTH TREATMENT ISSUES FOR SOUTHEAST ASIAN REFUGEE CHILDREN

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INTRODUCTION

Focusing on Southeast Asian refugee children as a special group is important. While many of the initial and urgent problems of refugees have been dealt with in various ways, the needed adjustments, learning, and skills necessary for these children to succeed in a Western society must be recognized and planned for if they are to reach their full potential.

SUMMARY OF SOME OF THE PUBLISHED MATERIAL ON REFUGEE CHILDREN

Until the present time, several publications have dealt with Southeast Asian refugee children as separate from other refugee groups (Carlin 1979; Gollnitz 1955). Southeast Asian refugee children include Vietnamese, Cambodian (Khmer), Laotian, Lao Hmong, Lao Yao, Lao Mien, and other hill tribes, as well as ethnic Chinese from several countries. They are from very different cultures with different languages and alphabets, but all have been through war and escapes and are now refugees. In addition, there are the children of refugees born here in America.

Some papers have reported on the nutritional and health problems of children, and these are relevant to refugee children (Brozek 1978; Carlin, unpublished b; Galler et al. 1983; Goldenring et al. 1982; indochina Refugee Action Center 1980; Murray and Murray 1977; Murray et al. 1978; Tayabas and Pok 1981; Winick 1980; Winick et al. 1975). One report in 1975 discussed the problems facing educators in the public schools (Mortlands and Egan, unpublished). Some journal articles and government publications have dealt with the numbers and distribution of refugees (including children) in the United States (Tyhurst 1951, 1977). Literature covering adopted refugee children and refugee foster children (unaccompanied minors) has appeared recently (American Academy of Child Psychiatry 1976; Carlin, unpublished e; Carlin, in press; McBogg and Wouri 1979; Sokoloff 1979; Wolff 1974; Work 1971). In a paper presented at a conference and in a chapter in a soon to be published book on refugees, the special emancipation issues facing Southeast Asian refugee foster children are discussed (Carlin, unpublished e; Carlin, in press). An earlier chapter by Carlin (1981) described the changes that will be needed in the mental health delivery system if it is to be able to meet the anticipated needs of Southeast Asian refugee children.

A recent issue of Clinical Pediatrics carried the first part of a 5-year followup study (questionnaire) of the physical and intellectual developmental progress of Southeast Asian refugee children who were under 10 years of age at the time of the study (Sokoloff et al.

1984). Part II of that project covers physical, psychological, school, and social adjustments and future career plans of refugee children who were 10 years of age and older at the time of the study; it will be submitted for publication in the near future. Some of the data from Parts I and II of the above study are cited in this chapter under the section on recent research data.

PRESENT AND FUTURE TREATMENT ISSUES

LANGUAGE

Southeast Asian refugee children began arriving in 1975 and 1976, arriving in smaller numbers during 1977, increasing in number again from 1978 to 1980, and then leveling off to a smaller number from 1980 until the present. These waves of arrivals have significance, because the present treatment issues for the newest arrivals (1 to 3 years ago) will still include language problems, whereas the children who arrived 4 to 9 years ago generally have attained an adequate command of spoken (although not necessarily written) English. For all of the children, the conflict over remaining bilingual (or trilingual, etc.) persists. English is used at school and in activities with American peers, but the primary language is still used at home (for children with their own families) or with their compatriots (for foster and adopted children). But some adopted children have lost their primary language due to a lack of contact with compatriots. This loss may create later identity problems and exclusion when the child meets other refugee children who will have a "private" language.

Since emotions and dreams are usually in one's first or primary language, it may be difficult even for the bilingual or trilingual child or adolescent to express problems in English to a therapist. The adopted child who has forgotten his or her primary language may dream in it but be unable to describe the dream when awake. Also, children who were adopted before 12 to 18 months of age have had only primary process memories, which are not expressible in any language.

These language problems, combined with a cross-cultural background can lead to school-versus-home conflicts and cause the child to be viewed as being in need of help. This is somewhat analogous to the phenomenon of the 6-hour-retarded child--a child with a borderline IQ who is accepted as normal at home, but who is seen as slow or retarded in school. Also, children usually learn English faster than do adults, so refugee children often must be interpreters of language and culture for their parents and elders. This creates role reversals and problems within the family.

CULTURE

The problems created by cultural differences may be very difficult for a Western therapist to understand or even to identify. Rarely will the patient realize that a cultural conflict is a part of the problem. When one is raised with a particular world view, one rarely realizes that others may view the world in a way that is very different, sometimes even diametrically opposed to one's point of view. Because patients may be unaware of the role of their cultural backgrounds in their present problems, the therapist needs to learn to consider and suspect this. Awareness of the role of culture, one's own and that of others, is not always a part of a therapist's education. Thus, working with patients from other cultures, even if they speak English, can be very difficult but also very exciting and challenging (Carlin 1981; Gordon et al. 1980; Indochinese Refugee Advisory Committee 1980; Kinzie 1981; Kinzie et al. 1980, unpublished a,b; Leyn 1978; Lin et al. 1979, 1984; Masuda et al. 1980; Montero and McDowell 1979; Mortlands 1983; Munoz 1980; Nguyen 1982, 1984; Rue 1980; Santopietro 1981; Silverman 1979; Simms and Conlyn 1983; Tayabas and Pok 1981; Tobin and Friedman 1984; Tyhurst 1957; Vignes and Hall 1979).

Eastern and Western world views differ in significant ways--some of these differences are prominent and well described in many sources, and others are subtle and not as well known. There are, for example, major differences in role identities. The Westerner has learned to value and expect personal autonomy,

independence, freedom of choice and its consequences, self-motivation, self-determination, truthfulness, honesty, youth, and physical vigor until advanced age. When Western patients are not striving to be independent, do not make decisions, and lack motivation, Western psychiatric practice diagnoses them as "dependent personalities," "passive dependent," or "passive aggressive," etc.

The Southeast Asian learns to respect elders, authority, status, and position in the family and elsewhere. Interdependence and obedience are valued, and independence and self-determination are not only not valued but are discouraged. Freedom is poorly understood, and techniques for handling freedom and decisionmaking and its consequences are not taught. The family has clear expectations of each of its members. Duty to one's god, ruler, teacher, parent, etc., in that order, are carefully taught.

Truthfulness and honesty in the abstract are second in importance to saving face for one's self and others. Thus, if saving face and being absolutely truthful are in conflict, saving face generally will take precedence. This does not mean to imply that untruthfulness and dishonesty are valued. They are not--only when a choice involves saving face does a conflict arise.

Southeast Asians have learned that sickness and suffering are to be expected. They pray for health, but they are not shocked by sickness, suffering, or even death. Yet, despite what some Westerners have concluded, they do grieve over the death of a loved one. They are not fatalistic. They may not show grief (or any emotion) publicly out of respect for the one who has died, they suffer in silence publicly and grieve and cry privately at home.

They have learned that if a person reaches age 50, he or she is old and does not need to work any longer. The elderly expect to be cared for by their children. Often they do not feel they need to prove their youth and vigor any longer. Southeast Asian society imposes the status of its elderly of being looked to for advice and being given obedience.

There are many other areas of cultural difference, but from the few mentioned, it is easy to extrapolate the possible conflicts that a Southeast Asian person could have in a Western culture that values different things. Children raised in a Western culture by parents imbued with ideals or values from a very different culture will have a difficult time coming to terms with serious ambiguities and conflicts concerning values and customs. The Southeast Asian refugee child who must be quiet, obedient, deferential, and humble at home must also be able to be independent, assertive, questioning, self-reliant, and self-assured in school and in Western social settings. Even such things as eye contact and other body language patterns are different, and the refugee child must change their usage twice each day--from home to school to home. Behaviors such as these are stressful and may produce much anxiety and frustration.

CAREER ISSUES

The Southeast Asian refugee adolescent begins to think about the future in terms of career choices (Lin et al. 1979; Carlin unpublished e). Some career plans are expected and are acceptable to Southeast Asian parents; other career choices are not acceptable to these parents. Typical acceptable choices are the professions of law, medicine, dentistry, teaching, or pharmacy. Choices not acceptable might be art, music, athletics, writing, dancing, or business. Thus, some talented Southeast Asian adolescents might feel they must choose careers other than the ones they prefer to please their parents.

In addition, these adolescents are often their families' hope for a better status in the future. Because the parents' generation may have suffered a severe setback in status upon becoming refugees, much may be expected of the next generation. For the average child, the expectations may be too high, and the child will feel he or she is a failure despite trying very hard. Some adolescents and young adults have become suicidal. Some actually commit suicide. Suicide also occurs in their countries of origin for similar reasons.

MARRIAGE ISSUES

As Southeast Asian adolescents look forward to marriage, they must consider who they marry in terms of parental approval (In et al. 1979; Carlin, unpublished e). For those here with their own families, the parents may take an active part in the choice and approval. For foster refugee adolescents, the parents are far away, but the adolescent considers whether or not they would approve. Also, should the choice be from their own ethnic group or some non-Southeast Asian peers? Some adolescents are isolated from ethnic compatriots, so what are their choices? And what about the adopted children raised as non-Asians? Who will they choose? What are their options and guidelines?

RELIGIOUS DIFFERENCES

In Southeast Asian countries, there are many religions: Buddhism, Catholicism, Protestantism, Animism, Caodaism, Hinduism, Confucianism, and Taoism (the last two technically are philosophies, not religions). Some of these religions are not compatible with Western cultural values, and this may also create conflicts in world views (Roberts and Myers 1954).

LACK OF PSYCHOLOGICAL-MINDEDNESS

To many Southeast Asian parents, psychological problems and conflicts do not make sense. Disturbed behavior is perceived as being the result of either willfulness or physical illness. "Talking" about it is not seen as helpful. Furthermore, talking to strangers outside the family is not acceptable. The elder members of the family, often a grandparent, or the spirit of a departed ancestor, are the ones sought for advice. This creates problems for teachers, sponsors, counselors, and mental health professionals, including physicians, who try to intervene to help a troubled child or adolescent and the family. The family may refuse to cooperate and may forbid the child or adolescent to receive help. This is not because they lack love and concern, but because they do not understand this kind of treatment.

Even accepting some Western-type treatment for medical problems may pose conflict, because Southeast Asian parents may perceive an illness as having causes for which non-Western treatments should be sought (Carlin, unpublished c). Culture-bonded syndromes and diseases are known, and the Southeast Asian parents (often correctly so) believe Western doctors do not understand them. They may seek help from non-Western healers also now in the United States as refugees. Herbs and rituals may be prescribed.

IDENTITY ISSUES

"Who am I?" For an Asian in a Western culture, this is another source of emotional conflict (Lin et al. 1979; Carlin, unpublished e). Some identity problems exist for all adolescents, for all minority group adolescents, and for all refugees. Because of the extreme unpopularity and lack of understanding and support for the so-called "Vietnam War," this makes the identity conflict even more acute for the Southeast Asian adolescent now in America.

AMERICAN VERSUS SOUTHEAST ASIAN VIEW OF VIETNAM WAR

To Southeast Asian refugee adolescents, the American view of the war in Southeast Asia that they are taught in school, by the media, and in literature may create serious conflicts when compared with what they remember or are being told at home. This may contribute to their problems of identity and self-esteem. For example, if the adolescent adopts the American view that the war was wrong, that the Southeast Asians liked things the way they were and preferred communism, or that communism isn't so bad for Asia, etc., then he or she is faced with conflicts over why relatives fought and died to prevent communism. Also, why was it necessary to lose everything and flee? These and other insoluble problems arise. But if the adolescents adopt their parents' point of view, they might hate communism and hate Americans also, though for different reasons. Yet they are in America and trying to live with the Americans they were taught to

hate. They cannot decide whether to become Americans or to resist doing so. Who helps them with this? Can the American Western therapist tolerate their ventilation of hate toward America and Americans when the therapist may expect them to show gratitude? Can an American therapist understand this ambivalence and work with it?

DUTY TO THE EXTENDED FAMILY IN AMERICA AND IN SOUTHEAST ASIA

The Southeast Asian world view includes duty to the extended family both with the child and possibly also with the family left in the country of origin (Lin et al. 1979; Carlin, unpublished e). What burdens and guilt does this place on the child? And what memories are revived by the family's frequent reference to atrocities and experiences and to the starvation, illness, and torture of family members still in Southeast Asia? What will these memories do to the child in the future? Nightmares (or night terrors in children young enough to have only preverbal memories) and "unexplained" fears are to be expected now and in the future. Some of the children have witnessed many atrocities, rape, and death, or have experienced violence or rape, so it is likely that this suppressed or repressed anger will come out as violence under stress in the future. Masked depression in parents or children can occur. Revival of emotions in the presence of certain stimuli or stressors might not be recognized as related to past experiences. These phenomena, described in DSM-III of the American Psychological Association as the post-traumatic stress disorder (PTSD), are well publicized in relation to American Vietnam veterans but are equally applicable to Southeast Asian parents and children. They have lived through the same experiences American veterans have and, in addition, have undergone the stresses involved in escaping and then in trying to adjust to a Western culture (Carlin, unpublished f). The PTSD initially is present; an adjustment reaction is superimposed as the refugee must adjust to a new culture. DSM-III defines adjustment disorder with the requirement that it not meet the criteria for any other specific disorder (which includes PTSD), but that exclusion does not seem to be useful for refugees.

It is more useful to consider PTSD and adjustment disorders as two separate conditions that in some refugees can coexist. (Actually, this may also have occurred in some American veteran patients: PTSD came first, and readjusting to American society, with its antiwar attitudes and materialistic values, led to an adjustment disorder secondarily.)

RECENT RESEARCH DATA

A 5-year followup study of Vietnamese refugee children was done by Drs. Sokoloff, Carlin, and Pham (part I, Sokoloff et al. 1984; part II, Carlin et al., unpublished). Some of the findings are relevant to this chapter. They sought to answer the question "What happened to the Vietnamese refugee children 5 years later?" This study attempted to ascertain the current functioning of Vietnamese refugee children (at that time, only the Vietnamese refugees including orphans, foster children, and children with their own families). Comparisons of refugee children based on developmental scales, health assessments, personal statements, and school functioning as reported on questionnaires filled out by adoptive parents, foster parents, and "own" parents, plus self-evaluations completed by children 10 years old or older, were the basis for this two-part study.

Part I of this study examined the past and present physical conditions and the developmental progress of children under 10:

> The existence of physical problems was, as expected, quite high during the first year after arrival. Malnutrition, anemia, and parasitosis were common denominators functioning to cause the increased rate of respiratory infections, etc., shortly after arrival. Winick and his group (Winick 1975) demonstrated quite well in studies of moderately and severely malnourished Korean children that there is a "catch-up" to norms in physical and mental development after adoption into middle-class American homes.

Developmental "catch-up" was excellent. Using the Denver Developmental Table as comparison, the developmental norms of these refugee children for crawling, standing, walking, and language skills began at a slightly later age, but they rapidly caught up to American norms by age 1½ to 2 years. This was attributed to the enrichment in the nutritional and environmental status of the refugee children. The children are now, for the most part, doing well in school.

Behavioral and emotional problems were initially, as predicted, fairly severe in frequency and type. The younger arrivals (mostly adoptees) suffered an interruption in their preverbal and verbal development. All of the children have survived an unrealistically stormy past in Indochina. The incidence of nightmares and fears was, consequently, initially quite high. Verbal reports suggested that by the end of the first year the incidence of most emotional problems had dramatically decreased.

The older children (most of whom are in foster care) have displayed a higher percentage of adjustment problems not unlike older American foster children.

The foster children were also functioning better than anticipated--but with more "acting out" problems probably due to the significantly older age of the refugees.

(Sokoloff et al. 1984, pp. 565-570)

Part I of this study demonstrated "that the refugee children (especially the younger adoptees) have fared well in this country physically, developmentally, emotionally, and socially." Advance preparation of the adopting family by agencies involved (and availability of prepared medical and social services) seemed to be of great importance in assuring the good quality of life that these adoptees and their families enjoy.

Part II of this study (Carlin et al., unpublished) covered the educational, social, cultural, and psychological progress of the children 10 years old and over at the time these data were collected as reported by their parents (own, adopted, or foster).

Comparisons between adopted, foster, and "own" children's answers were analyzed. A few selected examples are presented below.

Early in 1976, some predictions were made as to the future adjustment of refugee children. The present study attempted to evaluate the current status of the children with special emphasis on adjustment in the areas of the predictions. The predictions were based on the assumption that the age of the children at the time they left their country as refugees is particularly significant.

When asked how their schoolmates treated them, there were no significant differences between adopted, foster, and "own" children. Of those children interviewed, 77 percent said "very well," 21 percent said "not well," and 2 percent said "badly." There were no significant differences by age categories.

When asked whether they were happier here or in Vietnam, there were no significant differences among the groups. (There was a trend, with χ^2 at the 0.13 level, for adopted and foster children to report being happier here, and "own" children to report being happier in Vietnam.)

When sex and age are held constant, among males 10 to 13 years old, adopted and foster children are happier here, with χ^2 significant at 0.000; but the sample size was very small.

Among all the children, 64 percent ranked themselves as "equally smart," 29 percent ranked themselves "smarter than," and 7 percent ranked themselves "less smart" than their American peers. This suggests these children have a good and realistic self-image thus far. For all groups, 86 percent plan to go to college. Data from the schools in California support these self-reports given by the children.

The children were asked to report their three best subjects. Art was not rated very highly by any group, but foster children rated art higher than did "own" children; adopted children rated art between foster and "own" children.

Music rarely rates as one of the top three subjects, and it showed no differences among adopted, foster, or "own" group or for sex or age category.

Mathematics was rated in the top two places by 60 to 69 percent of all the children. Science was ranked in the top three places by 60 percent. The older the child, the more likely it was for science to be ranked as the best subject.

Gym was ranked much higher by adopted and foster children (33 and 24 percent, respectively) than by "own" children (8 percent), again perhaps because it would not be acceptable to Vietnamese parents. Females rated gym higher than did males (48 percent versus 27 percent). "Own" children rated gym their best subject only 8 percent of the time, adopted children rated it best 33 percent of the time, and foster children rated it best 24 percent of the time. X^2 was significant at the 0.029 level.

The study concludes:

> The majority of the refugee children from Southeast Asia reported making good adjustments to school, peers, and families. They reported doing well personally and emotionally. Many of them are retaining their Vietnamese ethnic identities including language, friends, and activities while simultaneously learning and using English and joining their American friends in activities. However, maintaining a dual identity may create problems for adopted children who have limited contact with others of their ethnic group and who feel pressure to fit into their American families. . . . Maintaining a dual ethnic identity may create problems for foster children who are older (10 years or more on arrival), who feel a strong loyality to their families of origin in Vietnam, who sometimes fear that permitting

themselves to feel that they are really members of their foster families is being disloyal to their Vietnamese families (with whom they still try to communicate and to whom they try to send money). . . . . Maintaining a dual ethnic identity may create problems for "own" children who often are in multigenerational families which expect each child to conform to Vietnamese ethnic norms even when these are in conflict with the norms and expectations of the majority culture.

(Carlin et al., unpublished)

This area needs to be studied further. The childrens' adjustment thus far appears to have been generally good, but there may still be psychological problems to be faced in the future.

SUGGESTIONS REGARDING PSYCHOTHERAPY

Psychotherapy with Southeast Asian patients often must be done differently than with Western patients (Carlin 1980, unpublished a,d; Kinzie 1981; Rosenthal et al. 1975; Santopietro 1981). First, many families do not "believe" in psychiatry. They resist psychological etiologies. Sometimes beginning as an educational or tutorial program (as the "Teacher Chan" mental health clinics in Taiwan have discovered) is useful. Second, paternalism is expected and responded to; the therapist is older and wiser or at least has status, so the Southeast Asian patient and family expect some specific statements--not open-ended questions, or permissiveness in decisionmaking, or "What do you think about that?" The latter approaches elicit discomfort, since patients have had little or no experience being independent or thinking independently. This, too, must be taught. A more direct approach works better initially. In addition, an ability to speak the language of the patient would facilitate emotional expression; but even then, emotional expression to a stranger is rare. Even when the patient speaks English, the reticence will persist and words for emotions will be difficult to find. Therapists who are well trained and able to speak their patient's language are very valuable.

Younger children and adolescents who have been in the United States for a time may talk more freely, but if their parents are present, they may revert to their dutiful role.

The use of interpreters during therapy is extremely complicated and confusing to everyone. It takes a skilled therapist and a skilled interpreter to make this system work.

Patients often prefer medication, even injections, to "just talking." It is important to differentiate normal Southeast Asian culture variations from psychotic processes or character problems before deciding on treatment of any kind. Many Southeast Asians believe in ghosts (which they do see) and evil spirits. This may be entirely normal.

SUGGESTIONS FOR FUTURE RESEARCH

Followup studies of these children, 10, 20, and 30 years after arrival in the United States, would provide longitudinal data that would be useful in helping other refugees who come to the United States in the future. It would also shed light on ways of coping with catastrophe-related stress and uprooting. It would be valuable to compare with data about previous refugee and immigrant groups in the United States.

Locating a representative sample of these children and studying them in depth individually is the next step needed in aiding and understanding the refugee experience and adjustments.

Studying the half-Vietnamese, half-American children who are still in Vietnam at this time, but who are scheduled to be brought to the United States, should be done soon. They are a unique group because of their dual ethnicity and because they have been living in a communist country for nearly 14 years. They were not accepted in Vietnam and won't be acccepted readily in the United States. What world view will they have? What identity conflicts will they have? Will they become depressed when their dreams are disillusioned, when their American fathers aren't what they imagined, or

when the United States turns out not to be Utopia, or when they find they are not accepted here either?

In addition, the refugees have had children born in America. What will be their problems as second-generation children? Will they be like the children and grandchildren of the Holocaust survivors, with problems extending to the second and third generations? These people also need to be studied and helped.

SUMMARY AND CONCLUSIONS

This chapter has reviewed some of the data written about Southeast Asian refugees, with special emphasis on refugee children (Boman and Edwards 1984; Nguyen 1982). It has presented some current research findings on the adjustment of some of these children 5 years after arrival in the United States. Present and future treatment issues have been presented and examined. Some suggestions have been made regarding therapy, if needed, for these children, and some suggestions for future research have been offered.

In conclusion, Southeast Asian refugee children have arrived in the United States in several relatively discrete waves. There are some differences between these groups, which will lead to some differences in issues of therapy, and there are also some issues in common. The data showing amazingly good progress to date are valuable but do not rule out the possibility of future problems at times of stress. The usefulness of looking at the problems of refugees, including children and adolescents, from the perspective of PTSD, sometimes overlaid with secondary adjustment disorders, has been suggested. The wealth of data on United States veterans with PTSD may aid in the understanding of refugee problems also.

Diagnosis and treatment of emotional and behavioral problems of Southeast Asian refugee children and adolescents have some unique challenges. Understanding the childrens' backgrounds, the history of their countries, and the cultural conflicts, nutritional and physical problems, language problems, identity problems, career decisions, and persisting guilt should give the

therapist much to start with in working with these children.

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OVERVIEW OF CLINICAL ISSUES IN THE TREATMENT OF SOUTHEAST ASIAN REFUGEES

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INTRODUCTION

The psychiatric treatment of Southeast Asian refugees is both challenging and rewarding. Since 1978, the Department of Psychiatry, Oregon Health Sciences University (OHSU), has maintained a weekly Indochinese Psychiatric Clinic. During this time, over 350 different Southeast Asians have been evaluated, and there have been over 4,000 clinic visits. Based on our experience, we will describe the basic requirements for an Indochinese clinic and discuss the cultural aspects of psychotherapy and psychopharmacology for Southeast Asian refugees. A special discussion of posttraumatic stress disorder is included. First we will give an overview of our clinic setting and patient population.

OVERVIEW OF OHSU INDOCHINESE PSYCHIATRIC CLINIC

A fuller description of the clinic has been published elsewhere (Kinzie et al. 1980; Kinzie and Manson 1983), but a review here will help to give a background to

our experience. The clinic has run for 6 years with the author as director and has always had at least one psychiatric resident in attendance. A psychiatric nurse coordinates visits and provides continuity of care and community contacts between visits. The Portland Indochinese Cultural and Service Center has provided mental health counselors who additionally serve as interpreters at each clinic. These counselors, who are Vietnamese, Cambodian, Laotian, Hmong, and Mein, have received training to identify and support treatment of mental illness among refugees. For the past 2 years, the clinic has treated about 25 return patients and performed one or two new evaluations during each clinic session. The clinic, as part of the University Hospital, provides inpatient and emergency services for refugees as well. It should be recognized that the clinic is somewhat of a tertiary facility and usually evaluates patients who have received some medical or counseling help from other physicians or mental health counselors. The patients tend to have more severe psychiatric disorders. The most common of these is major depressive disorder, for which about 50 percent of the patients were diagnosed over the past 2 years. Schizophrenia was diagnosed in 19 percent of the patients. Anxiety and other neurotic conditions were diagnosed in 14 percent, but alcohol or drug abuse in only 1 percent. Adjustment reactions were also seen infrequently, accounting for only 4 percent of the clinic population.

Patients generally are evaluated thoroughly on the initial visit to the clinic; however, because of the large number of patients, the followup visits tend to be briefer and supportive in nature. The counselors provide more frequent or extensive counseling if needed. The patients generally keep their appointments, and they are seen for an average of 10 sessions. The exceptions are the schizophrenic patients, who are encouraged to maintain ongoing contact with the clinic.

PROVIDING COMPREHENSIVE SERVICES

It is essential that a full range of services--emergency, inpatient, and outpatient--be provided for refugees by a competent, well-trained staff. In our experience,

many refugees have suffered from fragmented or incomplete services and from inexperienced staff unfamiliar with refugee problems. Since refugees are often overwhelmed by the complexities of American life, it is important that services be provided in as straightforward a manner as possible. Because it is unusual for Asians to present for psychotherapy or counseling services directly, one point of entry into the system is often a crisis or a dramatic decompensation by the patient. It is essential that there be appropriate emergency service to handle such situations: this not only provides relief for the family but also establishes credibility in the psychiatric services. A number of the patients originally seen in our clinic were psychotic, and hospitalization was required to gain control of the symptoms and to help the family cope with the situation. Indeed, 36 percent of our first 50 patients were psychotic and required some inpatient treatment. The clinic then provided outpatient services for the followup of these patients.

A second major requirement to provide care for Asians is a psychiatric staff capable of offering modern psychiatric services. These include evaluating and diagnosing major psychiatric disorders, individual and family psychotherapy, employing modern psychopharmacology, and referring patients for any further medical or neurological evaluation.

Additionally, such a staff should have the empathy and knowledge of Asian cultures necessary to deal effectively and sensitively with the refugees. More thorough discussion of this point will be presented later. It is important that the staff have access to medical evaluations, since many refugees have multiple medical problems (Judson et al. 1984). Often the refugee's initial presentation is a mixed psychiatric-medical one that calls for a medical evaluation.

Perhaps the primary factor in providing comprehensive services is to have well-trained counselors representing each ethnic group. Such counselors not only are interpreters of language, but also need to be sensitive in reporting and interpreting the nonverbal, and sometimes the chaotic verbal, communication of patients. They should not be overwhelmed or unduly anxious by the

sometimes unpredictable and bizarre utterances and behavior of psychiatric patients. Furthermore, they need to be sensitive to psychiatric interviewing and psychotherapy so they can communicate appropriately and intelligently with patients. They need to have a knowledge of psychopathology and supportive psychotherapy. With some assistance, many mental health counselors can provide ongoing therapy and contact for patients. These counselors are themselves responsible for referring patients to the clinic.

CULTURAL ASPECTS OF PSYCHOTHERAPY

There is evidence that Asian Americans underuse psychiatric services in this country (Sue and McKinney 1975; Yamamoto 1978). Southeast Asians in particular find difficulty accepting such services. It is likely that problems in the treatment of some Asian patients have to do with philosophical and cultural differences between them and the American psychiatrist. I would like to highlight some of these differences and suggest approaches to help in the treatment of Southeast Asians.

Southeast Asians' medical concepts, although differing among the various ethnic groups, tend to be influenced by the culture of China, where there are separate traditions based on scholarly belief and folk medicine (Lin 1980; Tung 1978). The scholarly tradition emphasizes a theory of disease caused by an imbalance of cosmic forces--yin and yang. Chinese medicine, holistic in its approach, focuses on function rather than structure of the body and is preoccupied with the restoration of balances (Lin 1980; Singer 1976). However, many Southeast Asians explain illness as a supernatural event. There is a folk tradition in which illness, particularly mental illness, may result from an offense against deities or spirits. Westermeyer and Wintrob (1979), in studying the folk beliefs of mental illness in Laos, found that supernatural explanations were common. Many Southeast Asians have an unwillingness or an inability to differentiate between psychological, physiological, and supernatural causes of illness. They also tend to develop somatic disorders that may be a more effective and legitimate way to request medical help than through an emotional problem (Nguyen 1982a; Tseng 1975).

The Asian attitude toward the mentally ill is characterized by fear, rejection, and ridicule. Families are reluctant to admit the existence of a "crazy" person for fear of the effects on the family (Lin 1980; Yamamoto 1978). Mentally ill Chinese are often kept within their own families for long periods before being presented for mental health care (Lin 1978).

The philosophical concept of self in the Eastern world is different from that in the Western world. Asians have an interdependent, holistic, psychosocial orientation that strongly emphasizes correct social relationships, particularly in the family. They identify themselves as interacting in a social group rather than autonomously (Chang 1982; Tung 1984). Southeast Asian refugees also differ from their American psychotherapists in the suffering and other problems that have resulted from a long history of war and destruction in their homelands. They are faced with adjusting to a new life in an alien country and culture as refugees (Lin et al. 1979, 1982; Masuda 1980; Nguyen 1982b).

Refugees have often met other American doctors or had contact with native healers. Both emphasize rather rapid results and minimal interview techniques. Therefore, refugees will have had little experience with the depth of interviewing done and the psychological questions asked for what often appears to be a physical problem.

The philosophical assumptions and concepts of American psychotherapy are rooted in Western science, psychology, and metapsychology. The multiple schools of psychotherapy sometimes are founded on conflicting assumptions (Chessick 1980). However, it has been suggested that they are dominated by a value system of clinical humanistic psychology that promotes self-aggrandizement and satisfaction, autonomy, rejection of authority, relativity in values, situational ethics, and avoidance of long-term relationships and responsibility (Bergin 1980). Other schools, although criticizing this list, agree with the high value that American psychotherapists place on the autonomy and independence of the individual (Ellis 1980; Walls 1980). Often the values are covert and are reflected by therapists who treat "interesting patients" for growth experience

and shun those for whom a supportive long-term relationship is necessary (Halleck 1981). It is apparent that these values are vastly different from those of Eastern values, which stress interdependence and traditional social relationships. Table 1 illustrates some value conflicts between Southeast Asian patients and American psychotherapists.

TABLE 1.--Value conflicts between Indochinese patients and American psychotherapists

Indochinese Asian patient values	American psychotherapist values
Interdependence and traditional family values	Autonomy and independence
"Correct" social relationships	Relativity in values; situational ethics; rejection of authority
Holistic culture; i.e., people living in harmony with nature	People versus nature; the need to master or control nature
View of mental illness as imbalance of cosmic forces or supernatural events	View of mental illness as result of psychological and biological factors
No cultural analogy of extended psychological therapy	Belief that psychotherapy is valuable and promotes "growth"
Belief that cure should be rapid, healer active; little history of maintenance therapy	Awareness that cure will be extended and time-consuming, and therapist will often be passive
Fear of mental illness	Comfortable attitude about handling mental illness and symptoms
"Refugee" status--insecure in language, vocation, position in society	Secure status in "society," language, vocation, and position

Another origin of American psychiatric practice is the medical model, which emphasizes symptom reduction, alleviation of pain, and curing of illness. This model is useful for social purposes in treating the ill and assuring that no one is blamed for the illness (Kinzie 1978; Seigler and Osmond 1974; Shagoss 1975). The physician, in interactional relationships with the patient, can confer the sick role and excuse the patient from some or all social responsibilities for a time. Asians are familiar with healers of all types, and these roles--healer and patient--are acceptable to Southeast Asians. Thus, the interactional relationship of the doctor and patient can form a basis for a strong therapeutic relationship without the value conflicts inherent in a psychotherapeutic relationship. Table 2 summarizes the expectations of Southeast Asians toward a healer and the role performed by American physicians.

TABLE 2.--Indochinese expectation of healers and roles of American physicians

Indochinese expectations and needs of healer/physician	American physician's roles and duties
Expects healer to understand illness or problems	Actively involved in diagnosis
Needs explanation of illness in understandable terms	Gives firm concept of etiology and education
Wants active treatment to reduce symptoms or cure	Actively involved in treatment, often with medicine
Expects rapid cure--hope in medicine	Goal: to reduce symptoms or cure illness
Often needs to have sick role confirmed	Confirms the sick role
Needs to have family stresss, fear, and guilt reduced	Prevents anyone from being blamed for misfortune

As mentioned above, the mental health counselor-interpreters are the important third person in the clinic. With appropriate training, the counselors are a major asset in psychotherapy. In addition to appropriately interpreting the communications, they help to bridge cultural and value differences between patient and therapist. At times, they set aside the role of interpreter to evaluate the content of what is being translated and thus fulfill a cultural consultant role. Indochinese expectations and needs contrasted to the American physician's role are illustrated in table 2.

Several reviews on cross-cultural therapy with Asian patients (Hsu and Teng 1972; Kinzie 1981; Singer 1976; Yamamoto 1978)) concur that therapists must recognize the cultural and value differences that exist between themselves and the patients and modify their techniques to approximate the expectation of the patients. This usually means that psychiatrists must take a more active and direct role to relieve symptoms. In our opinion, the medical role of American psychiatrists is more consistent with Asian expectations and becomes the easiest point of entry in establishing a relationship with refugees.

A thorough history taken at the initial interview may allow development of a strong relationship and permit formulation of a mutually acceptable treatment plan. Of necessity, this is a time-consuming process, since the interaction needs to be translated. The interview should be done in a slow, cautious, sensitive manner, concentrating initially on the patient's chief complaint, which is often a somatic one. After credibility is established, a complete psychosocial and past history should be taken. The special areas that need to be handled in detail are listed below (Kinzie 1981):

1. Life in the homeland--education, socioeconomic status, health, family members, and the problems of war

2. The escape process--who came, who stayed, and difficulties in escaping

3. Life in the refugee camp--length of time there and problems

4. Adjustment in the United States--attitudes, problems, expectations, and losses

5. Current problems and worries about the future

It is important to do a mental status examination, particularly to determine problems, symptoms of depression, and schizophrenia. A review of symptoms often reveals further medical problems that are common in refugees.

After the history, an understanding of the patient's view of the illness should be reached to see whether a mutually acceptable model can be determined. If it is consistent with the patient's view, we emphasize a stress model. We recount the stresses that the patient mentions in the history and then describe the way his or her body has reacted to produce the symptoms. This is often understood by the patient and incorporates both life stress and reactions, whether physical or psychological.

We emphasize the importance of patients' complying with both followup therapy and medication. This necessitates clarifying the goals of treatment and working with any resistance the patient may have based on fear or lack of information. We go through a treatment plan in some detail with the patient. Asians have little experience in dealing with chronic medical problems or in understanding that maintenance treatment is required to treat symptoms of severe depression or schizophrenia. We particularly discuss the need for continued therapy. This has been one of the most difficult areas for patients to accept.

Open-ended therapy with outpatients is often needed. Many of the problems faced by refugees are chronic, and adjusting to a new culture is a long and difficult process; therefore, the approach involves long-term supportive therapy and should be flexible in dealing with crises when they occur. The approach we suggest is regular, predictable contact with the patient through scheduled appointments. We attempt to establish an ongoing, personal relationship, with common themes that carry over from each session. These themes can deal with major symptoms, side effects of medicines, current stresses, children, or financial problems.

The therapist should model positive social behavior that, it is hoped, the patient can imitate. This includes clear communication, genuine calmness, and constructive use of humor. A realistic approach to solving the many difficulties faced is emphasized. Since mental illness or severe distress may be stigmatizing to a family, much family education and support is needed. It is important to talk with family members and answer their questions. Family disruptions, particularly between spouses, are significant problems, often making supportive family therapy a necessity. This is a difficult issue requiring tact and patience, as many of the problems are considered private matters that should not be spoken of outside the families.

CULTURAL ASPECTS OF PSYCHOPHARMACOLOGY

We have found psychotropic medicine to be very useful in treating Southeast Asians. It meets their need to have the physician take an active part in treating the illness and provides good symptomatic relief. For some disorders, such as schizophrenia, it is the treatment of choice, and for depression, it has greatly augmented our ability to help patients. Effective symptom reduction increases the confidence of the patient in the clinic.

There is a body of literature and much anecdotal evidence indicating that Asians react differently to psychotropic medicine. In general, this information indicates that Asians need less of neuroleptics, antidepressant medicine, and lithium (Glassman and Roose 1979; Yamamoto et al. 1979; Yamashita and Asana 1979). Asians are reported to have more frequent extrapyramidal system symptoms (EPS) with neuroleptics than black or white patients (Binder and Levy 1981). Lin and Finder (1983) found that Asians needed significantly less neuroleptic medication than did matched white control patients. A group comparing schizophrenic patients in the People's Republic of China and the United States found that on the same dose of haloperidol (Haldol), the Chinese had 52 percent higher plasma concentrations of the drug than did the American patients (Potkin et al. 1984). However, not all people have found that

lower haloperidol doses are necessarily called for in Asians (Binder and Levy 1982). It has been well established that there are interethnic differences in drug metabolizing capacities; it is unclear, however, whether these differences are primarily a consequence of nature or nurture (Kalow 1982) or what mechanisms might be involved in interethnic differences in reactions to psychotropic drugs.

Our experience with antipsychotic medications in Southeast Asian patients generally conforms with the literature; i.e., the dose tends to be lower than for Americans. However, there is much variation in this. Many patients when initially hospitalized require a rather high dose of antipsychotic medication, often exceeding 50 mg of haloperidol a day or its equivalent. This is often reduced after discharge, and the patients can then be maintained on a dose lower than that generally required in American patients. Perphenazine (Trilafon) has been the drug most easily tolerated by the patients. Most patients have been prescribed a maintenance dose of 16 to 32 mg of perphenazine a day, with 24 mg being the average. Nevertheless, in our early experience, we found that patients were not compliant with this. Since then, we have encouraged a large number of our patients to take intramuscular fluphenazine decanoate (Prolixin Decanoate). About half of our patients have been maintained on this, at a dosage of 12.5 to 25 mg every 3 to 4 weeks.

Even with this regimen, compliance continues to be a problem until the family becomes involved in drug monitoring or until the patient recognizes the significance of further psychotic decompensations. It has been very difficult to educate the patients and their families concerning the importance of maintenance therapy. A usual pattern is for patients to stop the medicine soon after they have shown some improvement. After a second decompensation, and the family recognizes the patient's need for medicine, compliance improves.

It is difficult for us to evaluate whether Asians in general have more or less EPS. Half of our patients are not taking anticholinergic medicine for EPS. This includes even high-potency drugs like fluphenazine.

Our experience with antidepressant medication is more complicated. In the past year, we have developed the capacity to routinely test blood tricyclic levels in all our patients receiving antidepressant medicine. We began by checking the blood levels of 35 patients who have chronic depression and have been maintained on antidepressant medicine for from a few months to 4 years. Our goal was to determine the optimal dosage of medication that produced a therapeutic blood level. To our surprise, we found that only 13 of the 35 (37 percent) had any detectable blood levels of the antidepressant medicine. In other words, almost two-thirds of our patients were simply not taking their medicine at all or were doing so on such a sporadic basis as to have nondetectable blood levels. There was an ethnic difference in this: only 20 percent of Vietnamese and Mien patients had detectable blood levels of medicine, compared with 60 percent of Cambodians. Compliance, therefore, seems to be a major problem, both clinically and theoretically. One simply cannot determine whether Asians need less medicine if they are taking none at all!

These results were discussed with the individual patients involved who generally acknowledged their noncompliance. The most common reason given was concern about the side effects. Many of the patients came with somatic symptoms and found somatic problems increased after taking the medication. Some developed constipation; others, a fainting sensation, perhaps from orthostatic hypotension; and others, increased sedation. Many felt the medication was "too strong" and reduced it or took it sporadically. Other patients only took it as "needed" when they were "feeling bad." Several patients discontinued antidepressant medication when they saw physicians for other problems often related to the depression. They did not want to combine medications, so they stopped the antidepressant. Some patients, however, used the medicine and the clinic visits for other reasons. One woman stopped her medication 3 days before each visit to "let the doctor know the disease was still present." Another patient admitted sending her medicine every month to her brother in Vietnam who had the same symptoms. For the majority, however, noncompliance was the result of cultural differences in the understanding and treatment of

depression. The Asian patient expected to use the medication periodically for such symptoms as agitation or insomnia, and the American psychiatrist expected continual use to treat a full range of depression symptoms. This noncompliance had significant effects, since the majority of the 35 still had major depressive symptoms.

We were able to correlate blood levels with medication actually taken in 14 patients. Of these 14, 6 had a blood level of imipramine plus its metabolite desipramine above 150 ng, the minimal level thought to be therapeutic. For eight patients, the blood level was below 150 ng. Five of the six who had a blood level above 150 ng were taking 150 mg of imipramine or more. Seven of eight whose blood levels were below 150 ng had taken less than 150 mg, usually much less than the prescribed dose. On the basis of this information, it seems that at least 150 mg of imipramine is needed to get a blood level of 150 ng of imipramine and desipramine. This result does not support the idea that Asians need less antidepressant medication: that dose is within the accepted range for antidepressant effect in Americans. It does not, however, answer another question: Does a lower blood level of trichloroacetic acid (TCA) still have therapeutic effect in Asians? We are investigating this question with a prospective study.

Our impression at this time is that Asians have a severe noncompliance problem with psychotropic medication regimens. This is most noticeable in the case of TCA. The reasons for this are probably related to intolerance of side effects and lack of education regarding the long-term need for these medicines. To improve compliance, it is our recommendation that the following be done:

1. Good education and clear instruction should be given to the patient on the need to take the medication, the likely side effects, the likely time course, and beneficial action.

2. Frequent followup visits should be scheduled at first to monitor the side effects, the positive effects, and the patient's experience with the medication. It is necessary to determine the effect of

medication on various depressive symptoms such as sleep, appetite, and energy level. Encouragement to take the medicine is also important in these early visits.

3. Blood levels of the medication should be obtained to determine whether it is being taken and at what dosage level the desired blood level is being achieved. This assures compliance and provides a basis for discussion if the medication is not being taken.

4. Medication should be changed after a trial of 1 month if the blood level indicates the patient is not taking it or if the patient complains of side effects. If imipramine provides too much sedation, desipramine can often be used. If the patients have too many side effects from anticholinergic medication, particularly dry mouth, and complain that "things taste bad," doxepin could be helpful. It also has the benefit of being sedative, which is often helpful with insomnia in severely depressed patients.

POSTTRAUMATIC STRESS DISORDER

Among the Asian refugees are those who have undergone unusually severe traumatic experiences. This is especially true of Cambodians, who survived 4 years of a concentration-camp-like experience similar to the Nazi holocaust. Because posttraumatic stress disorder is unique in its symptoms, pervasive and enduring in its effects, and because it presents difficulties in diagnosis and treatment, a special discussion of it is needed to help clinicians deal with this problem.

Most of our refugee patients, despite the severe experiences they had endured, did not have the full syndrome of the posttraumatic stress disorder. However, survivors of Cambodia's Pol Pot regime of 1975-1979 revealed a high prevalence of this disorder. We have previously described the symptoms of the disorder among these Cambodian survivors (Kinzie et al. 1984). The symptoms of posttraumatic stress disorder include: 1) recurrent or intrusive recollections; 2) recurrent dreams and

nightmares; 3) feeling saddened, as if the traumatic events are reoccurring; 4) social numbness and withdrawal; 5) restricted affect; 6) hyperalertness, hyperactive startle reaction; 7) sleep disorders; 8) guilt; 9) memory impairment; 10) avoiding activities that prompt recollection of events; 11) reactivation of the symptoms by exposure to events similar to the original trauma.

Among the Cambodian patients, we found that these symptoms were extremely common. Particularly widespread were recurrent thoughts and nightmares regarding past experiences. Equally widespread, though, was the unique avoidance of thoughts or activities that reminded these patients of the past. The patients often refused to tell their story in any detail, and many had never told it to anyone else before. There was a conscious effort to deny events of the past. To some extent, this pattern was characteristic of the reaction of Cambodians to stress. On the other hand, it served to diminish the intrusive thoughts and nightmares. However, the patients were not symptom free, and most of our patients had severe depressive symptoms that were the reason they were originally brought to treatment. When these patients told their stories in detail, appalling inhumane events were described that were extremely difficult to listen to and very difficult for the patients to relate as well. In addition, many of the patients became worse for the succeeding 1 or 2 months after they told their stories. It appeared that retelling the story served as a further stimulus to the disorder.

After working with these patients for over a year, we have been encouraged by some of the results (Boehnlein et al., in press). Five of our original 12 patients were so much improved they no longer had posttraumatic stress disorder at 1 year, and 3 others were significantly improved although they still had the diagnosis. Furthermore, the most symptomatic behaviors--startle reactions, nightmares, and sleep disorders--improved for most of the patients. However, avoidance behavior and shame did not. Several therapeutic approaches are needed to help these patients:

1. A predictable, structured, supportive therapeutic approach that pushes for neither details of the past nor withdrawals when it is necessary to discuss them.

2. Clearing the social and administrative hurdles needed to secure some consistent financial stability for the patient and reduce the pressure to conform, either in school or at work. Increased pressure almost always exacerbates the symptoms.

3. Antidepressant medication, which seems to decrease not only the symptoms of depression, but also some of the most troublesome symptoms of posttraumatic stress disorder as well.

Some patients, however, have not improved and remain both a serious clinical challenge and a reminder of the prolonged human suffering that can occur after severe trauma.

CONCLUDING REMARKS

The following cases illustrate some common psychiatric disorders of Southeast Asian refugees. They also illustrate approaches to psychotherapy, psychopharmacology, and treatment of posttraumatic stress disorder.

CASE 1

This patient is a 34-year-old widowed Vietnamese female with three children. She was referred because of headaches, poor concentration, and difficulty sleeping. These problems had been present for about 2 years following a very traumatic event. Her headaches had increased in severity in the past few months, and she developed difficulty concentrating. She felt tired and lost interest in most everything in her environment except her children.

The patient was raised in South Vietnam, where her father was a businessman. Her parents left Vietnam in 1975. The patient married, and her husband worked for the South Vietnamese government. When

the communists took over, they were unable to continue their usual life, and 2 years later, they escaped with their two children in a boat with about 120 people. She was pregnant at this time. In the process of trying to get to shore in Malaysia, 35 people drowned, including her husband. The next day her youngest child was delivered. The patient was in Malaysia for 5 months before she was able to come to the United States.

She was a sad-appearing woman who complained of profound subjective depression since the death of her husband. She admitted thinking about him every day and having recurrent thoughts of his death.

This patient was diagnosed as suffering from a major affective disorder and from the effects of very severe traumatic events--losing her husband, giving birth to a child, and then living as a refugee without support. She began treatment for depression, which included regular clinic visits and medication. A Vietnamese mental health worker kept in regular contact with her. Her course was quite erratic. At times she would feel better, with decreased headaches and depressive symptoms; but at other times she would feel irritable and severely depressed. She continued to have difficulty concentrating in school. About 1½ years after starting antidepressants, her blood TCA level was 0. When confronted with this, she admitted she had been very erratic in taking her medicine, stopping 2 or 3 days prior to her visits to "see how I do, and let the doctor know the disease is still there." On the following visit, she stated that she was taking 50 mg of imipramine every night, and her blood level was 171 ng. At that time she felt less depressed and was sleeping and eating better. She continued to have poor concentration, which caused difficulty in learning. She reported some intrusive memories of the death of her husband. Overall, in 2 years she had made significant progress in the major symptoms of depression but remained impaired to such a degree she was unable to work or attend school.

CASE 2

A 34-year-old Cambodian male was referred for a variety of confusing symptoms. When he was first seen, his only complaint was coughing two or three times a week. He related this to chronic bronchitis he had developed when he worked in a mine in Cambodia. He described other symptoms, including poor concentration, fatigue, weight loss, and a sleep disorder. He had had poor concentration and memory in the previous 2 months and had very few interests and little happiness in his life. However, he concentrated only on his cough and stated that the cough would improve when he got well. He denied feeling depressed or having any other disorder. At that time, although it was clear that he was very depressed and had had a very traumatic past, he refused treatment.

Nevertheless, he returned 3 months later feeling worse, with an inability to work or to learn English. He described more complete symptoms, which were a poor sleep pattern, very poor appetite, poor concentration, no energy, irritability, anger, and thoughts about dying. In addition, he described major posttraumatic stress syndrome, including intrusive thoughts and nightmares of life in Cambodia, startle reaction, and an inability to forget about Cambodia when he tried. He had been under a great deal of stress when the Pol Pot regime came to power in Cambodia. During this time, his father and three brothers were killed outright. He experienced starvation, threats, long labor, and separation from his family. When the Vietnamese invaded, he was able to leave Cambodia with his mother, wife, and a few other relatives. He was in Thailand for 2 years and was then brought to the United States; by this time he had a 4-year-old child as well. Although at first he clearly used denial and suppression regarding problems of the past, on his followup visit he was clearly saddened and open to suggestions and help.

We started him on imipramine and followed him with supportive therapy at the clinic. In the first few months, he showed very little improvement, and the imipramine was gradually increased to 150 mg at night. However, during the fourth month of treatment, he

showed significant improvement. He said he felt much better, with increased sleep and marked reduction of nightmares and startle reaction, and was eating better. He was sleeping 6 hours a night and he subjectively felt 40 percent better. He became involved with realistic concerns about finding a job and providing for a family. He was able to become involved effectively in the care of his child while his wife found a job. Support was obtained to enable him to receive some disability compensation because of his severe illness. This reduced the financial pressure on him, which resulted in some immediate symptomatic improvement. His blood level of imipramine plus desipramine after 3 months on 150 mg was 447 ng.

This man showed evidence of both posttraumatic stress disorder and major affective disorder. Originally denying his symptoms, he returned for help and subsequently received support, financial assistance, and antidepressant medication. This resulted in a marked reduction in the symptoms of both depression and posttraumatic disorder. However, he remained unable to work, and pressure caused an increase in symptoms.

CASE EXAMPLES

The Southeast Asian refugees represent some unique challenges in providing comprehensive, culturally acceptable psychiatric services. The experiences can be very rewarding as we share the fears and hopes of the latest immigrants to America and as we develop our skills as clinicians for those whose experiences are different from ours.

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PREVENTION

The major theme of this section is the proposition that adding primary prevention to mental health services delivery systems can provide a new and immensely productive approach in attempting to minimize future mental health needs of the Southeast Asian refugee population. The authors in this section present a case for the compatability of primary prevention efforts with the lifestyles of Southeast Asians. Consistently incorporated

are a number of primary prevention principles: interventions directed to large numbers of people, a belief in the ability of people to help themselves, the use of psychoeducational approaches, and the enhancement of social support systems.

Owan suggests that the cutting edge of new technology in primary prevention features combining the community model with the use of mass media. He discusses the phenomenal population growth and the cultural diversity within the Southeast Asian refugee population that will make the task of providing one-to-one treatment services less appropriate in the future. Owan argues that primary prevention emphasizing education, competence training, stress reduction, and the use of natural support systems is eminently syntonic with Southeast Asian cultures and is inherently nonthreatening and nonstigmatizing.

The chapter by Silverman provides a concise discussion on the definitions pertinent to primary prevention in mental health. He suggests that primary prevention must make great strides before it is considered an accepted part of the mental health armamentarium. It must develop effective reactive strategies for individuals at risk for identifiable mental disorders. At the same time, proactive interventions to develop positive, adaptive, adjustive capacities and skills must be nurtured. Silverman also lists some primary prevention strategies. These strategies include the management of stress, the reduction of unnecessary emotional distress, and the improvement of social support networks and skills.

The chapters by Bliatout et al. and Khoa and Bui provide details for these types of strategies. They outline a comprehensive three-part mental health prevention effort that includes: (1) enhancing natural support systems, (2) enhancing individual social and coping skills, and (3) nurturing a secure and solid sense of personal and community identities. Community centers and cluster housing arrangements can serve as vehicles for a more effective community support network. Language and vocational classes, workshops in parenting skills, cross-cultural exchanges, etc., can develop more effective social skills. Reviving native crafts, songs, stories, and dances, as well as establishing

summer camps for young people, can help develop cultural pride and self-esteem and improve personal and community identities. Khoa and Bui point out that there are about 500 known Southeast Asian mutual aid associations in the United States, and see them as an expression of the Southeast Asian's sense of identity.

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SOUTHEAST ASIAN MENTAL HEALTH: TRANSITION FROM TREATMENT SERVICES TO PREVENTION—A NEW DIRECTION

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> In the long run, prevention is far more effective than our capacity to repair and it is shortsightedness bordering on blindness to build up the clinical endeavor at the expense of the preventive one.[1]
>
> Seymour B. Sarason

INTRODUCTION

During the past two decades, Asian/Pacific Islanders, along with blacks, Hispanics, and Native Americans, have struggled to obtain appropriate, acceptable, and accessible mental health services that are equal in quality and scope to those available to the majority population. Despite significant contributions made by the Community Mental Health Center (CMHC) movement to

[1]Sarason, S.B. Work, Aging, and Society: Profession and the One Life One Career Imperative. New York: Free Press, 1977.

increase the range and quality of community-based care, there are still major gaps, particularly in those services intended for racial and ethnic minorities, who represent large segments of the high-risk, underserved, and unserved populations. To a large extent, the CMHCs, the Federal, State, and local governments, and the private sector have not adequately responded to the special needs of pluralistic and culturally diverse communities, especially in major metropolitan areas. Sufficient attention has not been given to race and ethnicity, which are significant variables affecting utilization, treatment modality, and treatment outcome. Indeed, the present mental health services providing care to racial and ethnic minorities, by and large, have been inappropriate and ineffective (President's Commission on Mental Health 1978, Vol. III).

This chapter describes an alternative approach to mental health services for Southeast Asians; namely, prevention intervention programs and research. Primary prevention concepts are suggested as a way to launch a new direction in mental health services. Primary prevention can become a far-reaching innovation in public health policy and, perhaps, a new paradigm for addressing the diverse needs of Southeast Asians.

The challenge is not to ignore the importance of developing critically needed, culturally syntonic treatment services, but rather to add primary prevention as an integral component of the overall mental health services delivery system. Indeed, doing so could become a mechanism for stimulating and enhancing the development of multiple approaches to serve multiethnic populations in the United States.

JUSTIFICATION FOR PRIMARY PREVENTION TARGETED TO SOUTHEAST ASIAN REFUGEES

CHANGING DEMOGRAPHIC TEXTURE OF THE UNITED STATES

The Harvard Encyclopedia of American Ethnic Groups contains entries on 106 different ethnic groups in the United States (Thernstrom et al. 1980, p. vi). The

book makes vivid an image of an immense sociocultural mosaic, a veritable "nation of immigrants." For more than two centuries, an incessant human stream has come to the United States from all over the world. Every decade, the census gives a different perspective. The Nation, now approaching 235 million inhabitants, has received nearly 50 million immigrants since the time of the Pilgrims (U.S. Bureau of the Census 1982).

Some drastic changes in the population have occurred. For example, in California, 35 percent of the population is made up of minorities; it is estimated that, by 1990, over 19 million of California's total population of over 31 million will be members of minority groups--a staggering 60 percent (Francisco, unpublished).

As of January 1983, 660,000 Indochinese refugees had been admitted to the United States. The majority of these refugees were Vietnamese (66.6 percent), Khmer (20.5 percent), Lao (13.5 percent), and Hmong (7.8 percent) (Office of Refugee Resettlement 1984). Given the current resettlement trend, Southeast Asians may soon constitute the largest Asian/Pacific Islander group in the United States (Rumbaut, unpublished). As the phenomenal growth in ethnic populations continues, providing one-to-one, culturally syntonic treatment services is destined to become even more difficult in the future.

UNFAMILIARITY AND CONFLICT WITH WESTERN CONCEPTS AND TREATMENT MODALITIES

Unlike orderly immigration procedures, under which planning is possible and linkages can be established prior to arrival in the host country, the disordered experience of refugees is traumatic. An increased incidence of depression, anxiety, reactive psychosis, adjustment disorders, psychosomatic conditions, and interpersonal problems has been observed in refugees from Eastern Europe (Etinger 1959; Etinger and Grunfeld 1966; Tyhurst 1951), Hungary (Meszaros 1961; Mezey 1960), Cuba (Rumbaut 1977; Rumbaut and Rumbaut 1976), and Taiwan (Chu 1972). More recently, similar findings have been documented in Vietnamese

and other Southeast Asian refugees (Kinzie and Manson 1983; Lin et al. 1979; Nguyen 1983; Rumbaut, unpublished).

Sporadic attempts to offer conventional Western treatment to Southeast Asian refugees have resulted in only limited success for the following reasons: 1) the language and cultural barriers between the refugee patients and their therapists are often substantial, making not only treatment, but diagnostic evaluation difficult; 2) mental illnesses are highly stigmatized in Vietnamese culture, and, consequently, patients and family members tend to deny the existence of such problems, significantly delaying the decision to seek mental health care; 3) there is neither a comparable therapist's or counselor's role in Vietnamese societies nor a tradition of regarding self-revelation as a treatment method, so it is often difficult to engage these patients in the Western-style therapist-patient relationship; 4) there is a strong tendency toward somatization--the expression of distress is usually subtle and indirect, with somatic idioms often used (Ishikawa et al., this volume; Lin and Masuda 1981; Tung, this volume). Patients suffering from a mixture of physical and psychological symptoms frequently concentrate on the physical side of their suffering and expect treatment to be aimed in that direction.

INAPPROPRIATE TREATMENT SERVICES TARGETED TO MINORITIES

Differential Treatment

Numerous investigators provide continuous and widespread evidence of differential mental health treatment based on race and ethnicity. Mollica and Redlich (1980) found that "special" patient groups (blacks, Hispanics, elderly, alcoholics) were primarily receiving low-intervention treatment provided by semiprofessional and nonprofessional staff. In contrast, patients from higher socioeconomic classes, often with less debilitating illnesses, received higher intensity treatment (i.e., psychotherapy) (Mollica 1983; Sue et al. 1974).

Minority groups frequently receive qualitatively inferior or less preferred forms of treatment. Of 143 chronically mentally ill Chinese Americans carried by an aftercare program in San Francisco, 40 (28 percent) were randomly selected to determine their State hospital experience. The average length of stay in the State hospital was 17 years, and the treatment most often received was chemotherapy (33 patients) (Wang and Louie, unpublished). Length of stay and percentage receiving chemotherapy were significantly lower for white patients. Flaherty and Meagher (1980) found that black patients, compared with white patients, spent less time in the hospital, obtained a lower privilege level, were given more medication, and were less likely to receive recreation therapy and occupation therapy. Seclusion and restraints were more likely to be used with black patients. Black patients also ran a higher risk of being misdiagnosed than did white patients (Adebimpe 1981).

Negative Outcome

Premature termination of psychotherapy by patients is a common problem. This problem occurs even more frequently if the patients are poor, working-class, or minority individuals (Sue 1977; Yamamoto et al. 1967). Unilateral termination of therapy among minorities reflected dissatisfaction with therapists and therapy received by clients as reported during followup contacts (Kline et al. 1974). Sue et al. (1974) found that 52.1 percent of blacks dropped out of treatment after the first psychotherapy session, as compared with only 29.8 percent of whites. Various researchers have attributed this behavior to unmet patient needs and a lack of integrating culture-specific treatment modalities with psychotherapy (Acosta et al. 1982).

In citing the conflict between expectations and experience among the lower socioeconomic groups regarding psychotherapy, researchers suggest that such persons typically prefer advice for the resolution of "social," rather than intrapsychic, problems (Lorion 1973; Sue et al. 1976; Yamamoto 1978). Thus, unlike the case with the passive "Anglo" approach, which relies on the patient's talking about problems introspectively, with the therapist taking a neutral, nonjudgmental,

noncritical role, special population groups (particularly the non-English- and limited-English-speaking, the marginal and unacculturated, and refugees) expect the therapist to be actively involved in the relationship, giving them advice and prescribing medication or giving tangible treatment. As Goldstein (1980) emphasized, social workers and other mental health professionals need to rely less on abstractions and become more active in pursuing information about real-life problems that clients face and in utilizing specific interventions that are effective. Thus, the goal for therapists in these situations should be less often insight and more often better coping by their patients with their problems.

Sue and McKinney (1975) found in their study of 17 community health centers in the greater Seattle area over a 3-year period that the dropout rate for Asian patients after the initial intake session was 52 percent, or almost twice the dropout rate for white patients.

These studies reveal that nonwhites usually have less positive treatment outcomes than others in the general population. A National Institute of Mental Health report concludes that when patients come from minority groups or low socioeconomic classes, the difficulty of determining the appropriateness and efficacy of treatment is particularly great (Segal, unpublished).

Underutilization

A comprehensive review of mental health literature documents widespread underutilization of mental health services by Hispanics, Asian/Pacific Islander Americans, and Native Americans. Patterns of underutilization by Hispanics have been reported for California State mental health facilities (Karno and Edgerton 1969), the San Jose California Mental Health Center (Torrey 1972), Denver Spanish Community Center (Kline 1969), and Texas State mental hospitals (Pokorney and Overall 1970), among others. Burruel and Chavez (1974) and Ramirez (1980) indicate that the patterns of underutilization among Mexican Americans are primarily the result of the viewpoint in communities that the services that are offered are culturally irrelevant. Conversely, Morales (1978) and Chavez (1979) have shown that

when specific mental health programs are culturally relevant, services show an increase in the rate of utilization.

In Los Angeles County, which has the largest concentration of Asian/Pacific Islander Americans in the United States, the 1971 admission rate of Asian Americans to inpatient and outpatient mental health services was 0.9 percent of the patient population, although their representation in the county was close to 4 percent (Hatanaka et al. 1975).

Native American tribal councils have described grossly inadequate services to tribal communities. For the Native American, who is probably worse off in any overall comparative analysis of quality of life, underutilization is far from being merely an academic problem; it has now reached epidemic proportions.

To the extent that providers of services continue to respond unsuccessfully to the basic needs of racial and ethnic minorities, minority users will likely drop out of treatment and discourage their families, friends, and associates from seeking help.

The aforementioned major problems in the mental health services system illustrate the need for more appropriate, acceptable, culturally syntonic mental health services for ethnic minorities.

PREVENTIVE INTERVENTION: CONCEPTS AND DEFINITIONS

Several excellent reviews (Kessler and Albee 1975; Bloom 1979; Levine and Perkins 1980; Cowen 1983) provide a valuable introduction to the vast array of concepts and definitions in the field of prevention research and programing. Though debate continues regarding the most appropriate terms with which to characterize prevention, the tripartite division of primary (to decrease the incidence of new cases), secondary (to reduce the severity of the disorder), and tertiary (rehabilitation) prevention, each with separate methodological emphases, has the greatest currency (Caplan 1964).

Several widely cited definitions of primary prevention by Caplan (1964), Bower (1969), Goldston (1977), and Cowen (1980) are worthy of note. All agree regarding the two basic goals of primary prevention: psychological health and forestalling the development of psychological problems. These writers stress that the foundation of the approach lies in developing programs (interventions) designed to enhance those goals, and they point to several qualities that programs must have: 1) they must be mass- or group-oriented, not targeted to individuals; 2) they must be directed to essentially "well" people, not to the already affected, although targets can appropriately include those who, by virtue of life circumstances or recent experiences, are known (epidemiologically) to be at risk for adverse psychological outcomes; 3) they must be "intentional"; that is, they must suggest that a program's operations can strengthen psychological health or reduce psychological maladjustment (Cowen 1983).

PRIMARY PREVENTION– ESTABLISHING A "BEACHHEAD"

To avoid the pitfalls of the past decade in mental health treatment and services aimed at ethnic minorities, minority researchers and community leaders have focused on the potential benefits of including primary prevention as an integral component of mental health services. For Southeast Asians, the distinctive strength of primary prevention lies in the methodologies used to attain program objectives, such as mental health education, competence training, support systems, and social system modifications.

The absence of adequate knowledge to address the critical question, "What are you preventing?" has been a major reason for not undertaking a prevention program tailored to minority communities. The review by Cowen (1982), however, has contributed immeasurably to increase the scientific underpinnings and justification for primary prevention. He identified nine studies that indicate preliminary evidence of program effectiveness and true prevention effects. The studies provide heuristic models and a foundation on which primary prevention efforts can build.

Bloom (1982) argues that preventive intervention programs can be organized to reduce the incidence of particular stressful life events whenever possible or facilitate their mastery once they occur. This new paradigm begins by abandoning the search for a unique cause or set of causes for each disorder. Bloom describes the following sequence of steps to mount this new paradigm (p. 136):

1. Identify a stressful life event that appears to have undesirable consequences. Develop procedures for reliably identifying persons who have undergone or who are undergoing that stressful experience.

2. By traditional, epidemiological, and laboratory methods, study the consequences of that event and develop hypotheses related to how one might go about reducing or eliminating the negative consequences of the event.

3. Mount and evaluate experimental preventive intervention programs based on these hypotheses.

If primary prevention programs are to take their place in the array of services at the local level, research and evaluation efforts are needed, not only to demonstrate program effectiveness, but to continually improve ability to research underserved populations (Price and Smith 1985).

Several research efforts in primary prevention, supported by the National Institute of Mental Health, are identifying high-risk populations, specific outcomes that may be prevented, and interventions that promise effectiveness. These are 1) "Prevention With Black Preadolescents at Social Risk," under John D. Coie, Ph.D., Duke University, Durham, N.C.; 2) "Native American Samoan Prevention Intervention Project," under Alexander Mamak, Ph.D., National Office of Samoan Affairs, San Francisco, Calif.; 3) "Physical Illness, Depression, and Elderly American Indians," under Spero Manson, Ph.D., Portland State University, Portland, Ore.; 4) "Hispanic Social Network Preventive

Intervention Study," under William Vega, Ph.D., San Diego State University, San Diego, Calif.; 5) "Depression Prevention Effects on Medical Outpatients" [includes Hispanics and Chinese], under Ricardo Munoz, Ph.D., University of California, San Francisco, San Francisco General Hospital; 6) "Psychiatric Risk Factors Among Adult Black Americans," under Harold W. Neighbors, Ph.D., University of Michigan, Ann Arbor; and 7) "A Model of Preventive Intervention on Behalf of Hispanic Infants and Their Families," under Alicia F. Lieberman, Ph.D., University of California, San Francisco. These pioneering preventive intervention research efforts will not only increase the scientific basis, but also create opportunities for developing a new model of primary prevention targeted to minority groups.

THE COMMUNITY MODEL IN PRIMARY PREVENTION

Because prevention projects inevitably must be implemented locally to reach vulnerable community populations, the community model can greatly aid in the effort to implement preventive intervention strategies. Social isolation and feelings of alienation generally are viewed as fertile grounds for the development of emotional disorders. Encouraging people to become part of significant social networks, to organize mutual aid groups, or to become identified with some community is crucial to prevent mental illness (Plaut 1982).

The real value of the community model (see figure 1) lies in its capacity to enhance and strengthen the rich resources of the minority communities--church, family, extended family, mutual assistance associations (MAAs), mutual help and self-help groups, etc. It provides the catalyst for empowering individuals, groups, and institutions to develop culturally syntonic coping skills from their communities, rather than external support sources.

The community model is an integral part of the overall primary prevention schema for minority groups. Perceiving the problem of prevention from a community perspective affords minority groups the opportunity to develop a threefold approach (personal, social, and

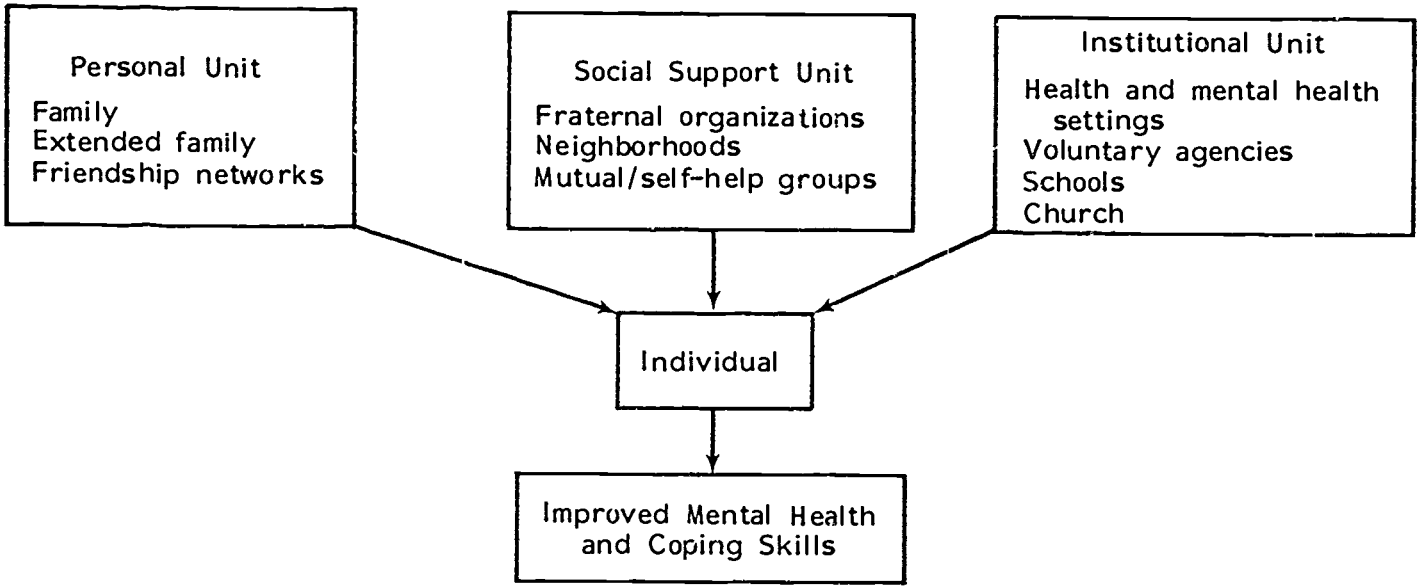

FIGURE 1.--Community model[1]

[1] Developed with Manuel Miranda, Ph.D., School of Social Welfare, University of California at Los Angeles.

institutional), resulting in more appropriate and acceptable mental health services.

The community model permits a holistic approach to primary prevention rather than focusing on the fragmented parts. The following are some of the key elements of the community model; they are not an attempt to develop the model in its entirety, but rather to provide a starting point for researching and/or defining the operational processes of the various units.

PERSONAL UNIT

To a large extent, most Southeast Asian refugees, particularly the ethnic Chinese and Vietnamese, tend to rely heavily on self, family, extended family, and friends when dealing with psychosocial problems (Moon and Tashima, unpublished; Nguyen 1983; Tung, this volume). Thus, program activities, such as psychoeducational classes, counseling, and utilization of resources, must be planned carefully to include the family as central to promoting and enhancing ongoing services tailored to Southeast Asians.

SOCIAL SUPPORT UNIT

Like others who came before them, refugees from Cambodia, Laos, and Vietnam have followed a pattern of joining together to help one another survive the acculturation process in the United States. For Southeast Asian refugees, the MAAs have proven to be one of the most constructive and logical extensions of the support systems to fill the need for culturally appropriate and acceptable services.

Since 1975, more than 500 MAAs have been created in Indochinese refugee communities in the United States. These groups vary widely in purpose and orientation. Bui (1981) has divided the MAAs into eight categories to give a sense of the diversity of these organizations: 1) social/fraternal groups; 2) educational/cultural groups; 3) religious/spiritual organizations; 4) professional societies; 5) political groups; 6) student groups; 7) groups with distinct needs, such as senior citizens,

veterans, women, and refugees without families; and 8) volunteers and paid staff to handle emergency refugee resettlement needs such as housing, jobs, and sponsors.

The spontaneous appearance and proliferation of MAAs reflects the Southeast Asian refugees' belief that an investment in community-based self-help efforts offers genuine hope for bringing about a successful social and cultural transition and attaining true economic self-sufficiency in America.

MAAs enhance and strengthen ethnic pride and coping styles rooted in ethnicity and may serve to effectively lessen the deleterious effects of stress and, hence, the risk of mental illness. The findings of Lin et al. (1979) suggest that social support contributes significantly toward reducing the severity of illness symptoms. More specifically, the stronger the social support an individual can amass, the less likely it is that the individual will experience episodes of illness. Reviews of research findings by Cobb (1976), Kaplan et al. (1977), the President's Commission on Mental Health (1978), and Hamburg and Killilea (1979) conclude that social support may play a major role in modifying the deleterious effects of stress on health.

INSTITUTIONAL UNIT

Too often, institutional units that serve large segments of minority groups (e.g., schools, churches, public and private agencies) focus on the weaknesses and problems of their patients while overlooking strengths and resources within the minority communities. In the community model, these institutional units can provide valuable leadership training to help minority groups increase their self-determination and capacity building, thus strengthening their internal networks for mutual problem-solving. In addition, institutional units can play a major role providing resources and expertise to develop culture-specific psychoeducational approaches to primary prevention activities.

USE OF MASS MEDIA TO PROMOTE PREVENTION AND ENHANCE COPING SKILLS

Because prevention and psychoeducational approaches are considered nonthreatening and nonstigmatizing, they are preferred when dealing with sensitive mental health problems and issues of Asian/Pacific Islanders (Chen 1977; Lin and Lin 1978; Lum 1981; Mamak 1979). In this regard, the use of mass media (cable television, radio, videocassettes, ethnic newspapers, etc.), especially community-access cable television tailored to the specific needs of the Southeast Asians, presents exciting challenges and opportunities to promote primary prevention and enhance coping skills aimed at high-risk groups.

Most cable operations are required to provide a specified number of cable channels at no cost to the community (Katz, unpublished). Southeast Asians, through their MAAs, can play a major role in and take advantage of this medium by focusing on primary prevention efforts. These efforts are aptly described by Goldston (1977) and are ideally suited for the Asian/Pacific Islanders:

> Primary prevention encompasses activities directed toward specifically identified vulnerable high risk groups within the community who have not been labeled psychiatrically ill and for whom measures can be taken to avoid the onset of emotional disturbance and/or to enhance their level of positive mental health. Programs for the promotion of mental health are primarily educational rather than clinical in conception and operation, their ultimate goal being to increase people's capacities for dealing with crises and for taking steps to improve their own lives.
>
> (p. 20)

Community-access television offers community groups the conduit to 1) extend their outreach capabilities by reaching people who wish to remain anonymous or who would not want to participate face-to-face; 2) provide opportunities to develop psychoeducational approaches (via videocassettes or film) on how to cope with stressful life events from those who have overcome

major problems and learned to cope; and 3) promote education and prevention, information and referral, and programing for special groups (Katz, unpublished).

Television has become a common fixture in American homes. Almost all homes have one or more television sets, and approximately 20 percent of them are linked with cable (Broadcasting Yearbook 1983; Roberts 1974). Television has been called by George Gerbner, Annenberg School of Communications, "the universal curriculum of children, parents, and grandparents alike" (The Miami Herald 1982). Within the 4,083 square miles of Los Angeles County in which 104 languages are spoken, one television station, KSCI Channel 18, broadcasts in 14 languages including Persian, Thai, Pilipino, Samoan, and an Indian dialect called Run Hee Run Zaidi (The Washington Post 1984). The use of mass media is so pervasive that it is estimated that adults are occupied with mass media for 50 percent of their leisure time (Comstock et al. 1978; Lee and Browne 1981; Stroman 1984), and it is estimated that at the time of graduation from high school a child will have spent 12,000 hours of formal education and 22,000 hours in front of the television set (Looney 1976).

Indeed, the Southeast Asians are no exception; the preponderance of families own a television set (Rumbaut, unpublished), and the utilization of mass media would represent a significant and inexpensive advance in primary prevention intended for the unserved and underserved populations who are considered to be at high risk.

THE USE OF MASS MEDIA: MODELS

The following are prime examples of projects that can serve as models in developing primary prevention activities through the use of mass media:

- Asian Community Mental Health Services, Oakland, California, developed mass-media-oriented mental health promotional material targeted to the Vietnamese, Chinese, and Samoans, based on the theme "Friends Can Be Good Medicine." The printed booklets highlighted the cultural values and strengths

of each community and attempted to present more favorable and accurate portrayals of Asian/Pacific Islanders. Visual media consisted of 30-second public service announcements aired over local television stations. The response from the public to date has been very favorable (Lum, this volume).

- In a recent psychoeducational adaptation through the use of television media, Munoz et al. (1982) adapted an intervention program to prevent depression originally based on a classroom and seminar format. The brief intervention programs included methods for and information on using individual coping skills to resist depression. These proved to be helpful in reducing symptom levels among the community residents who watched.

- Acosta et al. (1982), in collaboration with actor Ricardo Montalban, developed a videotape program for monolingual Spanish-speaking psychotherapy patients, titled "A Compromiso With Yourself," which is widely used for assisting patients in psychotherapy. The potential for use in primary prevention efforts is great.

- In his current research on preventing depression among older Native Americans, Manson (unpublished) is utilizing the "Coping With Depression" course, which includes class activities involving self-monitoring, increasing pleasant activities, decreasing negative activities, changing negative cognitions, developing social skills, assertiveness training, self-control techniques, anxiety reduction, and time management. The class sessions are nonstigmatizing and can be compared with other experiences that these older adults are likely to have had. The replication of these activities through the use of tribally owned television and radio stations is very encouraging in light of the vast need for such services, especially on remote reservations.

- Boulette and coworkers (Boulette 1980) created Spanish-language radio programs titled "Una Familia Sana--A Healthy Family." The programs utilized colloquial terminology and Latin music appropriate to Hispanics of Mexican heritage, along with

colloquial psychological and medical concepts. The series was focused on increasing the target population's awareness of negative overt and covert child-rearing practices; providing positive information regarding child development, discipline, conflict resolution, and utilization of services; and reinforcing constructive parenting and cultural practices. The programs were recorded on five video cassettes, each containing 10 separate 5-minute programs. In addition to being used over the air, these cassettes have been used with families and small groups for discussion.

DEVELOPING CULTURALLY SYNTONIC COPING SKILLS AND PSYCHOEDUCATIONAL APPROACHES

For heuristic purposes, the following examples are cited to demonstrate how the community model can be utilized to achieve the objectives mentioned.

Utilizing the community model, the Lao Family Community Association, Orange County, California, a tightly knit organization reminiscent of the typical Hmong clan structure in Laos, provides an excellent source for mutual help/self-help activities. They have developed outreach services, child care centers, English classes, and newsletters to inform the Laotian communities of the availability of services tailored to their needs. These activities lend themselves to the development of a series of workshops on parenting, how to cope, developing better linkages with extended families, etc.

For the Khmer, the Buddhist church is increasingly becoming the focal point for seeking community support and spiritual strength and for fostering mutual help/self-help activities.

The loss of family support is particularly difficult for a subgroup of Vietnamese refugees consisting of young, unmarried ex-servicemen who escaped from Vietnam during the final stages of the war, leaving behind their families and extended family network. During the past several years, these individuals have developed "pseudofamilies"--three or four of them will share an

apartment, go to the same school, work in the same factory, and develop close ties reminiscent of the extended family relationships in Vietnam (Lin and Masuda 1981). Utilizing the community model, the institutional unit can provide valuable services in developing the network to establish "pseudofamilies," especially among those who are isolated and in need of extended family relationships.

Based on their vast experiences in providing resettlement services, voluntary agencies such as the Church World Services; the American Council for Nationalities Service; the International Rescue Committee, Inc.; the Lutheran Immigration and Refugee Service; and the United States Catholic Conference can provide a major contribution toward the development of psychoeducational and coping training programs tailored to Southeast Asian refugees.

SUMMARY

The proposed prevention efforts featuring the community model combined with use of the mass media represent the cutting edge of new knowledge or primary prevention. They offer the mental health field the potential to reach citizens heretofore largely excluded from participation: refugees, non-English-speaking and limited-English-speaking groups, and ethnic groups.

The goal of promoting psychological adjustment and preventing maladjustment in the community contrasts sharply with the one-to-one treatment focus. It involves a number of prevention principles appropriate to broad segments of the public, including early intervention; involvement of large numbers of people; belief in the competence of people to help themselves, solve problems, and learn to cope in response to psychoeducational approaches; and the use of the social support systems, an important resource in minority neighborhoods.

Among Southeast Asian refugees, a conviction that governmental entities have ceased to adequately respond to their major mental health needs results in debilitating feelings of powerlessness, alienation, and hopelessness. Primary prevention efforts using the proposed

community model serve as an alternative mechanism--a refocusing toward a more appropriate, acceptable, and humane effort to overcome the major obstacles of differential treatment, negative outcome, and underutilization of mental health services for Southeast Asian refugees. This proposal by no means advocates curtailing urgently needed culture-specific treatment services; rather, it supports strengthening the rich resources within Southeast Asian groups to complement ongoing mental health services.

Primary prevention efforts in a pluralistic society provide a more diversified solution to problems that are, after all, diversely caused and diversely defined. The ultimate goal of primary prevention aimed at Southeast Asian refugees is to promote psychological health and forestall psychological distress in the hope that individuals will devise, discover, and accept a solution that fits.

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PREVENTIVE INTERVENTION RESEARCH: A NEW BEGINNING

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INTRODUCTION

In the introduction to his classic work, Psychotherapy: The Purchase of Friendship, Matthew Dumont (1964) reflected on his early experiences as a psychiatrist in a large urban psychiatric outpatient setting. Each day, his hours were spent responding to the needs of patients, new and old. As treatment for one was completed, another was always there to fill the hours. Gradually, Dumont recognized that continued reliance on the treatment method with which he was most familiar, that is, psychotherapy, would never result in a reduction in the flow of new cases. With that insight, he came to understand a principle long recognized by public health professionals: "that no condition has been controlled or prevented by treating its victims" (p. iv). He also came to recognize that no matter how many hours, weeks, months, and years he and his colleagues worked, they would never be able to keep up with the demand for their services and would, at best, barely scratch the surface of the social need for assistance with emotional disorders. In a sense,

he came to see his role as being not unlike that of the little Dutch boy holding back the flood waters with his finger. The fear for Dumont, as for many of those involved in the delivery of mental health services (Albee 1982), is that their efforts serve only to postpone rather than avoid the deluge. For that reason, the goal of our efforts at the National Institute of Mental Health (NIMH) Center for Prevention Research is to support research that points the way to reducing the incidence of new cases and, consequently, the need for treatment services by preventing entirely the onset of disorder or by intervening as early as possible in its evolution.

GENERAL CONCEPTS

It is appropriate, indeed essential, when discussing prevention, to define one's terms operationally. Given the interdependence among the multiple interpersonal, economic, occupational, and environmental factors that affect the human emotional condition, an overly global view of prevention results in an all-inclusiveness that causes the concept to be lost in its own diffuseness. As Kessler and Albee (1975) noted when describing their attempt to conduct a comprehensive review of the professional literature on primary prevention:

> During the past year, we found ourselves constantly writing references and ideas on scraps of paper and emptying our pockets each day of notes on the primary prevention relevance of childrens' group homes, titanium paint, parent-effectiveness training, consciousness raising, Zoom [TV show], Sesame Street, the guaranteed annual wage, legalized abortion, school integration, limits on international cartels, unpolished rice, free prenatal clinics, anti-pollution laws, a yoghurt and vegetable diet, free VD clinics, and a host of other topics. Nearly everything, it appears, has implications for primary prevention, for reducing emotional disturbance, for strengthening and fostering mental health. And anyway, as Bleuler said, they are good things in themselves.
>
> (p. 560)

In an attempt to establish some boundaries around the concept of "primary prevention in mental health" and thereby focus research and service efforts in that domain, Emory Cowen (1983) recently distinguished among four basic, but importantly different, terms:

Prevention is the broadest term that can be applied to the alternative strategies already mentioned. The term's all-inclusiveness makes it applicable to any strategy that intentionally or unintentionally reduces the incidence of any disorder. Consequently, the generality of the term tells us little about its focus or procedures.

Prevention in mental health defines the focus of intervention strategies included within this category; namely, they are aimed at that range of behavioral dysfunctions and psychological disorders (i.e., the psychoses, neuroses, and character disorders) traditionally considered to be the purview of the mental health field. The issue of how one accomplishes this overarching goal remains undefined and leaves open as potential methods all three classic public health preventive strategies: tertiary, secondary, and primary.

Tertiary interventions occur once a disorder manifests clinically diagnosable signs and symptoms and are, by definition, oriented toward treatment and rehabilitation. The goal of such activities is to minimize, insofar as is possible, long-term sequelae and the recurrence of the disorder.

By contrast, secondary interventions focus on the introduction of early detection and remediation procedures. Ideally, such procedures enable one to initiate intervention at the earliest possible moment, thereby bringing about the effective interruption of the pathogenic process. Secondary interventions take advantage of currently available mental health service technologies, i.e., diagnosis and treatment. Secondary efforts are directed toward individuals and are instituted only after some initial manifestation of disorder is identified.

Primary prevention refers to that category of intervention procedures designed to avoid entirely the onset of a predetermined target disorder. As a generic term, its focus may include physical, as well as psychological,

dysfunctions. In a broader sense, its impacts will always be linked back to mental health outcomes, since improved physical status results in an avoidance of the negative emotional sequelae and concomitants (i.e., anxiety, depression, and adjustment disorders) often associated with physical concerns and maladies. Primary preventive efforts are directed at populations (either at large, or selected on the basis of epidemiologically defined risk status) and rely upon the utilization of public health, education, and other strategies. Primary preventive efforts represent a marked contrast in terms of target populations, procedures, and outcome criteria as compared with secondary and tertiary efforts.

Primary prevention in mental health is the most specific of the four terms considered thus far. This category of intervention strategies focuses exclusively on mental health/psychological variables and outcomes. Such strategies must, by definition, be targeted to well-defined populations, must precede the onset of detectable disorders, and must result in demonstrable reductions in the incidence of a specified target disorder and in the use of related treatment services.

This latter term defines specifically a major programmatic thrust of the NIMH Center for Prevention Research. Primary prevention in mental health represents the most challenging and potentially the most promising direction for research and service/intervention activities concerned with understanding and responding to the Nation's mental health needs. The challenge exists at multiple levels for implementation of primary prevention strategies, and it requires that we in the mental health profession reconceptualize the following questions:

- Which mental health problems are most amenable to preventive intervention strategies?
- Who are appropriate targets for interventions?
- What form should these interventions take?
- What role should major social systems (e.g., schools, courts, public health departments, and welfare

agencies) play in responding to the Nation's mental health needs?

- How should scarce resources for human services be allocated among tertiary, secondary, and primary prevention efforts?

DIRECTIONS AND STRATEGIES

The field of primary prevention must make significant strides before it becomes a major component of the Nation's armamentarium against emotional disorders and behavioral dysfunctions. To do so, it must develop on two fronts simultaneously. First, it must create a series of reactive strategies focused on individuals at risk for identifiable mental disorders. Determination of risk represents, in and of itself, a formidable challenge that will test both the predictive accuracy of state-of-the-art epidemiology, strategies and the existing knowledge bases in the behavioral sciences. The NIMH Division of Biometry and Epidemiology through a cooperative agreement with the five-site Epidemiological Catchment Area program, is undertaking a landmark research effort to address this issue (Regier 1984). Suddenly, speculation about the etiology of dysfunction must be replaced by a rigorous understanding of its individual, familial, sociocultural, and environmental determinants. Simple-minded univariate conception of cause and effect must give way to complex transactional and diathesis-stress models of psychopathology, which will enable us to determine who is at risk for what dysfunctions under what specific conditions (Sameroff 1975). Primary preventive efforts may then be designed either to modify the "whos," in order to fortify them against potential pathogens and pathological processes, or to modify the conditions, in order to remove them from the environment. The former approach will require us to make use of epidemiological definitions in order to change the personal and interpersonal resources available to people; in short, we must change people. By contrast, in order to modify the conditions, we must accept the challenge of learning about the ecology of health and pathology, in order, ultimately, to engineer environments, social as well as physical, that minimize negative emotional states and promote positive adaptive coping styles.

Another direction for primary prevention efforts to take is toward promotive or proactive interventions, which focus, not on the alleviation of pathology per se, but on the development of positive, adaptive, adjustive capacities and skills as ends in and of themselves. In essence, proactive efforts carry the promise of allowing the mental health professions finally to focus on that very outcome: mental health.

Regardless of whether the focus of the primary prevention activity is reactive or proactive, it is essential that it be characterized by specific actions directed at specific populations for specific purposes. Each of these facets must be operationally defined so that the intervention process can be monitored and its impacts objectively assessed, be they reactive or proactive. It is equally important, given the population-focused nature of such efforts, that public health strategies of education, community organization, and coordination of the major social systems be integral components of the specific interventions affecting the target population. Finally, all primary prevention efforts are by definition based on prediction of future events and an awareness of developmental processes unfolding across the lifespan (Leavell and Clark 1953). These concerns have been incorporated into the working definitions of prevention research used by the NIMH Center for Prevention Research.

Preventive intervention research proposals should offer:

- A clearly articulated theoretical model that is empirically based, reflective of developmental processes underlying the specified disorders, and a conceptual link among the chosen target group, intervention, and outcome measures

- An assessment of the processes, effects, limitations, duration, and safety of the proposed preventive intervention

- Research designs and procedures appropriate to the developmental and sociodemographic characteristics of the target group and conducted in settings relevant to the target group and the occurrence of the disorder

- Methods to evaluate whether the predicted changes in the hypothesized mediating variables occurred

PRIMARY PREVENTION TARGETS

Primary prevention efforts may be aimed at four primary targets (Goldston 1977). The first target is mental illnesses of known etiology, caused by such factors as poisoning (e.g., lead poisoning), infections such as encephalitis and rubella, genetic disorders such as phenylketonuria, malnutrition disorders such as pellagra, general systemic diseases such as arteriosclerosis, and accidents or trauma.

The essence of such interventions is specification of relevant antecedents and, in most cases, either environmental modifications, resulting in a reduction of pathogens, or the initiation of appropriate physical, physiological, or behavioral (e.g., exercise programs) interventions.

A second target is mental illnesses of unknown etiology (e.g., functional psychoses, neuroses, and personality disorders). Although this category of potential targets represents perhaps the most seductive focus for primary prevention interventions, it is also the one most fraught with potential for disaster. By definition, the causes of such disorders are as yet unknown. Once determined, they will, in all likelihood, reflect the complex interaction of multiple biopsychosocial factors. At present, predicting their onset with any accuracy is an unachieved goal. At best, we can adopt available epidemiological strategies and identify which groups are at highest risk for specific dysfunctions (e.g., physically abused children, children of emotionally disturbed parents, children with chronic physical handicaps, and persons experiencing high levels of stress) and attempt to promote mental health in these groups. Given the lengthy gestation period characteristic of most of these disorders, intervention prior to their onset is obviously problematic and, in most cases, directed to early- and middle-childhood-aged populations.

If we identify critical life events as significant stress-related precursors of at least a fraction of the disorders within this category, a number of alternative strategies become possible:

1. Stressor management (e.g., controlling the level of competition in children's sports)

2. Stressor avoidance (e.g., changing jobs)

3. Stress resistance building (premarital counseling, parent effectiveness training, bereavement seminars)

4. Stress reaction management (workshops for the recently bereaved, workshops for the newly divorced, retirement workshops)

Another target category is emotional distress, maladaptation, and maladjustment. This category of disorders represents, at present, the most viable target for primary prevention efforts. It entails the adoption of a psychological, sociological, cultural, and educational approach in which crisis theory, crisis intervention, and anticipatory guidance are particularly relevant. The overarching goal of these efforts is to reduce unnecessary emotional distress.

A fourth category is promotion of personal, social/interpersonal, and functional competency. This category involves maximizing the positive, health-related capabilities of individuals in order to improve the quality of their lives and consequently their general state of mental health. As better spouses, parents, workers, and people, they are likely to experience more positive daily lives. They are also likely to have a positive influence on those with whom they interact and, therefore, have the potential for producing an exponential extention of the impact of such efforts. A major thrust in this area involves the introduction of social-problem-solving skills curriculums within elementary and secondary schools. Management training and stress management workshops also fit within this category of efforts. The creation of a warmer, more supportive and understanding interpersonal and occupational environment may, in the long run, be one of the major contributions of prevention efforts.

TYPES, TARGETS, AND SETTINGS OF INTERVENTIONS

The types of interventions that are being explored are branching out from the traditional psychoeducational, psychosocial, cognitive, and community-based approaches to preventing mental illness and promoting mental health. Much new work is being done in the areas of stress, coping, adaptation to stress, stress management, and stress reduction. New work is being explored in the areas of physiological interventions (relaxation therapy, exercise), biological interventions (genetics, psychopharmacology, nutrition, diet, etc.), and environmental manipulations (noise, lighting, exposure to toxins, etc.). Some of these interventions include the full range of available technologies and approaches, including printed materials, video presentations, television commercials and programing, group interaction, mutual support, and self-help modalities.

The targets of preventive interventions are expanding to include new populations (parents of children at risk, families at risk, immigrants, recently bereaved, etc.) in addition to those populations currently being studied (e.g., newly diagnosed patients with chronic physical illnesses, children experiencing marital disruption, cancer patients and their families). The targeted disorders falling within the grasp of current preventive interventions include primary and secondary depressions, social isolation/withdrawal syndromes, suicidal behavior, substance abuse, and conduct disorders. New interventions are being developed to attack such dysfunctions as psychosocial failure-to-thrive syndromes, attention deficit disorders, learning disabilities, anxiety/panic disorders, and bereavement syndromes.

Just as the types and targets of preventive interventions are expanding, so are the settings in which interventions are being undertaken. New settings include the primary care setting (outpatient clinics, inpatient hospital consultation-liaison services, etc.), the worksite, and the home environment Coupled with interventions being disseminated and evaluated in the schools, the community, and other service settings, these new settings will allow prevention researchers the opportunity to reach most at-risk populations.

4. The development of culturally relevant interventions and their generalizability to other settings.

5. The quantification of the effects of family and community as mediating variables.

The importance of these barriers to doing quality research should not be minimized. Some of this Nation's best minority researchers are now addressing these issues in a creative, scholarly, and scientific manner. Some of these prevention researchers are James Jackson, James Comer, Spero Manson, Alexander Manuak, Harold Neighbors, Lonnie Snowden, Richardo Muñoz, Ramon Vallé, William Vega, William Liu, Frank Acosta, and Joe Yamamoto. Despite the obstacles referred to above, I think it is important to emphasize the unique opportunities that prevention research offers by comparing it to my favorite "straw man"--psychotherapy.

Psychotherapy research and the development of our vast armamentarium of therapeutic techniques became formalized, codified, and institutionalized long before the mental health profession was properly sensitized to cultural and ethnic differences and distinctions in the etiology, expression, management, and treatment of mental disorders and dysfunctions in non-Anglo populations. A similar argument could be made when looking at the history of the development of the treatment service delivery system in general. On the other hand, primary prevention research and the development of specific preventive interventions are truly in their formative stages--from the viewpoints of theory, methodology, outcome assessment, and application to specific populations. Thus, minority mental health concerns can be incorporated into these endeavors from the very beginning.

It is exceedingly important that researchers who study minority communities decide a priori whether preventive intervention research is feasible for their research teams and for the populations involved in their work. There is no question that minority populations are in great need of multifocused and multifaceted clinical and treatment services across the lifespan, and all efforts should be made to provide them with such needed services. Yet the enormity of the problem

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strongly suggests the need for the development of preventive intervention services. At this point in time, we must keep the distinctions between treatment and preventive interventions and between service delivery and research on the delivery of preventive interventions. Preventive intervention research is still in its infancy. We are a long way from documenting timely and successful primary preventive interventions. We believe that research on primary preventive interventions must precede the dissemination and generalizability of primary preventive intervention services. NIMH is just now exploring what role the emerging technologies associated with knowledge transfer research may play in the dissemination of successful preventive intervention models. We are hoping that within the next few years there will become available well-developed and tested models of successful primary preventive interventions.

CONCLUSIONS

As the field of preventive intervention research develops, the questions we will be trying to answer are analogous to those that psychotherapy outcome researchers have been addressing for years; namely, "What kind of intervention works for which kind of disorder, among which populations, at which point in the developmental sequence or pathological process, when delivered by what method, and by what type of service provider?" We at NIMH believe that there is a prominent place for minority researchers and the unique concerns of minority populations in approaching these challenging questions. In order to ensure that this effort endures, preventive intervention research must begin with manageable and attainable goals. We believe that effort has begun. It represents, for all of us, a new beginning.

ACKNOWLEDGMENT

The author wishes to thank Raymond P. Lorion, Ph.D., who provided invaluable assistance in the conceptualization and development of this manuscript. Dr. Lorion was a Visiting Scientist to the NIMH Center for

Prevention Research when the original version of this manuscript was written.

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Southeast Asian Mental Health: Treatment, Prevention, Services, Training, and Research. T. C. Owan, editor
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MENTAL HEALTH AND PREVENTION ACTIVITIES TARGETED TO SOUTHEAST ASIAN REFUGEES

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INTRODUCTION

In this time of limited financial resources, it is incumbent upon Southeast Asian communities in America to develop more economical approaches to deal with the increasingly serious social and psychological maladjustments that are rapidly becoming a major public health concern. (See sections on treatment, services, and research.)

This chapter suggests that preventive intervention programs are crucial to ameliorate the severe stressful life events that Southeast Asian refugees undergo while adjusting to the American way of life. Because there are strengths within the Southeast Asian ethnic groups, e.g., the extended families, personal coping systems, religious beliefs, mutual help/self-help groups, these traditions must be included in any preventive effort. This chapter describes examples of preventive intervention methods acceptable and appropriate for Southeast Asian refugees.

PSYCHOLOGICAL AND EMOTIONAL STRESS POINTS

The purpose of this section is to describe the major problem areas that confront the elderly, adult males and females, and adolescents and children during their difficult transition period in their host country. By focusing on the serious social and psychological concerns, preventive intervention activities for the Southeast Asians will be most effective.

THE ELDERLY

The elders of each Indochinese ethnic group have special psychosocial needs. The majority lack formal education, and find the English language and adapting to Western culture extremely difficult. Even with more time, it is very likely that the majority of the elders will continue to have a difficult time adjusting to the new lifestyle, especially within the urban environment.

Many Indochinese elders find themselves overly dependent on their children. They need help to fill out applications and necessary documents, to pay their bills, etc. They need translators in dealing with the American community. Many are nearly housebound, as they are afraid to use the public transportation system.

Elders find that in this new society their expertise is no longer valued or appreciated. Their families seem to consider them less important. This is difficult for most Indochinese elders to accept, because in their native society, they were revered and respected and their opinions were essential for any major family decision.

In addition, elders are forced to live in situations they may have difficulty accepting. Many would prefer to live with their extended families, all under one roof. Now, not only do their children live in different houses, but some live in different areas of the city, or even in other States.

Another consideration is that the definition of old age for most Indochinese is different from the Western definition. For example, a man as young as 35 years of age could be considered an elder in Hmong society, simply because anyone who already has grandchildren can achieve this status. Since it is the custom of some groups to marry in their mid-teen years, it is common for couples to become grandparents during their middle to later thirties. In their former countries, if couples such as these chose to go into semiretirement, it was considered acceptable. Sons would accept the head-of-household duties and see to their parents' needs. In the United States, persons in their mid-thirties are expected to enroll in training programs and/or seek gainful employment. They are considered young and in the prime of their lives. This causes a considerable amount of stress for Indochinese refugees, as many came with the false expectation that they would be able to live in a semiretired state after resettlement.

ADULT MALES

A major problem for adult Indochinese refugee males is accepting the American definition of the head-of-household role. Indochinese societies were completely male-dominated societies. Roles were well defined, and it was the duty of the male to work to support the family. In return, wives and children were supposed to give total obedience to the husband and father. Women and children were not supposed to socialize as males did. Women were expected to stay at home, run the house, raise the children, and support their husband's work. Children were expected either to help in farming chores or to study hard. The father handled almost all monetary transactions and made almost every major family decision. Whatever the head of the household ordered, whether it was reasonable or not, everyone in the family knew it was to be obeyed. If not, physical punishment could be expected.

All of these expectations and roles have changed dramatically, affecting parent-child relationships. Children learn to speak English at a quicker rate than their fathers. They, therefore, begin to assume many duties with which they would never have been involved in their native cultures. For example, children may now have to handle the money to pay bills. They must act as translators for parents in all dealings with the outside community. These activities create a sense of dependency on children, which tends to erode the image of parental authority and respect.

ADULT FEMALES

The role confusion is as great for the adult female as it is for the adult male. Because of limited financial resources and the fact that male family members were typically given priority over females for education, Southeast Asian females, in general, are less educated than males. This lack of education makes the females less confident about joining and succeeding in English as a second language courses or in job training programs. Some withdraw and limit themselves to the traditional role of homemaker and mother.

Indochinese women also are troubled by changing family roles. Sponsors and teachers encourage them to take a firmer stand about gaining equal rights in their homes. These new ideas, often not fully understood by the refugee women, can cause marital and family problems. The problem is frequently that the refugee woman may have rising expectations for more freedom and a better life but is not yet prepared to take on the responsibilities required.

Women from some groups have been made to feel that they are useless in this new society. Some feel that should their husbands leave them, or die, they would not be able to cope in their new environment. Some find the public assistance application process, cashing checks, or negotiating the food stamp process beyond their comprehension. They fear that their children, fast becoming westernized, will not care for them in their old age. All these feelings of insecurity are factors contributing to stressful life events among some female groups.

ADOLESCENTS AND CHILDREN

Refugee adolescents find themselves caught between two cultures (Carlin 1983). Westernization comes fairly quickly as they go to school and interact with their American peers. They begin to have new expectations as they are exposed to new forms of entertainment and new ideas about interpersonal relationships. If their parents cannot understand and facilitate their new desires, parent-child relations become strained.

Many refugee families cannot understand or accept that in American schools adolescents are expected not only to learn scholastic subjects, but also to socialize. Parents do not think it appropriate for adolescents to date or to take part in school sports activities. Students are expected to come straight home from school and to help with chores around the house or to study.

Many adolescents resist participating in traditional ceremonies and being responsible for the care of their parents. At the same time, they may experience a sense of guilt for not fulfilling their parents' expectations.

School is not always a positive experience. With little or no English background, many flounder. For those who were accustomed to a rote learning approach in their native lands, the switch to a system that stresses individual exploration and expression proves to be very difficult.

Since the majority of the parents have not been exposed to higher education, the children experience only limited guidance in the field of educational interests. Thus, while the parents may encourage their children to achieve higher education, the adolescents, to a large extent, must cope for themselves in shaping their future vocations.

The children are, in general, rapidly becoming westernized. Many are American-born and less tied to their ethnic backgrounds. They speak English as their first language and lack fluency in their parents' native tongue.

Parental authority with strict discipline is part of the Southeast Asian culture. This has led to frequent challenges to that authority by the Southeast Asian adolescents. The children see greater latitude given their "white" peer groups, which provokes conflicts with their Southeast Asian parents. At the same time the Southeast Asian parents are involved in a difficult transition adjustment to their new homeland. The adjustment problems combined with discipline problems result in an inability to maintain the Southeast Asian traditions and yet allow the children to adopt necessary Western behaviors.

SUMMARY

Psychological and emotional stress points are, of course, different for every individual. At the risk of oversimplification, however, general statements about major stress points for Indochinese refugees seem to be in order. The previous discussion indicates that the significant social disruption, dislocation, and resettlement as an alien in a new and strange culture have resulted in a very difficult and stressful adaptive process--a process that has not always been successful. The

culture conflicts and culture shocks that are inherent in such circumstances have added confusion to the already existing feelings of anger, fear, and loneliness. The refugee, whether elderly or young, male or female, is no longer sure of his or her role. The old roles are no longer appropriate. New roles have not yet been learned. The security in the sense of one's clear identity is gone. Identity conflicts in the young, and feelings of alienation in the adult, lead to a sense of diminished value. The absence of some of the relevant basic skills, e.g., language, customs, and vocation, results in the perception of the American community as being hostile. Parent-child conflicts and erosion of the family structure are inevitable. These are the major sources of stress that need to be addressed in any mental health prevention effort.

A PREVENTION SYSTEM DESIGN

It is strongly suggested that any mental health prevention program designed for Southeast Asian refugees needs to have three basic components. The first is the enhancement of the natural social support system. This would involve the utilization of traditional support systems adapted to the realities of the American scene. A second critical component is the enhancement of basic adaptive social skills, skills relevant to the new life Finally, a sense of pride in one's culture, and in one's family and oneself needs to be enhanced.

ENHANCEMENT OF THE NATURAL SUPPORT SYSTEM

The refugees' traditional natural support systems represent a rich resource in Southeast Asian communities, and we need to build their capacities so that they can become an integral part of community social support systems.

Cluster Housing

All the Indochinese refugee groups come from backgrounds in which the family provided an extensive

support system. Many groups would prefer to live in an extended family situation. A suggested program would be to find apartment buildings or several houses next to each other and to make these settings available to extended families. This would help preserve the family self-help network and enhance the natural prevention process.

Religion

The r establishment of Buddhist pagodas would be of great importance in developing a preventive effort. There are, however, some major barriers to establishing such pagodas. One is fiscal. The most inexpensive real estate for a pagoda is often beyond the financial means of the refugee community. Acceptance by the nonrefugee community is another barrier. Monks have tried to establish themselves in residential homes, but unfortunately, there have been incidents when they were in the midst of solemn ceremonies: the neighbors have complained to the police that there were too many cars parked in front of their homes and that there was too much noise coming from the monks' houses. Incidents such as these have made many refugee communities uneasy about supporting pagodas. The dilemma is that if the community located a pagoda in a less densely populated area where the monks could have expanded privileges to conduct their religious ceremonies, the community would not have easy access to the facilities. Therefore, a program to help refugee communities find affordable pagoda sites near their communities represents a real challenge.

Community Centers

Many refugees have not only lost their network of extended families but have also lost their network of former friends. The establishment of a new network of friends is important. The existence of a place where refugee groups can meet, make friends, socialize, and reestablish helping networks would enhance development of the natural support system. Such a center would not only provide a site for a variety of

programs and cultural exhibits but also would be a source of community pride.

Most refugee groups lack the resources to support such centers. Assisting them to help raise funds or make use of existing facilities would be extremely beneficial and productive. If a permanent full-time site could not be afforded, a site that could be used only 1 day a week or on a scheduled basis would be a good starting point. Churches and service organizations have an exemplary history of providing free space to small, needy minority and handicapped groups.

Mutual Assistance Associations

Most ethnic groups in cities where the refugee population density is high have formed mutual assistance associations (MAAs) (Bui 1983). These associations are reflections of the community's effort to provide substitutes for former social networks and support systems. While some mutual assistance associations are working well, many need intensive technical assistance.

A major problem faced by the MAAs is their lack of some basic information. Many do not know how to apply for nonprofit status, corporate status, etc., and if they did achieve these statuses, they would then have to worry about tax forms and the like.

A second problem is the lack of monetary support. Many refugee communities are unsure of the role the MAA can and should play and, therefore, resist contributing money or time. In addition, the MAAs are not aware of funding sources and do not have the expertise to seek and capture available funds. Assistance in pinpointing possible sources of funds and writing grant proposals is sorely needed.

Programs to help MAAs would enable them to assist their communities in networking and to be agencies of contact and communication with the larger American community. The MAAs also can be a vehicle to give the refugee community a sense of belonging and leadership.

SOCIAL SKILLS ENHANCEMENT

While social skills enhancement is a powerful mental health prevention tool for any population group, it is a particularly critical objective for a group whose skills have been honed for a different setting in a different culture. Not only must new sets of skills be developed, but old ways of doing things must often be unlearned.

Skills in language (English as a second language), vocation, and the like, are basic building blocks. In addition, however, it is critical that interpersonal skills appropriate to America are enhanced. Some areas of concern are discussed in the following sections.

Programs for Elders

A series of mini-seminars, conducted in community centers together with recreational activities, would enhance the well-being of refugee elders. Seminars should cover such subjects as changing roles in American society; how to ride the bus; how to shop in American stores; how to access the Western medical health delivery system; and Social Security, public assistance, and disability benefits--what they are and how to apply. These skills-building activities should be integrated into the social and recreational activities that might include trips to the local parks, going to movies, etc.

Programs for Adults

It would be of great benefit to the adults to participate in workshops and seminars that help to define their new roles in American society. For males, a few suggested workshop/seminar issues are Western versus Indochinese male-female roles, raising children in the United States, urban lifestyles versus Indochinese lifestyles, the American work ethic, capitalistic systems, and hierarchies in the work world.

Both American and Indochinese role models should be selected as leaders of the workshop or seminar.

Sessions should include time for participants to share experiences, so that the participants will know their concerns are shared by many and thus be better able to confront their situations.

Workshops concerning refugee women's roles should also be offered. Some suggested workshop subjects are American versus Indochinese women's roles, the working mother/career woman, adapting dual (American and Indochinese) roles, child rearing, family planning, and equal rights. Workshops would be presented in the appropriate languages and, whenever possible, by other women. Indochinese women would benefit from assistance in defining their new roles in their new society and in handling stress they may experience within their families.

Many Indochinese parents would benefit from parental skills workshops. Many of their problems stem from having lost their traditional child-rearing and disciplinary systems. New methods of disciplining children need to be learned. Acceptable child behavior in America is quite different from acceptable child behavior in Southeast Asia. Parents must learn what behaviors are considered appropriate in America. The workshops will, it is hoped, help Indochinese parents to understand the need to change their roles as parents and diminish parent-child conflicts.

Programs for Children and Adolescents

Some refugee children form gangs and, if confronted in any way, respond by fighting or using physical threats. Children who exhibit such antisocial behavior would benefit from learning how to relate to others without violence. They need to learn alternative ways to respond to confrontation or to stress. Skills workshops that address these and a multitude of relevant interpersonal issues would be useful in assisting the refugee children in adapting to American life and in minimizing stress levels.

Children and adolescents are often prevented by their parents from participating in traditionally American activities that their parents do not consider acceptable.

Organizations such as the Boy Scouts were known and acccepted in many Southeast Asian countries. Boy Scouts, Girl Scouts, Camp Fire, Boys Club, and 4-H associations may also be accepted in American refugee communities as suitable activities for children and adolescents. Such organizations and organizational activities would enable refugee children to socialize more with children of other cultures and help them feel better about their new environment. A program of integrating Indochinese members into existing groups would help the Indochinese children to upgrade their social skills and to learn more about the American culture. However, care must be taken to explain to the parents the value of the skills and values that will be learned by their children.

Cross-Cultural Programs

Many refugee families would like to have non-Indochinese friends. Such cross-ethnic friendships would increase their feelings of security about life in the United States and would also move them more into mainstream America. A program that matched a refugee family with a non-refugee family to promote cross-cultural, cross-ethnic friendships could be very productive. Refugees who have adopted Western religions are especially ready for these friendships, and churches could be encouraged to sponsor programs of this type.

ENHANCEMENT OF IDENTITY

The ability to withstand stress and to resolve life problems gains strength from the integrity of one's sense of identity. When one is clear about and proud of who one is, where one comes from, and where one is going, the individual's sense of well-being is enhanced. One needs to feel good about oneself and to feel proud of being Laotian, Vietnamese, Hmong, etc.

Understanding of and having pride in one's cultural heritage is a basic building block in developing a clear self-identity, but many refugees have been made to feel that their culture is inferior. There is a stigma attached to the refugee status. The refugee feels

like a person with no country and no loyalties. To neutralize those feelings, refugee communities must engage in a significant effort to revive, reestablish, and preserve their native cultures to counteract this negativism and to offer a more positive alternative. Preserving native crafts is an activity that speaks to the cultural issue. An example of a successful program is the revival of weaving among Lao women in Portland, Oregon. Lao weaving produces beautiful, as well as useful, cloth. Through this program which provides the looms and space, Lao women can once again weave magnificent products.

Other crafts that could be revived are basket and mat weaving, making traditional musical instruments, silversmithing, and goldsmithing. The Hmong and Mien groups are presently making efforts to market their embroidery work. It is beautiful handiwork, but those producing it need technical assistance to market their items and to adapt their products to be more saleable.

The songs and stories of the Indochinese cultures are not documented and are in danger of being lost. They need to be collected and put into print. Having written resources would provide refugee children with a testimony to their unique culture in which they can take pride.

Traditional dance groups can be formed. Such groups not only provide a source of intrinsic satisfaction and joy for the participants but can also be a cross-cultural communication vehicle. Refugee groups would like to see themselves well represented to the American community. They would likely be proud if well-trained dancers could communicate their cultural heritage to others.

Playing native instruments is a fast-dying art among many Indochinese refugee groups. While the resources still exist in the communities, every effort should be made to tap them so that these arts will not be lost. A mini-grant was given to a group in Portland enabling an elder Hmong and an elder Mien to teach a small group of young adults how to play traditional instruments. The grant also helped to import some musical instruments from Thailand. This program was very rewarding in that it provided the refugee communities

with difficult-to-obtain instruments, it trained additional resource persons, and it provided persons who could represent the refugee communities in cross-cultural events. The program promoted a sense of pride in the former cultures of the refugee communities.

Summer camps for Indochinese teens have proved to be a very useful and productive means of bringing youths together and providing them with a setting in which they can become more conversant with their cultural backgrounds. Pilot summer camps have been conducted for a Christian Hmong group and for Khmer youths. At the Khmer Studies Institute, courses were given on the Khmer language, Khmer traditional and royal ballet dancing, folklore, stories, history, geography, traditional foods, and other aspects of Khmer culture. These types of camps would help youths identify with their past cultures and provide them with a basis for pride. At the same time, the youths would have the opportunity to meet with other youths who have similar backgrounds, to share experiences, and to give and receive support. These are important ingredients in the development of a mature sense of identity.

The foregoing activities, in the context of a developing and visible effective social support network and accompanied by the honing of social coping skills, will contribute to the enhancement of the feeling that "I am somebody."

PREVENTION PROGRAM IMPLEMENTATION ISSUES

The first major consideration in implementing mental health prevention efforts for Indochinese refugees is how they will perceive the effort. This is an issue, of course, that is relevant to any program. The nature of the perception will determine the nature of community acceptance. A program that is viewed as being for "crazy" persons, for example, is likely to gain little support and benefit few Indochinese persons. Therefore, rather than identifying a prevention program as a "mental health program," it may be more appropriate, for example, to speak of educating individuals in such areas as parenting skills, coping skills, etc.

ETHNIC ISSUES

Most refugees have similar backgrounds and needs. Most have experienced either direct or indirect war-related events. Almost all have lost family members and/or have had their families torn apart. Everyone has lost his native country, former job, and former home and most start a new life with skills that are no longer applicable (Asch 1984). Many speak little English and thus have difficulties in schooling, finding jobs, or obtaining advancement. Adapting to new types of housing, new kinds of foods, and different weather and environment is not always easy. Some face forms of racial prejudice and find that they are not readily accepted into the mainstream of society. Many find that their preference for a traditional lifestyle cannot be met because of such constraints as available housing not being suitable for extended families and public health laws that forbid raising livestock in residential areas.

While refugees as a whole face similar stresses and problems, there are also many differences in the ways various ethnic groups view and attempt to adapt to these stresses and problems. Differences in interest, language, and experiences make it difficult to design and implement multiethnic programs. The Indochinese languages are completely different in linguistic backgrounds. Moreover, there are several distinct differences in what are considered appropriate cultural services. The Vietnamese group, which is relatively urbanized, may benefit from very different sorts of programs than do the Hmong and Mien, whose backgrounds are rural.

Past rivalries between ethnic groups present another difficulty. Nepotism is an accepted system in Eastern cultures, and it is commonly known that families use whatever official position they have to serve relatives first and best. This type of behavior has, to some extent, been transferred here. It is not uncommon to find workers of one ethnic background preferring to serve only persons of the same ethnic group. Most of this behavior may simply be the result of the language barrier, but in some cases, it may be a holdover from past customs and past prejudices.

What is being suggested here is that ethnic-specific programing is the approach of choice within the constraints of funding and population patterns. Each refugee group should be viewed separately, since each group sees itself as being culturally separate and unique (Lin and Masuda 1983). It is difficult to operate a program for the Hmong, Khmer, Lao, Mien, and Vietnamese as a single group, just as it would be difficult to have the same refugee program for Russian Jews and Ethiopians.

COMMUNITY POWER SYSTEM ANALYSIS

How a mental health prevention effort will be perceived and accepted by the community often will be very much influenced by the refugee community power brokers and gatekeepers, or by key formal and informal sources of influence. These key persons must first be identified, and then their understanding and support must be gained. These persons are clearly a force that can strongly influence community perception and acceptance of community-aimed efforts.

Westerners often make erroneous assumptions about who makes up the leadership of refugee groups. A common mistake is to assume that bilingual refugees who work for social or health agencies are community leaders. Refugees who are fluent in English are usually young, Western-educated individuals without extensive knowledge of their native cultures, and Indochinese communities rarely look upon them as community leaders.

The assumption that former refugee political or military leaders are community leaders also can be erroneous. These persons may have influence over some segment of the population, but many other refugees may view them with very mixed feelings.

One other assumption that is not always valid is that leaders of MAAs are community leaders. Member participation in MAA functions in some ethnic groups may be minimal. The major function of the MAA may be simply to produce an annual New Year's party. The leadership of this type of MAA may have very little influence on the community. Other MAAs may select

their leaders for their ability to speak English and their presentability to the American public. They may simply be figureheads.

Each refugee ethnic group has a slightly different community structure and leadership pattern. There are so many variations from location to location and from group to group that it is difficult to state firm rules and guidelines for identifying community leaders. The following description of how various ethnic groups are often organized may give clues as to where to look for the power brokers and gatekeepers.

Hmong

Hmong communities range from small (fewer than 500 persons) to very large (over 6,000 persons). Whatever the size of the population, there has been only one MAA in any given area. The Hmong mutual assistance leaders tend to be young men who have bilingual abilities. The president and other officers may have considerable influence in some communities; in others, they may not. The Hmong MAAs generally have either a board of directors or an advisory board. Hmong elders or scholars with considerable community influence usually are members of these boards.

Hmong communities place emphasis on clan divisions. There may be, in addition, distinctions made between the two linguistic groups, the Green and the White Hmong. The Hmong usually divide into large family groups. A family group consists of nuclear families of the same clan and color who share a common ancestor. The leaders of these family groups, referred to as clan leaders, are perhaps the most influential of the gatekeepers. Each family group usually has one male adult who is the named leader. There may be, in addition to the named leader, several other elders who can also influence the clan. Two or three younger men with bilingual ability may be in the process of being trained for clan leadership and may, therefore, also have positions of influence.

Religious leaders are another source of influence. A sizable percentage of the Hmong in the United States

have converted to Christianity. Both Catholic and Protestant groups exist, with the Protestants more numerous. Hmong Protestants often refer to themselves as "Christians" to differentiate themselves from Catholics. Both Catholic and Protestant groups are composed of members from different clans and color groups. Some Hmong Christians become estranged from their family groups that have retained the traditional religions. For such persons, the Christian group replaces the family group, and the religious leader takes the place of the clan leader.

There exists in some Hmong communities what might be termed the "educated elite." Members of this elite group may also have influence in the Hmong society. These persons are often former educators or those who have earned college degrees from Western countries. The majority of these persons prefer not to hold office in MAAs but may be members of the board or may simply be active members. These persons may not always be visible because they do not hold official positions, but they are persons of influence.

Khmer

The Khmer group may be one of the lesser-known Indochinese groups, but they are found in many of the major American cities. Khmers, more often than not, have more than one MAA, but the association members may not represent the majority of the population. Nevertheless, the leadership of MAAs is the most easily identifiable type of community leadership. Every effort should be made to tap this leadership, taking care that all of the associations are represented.

Some former political and military leaders also have small follower groups.

One must be sensitive to the differences within the various groups, but one must also remember that there may be rivalries between the groups. Many Khmer are distrustful of "leaders," since they have witnessed the constant rise and fall of corrupt political and military leaders in the old country, especially after the

era of the Pol Pot regime when the Khmer saw what their fellow countrymen did to each other.

The one type of leader that may still have considerable influence over the Khmer society in the United States is the Buddhist monk. The majority of Khmer refugees have retained their traditional religious beliefs, with only a few having converted to Western religions.

Lao

Most Lao communities in the United States tend to be segmented. The segmentation may occur because of differences in political inclinations or religion or because of personal differences between leaders. In any event, such segmentation leads to the development of more than one MAA in any given area. The leadership of these MAAs does hold considerable influence over the members.

A second group of Lao leaders are the religious leaders, among them Buddhist monks and the Lao ministers and lay leaders for those who have converted to Western religions. These all have undeniable influence.

There are also former political or military leaders who, in some Lao societies, are highly respected. Included in the influence group are those who were teachers, doctors, and lawyers in the old country, who are still highly regarded. And finally, there are the Western-educated Lao persons holding positions in social service agencies, government agencies, or even in private industries, who are considered influential.

Mien

There are five or six sizable Mien communities scattered along the West Coast. Seattle, Portland, and San Diego each have a sizable community, and there are several other communities in the San Francisco Bay area. Each Mien community has one MAA. The officers of the Mien MAAs tend to be young men who can speak English. Most of the MAAs have boards of directors usually made up of both elders and younger educated men.

The leadership of the MAAs may have some influence over the Mien society, but most Meins view the activities of MAAs to be mostly social.

The more powerful leadership of the Mien community is the elected leadership of the Mien "village." The Mien define all Miens living in any one city or town as composing a village. The families elect a village leader who holds considerable influence over the Mien population. There is also a village mediation board, made up of elders and younger educated men. The advice of the younger men is followed in affairs dealing with the outside community. The advice of the elders is followed in intra-Mien community issues.

The third group of Mien community leaders is the Mien Christian leaders. About a quarter of the Miens living in the United States have converted to Christianity. The majority have become Baptists. Some have joined American churches, but most follow a Mien religious leader. There have been some clashes between Mien groups who have converted and those groups who have retained the traditional beliefs, but the two groups have engaged in dialog and arbitration, and the result has been the cessation of incidents.

Vietnamese

The Vietnamese make up the largest percentage of the Indochinese refugees. They have much larger populations than any of the other groups and have many more subgroups.

The majority of Vietnamese societies are divided along religious lines. There are strong Catholic, Protestant, and Buddhist groups. The most influential leadership of the Vietnamese in the United States is, therefore, the religious leaders. Most religious groups have weekly services and, consequently, come into contact with large numbers of individuals. Each of these religious groups has an MAA, and the association leaders have influence and must be viewed as significant gatekeepers.

The Vietnamese, being generally more urban in background, more highly educated, and quicker to adapt to Western life than other Indochinese groups, do not usually turn to former political or military leaders for leadership. There is a strong sense of leadership crisis and vacuum among the Vietnamese, primarily because of reaction to the corruption and failures by former leaders in Vietnam before 1975. Scholars, professionals, and businessmen are often respected, but they usually play a low-key role. Nevertheless, endorsements from these types of people are important and should be sought.

Traditional Healers

Many Indochinese groups perceive the traditional healers as people who are to be respected, though the role of the healer was not a leadership one. Most Indochinese continue to believe in traditional healing practices and usually follow advice given by the traditional healers. These healers can be very influential, and their participation in the development of a mental health problem prevention effort should be secured, if not in an active supportive role, at least in a neutral one.

The traditional healers do not advertise, and the only way to discover them is via the informal, natural community information lines. The types of healers most likely to be influential in their societies are:

- Hmong: herbalists, shamans, "kawv koob" (spiritual masters)
- Khmer: Buddhist monks, herbalists, "krou Khmers" (spiritual masters)
- Mien: "Sip Mien Mien" (spiritual masters), herbalists
- Lao: Buddhist monks, ritual masters, "Phii Pawb" and "Phii Ka Tai" (spiritual masters)
- Vietnamese: Vietnam and/or Chinese health practitioners, Buddhist monks, Taoist teachers, sorcerers

ORIENTING POWER BROKERS AND GATEKEEPERS

Once the gatekeepers and power brokers have been identified, the next step is to provide them with orientation to mental health prevention concepts. The best forum in which to do this is a series of bilingual workshops. Each ethnic group, and perhaps each ethnic subgroup, should be individually targeted, for the reasons outlined in the previous section.

The objective of the workshops is to help the power brokers and gatekeepers recognize the benefits of preventive intervention activities especially targeted to their high-risk groups. Since the stakes are high, careful thought must go into how mental health prevention concepts are presented. Because of the fear of being stigmatized as "crazy," workshops concerning mental health should be conducted under the umbrella of the general health focus. The workshop could begin with a brief, organized presentation of information on local health delivery systems and about local hospitals, health clinics, and private practitioners.

The next step would be to emphasize that refugees are now in a new society and that they are facing new problems of underemployment, breakdown of family networks, and changing family roles, for instance. Most refugees would agree that these experiences and problems contribute to stress in their lives. It would be helpful to point out cases, unidentified of course, in which mental illness developed because of the stress of problems.

The next step, and it should be a definitive one, is to convince the refugee groups that since their new lives have new problems, they need new programs to prevent stress and possible mental illness. If it is emphasized that the proposed program is designed to address new problems, there will probably be a better chance of program acceptance. If, however, the mental health prevention program is to consist primarily of social skills training, cultural development and preservation, and social support network development, as is being suggested in this chapter, the issue of mental health per se need not even be raised.

WHO SHOULD MANAGE THE PROGRAM?

Most refugee communities strongly favor the idea of providing services for their own people. The mental health prevention program presented in this chapter is tailored to a community-based, self-help approach. Who is better qualified to determine the nature of cultural development and preservation than the people who are indigenous to and identified with the particular culture? Who can better understand the pain and despair caused by the ravages of war, dislocation, and resettlement in a strange and sometimes hostile environment? The community may need help in acquiring the more technical aspects of social skills training and organizational dynamics and processes, but these can be obtained on a consultation or contractual basis. Developing community pride and a community and personal identity is a responsibility that must be shared by all of the community members.

The MAAs appear to be one of the best vehicles through which to manage a prevention effort. There are many advantages in utilizing MAAs. The MAAs are knowledgable about community structures, self-help networks, traditional healers, and cultural issues. They have members who have many of the skills required to provide the services needed in the prevention effort, and they can provide the necessary audiences and participants.

Refugee community and religious organizations are well suited to conduct social and cultural preservation projects. They are organizations with ready access to the people and with physical settings at which people are accustomed to congregating. They are also very much in touch with the needs, problems, and aspirations of the community. They can tap the resources that exist in every community.

The most critical problem that must be addressed, however, if such community organizations are to manage a major prevention effort, is the apparent lack of organizational and program management expertise. An effective and efficient way to provide necessary consultation and training expertise is to develop a mobile team of Indochinese mental health prevention program and

management experts. They can provide the necessary consultation and training to the communities in the appropriate language and with sensitivity to cultural and local community issues. The team would operate nationally.

Social skills training programs can be negotiated with existing educational, mental health, and social service systems, with these systems providing the resources and the instruction of training leaders. The training leaders could be volunteer, part-time, involved Indochinese.

A final and most important note must be made with regard to the implementation of a mental health prevention program. An extremely valuable resource exists in the refugee communities that needs to be recognized. This resource is the elders. A project that utilizes the elders as teachers and as consultants to the project will gain at least two benefits. The expertise of elders, whether it be in cultural preservation or the establishment of a sense of identity or a sense of orderly progression, or simply the contribution of wisdom, will enhance the project and, in the long run, the integrity and work of the community. In addition, the participation will help elders feel valued and worthwhile and feel that they are still contributing to their society.

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SOUTHEAST ASIAN MUTUAL ASSISTANCE ASSOCIATIONS: AN APPROACH FOR COMMUNITY DEVELOPMENT

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INTRODUCTION

Whenever immigrants have come to the United States, they have coalesced to help their own people adjust and adapt to life here. Like those who came before them, the refugees from Cambodia, Laos, and Vietnam have repeated the old pattern of joining together in mutual associations wherever they have settled.

There has been general recognition that one of the major roles of the ethnic community is to help the newcomers proceed more easily in the course of adjustment to the new society. However, when the first Southeast Asian refugees arrived in the United States 10 years ago, there were no existing ethnic organizations to provide guidance and support. In addition, to avoid the kind of geographic concentration experienced with the mass influx of Cubans in the 1960s and also to accelerate the process of acculturation and integration of these new refugees into the melting pot, an effort was made to scatter them as widely as possible throughout the United States.

In actuality, this intended goal has not been achieved. The refugee resettlement programs, for all their variety and practicality, could not assimilate all the newcomers in their initial settings. The American sponsors, whose hospitality and generosity were exceptional, were unable to provide many refugees with the emotional support that could be found only in a familiar sociocultural environment. As a result, refugees from Vietnam, Cambodia, and Laos have been moving from small towns to large metropolitan areas, forming nuclear community organizations for mutual support and for the preservation of their cultural heritage.

Despite preliminary indications of adverse public opinion caused by this Nation's long and bitter Indochinese venture and by rising national unemployment rates during the economic recession of the late 1970s, the refugees have been received with sympathy and generosity. Therefore, unlike the development of ethnic enclaves of Chinese and Japanese immigrants in the early 20th century, which evolved out of the necessity to survive and succeed in a generally hostile and discriminatory society, the most important function of Southeast Asian community organizations consists of creating among the refugees a new sense of self-confidence and a firm belief in the future. This function pervades all social and cultural programs and activities of refugee communities, which are indispensable to refugees' mental and emotional well-being.

TRADITIONAL CULTURAL PATTERN AND IDENTITY STRUCTURE

The tendency of Indochinese refugees to cluster together and to form community organizations can be traced back to a traditional pattern common to all agrarian societies in Southeast Asia. People in rural areas live in villages in which mutual assistance and solidarity have become essential for their existence. In fact, villagers are supposed not only to help one another but also to share responsibility for the security and development of the community. In Vietnam, community life centers around a communal house, called a dinh, in which villagers worship their spirit protector and hold public meetings, ceremonies, and cultural

performances. In a Cambodian village, all these activities are carried out in a wat, or Buddhist pagoda. In Laos, only religious and cultural events are held in the wat; all other public functions must be conducted in the house of the village chief.

Community activities in rural Southeast Asia have helped knit a tight bond among the villagers, all of whom live in close relationship with the riceland of their ancestors. In this connection, what Frances Fitzgerald (1972, p. 10) wrote about the Vietnamese also applies to other Southeast Asian ethnic groups: "As the source of life, the earth was the basis for the social contract between the members of the family and the members of the village." This special pattern of living, coupled with the limits established by a restrictive society (particularly in Vietnam, which used to be under the strong influence of Confucianism), has resulted in the absence of an individualized, self-determining ego identity such as is generally found in most societies of Western cultures. For a traditionally minded Vietnamese, Cambodian, or Laotian, individualism is something inconceivable, because the primary sense of identity is so indissolubly linked with a broader, collective ego structure: the totality of a family or societal unity (Slote 1972).

COMMUNITY ORGANIZATIONS AS PREVENTIVE AND CURATIVE MEASURES

For the past hundred years, traditional societies in Southeast Asia have been subjected to a long period of intrapsychic turmoil caused by the introduction of new concepts, values, and practices from completely alien cultures and ideologies: French colonialism, Sino-Russian communism, and American capitalism. The Indochina war, in particular, has overturned several established institutions and triggered internal refugee movements from many insecure rural areas to the overpopulated cities. Since 1975, hundreds of thousands of people have left their native countries to seek refuge in the Western hemisphere, mostly in the United States.

For many refugees, identification with family or village has been destroyed, and the whole refugee population has experienced a deep sense of uprootedness and

alienation. As a result of the terrible ordeals of hardship and loss that occurred before and during the course of resettlement in a new country, the Southeast Asian refugees have undergone a wide variety of mental health problems ranging from general depression suicide attempts. This does not mean that mental health problems among the refugees have reached an alarming level but, rather, confirms the inevitable existence of these problems, even among those people whose stoic endurance has become second nature. Being cut off from their families, villages, and countries, refugees feel an urgent need to cluster together and to form community organizations as secondary sources of security. Through mutual assistance and other community activities, such as religious ceremonies, ethnic New Year celebrations, and special social or cultural events, a sense of belonging is developed, and the individual refugee can reestablish his or her identity, probably a new one that reflects the way the community has adapted to life in the new land.

As sources of guidance and support, community organizations or Mutual Assistance Associations (MAAs) can become highly effective in the prevention and, to a limited extent, in the treatment of mental health problems in the refugees. Community members can find solace in their moments of distress, share experiences and help one another in their adjustment problems, express their concerns over cross-cultural conflicts, and discuss and try to resolve issues of common interest. Members of the community can have a chance to preserve the ethnic cultural values of which they are proud. Ironically but understandably, considering the destructive policies of current communist regimes in Indochina, one could rightly contend that traditional cultures of Cambodia, Laos, and Vietnam can be safely preserved only by the refugee communities in Western countries. In the United States, refugees from Cambodia, Laos, and Vietnam are fortunate in that, not only do they have the right to maintain their own cultures, but refugees can take encouragement from a growing emphasis on the validity of ethnic cultural heritage preservation as an enriching contribution to this pluralistic society.

UNDERSTANDING THE SOUTHEAST ASIAN MUTUAL ASSISTANCE ASSOCIATIONS

Since 1975, close to a thousand MAAs have emerged from within the Southeast Asian refugee community in the United States. The Indochina Resource Action Center has been able to identify a total of 800 MAAs throughout the country, the greatest concentrations being in California (206) and the metropolitan Washington, D.C., area (51), with the Great Lakes States coming in a close third. The geographic distribution of known MAAs by ethnic group is illustrated in table 1.

These groups vary widely in purpose and orientation. After performing a 10-year longitudinal study of the Southeast Asian MAAs, we propose a new categorical system for describing MAAs, according to the following five types:

- Cultural and spiritual integrity
- Resettlement service provision
- Special interest
- Economic development
- Advocacy and political action

These five categories may require some explanation. First of all, it needs to be stated emphatically that all MAAs are intimately concerned with all focuses--any assignment of MAAs into a single category is simply a matter of convenience that hones in on a current primary focus. To serve their constituencies, MAAs must concern themselves with many areas. Our arbitrary division (see table 2) is based on 1984 activities carried out by known MAAs across the country.

CULTURAL AND SPIRITUAL INTEGRITY

This category of MAAs is the most numerous. Focuses range from cultural/spiritual value preservation to getting together for social activities on the occasion of a traditional holiday. MAAs of this type provide the encouragement and support needed by incoming refugees. These MAAs operate totally on a volunteer basis, picking up where the domestic resettlement system left

TABLE 1.--Distribution of MAAs by State and ethnic group[a]

State	Highland Lao	Khmer	Lowland Lao	Vietnamese	Mixed[b]	Total
Alabama	2	1	1	3	--	7
Arizona	--	2	1	8	2	13
Arkansas	1	--	--	--	1	2
California	24	16	18	141	7	206
Colorado	5	2	3	10	--	20
Connecticut	1	1	2	3	--	7
Delaware	--	--	--	1	--	1
District of Columbia	--	2	--	2	1	5
Florida	1	7	3	21	1	33
Georgia	3	2	4	5	1	15
Hawaii	--	1	6	6	1	14
Idaho	--	--	1	--	--	1
Illinois	12	2	10	15	1	40
Indiana	2	2	2	3	--	9
Iowa	8	1	7	7	--	23
Kansas	2	--	--	2	--	4
Kentucky	--	1	--	2	1	4
Louisiana	--	3	1	13	--	17
Maine	--	1	--	1	--	2
Maryland	--	4	--	8	--	12
Massachusetts	3	2	1	1	1	8

[a] Statistics drawn from the Indochina Resource Action Center's computerized listing of known Southeast Asian MAAs, current as of September 1984. The very nature of MAAs (community-based organizations that depend on volunteers for survival whenever funding becomes scarce) means that groups are constantly in flux--emerging, coalescing, and expanding, moving to another address when a new MAA president is elected. All data must, therefore, be considered only relatively accurate as of the most recent quarterly update.

[b] Membership may include lowland/highland Lao, Khmer, Vietnamese, and, in a few cases, refugees from Afghanistan and Ethiopia.

TABLE 1.--Distribution of MAAs by State and ethnic group--Continued

State	Highland Lao	Khmer	Lowland Lao	Viet-namese	Mixed[b]	Total
Michigan	7	1	2	13	--	23
Minnesota	7	5	7	12	1	32
Mississippi	--	--	--	2	--	2
Missouri	--	3	2	6	--	11
Montana	2	--	--	--	--	2
Nebraska	1	--	2	1	--	4
New Hampshire	--	--	1	--	--	1
New Jersey	--	1	1	8	1	11
New Mexico	--	--	--	--	--	--
New York	2	2	2	2	--	8
North Carolina	1	2	1	2	--	6
North Dakota	--	4	--	2	--	6
Ohio	9	5	3	12	--	29
Oklahoma	1	1	1	2	--	5
Pennsylvania	2	3	1	21	1	28
Rhode Island	1	4	1	1	2	9
South Carolina	1	1	2	3	--	7
South Dakota	1	2	--	--	--	3
Tennessee	1	3	6	5	--	15
Texas	2	5	2	27	1	37
Utah	2	1	1	4	1	9
Vermont	--	1	--	--	--	1
Virginia	1	7	3	23	3	37
Washington	4	9	5	14	3	35
West Virginia	--	--	--	--	--	--
Wisconsin	12	2	3	5	1	23
Wyoming	--	1	--	1	--	2
Total	122	115	108	421	34	800

[b]Membership may include lowland/highland Lao, Khmer, Vietnamese, and, in a few cases, refugees from Afghanistan and Ethiopia.

TABLE 2.--Distribution of MAAs by State and type

State	Cultural	Resettlement service	Special interest	Economic development	Advocacy/political	Total
Alabama	3	2	--	1	1	7
Arizona	6	3	3	--	1	13
Arkansas	--	2	--	--	--	2
California	101	34	38	9	24	206
Colorado	14	4	1	--	1	20
Connecticut	3	4	--	--	--	7
Delaware	1	--	--	--	--	1
District of Columbia	2	1	1	--	1	5
Florida	21	5	3	1	3	33
Georgia	8	5	2	--	--	15
Hawaii	8	4	--	--	2	14
Idaho	1	--	--	--	--	1
Illinois	20	16	2	1	1	40
Indiana	5	3	1	--	--	9
Iowa	20	2	--	1	--	23
Kansas	2	1	--	--	1	4
Kentucky	4	--	--	--	--	4
Louisiana	11	3	3	--	--	17
Maine	2	--	--	--	--	2
Maryland	8	1	2	--	1	12
Massachusetts	3	4	--	--	1	8
Michigan	13	7	--	2	1	23
Minnesota	17	4	6	3	2	32
Mississippi	1	--	1	--	--	2
Missouri	8	2	1	--	--	11
Montana	--	2	--	--	--	2
Nebraska	2	2	--	--	--	4
New Hampshire	1	--	--	--	--	1
New Jersey	4	2	3	1	1	11
New Mexico	--	--	--	--	--	--
New York	1	4	2	1	--	8
North Carolina	4	2	--	--	--	6
North Dakota	4	1	--	--	1	6
Ohio	18	9	--	1	1	29
Oklahoma	1	3	--	1	--	5
Oregon	5	5	--	1	--	11

TABLE 2.--Distribution of MAAs by State and type--Continued

State	Cultural	Resettlement service	Special interest	Economic development	Advocacy/ political	Total
Pennsylvania	14	7	2	--	5	28
Rhode Island	3	4	--	2	--	9
South Carolina	6	1	--	--	--	7
South Dakota	3	--	--	--	--	3
Tennessee	13	1	--	--	1	15
Texas	23	9	4	--	1	37
Utah	4	5	--	--	--	9
Vermont	1	--	--	--	--	1
Virginia	19	4	7	1	6	37
Washington	20	11	1	2	1	35
Wisconsin	10	12	1	--	--	23
Wyoming	2	--	--	--	--	2
Total	440	191	84	28	57	800

off and helping newcomers to find a home in American society. Included within this group are pagodas and churches as well as secular groups.

RESETTLEMENT SERVICE PROVISION

These MAAs have achieved a standing in their local community and generally have been able to acquire limited public funds to provide social services. The task is always far larger than the funding; the refugee community inevitably expects more services. These MAAs need both technical assistance and financial support to meet community service needs and become viable community agencies.

SPECIAL INTEREST

These are the women's groups, the senior citizen societies, and specific fraternal groups such as veterans of a certain branch of the military, graduates or students of a particular educational institution, and professional societies. Given the common, well-defined focus, these groups generally are able to mobilize volunteers and carry out a well-organized program of activities.

ECONOMIC DEVELOPMENT

Some MAAs have looked beyond direct resettlement assistance and have developed programs with a potential to enhance economic power from within the ethnic community. They are experimenting with bold initiatives, taking well-calculated risks in the hopes of building a sound financial base for the future. Their activities lay the groundwork for local refugee business associations or chambers of commerce.

ADVOCACY/POLITICAL ACTION

Some MAAs have begun to focus on political action/advocacy as a means to make a difference. Their activities range from plans to "liberate" the home country to regular election-year politicking in the United States. Tasks are varied: collecting money to buy guns; joining together in voter registration drives and working for selected political candidates; or mounting international initiatives to save Khmer refugees caught in limbo along the Thai border, to help the boat people (victims of piracy in the South China Sea), or to publicize the plight of Agent Orange victims from Laos.

This categorization of MAAs is intended to help readers better grasp the variety within these community-based ethnic organizations. In this respect, it is interesting to note how the different Southeast Asian ethnic groups break down into the five primary function areas we have observed over the past 10 years (table 3).

TABLE 3.--Distribution of MAAs by ethnic group and type

	Cultural	Resettlement service	Special interest	Economic development	Advocacy/ political	Total
Highland Lao	47	52	4	17	2	122
Khmer	61	37	3	--	14	115
Lowland Lao	68	33	2	1	4	108
Vietnamese	254	55	75	7	30	421
Mixed[a]	10	14	--	3	7	34
Total	440	191	84	28	57	800

[a] Membership may include lowland/highland Lao, Khmer, Vietnamese, and, in a few cases, refugees from Afghanistan and Ethiopia.

There are reasons why 60 percent of the Vietnamese MAAs focus on cultural and spiritual heritage preservation and only 13 percent focus on resettlement services. Vietnamese, in general, are considered by public funders to be somewhat better prepared for life in America and, thereby, less likely to receive government grants and social service contracts for resettlement services. A high proportion of Khmer MAAs (12 percent) fall into the advocacy/political action category. This is partially due to factionalism within the Khmer community but, even more so, is a result of events in Cambodia during recent years: Khmer refugees still are not considered presumptively eligible for third country resettlement, as are most other Southeast Asian refugees. They, like some Highland Lao groups, face the constant threat of forcible repatriation across the nearby Thailand/Cambodia border.

Primarily because of Highland Lao community cohesiveness and determination to take care of their own people, the Highland Lao MAAs appear to rank highest (among the ethnic-specific MAAs) in the resettlement service provision (43 percent) and the economic development (14 percent) categories. One might contend that this is a result of the 1984 Highland Lao Initiative Program funding--a special Federal initiative from within the Department of Health and Human Services Office of Refugee Resettlement, which may have fueled the resettlement service provision/economic development focus. The truth, however, is that Highland Lao leaders organized their communities, recruited responsive American advocates, and fought hard for the funding that enables their MAAs to continue working in these two areas.

Finally, readers may note aberrational statistics among the "mixed" MAA category. During 1984, the second highest percentage (41 percent) among MAAs focusing on resettlement service provision was the "mixed" MAA group. This is probably due to a premature and culturally insensitive tendency by both public and private funders to support multiethnic refugee coalitions over the more viable ethnic-specific MAAs. Given the level of financial support, a similarly high percentage of the "mixed" MAA coalitions (21 percent) have the resources necessary to allocate time and effort for advocacy and political action activities.

PROBLEMS AND NEEDS

In working with the MAAs, it is important to keep in mind that Southeast Asians think and organize themselves differently from Westerners. In Cambodia, Laos, and Vietnam, most social structures are patterned on the model of the extended family. This unit is headed by a patriarch whose authority is unquestioned. His responsibility for dependents is absolute: the relationship is really one of interdependency. Within the family hierarchy, each person is connected to the others by a clearly defined relationship; everyone has his or her own place and knows and accepts his or her role. Because of this emphasis on the family, people in Indochinese societies are less trusting of people outside their own extended families and small communities than are Westerners. Naturally, this traditional pattern is subject to change as values evolve within the American environment. Such change, however, takes generations, and even then, a certain amount of ethnic cultural identity remains.

Indochinese organizations work best when members have a preexisting relationship. Members who know and trust each other are willing to work together and accept the leader's authority. Influence and power in Indochinese organizations usually rests with the leader, filtering down as the leader delegates responsibility to trusted followers.

These social structures must be kept in mind by those who seek to aid the MAAs in developing both organizational skills and future leadership. Technical assistance and training must be sensitive to Indochinese cultural patterns. Research conducted by the Indochina Resource Action Center (IRAC) during 1980-1981 highlights evidence of MAAs coming together around specific issues and felt needs. MAAs are beginning to define priorities and work cooperatively. Future MAA activity appears to be focusing on four general roles:

1. Educational, cultural, and/or religious centers to preserve the heritage, spiritual values, and traditions that are vital to retain cultural integrity and provide a psychological base for smooth social adjustment

2. Community multiservice centers that could be funded to provide direct social services

3. Community economic development to foster refugee self-sufficiency through stimulation of small business opportunities, cottage industry, and cooperatives as well as partnerships with the American private or corporate sector to develop jobs and on-the-job training programs

4. Advocacy to achieve involvement in local, State, and Federal policy and planning, as well as in policy development and coordination of services with the established voluntary resettlement agencies, their local affiliates, and the mainstream community service providers

This large variety of missions may be one reason American agencies have misunderstood the MAAs and, on occasion, found them difficult to relate to. IRAC is very encouraged by this diversification and also by the increasing focus on specialized needs. Not only does role definition set clearer goals as the groundwork for a solid community base, it also permits latitude for many different MAAs to coexist, concentrate on a specific problem, and agree to cooperate on issues of common interest.

Following are several other observations that emerged from the IRAC's 1980-1981 national survey of MAAs and reinforced by data collected throughout a series of MAA workshops conducted nationwide by the IRAC in 1983.

- All associations expressed a tremendous need for developing a variety of means to obtain more resources than are currently available to them. Funding is needed to provide direct service and to support educational and cultural priorities and programs.

- It appears that, at least in some instances, MAAs are tending to develop only those programs that they consider fundable by government sources rather than seeking alternative funding to support projects that address the refugee community's priority cultural concerns.

- MAAs have significant needs in organizational development; fund raising; long-range program planning and development; and program, as well as fiscal, administration and management.

- Many of the longer-established associations show a growing interest in working together--often as loose coalitions--both to provide technical assistance to newer MAAs and to have a stronger voice in shaping national refugee policy that affects their own peoples' destiny.

- Previous capacity-building assistance to MAAs appears to have been most effective when in-depth and individualized training was given and when there was problem-solving followup through continuing personal contact.

CONCLUSION

Because the future survival of MAAs is so closely tied to economic and political strength within the community, the recent interest in economic development and election-year politics is extremely appropriate. As the history of immigrant groups in the United States has demonstrated, ethnic communities must first attain economic stability so as to sustain their own organizations; the future of community centers and cultural activities will depend more and more on the community's own ability to support such work.

An investment in the future of self-help is in the finest tradition of this country's historic response to all refugee and immigrant groups. It is essential that Southeast Asian self-help groups be nurtured, developed, and enabled to provide the kinds of appropriate mental health and resettlement services so desperately needed by the surrounding refugee community. It is only within a refugee's own ethnic community that this kind of cross-cultural understanding and lasting, long-range support can lead to successful social adjustment through meaningful, relevant, and cost-effective services.

Nevertheless, due to bitter experience with so many unworthy leaders during the Indochina wars, a strong

sense of suspicion still persists, not only among the refugees toward certain community leaders, but also among the leaders themselves. This is particularly true of the Vietnamese, and it accounts for the proliferation of Vietnamese and Khmer associations in those geographic areas in which refugees are tightly clustered. It also explains why there are so many organizations of the same type in a particular locale. Recently, these small, separate groups with similar purpose have begun to join together into larger and stronger groups so they can be more effective in the provision of services for the community.

There has been an increasing awareness in recent years that traditional mental health services in the United States are inappropriate for many subcultures and that mental health programs must be tailored to the peculiarities of specific ethnic minorities. The philosophy that instigates the development of new mental health programs contends that good mental health care alone is not enough; it must be culturally appropriate. In line with this philosophy, ethnic community organizations will be undeniably instrumental in the maintenance and enhancement of emotional well-being for individuals and families.

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SERVICES

This section addresses major issues in the development and provision of mental health services that are appropriate for the Southeast Asian refugee population. Examples of existing service models are discussed, with descriptions of their components that can be modified to suit a variety of conditions. For purposes of comparison, Nguyen's chapter illuminates patterns of major service delivery needs in Canada.

The development of an effective system of mental health services must be tailored to the specific and unique needs of this population. Both True and Nguyen identify barriers causing the underutilization of existing mental health services by Southeast Asian refugees. Among these barriers are the absence of culturally appropriate mental health services, the refugee's unfamiliarity with Western mental health concepts and practices, accessibility problems caused by language and communication issues, a lack of information on how to gain access to existing systems, the tradition of reliance on alternative resources such as the family and extended kinship, a preference for medical doctors and traditional folk healing practices, and the association of mental problems with the stigma of "craziness."

The authors in this section generally focus on service systems that are considered exemplary models based on acceptability and accessibility. While a wide range of service concerns and service settings are discussed, there is agreement regarding the components necessary to ensure an effective mental health service system. Summarized briefly, these are: accurate client assessment, culturally relevant interventions, effective matches between the clients and the providers, linkages with related services systems and natural support systems, and good organization and funding potential.

Murase et al. describe access models that may increase the use of mental health services. These include outreach efforts involving satellite stations in multiservice settings and work with community organizations, churches and temples, and similar resources. Mental health services embedded in more broadly used and accepted programs, such as general health care, social services, and other services not associated with "craziness," provide settings that encourage access. The existence of capabilities such as case management and advocacy systems and linguistic compatibility are of critical importance.

The need for accurate client assessment is stressed by Lum and by Lee. Lee describes an ethnomedical assessment approach that explores not only a premigration, migration, and postmigration case history, but also explores the client's and the client's family's

orientation to mental illness and their expectations about mental health treatment. The approach uses assessment techniques developed specifically for the client population and utilizes physical examinations sensitive to the client's medical and physical discomfort and approaches that are crisis and symptom oriented.

Community- and hospital-based examples of culturally relevant mental health service models are described by Murase et al., Lee, Lum, and True. They offer the reader the opportunity to review a range of existing services. The majority of the models stress homophyly (the use of indigenous personnel whose backgrounds--language, ethnicity, traditions--are similar to the client's) in providing direct services. A critical future issue will be the development of strategies to enable existing service systems to become more relevant to Southeast Asian refugees as the need may arise. This is especially important where the Southeast Asian population is too small to justify maintaining services designed expressly for this population.

Use of the client's natural support network--primarily the extended family and community resources--to improve refugee services is given high priority by True and Lum. True suggests using the family adaptation model, developed from experiences with the Hispanic population. The use of mutual assistance associations, village clan structures, and traditional healing practitioners is advocated by Lum.

A major organizational issue raised in this section is whether mental health services for Southeast Asian refugees ought to be separate and autonomous. True points out that isolated refugee mental health programs generally fail to achieve continuing support, and she advocates the establishment of refugee programs within a larger, broader system of mental health services. She points out that the Hispanic experience indicates that integration with another related service system can be a strengthening process.

Southeast Asian Mental Health: Treatment, Prevention, Services, Training, and Research. T. C. Owan, editor. National Institute of Mental Health, 1985.

ALTERNATIVE MENTAL HEALTH SERVICES MODELS IN ASIAN/PACIFIC COMMUNITIES[1]

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ALTERNATIVE AGENCY MODELS

CONCEPTUAL FRAMEWORK

Alternative agencies have three basic functions in providing bilingual, bicultural staff and services to Asian/Pacific Islander communities. These are 1) to deliver culturally appropriate services, 2) to improve Asian/Pacific Islander client access to existing services, and 3) to link clients to a comprehensive service network.

In this paper, examples of community-based programs that have succeeded in implementing culturally appropriate approaches to service delivery will be presented. Although an impressive array of community-based programs has been created for Asians/Pacific Islanders, the range (especially of bilingual services for the newer

[1] Supported in part by grant 1-R01-MH32148 from the National Institute of Mental Health, Department of Health and Human Services.

Asian/Pacific Island communities) is far from complete. A number of services will necessarily have to be obtained from the larger system of public service institutions. This paper also will look into approaches that have been taken by community programs to make this broader range of services more accessible to Asian/Pacific Islander American clients. Innovative approaches to community outreach have been developed, including efforts to create enabling systems, or support systems, to bridge the cultural and language barriers that may prevent client access to needed health and social services. Ways in which support systems have effectively improved access will be discussed in the section on Enabling Systems.

Generally, community-based efforts to create a wide range of services for Asian/Pacific Islander Americans have resulted in the growth of a number of individual programs and services that are geographically and administratively separate from one another. To link clients to appropriate services and ease their passage from one agency to the next, most programs have developed information and referral services, and many have a worker who functions as a case manager. The last section, on network models, focuses on these and other approaches that seem to be developing; for example, the creation of multiservice structures (multiethnic or single-ethnic), coordinating councils, and "umbrella" organizations.

CULTURALLY APPROPRIATE MODELS

Asian/Pacific Islander American agencies have employed a number of means to make mental health services more acceptable to hard-to-reach groups within their communities. One approach focuses on the point of entry into a mental health program. In order to reduce the stigma that is frequently associated with these services, entry is often somewhere other than a door specifically marked "Mental Health Services." Some programs, for example, have changed their names from one that obviously suggests a mental health facility to one suggesting a more neutral range of services (e.g., "children's services" or "family outreach services"). Asian Community Counseling Services (ACCS) in Sacramento is a

case in point. ACCS chose "Stepping Stones" for the name of its mental health program in order to reduce possible client resistance to mental health services. Stepping Stones was funded through a grant in 1981, after publication of an initial study by the Pacific Asian Mental Health Research Project (PAMHRP), and represents one of the newest mental health service programs in the Asian/Pacific Islander American community.

Mental health services also have been "embedded" in more broadly utilized and accepted programs. Two examples of embedding are presented by the Chinatown Child Development Center (CCDC) in San Francisco (Chan-Sew, unpublished) and the South Cove Community Health Center in Boston (Fogarty International Center 1975; Lee 1979). Although neither center was part of PAMHRP's initial study, they are included in this section, along with the other programs, to illustrate ways in which cultural considerations have been incorporated into the design and delivery of mental health services for Asian/Pacific Islander Americans.

South Cove Community Mental Health Center

The South Cove Community Health Center was formed in 1972 by a group of community leaders who saw a need for low-cost, comprehensive medical and mental health care for residents of Boston's Chinatown and South Cove area. In 1969, the income of area residents ranked the lowest among Boston's antipoverty tracts. The Chinatown community also ranked as the fourth largest Chinese community in the United States.

In 1976, the center moved to a complex that housed a public elementary school, the community council, a day care center, and a residential tower for the elderly. The center was to be an integral part of this service complex as well as of a larger network composed of other neighborhood-based organizations and extracommunity agencies.

Several considerations were incorporated into the design of the mental health program that was implemented within this setting. Among these were the organizers'

beliefs that bilingual providers with an understanding of their client community would produce better treatment outcomes; that programs controlled by a board composed of community representatives and community members would be more responsive to client needs and expectations; and that a mental health program, geographically located with other human services, would increase the program's visibility and facilitate successful referral and treatment.

Organizers also believed that a mental health program placed within a neighborhood health center would be more accessible and acceptable to Chinese clients. Such a setting would also enhance opportunities for prevention, early case finding, and the coordination of primary health and mental health care. The organizers' belief that a health care setting would facilitate access to mental health services was based on the view that Chinese people tend to see their problems in somatic rather than psychological terms. While Chinese residents might be prevented from directly seeking mental health services because of their fear of being labeled a "mental patient," organizers also believed that this tendency to somatize problems would bring residents into the center for medical assistance.

The organizers' views--that the Chinese fear the stigma attached to mental health services and that they are not psychologically minded--are also found in the literature. In a study on the mental health views of Chinese in Los Angeles, for example, Chen (1977) reported that 78 percent of his respondents believed Chinese people would avoid going to mental health agencies and that, when respondents were asked what barriers they foresaw, 76 percent answered "losing face." In a study with university students, Sue and Sue (1971, p. 45) found that Chinese students exhibited more somatic complaints than their non-Asian counterparts and speculated that "perhaps the Chinese are reluctant to admit psychological problems, since there is much shame associated with these problems." According to Sue, "physical conditions are better recognized and more accepted." Kleinman (1980) believes that somatization is the most frequently resorted-to mechanism for coping with psychological difficulties, such as depression, in Chinese culture.

Somatization is also considered common among Southeast Asian patients (Tung 1980), and this view may be supported to some degree by the experiences of agencies in PAMHRP's study. The Linda Vista Health Care Center in San Diego, for example, reported that among its Southeast Asian refugee patients, over 60 percent of the physical complaints brought to the clinic were psychogenic in nature. In such cases, referrals were made from the Center's general medical component to its psychosocial unit. Staff members similarly believed that a health clinic was an important point of entry into a mental health program and that the setting facilitated refugee acceptance of assistance with emotional and social problems. In a general health care setting, there was apparently less fear of "losing face."

Chinatown Child Development Center

The CCDC is another program that operates on the premise that the stigma that attaches itself to mental illness presents a formidable barrier to mental health service use. CCDC's approach to lowering the barrier is to provide mental health services within the context of a parent/child drop-in center and after-school program. Among the reasons for the choice of this setting was the actual need within the community for child care services and the traditional Chinese respect for education. CCDC program planners believed that "since parents traditionally went to relatives, teachers, or physicians for help if their children experienced emotional or behavior problems, seeking help from the mental health professionals who staff an 'educational' agency is acceptable and nonstigmatized" (Chan-Sew, unpublished, p. 7).

Although parents are told that CCDC is a mental health facility, their orientation to the program is educational, and mental health professionals and counselors are called "teachers" rather than therapists. Children are both formally and informally screened, and, for children who encounter problems, individualized programs are developed and implemented in a "classroom" setting. When a child or family is in need of more intensive clinical service, a referral is made to CCDC's clinical unit. Since the staff at CCDC has already

established a fairly warm and trusting relationship with the family, the parents are expected to be more receptive to the idea of evaluation and psychotherapy. Moreover, since the clinic is located at the same site as the other programs, the stigma of seeking help from a place labeled a "clinic" is reduced.

During their children's participation in the programs offered at CCDC, parents are free to shop, keep medical appointments, attend language classes, or run personal errands. They are also encouraged to attend a variety of low-key mental health education activities. In addition to weekly parent discussion groups, parent social activities (such as cooking, English, and sewing classes) serve as vehicles for discussion of parenting concerns.

Other Mental Health Settings

Child care and general health programs have been presented in this section as examples of what might be considered culturally appropriate or acceptable settings for the delivery of mental health services to Asian/Pacific Islanders. Program planners believed that clients were likely to utilize health and child care facilities and to be more receptive to mental health counseling if they were offered in conjunction with these programs.

In PAMHRP's study, we see that mental health services can also be offered in conjunction with English as a second language (ESL) classes, with recreation and socialization programs, and within various social service settings. As the director of one of the programs noted, "Asians do not use traditional mental health services but [do] use religion; social clubs and activities; and family or service-oriented people such as barbers, bartenders, and hairdressers for counseling services" (Yoshioka et al. 1981, vol. II, p. 339). In addition to the more institutionalized agency settings, these "natural" caretakers and environments, such as the client's home, have also been considered possibilities for the delivery of mental health services by Asian/Pacific Islander service providers (Arimoto 1975; Moriwaki and Hatakeyama, unpublished).

A question that faces planners who want to offer mental health services in conjunction with other programs is the choice of the appropriate service cluster. Asian/Pacific Islander agencies, for example, have had to decide whether to place mental health services within a general health care setting or offer them in conjunction with social service or ESL programs. Agencies have also had to consider the role of nonprofessionals in the delivery of mental health services to clients. If an Asian/Pacific Islander enters a social service agency for immigration assistance but has problems that might better be addressed by a mental health specialist, does the worker simply refer the client to another agency for counseling services? Should mental health workers be "outstationed" at the agency on a regularly scheduled basis? Or should workers at the agency be trained to provide primary counseling?

Asian/Pacific Islander agencies have taken different approaches to both sets of questions. In the case of the CCDC, mental health services are offered in the context of a child care program through mental health "teachers." To facilitate referrals for children with more severe difficulties, the agency maintains a clinical staff within the same building. Asian Americans for Concerned Involvement (AACI) in San Jose offers both mental health and social services programs. In AACI's case, each program maintains an independent staff, though members consult, or "share cases," in order to provide multiple-problem clients with integrated services.

Another approach to providing mental health services in conjunction with a second, widely utilized program was recently proposed by two of the San Francisco agencies included in PAMHRP's initial study: The Center for Southeast Asian Refugee Resettlement (CSEARR) and Richmond Area Multi-Services, Incorporated (RAMS). RAMS is a community-based mental health program that has been providing outpatient and crisis intervention services to Richmond District residents since 1974. CSEARR has been providing refugees with resettlement, job counseling, and social services since 1975. According to their joint proposal, RAMS mental health workers would rotate through CSEARR's three existing sites in Marin, San Mateo, and San Francisco, training and

working with CSEARR staff to identify and assess problems and provide crisis counseling. The joint venture would enable CSEARR to provide a wider range of services to its refugee clients while also enabling RAMS to reach a broader segment of clients in need of mental health counseling.

Agencies have also brought mental health workers into their programs on a consultation basis or have had mental health workers outstationed at programs on a regularly scheduled basis. Two agencies that have used consultants in a particularly sensitive manner are the International District Community Health Clinic and the Asian Counseling and Referral Service (ACRS). Both agencies are located in Seattle's International District. A formal agreement exists for ACRS to provide social and mental health services to clinic patients when needed. When a patient is reluctant to be "referred out" to ACRS or another mental health agency (because of the stigma attached to such programs), the arrangement also permits the clinic's "primary worker" (anchor worker) to provide counseling services to the patient in consultation with an ACRS psychiatrist. The rapport that has been established between the primary worker and the patient facilitates the latter's acceptance of these services. Workers at the Chinese Information and Service Center, also located in the International District, similarly report that if clients are hesitant to be referred to another agency for counseling, the caseworker will consult with ACRS staff in order to develop an apropriate treatment plan for the client. Once clients have established trust in their caseworker, they will often prefer staying with the worker to being transferred to another agency.

Worker-Client Relationship

Whatever the setting, worker-client rapport is seen as an important ingredient in the delivery of mental health services to Asian/Pacific Islander American clients. According to the CCDC, it was this rapport, along with the clinic's setting, that facilitated the client's acceptance of a referral to CCDC's clinical unit. Staff of the Chinese Information and Service Center also reported that clients began to let personal problems

surface for discussion only after an initial rapport had been established with their workers. Similarly, in the case of the International District Community Health Center, a health care setting became the vehicle for the delivery of mental health services because trust had been established between the primary worker and client.

There are any number of factors that might account for the rapport that is established between a worker and a client. For Mexican American clients, research results indicate that the personalismo (friendliness, warmth, sensitivity) of the therapist is essential in initiating a trusting relationship and in bridging the gaps between the therapist and client (Hassell 1980). The comments of Asian/Pacific Islander American service providers similarly indicate that a personalization of the relationship between the worker and the client is often necessary. Personalization generally refers to the service provider's ability to speak and act in the same cultural and language idiom as the client. It may involve maintaining proper social protocol (for example, refraining from touching a Laotian refugee on the head); or, as in the case of a Pilipino worker, first answering questions about one's family life and personal history ("What town do you come from in the Philippines?" "Do you have any children?" "Is your husband an American?") (Pe 1975, p. 51). In the case of one Japanese worker calling her client obasan (a familiar term whose literal translation is "aunt") and sharing personal opinions and life experiences where they were relevant helped to establish a trusting relationship with her client (Lake 1975).

Another important factor in building rapport is the worker's ability to establish himself or herself as a "helping person." Workers can often establish this role by providing advocacy services to their clients. ACRS, for example, reports that in working with Southeast Asian refugee clients:

> the refugee is much more likely to accept help . . . in transporting his elderly mother to the doctor, than to admit he has been having emotional or interpersonal difficulties. However, after the worker has provided advocacy

> services, such as transporting, interpreting, and teaching the clients about America, the clients will begin to accept and trust him. . . . In establishing this basic trust, the worker has been able to demonstrate that he is there to help them. More importantly, he has begun to draw out some of the problems that are facing the client and his family. As the worker-client relationship develops, the probability of the client being able to discuss his personal problems becomes increasingly greater.
>
> (Ishisaka 1977, p. 3)

Advocacy assistance also is seen as an important element in establishing trust and rapport with Chinese clients. According to the staff of the Chinese Information and Service Center, mental health counseling becomes more acceptable to clients if workers place their initial focus on concrete types of assistance such as the translation of a bill or welfare form. Assistance of this sort builds the client's trust in the worker and lays the foundation for later discussions of possible psychological and mental health problems. If Chinese clients tend to view their problems in terms of concrete (as opposed to psychological) causes (Kleinman 1980), this initial emphasis on concrete assistance may be quite appropriate for laying this foundation.

Apparently, advocacy assistance is considered more than a simple means of establishing rapport and trust between the worker and client. In Seattle, a model for mental health service delivery has been built on the advocacy role of the mental health worker ("clinician advocate"). The model places initial emphasis on services such as job assistance, language training, and welfare, but considers these services an entree into the more traditional aspects of mental health care. Until the necessary rapport can be established, the mental health care aspects of the program remain embedded in the more concrete forms of assistance that the client finds acceptable (Aylesworth et al. 1980).

ACCESS MODELS

The models for mental health service delivery that were presented in the preceding section emphasize the clients' reluctance to seek mental health services because of the stigma that is often attached to mental health problems. Cultural differences in the way Asian/Pacific Islander clients perceive their difficulties (i.e., as medical problems rather than psychological ones) were also considered a factor that would influence their use of traditional mental health facilities. The client community's lack of information about available services and anticipated language difficulties are two other major factors that might present barriers to service utilization. In a survey of Asian Americans in the Chicago area (Kim 1978), for example, 49.5 percent of the Chinese immigrants and 23.7 percent of the Korean immigrants questioned cited either language difficulties or not knowing where to go as reasons for not seeking help when problems arose. In the event of a hypothetical emergency specifically involving mental illness, over a fourth of the Chinese respondents stated that they would not know where to go for help. Similarly, in a survey of Chinese Americans in Los Angeles (Chen 1977), 92 percent thought that lack of information would present a likely barrier to seeking mental health assistance; 87 percent considered language a possible barrier; and 78 percent, finances.

In order to reduce some of these barriers to service utilization, the majority of the agencies in PAMHRP's study indicated that they were providing outreach and access services such as information and referral, language assistance, transportation, and client advocacy. Their efforts have been directed toward improving access both to the services provided by Asian/Pacific Islander American community-based programs and to the larger system of public service institutions.

Community Outreach

Agencies in PAMHRP's study have attempted to bring Asian/Pacific Islander clients into the service system through a number of different approaches. A basic strategy has been to increase the potential client's

knowledge and understanding of available services through informational mailings (brochures, bilingual newsletters), radio shows, and community workshops and presentations. Establishing outposts or satellite offices within other community-based agencies and ethnic community centers has been another common method of reaching potential client groups.

The most extensive use of satellite programing occurs in the Los Angeles area. The Oriental Service Center, for example, maintains 11 satellite offices in the Japanese, Chinese, Vietnamese, Korean, Pilipino, Samoan, Thai, and Tongan communities. For the Japanese community, outposts are maintained at the Little Tokyo People's Rights Organization and the Japanese Community Center. Outposts for the Pilipino community are maintained at Pilipino-American Community, Inc., and Pilipino Community of Wilmington. For the Chinese community, a satellite office is maintained at the Chinatown Senior Citizen Service Center.

Three agencies in PAMHRP's Los Angeles area study also serve as outposts, or satellite stations, for other programs. The Indochinese Refugee Service Center (IRSC) provides facilities for programs serving Southeast Asian refugees. Among the county agencies housed in the IRSC facility are the Community Development Department; the Department of Public and Social Service (DPSS), Indochinese Refugee Assistance Program Service Unit; the DPSS Asian Community Relations Outpost; and the Indochinese units of the health services and mental health departments. Other programs include a legal clinic; ESL classes; the Public Health Foundation Nutrition Program for Women, Infants, and Children (WIC); the Asian Women's Health Project; and the Southeast Asian Mental Health Training Project. The Asian Community Service Center similarly serves as an outpost for various community-based programs and public agencies. These include the Korean Cultural Center; the Korean American Senior Citizen Multipurpose Center; the Los Angeles Department of Community Development; the Department of Public and Social Services, Indochinese Social Service Unit; the Asian Pacific Coalition on Aging; the California Lao Association; and the Asian Voluntary Action Center. The Samoan Community Center, our third example,

serves as an outpost for other programs that, in conjunction with its own, offer the Samoan community counseling and recreational activities for youths; immigration, employment, education, health, and mental health counseling for adults; bilingual volunteer services; advocacy; and information and assistance with regard to social security and senior citizen benefits.

Satellite programing, as it has been occurring in the Los Angeles area, serves a double function. It enables programs such as the Oriental Service Center to reach a larger segment of their client populations than would be possible if their operations were confined to a central office. In Los Angeles, geographic distances often separate agencies as well as the ethnic communities they serve. Satellite programing in such cases can be considered an outreach activity. On the other hand, because many of the satellite offices in the Los Angeles area are maintained in structures housing a number of other programs, multiservice-type centers are developing. The IRSC, the Asian Community Service Center, and the Samoan Community Center provide examples of this multiservice potential.

One of the major functions of these agencies has been the development of comprehensive services for Asian/Pacific Islander communities in the Los Angeles area; in each of the cases, the focal point for this development has been a central facility housing other satellite programs. The IRSC facility provides Indochinese refugees with health, mental health, and social services in an atmosphere compatible with their linguistic needs. A special unit in the facility is responsible for coordinating these services and providing appropriate staff training and development. According to staff reports, a central, multiservice structure of this sort has facilitated interagency contact and the development of a referral network that increases client access to appropriate services.

The development of multiservice structures is also evident at other sites in PAMHRP's study. The distinctiveness of the Los Angeles development resides in the fact that these multiservice structures have occurred through agency outstationing. In San Diego, the development is the result of an effort by the Union of Pan

Asian Communities of San Diego County, Inc. (UPAC), and its affiliate programs to come together under a single structure. The new center housing UPAC and UPAC-affiliated programs was completed in January 1981. The center houses the Indochinese Service Center, the Pacific/Asian Preventive Program, the Pacific/Asian Parent Education Program, and the Pacific/Asian Latino Training Center. In Oakland, Asian Community Mental Health Services joined with several other Asian/Pacific Islander American groups, such as Asian Health Services, Inc., to relocate their services in a newly renovated structure in the Oakland Chinatown area. The move culminates a 6-year effort by the East Bay Asian Local Development Corporation to create a facility for various Asian/Pacific Islander American community service organizations in the East Bay area.

A third method of providing outreach services to Asian/Pacific Islander communities is one in which most community-based agencies engage, especially during the initial stages of their development. Access to potential client groups is often gained through the churches and the ethnic institutions that play a primary role in the lives of their communities. Korean churches in the San Diego area are one of the Korean Outreach Project's major sources of referral. In the case of UPAC, access to the Samoan community was developed through the support of Samoan community leaders. As PAMHRP's study indicates, Samoan churches provide one of the major leadership structures in the Samoan community. UPAC was cited as being the only organization outside these churches to provide acceptable services to the Samoan community. This success was due partially to UPAC's initial outreach to this natural leadership structure and partially to UPAC's later incorporation of community members into its own service delivery structure. Members of the Samoan community currently serve on UPAC's board of directors. Bilingual, bicultural Samoan workers are also on the staff of the Pacific/Asian Preventive Program, providing individual casework to Samoan clients; the Pan-Asian Parent Education Project, which provides parenting services; and UPAC's Pacific/Asian Senior Service program. A nutrition project, serving the Asian/Pacific Islander American elderly, has also recently been established. Through these programs,

Samoan workers are able to provide direct services to their community as well as access services that facilitate the use of the mainstream human service agencies that are part of UPAC's information and referral network.

Enabling Systems

In order to increase client access to public services, community agencies have developed a range of access and support services for Asian/Pacific Islander American clients. The basic service, which all of the agencies in PAMHRP's study provide, is information and referral. Many agencies also provide transportation, outreach, consultation, and education; and for the non-English-speaking, translation and interpreter services.

Two programs for Southeast Asian refugees in San Francisco illustrate an attempt to develop the type of support system necessary to effectively bridge the cultural and language barriers that may prevent client access to needed health and social service assistance. The two programs are the Indochinese Health Intervention Program (IHIP) and Indochinese Family Services (IFS). IHIP's main function is to ensure refugees access to all necessary health services. IFS provides crisis intervention and counseling, orientation services, and staff development and training services.

IFS's orientation program attempts to foster the refugee's understanding of available public resources. It identifies the types of service that refugees are likely to need and orients them to their use. What may be taken for granted by the average American (e.g., making appointments in order to see a doctor) may be an entirely new concept for some of the newer refugee arrivals.

IFS's staff development and training program attempts to orient indigenous workers to various aspects of the social service delivery system so they can provide the support and direct services that their clients are most likely to need. The program is available to IFS's own Southeast Asian workers and to the Southeast Asian staff of local voluntary agencies, school districts, mutual assistance associations, the Department of Social Services, and other Title XX agencies.

IFS and IHIP also conduct orientation and training programs for nonindigenous service providers. IHIP, for example, sends its workers to various hospitals and health facilities in the city and orients health providers in the special health needs of refugee populations, the differences between the Western health system and the health systems of Southeast Asian countries, and in the ways in which these differences may affect the refugee's acceptance of health practices and health facilities in the United States.

IHIP initially saw itself as "following the client around," providing interpreter and other support services as needed. Gradually, it has attempted to provide greater "management" of the health care systems as it pertains to services for the Southeast Asian refugee. An example can be seen in IHIP's efforts to identify available resources for its clients (see figure 1) and to develop additional sources of health care when needed. In the case of dental care, IHIP actively recruited the help of the University of the Pacific School of Dentistry. Prior to being approached by IHIP as a major referral source, the University had been largely unaware of the magnitude of the refugees' dental needs and unprepared to accept them as patients. With the assistance of IHIP interpreters, the school is able to provide dental services to both refugee children and adults.

IHIP's referral/escort program also illustrates its attempts to provide greater management of the health care system. In addition to setting up referrals by telephone, IHIP workers escort clients to their appointments. The advantage of providing escort services is that both clients and providers are assured of language assistance once clients have arrived for their appointments. The program also facilitates client compliance with health care requirements and makes possible client followup and tracking. Followup services might include helping clients fill prescriptions, making sure that medication is taken, and reminding clients of subsequent appointments. If clients are referred elsewhere for additional health care services, workers can also assist clients with their next referral. For clients who are likely to be unfamiliar with the Western health care system and are unable to speak English, a referral/escort program of this type is considered critical

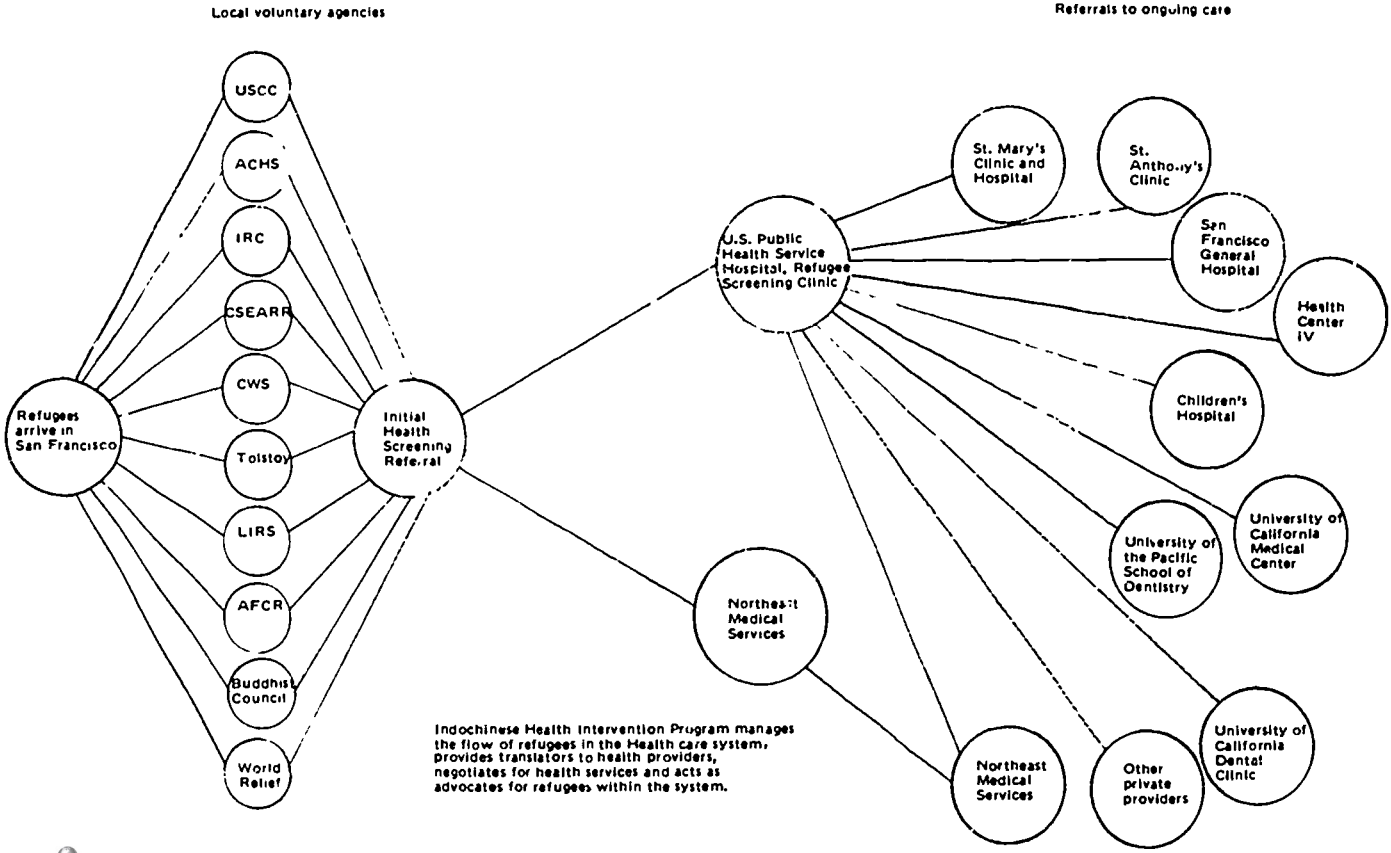

Figure 1—Southeast Asian health care flow, San Francisco

in helping refugees to regain their health and to become familiar with American health care practices and resources. The referral/escort program helps create a system of health care that refugees are able to use.

LOCAL NETWORK MODELS

One of the early answers to the fragmentation and inaccessibility of services for client groups was the neighborhood multiservice center. The idea was to reach out to underserved populations by moving services from large, centralized bureaucratic structures into the neighborhoods where they were needed. In the 1960s, the idea of increased accountability was added: making services more responsive to target groups by placing them in the hands of indigenous workers and governing boards. More recently, the failure of local groups to implement "one stop" centers offering a comprehensive, coordinated range of services to residents has led to a review of the multiservice concept. Many of the earlier experiments had fallen short of providing a comprehensive range of services to local residents; and many centers were seen as little more than a collection of unrelated (uncoordinated) services.

The local network model proposed by Kahn (1973, 1976) is an attempt to address these earlier failures and to define the components, or mechanisms, necessary to create a service network, whether the services are located within a single multipurpose structure or are administratively and geographically separate from one another. According to this model, a "network" implies some type of mechanism on the case level (e.g., case managers, multidisciplinary teams, etc.) that will coordinate different services for the client. On the program level, a service network includes the programs and services required by a target group and is comprehensive in its offerings. On the policy level, a service network represents a coherent design for the growth and provision of services; the policy permits the service field to develop in a coordinated, comprehensive fashion, rather than randomly, with fragmentation and service gaps. A service network also includes an access component that facilitates the client's entrance

into the service network as well as referrals to appropriate services within it.

While neighborhood multiservice centers have been seen as a way of delivering services to the general population, few Asian/Pacific Islander communities have experimented with the idea. One reason may be the geographic distribution of Asian/Pacific Islander communities. Rather than high neighborhood concentrations of Asian/Pacific Islander American groups, the general trend has been the geographic dispersal of ethnic communities into scattered "pockets" and small enclaves within a city. (The few exceptions in PAMHRP's study include the Chinatown/North Beach and Richmond areas in San Francisco and Korea Town in Los Angeles.)

Another reason may be the tendency for Asian/Pacific Islander agencies to define their client groups along ethnic, rather than geographic (neighborhood and catchment boundary), lines. The majority of the agencies in PAMHRP's study define their target population as either "multiethnic (pan-Asian)" or "single ethnic." An effort to reach Asian/Pacific Islander clients may be an effort to reach widely dispersed pockets of client groups.

Rather than developing multiservice centers, the general tendency has been for agencies to start with a few core services for a small target population and then gradually add a few additional components over time. Where the population has been large enough to support more specialized programs, special-issue agencies have also been developed. In Los Angeles, for example, we find rehabilitation services for the disabled, drug abuse services, and family planning and women's health services.

It is difficult to speak of the "proliferation" of individual agencies and programs to serve Asian/Pacific Islander communities when Asian/Pacific Islanders are still underserved in terms of the range and types of services that are available to them. However, during the past 10 years, there has been a noticeable growth in the number of agencies and special function services for Asian/Pacific Islanders and, with this growth, attempts to create a "service network" for Asian/Pacific

Islander communities. For example, in preceding sections of this report, we have noted that all of the agencies in PAMHRP's study engage in some sort of outreach to potential client communities or have developed an information and referral network, linking clients to other service providers, if the agency could not provide the necessary services itself. Several examples of this network-building on the case level were also presented in earlier sections of this report.

The consultation/referral arrangement between International District (Seattle) service providers and the referral/escort services of agencies such as IHIP in San Francisco illlustrated the role of workers in providing case-management-type services. In IHIP's case, we saw that escort/interpreters monitored their clients' progress and access to needed medical services through support services such as information and referral, escort, language assistance, and followup. International District agencies offered examples of "primary workers" coordinating and providing a combination of mental health, health, and advocacy (welfare, employment, housing) assistance to clients with multiple service needs.

It is evident that the Asian/Pacific Islander experience in developing local networks has been varied and is still evolving. Perhaps the most important development with respect to Asian/Pacific Islander American mental health over the last 10 years has been the creation of parallel systems of service. In most communities, these services have been instigated through the efforts of community action. For example, while the Community Mental Health Center system has been mandated to provide relevant, accessible, and appropriate services, it has been slow to respond to Asian/ Pacific Islander community needs; and community advocacy by Asian/ Pacific Islander Americans was essential in order to develop needed services (Yoshioka et al. 1981, vol. I).

Although each community and agency in PAMHRP's study presents unique concerns, a general trend has been the development of coordinating bodies to function as suprastructures for individual programs and services. These suprastructures have taken various forms, but

one of their major functions has been to solidify the networks and linkages developed through community action. In an effort to indicate the potential for long-term development and planning, four particular situations will be utilized to illustrate the potential available in the Asian/Pacific Islander American service system.

The San Diego Experience

The first illustration focuses on a single agency and the role it has played in the development of a multiethnic, multiservice structure. The organization of services in San Diego has been focused through several community-based programs. However, UPAC is the only community-based service agency that has developed a multiethnic, multiservice response to the needs and concerns of the San Diego Asian/Pacific Islander American community.

Since its inception in 1972, UPAC has functioned as an umbrella organization for various Asian/Pacific Islander American concerns within the San Diego community. A review of its program history indicates that it has been able to respond to the diverse needs of 14 Asian/Pacific Islander American communities during its 9 years of operation: in 1975, UPAC's Special Services Program focused on the needs of the Japanese, Samoan, and Guamanian communities; its Pan Senior Services (PASS) program served these communities as well as the elderly Chinese community living near the Market Street area. In 1976, a program was added to serve Vietnamese refugees; and in 1978, a mental health program, the Pacific/Asian Preventive Program, was funded through San Diego County Mental Health funds. In 1978, the Indochinese Service Center expanded its services to North County, and the Indochinese Community Health and Education Project was federally funded to provide training for bilingual Southeast Asian community worker/translators. In 1979, the Pan Asian Parent Education Project began as a preventive child abuse program to assist Asian/Pacific Islander American parents with the difficulties of childrearing and acculturation conflicts. Other programs between 1978 and 1979 included a summer youth program and various community workshops.

Currently, UPAC services are available through seven programs. All of these programs are under UPAC's administration, even though they may be staffed by separate directors and separate bookkeepers. The potential for greater coordination among these programs is indicated by UPAC's recent move to a multiethnic, multiservice structure that houses UPAC and its affiliate programs.

Through its programatic responses and an advisory board structure that includes community representatives and service providers from other Asian/Pacific Islander organizations, UPAC has been able to speak for a number of communities. The agency has also been able to mobilize a wide range of community and professional support and input with regard to various issues and programs of concern to Asian/Pacific Islander communities in San Diego. This ability to respond to and to speak for a number of communities is not technically replicated at any other site. Therefore, UPAC represents a significant development and points to the potential for greater coordination of services and more consistent long-range planning approaches to service delivery within Asian/Pacific Islander communities.

It is also important to note that UPAC, in conjunction with the Korean Outreach Project and the Council of Pilipino-American Organizations/Operation Samahan, has combined efforts to implement projects that respond to needs in communities not directly served by UPAC's existing structure. These joint efforts have served to establish constructive relations between agencies and communities without the intrusion of unnecessary competion for limited resources.

The Seattle Experience

The majority of the Asian/Pacific Islander American agencies included in PAMHRP's Seattle survey are located in the International District, a 50-block area that provides homes for many elderly Chinese, Pilipino, and Japanese residents, as well as a growing number of Southeast Asian refugees. The International District Improvement Association (INTER*IM) has been one of the prime catalysts in developing services for this area.

Originally founded in 1969 as part of the Model Cities Program, the agency has been instrumental in developing the International District Community Health Center, a child care program, an emergency meal voucher program, and free bus services for area residents. It also has been responsible for the renovation of three hotels and for securing 300 housing units for low-income residents.

INTER*IM is the only agency in PAMHRP's study that is a neighborhood multiethnic, multiservice planning and program development function for an entire neighborhood area. Unlike most of the agencies in PAMHRP's study, INTER*IM is not a direct service provider.

The Seattle experience also illustrates the point that program development possibilities are enhanced by geographic proximity. The International District is unique among all Asian/Pacific Islander communities in its high concentration of various Asian/Pacific Islander populations in one geographic area. This geographic proximity facilitates rapid communication among the various Asian/Pacific Islander agencies and organizations, as well as closer working relationships. The result is that there are probably a higher level of effective collaboration and more successful joint projects undertaken by Asian/Pacific Islander organizations in Seattle than in any other city.

The type of service networks that have been developed among service providers within the International District has already been indicated in earlier sections of this report. Specific case-level examples focused on the interactions between health and social service workers at the International District Community Health Center and the Chinese Information and Service Center and with mental health professionals at the ACRS. The interactions of these agencies represent an integrated approach to Asian/Pacific Islander American client problems and a sensitive response to cultural barriers to mental health service utilization.

The Los Angeles Experience

In the Los Angeles area, the geographical distances separating agencies and highly impacted communities, combined with a rapidly increasing and diverse population, have led to the development of several distinct service delivery models. Single agencies maintain a number of outstations or satellite programs in locations accessible to the communities being served. The centralization of administrative functions and limited investment in outstation facilities provides for flexibility in program planning and development in a rapidly changing social/urban landscape. This agency adaptation enhances the ability of a single agency to provide broad service capabilities without the encumbrances of redundant administrative support. Scarce fiscal resources can be allocated to line workers, and the service delivery capability of a particular agency can be increased without the additional costs of administrative staff being added for each new program or outstation.

A second concept particularly evident in Los Angeles focuses on the development of an agency resource to house the various outstation programs of different agencies. This concept provides a core agency staff to maintain basic administrative functions for the facility along with limited direct service capability. However, the primary function of the agency is to provide work space for the outstation staff of other programs. This concept provides for multiservice capability without the complexity of securing program funding for specific individualized projects. Most importantly, these facilities provide an interface between community-based service agencies; social organizations; and local, county, State, and Federal programs. As such, they represent an important potential for the development of networks encompassing a wide range of services for multiethnic or single-ethnic populations within a convenient and accessible central location.

The combination of outstation/satellite programs and centralized facilities in the Los Angeles area has provided a unique approach to the delivery of services in the community. The two types of facilities provide a reciprocal relationship that creates a more accessible

and functional program of services than either structure would be capable of as independent programs. While individual agency outstationing may provide outreach to communities that are widely dispersed and geographically removed from the main offices of various Asian/Pacific Islander agencies, centralization brings a wide range of services to communities within a single, accessible location. Centralized facilities of this sort, it should be noted, function optimally where there are high population concentrations of Asian/Pacific Islander Americans. Both of these approaches can be related to the nature of the geographical and ethnic makeup of the Asian/Pacific Islander American community in the Los Angeles area.

Finally, the organization and development of services aimed at the Asian/Pacific Islander American community in Los Angeles has been enhanced by the operation of the Asian Pacific Planning Council (APPCN). This organization/coordinating body serves as an umbrella for a coalition of service providers, individuals, and agencies in the Los Angeles community. The coalition effectively enables members to address a number of concerns within the Asian/Pacific American community.

Through its organizational structure, APPCN is a highly visible entity that can serve as an interface among Asian/Pacific Islander American agencies and between Asian/Pacific Islander American agencies and the larger Los Angeles community of service providers. Given the complexity of Los Angeles' Asian/Pacific Islander American community in terms of its geographical distribution and its rapidly changing ethnic structure, APPCN can serve as a major conduit of information. The maturation and growth of APPCN since 1977 is only one indication of the necessity for such an organizing body. APPCN has the potential to influence local program development within the Asian/Pacific Islander American community as well as to affect and sensitize non-Asian/Pacific Islander American agencies and bureaucracies to Asian/Pacific Islander concerns.

The Bay Area Experience

Efforts directed at areawide, ethnic-specific service coordination have been illustrated in our review of

various programs and agencies in Los Angeles, San Diego, and Seattle. A final example is provided by developments in the San Francisco Bay area and the activities of the Greater Bay Area Refugee Health Council.

The Refugee Health Council first met on February 6, 1981, with the goal of ensuring adequate and accessible health care for the various refugee communities in the greater bay area. The council is composed of concerned public and private health care providers from the six San Francisco Bay area counties (Alameda, Contra Costa, Marin, Santa Clara, San Francisco, and San Mateo) and includes agencies such as IHIP, CSEARR, and Indochinese Family Services. Major areas of council work include:

1. Advocacy: Advocating for a comprehensive, coordinated program of services to facilitate refugee self-sufficiency.

2. Education: Educating mainstream health providers to the special health concerns of refugee communities and, at the same time, educating refugee communities to the Western health care system and perspectives.

3. Technical Assistance and Information Exchange: Creating a network that provides technical assistance and facilitates the development of resources for refugee health services.

4. Consultation: Utilizing the experience and resources of Health Council members to aid in developing appropriate services and constructive policy for refugee health services.

Members of the council meet once a month to share information; to identify gaps in services and resources; and to monitor State, Federal, and local policy formulations that could affect their individual and collective abilities to provide needed services to Southeast Asian refugees. A recent position paper presented to the State legislature, for example, advocated the need for a comprehensive service package for Southeast Asian refugees if the Federal goal of refugee economic

self-sufficiency were to be achieved. The potential danger was that the State legislature would give a narrower definition of this goal and ignore many of the services that were its prerequisites, including job training; ESL classes; State licensure; and mental health, health, and health-related support services.

During its short history, the Refugee Health Council has been able to focus the abilities of the various member agencies on common problems and, as in the case of the APPCN in Los Angeles, to provide the nucleus for a network that can effectively respond to the numerous issues affecting their communities. As a model for policy and service coordination, the Health Council cuts across geographic divisions and represents a unique attempt to bridge the numerous bureaucratic and organizational divisions that lend themselves to a fragmented, competing field of services. Given limited resources and the magnitude of refugee resettlement problems, such structures are vital to the development and maintenance of appropriate services and facilitate a coordinated effort in this direction.

SUMMARY AND CONCLUSION

SUMMARY

In this report, we have reviewed and analyzed the experience of Asian/Pacific Islander American communities in responding to the need for mental health and mental health-related services. The basic problem addressed by these communities has been the underutilization or nonutilization of existing services. Various factors affecting service utilization by Asian/Pacific Islander communities were identified and analyzed. The types of alternative Asian/Pacific Islander American community-based agencies that have evolved were then reviewed in terms of their organizational characteristics, functions, and funding sources. A wide diversity of auspices, organizational structures, types of services, and funding patterns were found.

From this review and analysis, the major characteristics of alternative Asian/Pacific Islander community-based

agencies were conceptualized in terms of models of service delivery that address three major functions:

1. To deliver culturally appropriate services
2. To provide or facilitate access to services
3. To link clients to a comprehensive service network

Examples were given of agencies in various localities that exemplify each of these functions.

We then concluded our report with an analysis of developments at our four major study sites: Los Angeles, San Diego, San Francisco, and Seattle. The experiences reported for these sites may serve as models for other localities and are significant as indicators of developing trends or future directions.

CONCLUSION

Although the examples cited in this report may not fit the exact demographic or historical characteristics of a developing community, they represent a variety of successful and possible approaches to the delivery of mental health and mental-health-related services in Asian/Pacific Islander communities. The 10-year history of service delivery documented in this report points to the constructive direction taken by various Asian/Pacific Islander communities in an effort to establish and maintain effective and appropriate services for their respective communities. Their experience serves as an example to other Asian/Pacific Islander American communities of what can be accomplished through the collective efforts of concerned and dedicated members of a community.

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MENTAL HEALTH SERVICES FOR REFUGEES AND IMMIGRANTS IN CANADA

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HISTORY

Mental illness among immigrants has been studied since the 19th-century mass immigration to the United States. For many years, since the early studies of Ranney (1850) and especially since the works of Odegaard (1932) and of Malzberg and Lee (1956), it was generally believed that migration was associated with higher incidence of mental illness.

There have been continuing efforts to explain the apparent excess of mental disorders among immigrants.

NOTE: Revised version of a paper presented at the International Conference on Refugee Resettlement, Vancouver, Canada, July 15-18, 1983. Reproduced and adapted with permission from The Psychiatric Journal of the University of Ottawa, 9(2):85-91, 1984;

Two main theories were held. The first theory suggests that constitutional vulnerability to mental illness predisposes the person to migrate. The second view implicates the severe stresses of immigration as precipitating factors of the immigrants' mental disorders.

However, more recent epidemiological studies in the 1960s and 1970s (Cochrane 1977; Cochrane et al., unpublished; Iida-Miranda, unpublished; Morgan and Andrushko 1977; Murphy, unpublished, 1965, 1973) have proven that the former belief that immigrants always suffer from an excess of mental disorders is no longer valid, and the old rivalry between the social selection and social causation hypotheses has lost much of its relevance (Murphy 1977). There is now sufficient evidence to support the general conclusion that migrants need not have higher rates of mental disturbance than nonmigrants (Rack 1978). Therefore, it is fully time that we cease to regard migration as a unitary concept in studying the relationship between migration and mental health. The many aspects of immigration and the numerous factors in the process of adjustment to the host society have made us increasingly aware of the complexity of the problem. If one seeks to understand the mental health problems of any immigrant group, one has to consider three sets of factors:

1. The immigrant: characteristics (age, sex, education, social class, personality, etc.) and linguistic and cultural background

2. The migration: motivation for migration and circumstances of migration

3. The host society: public attitude, immigration policy, availability of immigrant services, presence of a preexisting ethnic community, and culture of the host society, etc.

BACKGROUND

Since 1975, over half a million refugees from Southeast Asia have resettled in North America. Canada, in particular, has admitted approximately 85,000 of those displaced persons. While the majority of the refugees

have resettled successfully, there has been growing evidence that a significant number of them are experiencing considerable emotional distress. Providing adequate mental health services for this high-risk population has been a major area of concern for those involved in refugee resettlement.

The purposes of this paper are:

1. To present the clinical findings on a group of 118 Southeast Asian refugee patients who have resettled in Ontario, Canada

2. To discuss the delivery of mental health services for refugees and immigrants

CLINICAL FINDINGS

The present study is based on the data on 118 Southeast Asian refugee patients who were referred to the author for consultation, assessment, and treatment during the 5 years from 1978 to 1983.

DEMOGRAPHIC DATA

Tables 1 and 2 show the distribution of the 118 patients with respect to sex, age, education, ethnic background, marital status, social class, and current employment status.

As a group, female patients outnumbered males. There are 52 male (44 percent) and 66 female (56 percent) patients in our sample, compared with the proportion of 55 percent male and 45 percent female in the general refugee population (Canada Employment and Immigration Commission 1980). This trend is statistically significant ($p < 0.0001$).

This is a predominantly young population, with the youngest patient being 9 years old and the oldest being 75 (mean age, 28). Sixty-one percent of the patients belong to the age group 18 to 35, which represents only 40 percent of the total general refugee population. This is also statistically significant at the $p < 0.0001$ level.

TABLE 1.--Characteristics of 118 refugee patients

	Male	Female	Total
Sex	52	66	118
Age			
Under 18	6	3	9
18 to 35	30	42	72
36 to 55	10	19	29
Over 55	6	2	8
Marital status			
Single	27	31	58
Married with spouse in Canada	15	20	35
Married with spouse in homeland	6	3	9
Widowed	1	6	7
Separated	2	3	5
Divorced	1	3	4
Ethnic background			
Cambodian	2	3	5
Chinese-Cambodian	0	4	4
Laotian	2	1	3
Hmong	0	1	1
Chinese-Laotian	1	1	2
Vietnamese	30	32	62
Chinese-Vietnamese	17	24	41
Education			
No formal education	6	12	18
Elementary	16	21	37
Secondary	18	29	47
University	12	4	16

TABLE 2.--Characteristics of 118 refugee patients

Social class	In Indochina	In Canada
Professional/managerial	11	0
Intermediate and artisan	56	9
Laboring	51	109
Total	118	118

Employment		No. of cases	Percent
Employed		46	39
Dependent		72	61
On children	5		
Housewife	9		
Public assistance	15		
Unemployment insurance	7		
In school or in training	36		
Total		118	100

Mode of referral	No. of cases	Percent
Doctors (GPs and psychiatrists)	48	41
Immigration services	39	33
Sponsors	12	10
Teachers, board of education	7	6
Family	4	3
Self	8	7
Total	118	100

With regard to ethnic background, there are 62 Vietnamese patients, 41 Chinese-Vietnamese, 9 Cambodian, and 6 Lao-Hmong patients.

With regard to marital status, 49 percent of our patients are single; 37 percent are married; and, in this subgroup, there are nine patients (8 percent) whose spouses are still left behind in their homelands.

With regard to social class and education, 15 percent of the patients had no formal education, 31 percent had an elementary-school education, 40 percent went to secondary schools, and 13 percent had some form of superior education (not always completed). Half of the patients were formerly merchants, white-collar workers, or skilled workers in Indochina. One can note the significant downward trend in their current occupational status in Canada, as 92 percent of the patients are now in the laboring class. Nearly 40 percent of the patients were working at the time of referral, and 60 percent were dependents or in school or in training (English classes or vocational courses).

PRESENTING PROBLEMS

The most common reasons for referral (table 3) were bodily complaints, either in the form of somatic manifestations of anxiety and depression or a hysterical disorder of functions. Because of the language barrier and the persistent complairts by the patients, many of these refugee patients were subjected to extensive clinical, laboratory, and radiological investigations before a psychological or emotional etiology was suspected.

Attempted suicide was the next most common presenting problem. Twenty-four patients took drug overdoses, and two patients attempted to kill themselves by hanging.

Abnormal behavior ranked third in precipitating psychiatric referrals. This included seven cases of school adjustment problems, nine cases with manifest delusions and hallucinations, five cases of agitation and wandering on the streets, and four cases of aggressive

TABLE 3.--Presenting problems in 118 refugee patients

		No. of cases	Percent
Somatic complaints		36	30
Suicide attempts		29	25
By overdose	24		
By hanging	2		
By self-stabbing	1		
By jumping (subway, river)		2	
Abnormal behavior		25	21
School problems	7		
Agitation and wandering	5		
Aggressive behavior	4		
Delusions and hallucinations		9	
Anxiety and depression		17	15
Antisocial act		11	9
Shoplifting	1		
Child abuse	4		
Wife beating	5		
Pedophilia	1		
Total		118	100

behavior. Antisocial behavior represented only a small number of patients (9 percent), and it included shoplifting, child abuse, and wife beating.

Only 17 patients (15 percent) were referred primarily for psychiatric problems such as anxiety or depression.

DIAGNOSTIC CATEGORIES

The distribution of patients according to diagnosis is given in table 4. We have used five main diagnostic categories to reflect the clinical picture and the difficulties facing our patient group.

Depression and Anxiety

Depression and anxiety are the most common mental health problems among the refugees. Symptoms of anxiety and depression are present in every patient in this series, including the psychotic ones. As a group, the diagnosis of anxiety and depression account for nearly 65 percent of this series. This high prevalence of depression and anxiety has also been reported by other researchers in various refugee populations (Koranyi et al. 1958, 1963; Mezey 1960; Tyhurst 1951).

TABLE 4.--Diagnostic categories

	Male	Female	Total	Percent
Anxiety	10	11	21	18
Anxiety with marked depressive features	3	5	8	7
Depression	19	27	46	39
Psychosis	11	13	24	20
Schizophrenia 14 Acute psychotic episode 10				
Transient adjustment reaction	4	8	12	10
School adjustment	5	2	7	6
Total	52	66	118	100

Most patients described their discomfort in somatic terms. Anxiety was diagnosed in 21 cases (18 percent) when the patient presented an anxious mood, restlessness, inner tension, feelings of insecurity, and worry about the future, coupled with panicky feelings, fear, palpitations, fatigue, headaches, insomnia, nightmares, and difficulty concentrating.

Depression represents the most frequent mental health problem in our sample, affecting 46 persons (39 percent). This diagnosis was made when a patient appeared sad and reported a gloomy outlook about the future, homesickness, emptiness, loss of meaning and purpose in life, loss of interest, lack of energy, disturbances of sleep and appetite, and a variety of other somatic complaints.

In eight other cases, anxiety and depressive features were equally prominent. This subgroup was classified under the heading of anxiety with marked depressive features.

Psychosis

In this series, there are 24 cases of psychosis (20 percent). Fourteen patients were schizophrenics, and 10 patients suffered from acute reactive psychosis that responded well to treatment.

Transient Adjustment Reaction

Twelve patients (10 percent) presented transient adjustment reaction that resolved rapidly with crisis intervention, and the patients subsequently made satisfactory adjustment to their new lives in Canada.

SOMATIZATION AND THE REFUGEE PATIENT

Of special interest is the prevalence in our patients of somatic complaints for which no organic basis could be found (table 5). Practically all of our patients, including the psychotic ones, complained of somatic

TABLE 5.--Somatization

	Male	Female	Total	Percent
Psychosomatic conditions				
Peptic ulcer	5	3	8	7
Hypertension	2	1	3	2.5
Ulcerative colitis	1	0	1	1
Asthma	0	1	1	1
Migraine	0	3	3	2.5
Somatic complaints				
Headaches	28	43	71	60
Insomnia	26	38	64	54
Aches and pains	14	18	32	27
Palpitations	10	20	30	25
Fatigue	15	10	25	21
Dizziness, fainting	3	21	24	20
Poor memory, poor concentration	18	6	24	20
Poor appetite	10	12	22	18
Indigestion	8	12	20	17
Loss of libido	11	4	15	12
Constipation	5	4	9	8
Diarrhea	2	3	5	4

problems in one form or another. Sixty percent of our patients complained of headaches; 54 percent, of insomnia; 27 percent, of various aches and pains; 25 percent, of palpitations; 21 percent, of fatigue; 20 percent, of dizziness and fainting; 20 percent, of poor memory and difficulty in concentrating; 18 percent, of anorexia; 17 percent, of indigestion; 8 percent, of constipation; 4 percent, of diarrhea; and 15 percent, of loss of libido.

Somatic complaints represent a cultural means of expressing psychological and emotional distress (Nguyen

1983). These physical complaints are genuinely experienced by the patient as physical sickness. The patient often feels that if the physical problems were eliminated, there would be no further difficulty.

DIFFICULTIES IN ADJUSTMENT

Most of the refugees' mental health problems were precipitated by the interaction of severe losses and difficulties in adapting to a new culture and environment. We asked our patients about their immediate concerns and worries in their new lives. Table 6 reflects the severity of the difficulties in our patients' current life situations.

One is struck by the magnitude of the problem of family dislocation in our refugee patients (75 percent). Separation from members of their immediate family (spouse, children, parents, and siblings) has been a major factor causing depression, anxiety, and psychosomatic problems in this group.

TABLE 6.--Major concerns

		Number	Percent
Separation from members of immediate family		88	75
Marital and family problems		60	51
Problem with spouse	21		
With children	9		
With parents	7		
With in-laws	5		
With relatives and siblings	10		
With boyfriends or girlfriends	8		
Worries about future		48	40
Difficulty learning English		32	27
Dissatisfaction with job		25	21

The next most frequent source of conflict is marital and family problems. Fifty-one percent of our patients reported some type of family discord: problems with spouse, 21 cases; with children, 9 cases; with parents, 7 cases; with parents-in-law, 5 cases; with relatives and siblings living in the same household, 10 cases; and with boyfriends and girlfriends, 8 cases.

Nearly 50 percent of the patients expressed worries and pessimism about their uncertain future. More than a quarter of the patients (27 percent) were having difficulty learning English. It is this group of patients who also complained the most about poor memory and difficulty in concentration.

SURVEY OF 285 HEADS OF HOUSEHOLDS

To explore the extent of emotional problems among the refugee population, in the fall of 1982, we conducted a survey of 285 heads of refugee households in the Ottawa region (Nguyen et al. 1983). The results of the survey are reported in table 7.

TABLE 7.--Interview with 285 refugee heads of households

Emotional problems	Number	Percent
Homesickness	228	81
Worries about the future	204	72
Loneliness	156	55
Feeling sad most of the time	106	40
Chronic fatigue	102	37
Headaches	90	33
Poor memory and concentration	90	33
Insomnia	82	30
Feeling of despair, discouragement	67	27
Life no longer enjoyable	55	24
Painful memories of war and traumatic experiences	52	21
Stomachaches	44	17
Palpitation	36	14
Use of alcohol and drugs	7	6
Gambling	2	1.6

Our study indicates that, on the whole, the refugees have resettled successfully; but a significant number of them are experiencing considerable emotional distress. Homesickness (81 percent), worries about the future (72 percent), separation from immediate family members (62 percent), and social isolation (55 percent) were considered serious problems. Nearly half of the refugees interviewed reported symptoms of depression and anxiety to varying degrees, although they did not perceive these as mental health problems.

UNDERUTILIZATION OF MENTAL HEALTH SERVICES

Past traumatic experiences, family separation, nostalgia, culture shock, inability to communicate, social isolation, unemployment, financial insecurity, etc., all contribute to increase the refugees' predicament, placing them at high risk of mental disorders; yet only a few refugees make use of our existing mental health facilities.

The underutilization of mental health services by minority groups in North America has been well documented (Allodi 1978). Of particular relevance to the Southeast Asian refugees are studies on the utilization of mental health services by Asian Americans in Hawaii (Kinzie 1974), California (Brown et al. 1973), Seattle, Washington (Sue and McKinney 1975), and Boston, Massachusetts (Hessler et al. 1975). Those studies have shown that Asian Americans are more reluctant to use mental health services than are Caucasian Americans. This is particularly true with the Southeast Asian refugees. Several reasons which follow may account for this phenomenon.

UNFAMILIARITY WITH NORTH AMERICAN MENTAL HEALTH CONCEPTS

Most of the Southeast Asian refugees are unfamiliar with mental health concepts as perceived and understood by North American societies. To most of the refugees, having a mental health problem is equivalent to "being insane" or "being crazy." Psychiatry is

commonly understood as a specialty of medicine that deals with the care of "insane people."

THE STIGMA OF MENTAL ILLNESS

In most Asian societies, mental patients are victims of much prejudice. The general public is frightened and repelled by the notion of mental disturbance. Afflicted individuals often feel too ashamed or embarrassed to seek help. Mental illness, especially the major psychiatric disorders, would bring shame and disgrace to the whole family. Minor psychiatric disorders are considered simply part of the human condition. According to Buddha's teaching, life is a "sea of sufferings." The strain and stress of daily living are a normal part of life and the lot of every human being. Each person should learn to cope with his or her individual problems, using his or her own resources, or accept them with resignation. No external help is expected for minor emotional problems. Family conflicts are usually handled within the small circle of relatives and friends.

THE USE OF FAMILY AND EXTENDED KINSHIP

Because of their perception of mental health and their attitude toward mental illness, most Southeast Asian refugees and immigrants continue to consider it a collective responsibility of the family to care for the sick member, as long as his or her behavior can be managed at home. Psychiatric help is sought only when the problem can no longer be kept hidden. In a study of help-seeking behavior of Chinese psychiatric patients in Vancouver, Lin et al. found that in 75 percent of the cases families had made intensive and prolonged efforts to cope with the psychiatric problem before turning to mental health agencies (Lin and Lin 1978; Lin et al. 1978).

AVAILABILITY OF ALTERNATIVE RESOURCES

Heavy Use of Medical Practitioners

Since many Southeast Asian refugee patients express psychological distress through somatic complaints, they tend to seek out medical practitioners rather than mental health professionals. Lin et al. (1978) found that Chinese Canadians tended to utilize medical treatment for psychological disturbances.

Use of Traditional Sino-Vietnamese Medicine and Folk Healing Practices

Many Southeast Asian refugees continue to resort to their own traditional cures for their health problems. The Lao-Hmong and the Cambodian people tend to believe in exorcism, whereas many Vietnamese and ethnic Chinese continue to use their traditional Sino-Vietnamese medicine (herbs, acupuncture, moxibustion, body massage and manipulation, etc.).

CULTURAL EXPLANATIONS OF MENTAL ILLNESS

Each culture has its own explanations of etiological determinants of disease. If one attributes feelings of emotional distress to physical or organic processes, one will seek medical forms of intervention. If one believes in psychological or interpersonal conflicts, psychotherapy and counseling are more likely to be accepted. Sue et al. (1976) found that Asian Americans (Chinese, Japanese, and Pilipino Americans) were more likely than Caucasian Americans to believe that mental illness is caused by organic factors. In an exploratory survey of Chinese in San Francisco, Lum (unpublished) noted that Chinese Americans believe that mental health results from the exercise of will power and the avoidance of morbid thoughts. Similarly, Arkoff et al. (1966) found that foreign-born students were more likely than Caucasian American students to believe in will power and pleasant thoughts as means of enhancing sound mental health. These studies suggest that Asian and North Americans do have different perceptions

and conceptions of mental health. The Asian group tends to perceive more organic or somatic etiology in emotional disturbance, hence they tend to seek medical treatment for emotional problems and see little relevance in Western psychotherapeutic approaches that often stress insight-oriented therapy.

LACK OF INFORMATION AND ACCESSIBILITY

Most refugees and immigrants lack information about existing mental health services and do not know how or where to go to get help. This difficulty is compounded by their inability to express their needs and their unfamiliarity with North American social services and mental health systems. Kim (1978) found that a significant number of Asian Americans did not seek help for their problems primarily because they did not know where to go for the necessary services.

LACK OF CULTURALLY APPROPRIATE MENTAL HEALTH SERVICES

If mental health services do not respond to the needs, values, lifestyles, and expectations of patients, one can expect underutilization of services, premature termination of services, and poor therapeutic outcomes. Our existing North American mental health service delivery system is ill suited to serve the Asian patient. To be of maximum benefit and value and to gain acceptance by the target population, there must be a match between the patient and the service. Any mental health service for the Asian patient should overcome the following barriers:

- Language and communication difficulties
- Lack of bicultural, bilingual staff
- Lack of cultural sensitivity on the part of service providers
- Lack of culturally relevant treatment models

TOWARD EFFECTIVE MENTAL HEALTH SERVICE FOR REFUGEES AND IMMIGRANTS

Efforts to provide mental health care for refugees and immigrants have been hampered by enormous language barriers and cultural differences, by scarce resource and by a lack of coordination and shared informatio among the organizations involved in settling the newcomers. It is apparent that our existing mental health service delivery system has been inadequate to meet the needs of the refugees and immigrants. While broad social and political solutions are required to alleviate the emotional stress of immigration, from the mental health service delivery point of view each receiving country should develop special me tal health projects to achieve the following objectives (Nguyen 1982):

1. To provide relevant direct services (emergency care, inpatient care, partial hospitalization, outpatient services, outreach programs, etc.)

2. To hire and train indigenous, bilingual, bicultural mental nealth workers and professionals who can serve as a link between the mental health facilities and the ethnic groups

3. To provide educational programs for the new immigrants on mental health and mental health services

4. To provide consultation and education for various agencies to promote cultural sensitivity

5. To carry out research regarding needs assessment; prevalence of mental illness; community perceptions of mental health; attitude toward mental illness; mental health services utilization; longitudinal study of adjustment; and development of culturally appropriate diagnostic, therapeutic, and preventive approaches that will be most effective with the specific refugee or immigrant population.

CONCLUSION

Our experience with Southeast Asian refugees and immigrants once again confirms the finding of other

researchers that the new immigrants' mental health problems are related largely to the difficulties they encounter in their adjustment to a new culture and a new way of life. Much can be done to prevent these adjustment difficulties and to foster the immigrants' mental health. The success of any resettlement program will depend largely on the adequacy of the support services provided by the receiving society, of which mental health care should be an integral part. Providing mental health services that are responsive to the needs of immigrants and refugees is indeed a great challenge for the mental health profession and for the receiving society.

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A COMMUNITY-BASED MENTAL HEALTH SERVICE TO SOUTHEAST ASIAN REFUGEES

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INTRODUCTION

The development of the community mental health movement during the 1960s took place at a time when there were few models. Although there are numerous acceptable and appropriate models, the profession is currently in the midst of constructing new models suitable for a particular clustering of new Americans: the Southeast Asian refugees. It has now been 5 years since the first major infusion of Federal funds for the development of mental health services to refugees. Despite the short period of time that service has been offered to these populations, there is a need to evaluate the models of service delivery that have been developed to serve these groups who are so culturally different from other Americans. This chapter, then, will examine the service design issues and review the development of Asian Community Mental Health Services, one of few programs almost exclusively devoted to serving Asian immigrants and Southeast Asian refugees.

In designing mental health services for Southeast Asian refugees, Asian Community Mental Health Services (ACMHS) has found it useful to consider the degree of match, or "fit," between client and provider, integration and linking of these services with other support systems, accessibility and utilization, accountability and community participation issues, staff recruitment and training, funding, and client community population characteristics. Somewhat similar concerns are put forth by Zane et al. (unpublished) and Murase (1977) with regard to designing more effective services for Asian/Pacific Islander populations. The following section reviews each of these design considerations from a general perspective and then details the development of ACMHS' refugee mental health services.

CLIENT POPULATION CHARACTERISTICS

It is imperative that providers clearly understand who makes up their potential client population in terms of geographical area, symptomatology, language or ethnic grouping, and sociodemographic characteristics. Additionally, numbers of individuals in specific target groups should be known as a means of planning staffing and resource allocations. However, in the case of Southeast Asian refugees, this kind of assessment is difficult for several reasons.

First, Southeast Asian refugees undertake both primary and secondary migration, with the latter making accurate census counts problematic. Primary migration refers to the initial resettlement, whereas secondary migration refers to subsequent relocation to another State or county for better employment opportunities or to reunite with family or social systems. Unless refugees subsequently register with local employment development departments or central intake units, it is exceedingly difficult to keep track of secondary migrants.

Where providers lack bilingual resources, it becomes difficult for them to accurately assess needs and

problems among the non-English-speaking refugees who are sampled or interviewed.

Differences in how Southeast Asians conceptualize and respond to mental disorder increase the likelihood that Western-oriented providers may misinterpret the presenting problems of refugees. Misinterpretation is greatest when there is a poor language match between client and provider.

Last, since 1975, and particularly since 1980, the ethnic breakdown of refugees has changed considerably. For instance, in 1975 and the years immediately following, Vietnamese composed about 90 percent of the total Southeast Asian refugee population. In 1981, these percentages were 72.3 percent Vietnamese, 6.4 percent Cambodian, and 21.3 percent Laotian. At the end of fiscal year 1982, the Vietnamese population ratio had decreased to 20.5 percent (Office of Refugee Resettlement 1984).

FUNDING

Once it is determined what and how extensive the problems are, the provider needs to know where funds can be obtained to develop appropriate services. The U.S. Department of Health and Human Services, Office of Refugee Resettlement, continues to provide project funds nationwide and, more important, block grants to each State's Department of Social Services (SDSS) to support an array of programs aimed at increasing the self-sufficiency of refugees through employment training, English as a second language (ESL), vocational ESL, employment support services, health care access, social adjustment, mental-health-related services, and central intake services. Prospective contractors are selected competitively for each county. Mental health-related services, unfortunately, have never assumed any priority within the Office of Refugee Resettlement or State social services.

Indeed, although California has the highest concentration of refugees in the United States, funding for mental health services has fluctuated every year since 1980. In October 1980, SDSS funded mental health

services to refugees. In January 1982, however, services were terminated. In April 1983, SDSS refunded programs. In April 1984, it again defunded services. These vicissitudes are due primarily to legislative priorities within each State and would suggest that providers must carefully diversify funding support to ensure continuity of care.

Foundation and corporate support of services is usually project oriented and short term and, therefore, unreliable as far as stablizing a system of care. In contrast, local United Way support for refugee mental health services has been steady and consistent in recent years.

ACCESSIBILITY AND COMMUNITY PARTICIPATION

To ensure meaningful utilization and design of mental health services, both community participation and accessibility issues have to be considered.

Key gatekeepers and community leaders must be identified as those who can provide initial input into service design, if they have not already defined themselves as individuals who should have input. Even though it has been some years since the beginning of many mental health services nationwide, the issue of community participation and community leader input is ongoing. Newly emerging leaders of mutual assistance associations (MAAs) all have a potential stake in services and need to have a voice in deciding how mental health services can best benefit their communities. Indeed, the Federal directive to foster self-sufficiency among refugees and the underlying message regarding the need for more leadership development, coupled with Federal allocations to each State for Refugee Incentive Grants, will generate new leaders and constituency groups within refugee communities. Consequently, existing services need to devise some means of providing a voice to new constituencies and leaders, rather than to rely almost exclusively on previous leaders.

However, the proliferation of new groups and leaders may also give rise to a greater potential for intergroup

conflict and tension, especially when there is a question of who represents whom. New groups within each refugee community certainly may represent differences in sociopolitical aims, political outlook, and advocacy strategies. Some groups are dedicated solely to the maintenance of cultural heritage and the arts; others are service advocacy oriented and still others have the long-term goal of eventual return to their countries. Each existing or potential contractor has to decide what mix of community input is most beneficial to its provision of mental health services.

Providers also must develop channels for receiving actual input from community groups, ranging from advisory status to community control of policymaking and administrative practices. Various reviews of the literature regarding community control and participation suggest that those community mental health programs with the most effective levels of community participation are those with good orientation programs (particularly for new board members); accessibility of representatives to decisionmakers; broad-based support from diverse community groups, all of whom are dedicated to the task of developing more responsive services; and a good team of administrators, board members, and community representatives who are genuinely committed to working together (Ahmed and Harm 1979; Greer and Greer 1979; Howell 1979; Morrison et al. 1978).

One means of ensuring community participation in service utilization and policymaking is to make the center geographically and physically accessible. Ideally, the center should be near, or in the midst of, refugee population clusters, which are usually around a Chinatown (particularly in the larger metropolitan areas of the United States). The center should also be near public transportation: the fact that most newly arriving refugees are without cars and are relatively unfamiliar with public transportation routes or fares, may cause them to face the prospects of using public mental health services, which are already alien to them with even greater trepidation. Greater accessibility of services, then, would help overcome some of the resistance to seeking mental health care.

MATCH OR FIT BETWEEN CLIENT COMMUNITY AND PROVIDER SERVICES

There is much evidence showing that the greater the degree of fit between client background variables and needs and the availability of appropriate resources from providers or provider organizations, the better the treatment outcome. Of course, much of the research has dealt only with limited background variables, such as race and social class of therapist and client, in predicting outcome. However, given the greater complexity of conducting similar research with Asian Americans a d Southeast Asian refugees because of vast differences in culture, language, social class, immigration status, degree of assimilation and acculturation, and other factors, we simply cannot state with the same degree of confidence what type of fit is most conducive to positive outcome. It would be safe to assume, though, that language match is essential when the client does not speak English.

In general, match factors refer to the availability of culturally relevant, linguistically appropriate services that are congruent with the world view and problem-solving strategies of Southeast Asian refugees. However, optimal fit should not be interpreted as referring strictly to a precise match between a client's traditional way of coping or of seeking outside help and the availability of traditional healers. The fact that the context of the problem is Asian American, and not Southeast Asian, must be taken into account. What may have worked in a refugee's native country may not work as effectively here because of the contextual differences.

Three strategies for maximizing the degree of fit between clients and the service delivery system have been identified by Sue (unpublished). The first strategy involves linking the client to an existing service that is already culturally or linguistically appropriate. Here, resistances to change or to help seeking are least pronounced because of the congruity of need with the resources of the provider.

The second strategy involves changing the person to fit the service. This type of change is perhaps the most common among service delivery models for

Southeast Asian refugees. Change may occur by altering client resistance to help seeking via attitudinal shifts or knowledge enhancement. Mental health education and information sharing are typical methods used. Orne and Wender (1968) have developed the "anticipatory socialization interview" for orienting clients with little or no previous exposure to or understanding of psychological treatment. The orientation includes an explanation of what to expect in psychodynamically oriented therapy, especially in treatment phases and associated issues in psychodynamic therapy. Although the actual content of such orientation is generally inappropriate for Southeast Asian refugees, the basic concept of preparing clients for a particular modality is sound. However, adaptation of an orientation program for refugees is needed. Aoki (unpublished) has suggested various modifications for Asian Americans.

The third strategy involves changing the provider organization or the provider. This process is certainly the most challenging and the most difficult, especially as it stirs up organizational resistances to shifts in treatment orientation. Change may occur in the form of increasing or establishing linguistic resources, improving the cultural awareness of therapists toward refugees, incorporating the use of indigenous healing methods (spiritualism, acupuncture, herbal treatments, etc.), modifying existing Western orientations slightly to create better cultural fit, or engaging in more outreach and supportive services to refugee communities.

In designing appropriate services, then, providers can quickly assess their activities in each of these three areas and identify priorities for change. Client and organization/provider changes are equally important if a total systems design is to work.

INTEGRATION AND LINKING OF SERVICES

Another important design consideration is the integrating and linking of refugee mental health services with the broader array of health, social, other mental health, and employment-related support services (e.g., ESL and vocational training), and the linking of these services with the natural support systems of refugee communities.

As newcomers, refugees have diverse needs and problems, which also tend to be more complicated than those of immigrants who by and large come to America by choice. Service providers can well testify to the multitude of interrelated problems of refugees. Many of those who utilize health care screening and treatment services have experienced significant symptoms of emotional trauma. About 90 percent of Southeast Asian refugees experience some form of mental disturbance meriting professional attention. In addition, 10 percent suffer from serious mental disorders and 50 percent have subacute emotional problems (ASIAN 1983). It is therefore incumbent upon providers within a common service area to coordinate services to refugees as a means of improving referral and treatment. Coordination between health and mental health services is especially appropriate, since many refugees tend to conceptualize mental health problems in somatic terms.

Second, although much attention has been devoted to efforts at integrating and linking with traditional health, mental health, and other support services, there has been little mention of the importance of integrating mental health services into refugees' natural support systems such as their MAAs, family or village clan structures, or indigenous support services (e.g., monks, priests, spiritual healers, "kru bouraan," or herbalists). This aspect of linking will become increasingly vital as MAAs assume greater leadership roles within their own constituency groups and lend direction to groups eager for articulated guidance from those well versed in advocacy and political action. Incentive grants from the Office of Refugee Resettlement intended to develop leadership among refugee communities and MAAs will expedite a natural evolutionary process and increase the importance of early linking.

If providers want to increase the appropriate utilization by refugees of mental health services by altering client expectations and attitudes, then networking with the refugees' natural support systems and their leaders is vital. However, this is not to say that concentrating on altering or influencing the potential help seeker is the preferred or primary approach to increasing the match between client and provider. Rather, this activity should be an important element in any design effort.

RECRUITMENT AND TRAINING

Ever since the origins of the Federal community mental health movement in the 1960s, observers have pointed to the acute shortage of trained professionals and paraprofessionals. This call for more human resources was further echoed by the 1978 President's Commission on Mental Health and, specifically, by the various ethnic minority subpanel task forces, which felt that services to special population groups were inadequately funded and developed. The President's Commission recommended increased recruitment and training of ethnic minorities to work in the mental health field. This recommendation must be underscored with respect to Southeast Asian refugee communities.

There is an acute and serious shortage of trained refugee professionals in psychiatry, psychology, and social work. In the San Francisco Bay area, where there are an estimated 100,000 Southeast Asian refugees, there are several psychiatrists, only one refugee psychologist (albeit nonclinical), and perhaps fewer than a half-dozen social workers. There is only one (Vietnamese) refugee psychiatrist for the entire East Bay, which consists of two counties and some 23,220 refugees.

This shortage of professional staff is compensated for by the greater availability of paraprofessionals who function as interpreters, translators, and supportive counselors. However, there is a general problem finding paraprofessionals with previous training in or exposure to mental health concepts and methods. Recruiting and training Vietnamese personnel is generally less of a problem than for other refugee communities because of their greater numbers and longer history in the United States.

Recruitment efforts are complicated by the refugee communities' general lack of understanding of mental health concepts and of the role of the mental health counselor. However, recruitment is easier if the job emphasizes community organizing and advocacy skills, thereby enabling providers to draw applicants and volunteers from the MAAs and their leadership pool.

Once personnel are recruited, there remain the questions of what type of training would be appropriate, in what areas, with what content and processes, and for what purpose? Do existing trainers have an adequate understanding of the cultural values and expectations of refugees to train refugee paraprofessionals? Will these trainers lapse into the trap of ignoring cultural considerations in mental health interventions? For instance, in Laotian culture and society, women occupy a lower status than men. This status differential must be considered when structuring family and marital therapy. Without the involvement of refugees in an advisory or consultative capacity in designing training programs, it would be difficult to develop an effective orientation and, consequently, an effective service.

STRUCTURE OF SERVICES

The structure of services must consider whether refugee mental health care should be an autonomous part of any agency effort; whether it should be, for instance, on a project-by-project basis with little identification with the mental health center, as a way of destigmatizing help seeking, or an integral part of the agency. If it is on an autonomous basis, should the project have its own board of advisors made up primarily of refugees? If it is to be an integral part of the agency or center, how many refugees should sit on the board of directors and how much control will refugee representatives have in setting policy? Also, some decision has to be made regarding whether preventive interventions (consultation, education, information and referral, and community organization) are more relevant and important than clinical services, or vice versa. This decision also affects recruitment, hiring, and training efforts.

A survey by the Pacific Asian Mental Health Research Project (Egawa and Tashima 1981) on mental health service delivery models to Asian/Pacific Islander communities shows that most services are clinical in orientation and are structured as projects due to the unstable funding base of refugee services nationwide. Most of

these services rely on paraprofessionals and nonprofessionals, who are also primarily Vietnamese.

A COMMUNITY-BASED MODEL OF MENTAL HEALTH SERVICES: THE CASE OF ASIAN COMMUNITY MENTAL HEALTH SERVICES

POPULATION CHARACTERISTICS OF THE SERVICE AREA

The service area of ACMHS spans two adjoining San Francisco East Bay counties, Alameda and Contra Costa. The total population is 1,761,764, according to 1980 U.S. Census Bureau data, with Alameda accounting for 1,105,379 residents. Ethnic minority populations make up some 32 percent of the total in the East Bay. Asian/Pacific Islander populations account for 7,202 residents in Alameda County and 32,143 in Contra Costa County.

Southeast Asian refugees generally reside in Oakland, a major city directly opposite San Francisco across the bay. There is, however, a growing population in Richmond, 12 miles north of Oakland in west Contra Costa County. As of December 1982, there were an estimated 23,200 Southeast Asians in both counties, the majority of them (16,168) in Alameda County. Indeed, the large cluster of refugees in Alameda County makes it one of the most heavily impacted counties in the United States. Most of these refugees are Vietnamese or ethnic Chinese-Vietnamese (11,641, or 78 percent), although there are growing numbers of Laotians and Cambodians.

Although no comprehensive assessment of mental health problems has been conducted countywide, an examination of utilization records at ACMHS, as well as interviews with key informants, suggest that mental health problems are widespread, particularly among unemployed or underemployed refugee males, whose traditional status within the family has undergone major change.

Throughout the past 5 years of serving Southeast Asian refugees, ACMHS has seen an increasing number of

cases of family violence and disruption. The Oakland Police Department reports a significant increase in summonses issued to Southeast Asian youths for delinquent or antisocial conduct.

Various public health and mental health surveys estimate that 60 to 90 percent of refugees in the bay area suffer from significant emotional disturbances, usually of a reactive nature. This local picture corroborates independent studies and assessments that demonstrate a clear link between radical cultural, social, and economic changes and the potential for developing significant mental and physical disorders (Chu 1972), as well as a higher incidence and prevalence of mental disorders (Aylesworth et al. 1980; Lin et al. 1979).

An analysis of more than 200 refugee cases at ACMHS indicates that 52 percent of clients suffering from emotional disturbances are between the ages of 18 and 50, the most productive years in one's lifespan, and that 63 percent of them are males. Forty of the patients have been diagnosed as having severe psychotic disorders, profound depression, or crippling anxiety attacks; 190 of the patients exhibit more moderate disorders, such as reactive depression, situational anxiety, and episodic psychotic reactions resulting from social adjustment difficulties, family problems, or generalized feelings of distress associated with resettlement and unemployment. Due to extremely limited inpatient services for Southeast Asian refugees, ACMHS refugee staff provides periodic home or office counseling and social networking to minimize the need for psychiatric hospitalization. More acutely disturbed patients are generally referred to Highland General Hospital, the local county facility in Alameda County, or to Contra Costa Hospital.

FUNDING

Funding of our refugee mental health services has had a checkered history. Initial funding was received from the California State Department of Mental Health by way of its subcontract arrangement with the Department of Social Services. Hence, an outpatient and prevention program was implemented in October 1980 to cover

two adjoining counties. However, due to Federal cutbacks, the State legislature developed budget control language for Federal fiscal year 1981-82 that eliminated mental health and social adjustment services as of January 1, 1982. In effect, all previously contracted programs either had to close their doors or find other means of continuing services.

Due to vociferous protest from groups throughout the State, the SDSS reallocated funds in April 1983 for mental health and social adjustment services. At this time, ACMHS again received a contract to serve two counties. Unfortunately, the State later faced another deficit, and exactly 1 year later, mental health programs were defunded. As of this writing, there is no provision or plan for SDSS to reconsider funding of mental health services until at least April or October of 1986.

The lack of consistency in SDSS support of mental health services has created tremendous pressures on community-based mental health programs to diversify funding or risk discontinuous, fragmented care, causing confusion among the client community. In response to funding instability, ACMHS has developed a long-range plan for offering services to refugees by securing other sources of both continuing and project-related support.

First, ACMHS has received Short-Doyle[1] funds from Alameda County in the amount of $43,000 for fiscal year 1984-85, the second year in a row that Short-Doyle funds have been allocated. Second, the United Way of the bay area has allocated about $69,000 for fiscal year 1984-85 for refugee and immigrant mental health services to cover two counties. These two funding sources provide a more stable base of support and ensure continuity and consistency of care that were previously lacking. Furthermore, project-related support was received from the State Department of Health Services to foster closer links between mental health and health care services in Alameda County during this past year; funds from the State Department of

[1] The California Short-Doyle Act provides for a State/local fund formula to develop and maintain mental health services in local communities.

Mental Health, Mental Health Promotion Branch, in fiscal year 1981-82, to develop mass media-oriented mental health promotional materials for Chinese, Samoan, and Vietnamese communities in the State of California; from the San Francisco Foundation to help support outpatient services in fiscal year 1983-84; and from Contra Costa County Mental Health Services to support a partial outpatient clinic service consisting of interpretation support for the psychiatric staff during fiscal year 1984-85.

Our experience with funding sources has created a stronger commitment to diversify funding support for mental health services for Southeast Asian refugees and to develop an integrative approach to service.

STRUCTURE AND STAFFING OF MENTAL HEALTH SERVICES

ACMHS has developed an approach that incorporates health professional/paraprofessional retraining, business development assistance, case management for the developmentally disabled, and mental health care. This approach interrelates the creation of new jobs through new business enterprises, employment of individuals in existing jobs in the public sector, and mental health services. The mental health component is by far the largest and most central element of this approach.

The mental health component consists of five refugee paraprofessional staff members (two Vietnamese, two Laotians, and one Cambodian), one Vietnamese psychiatrist, and one Afghani consultant. In addition, a Chinese-speaking psychiatrist provides consultations and counseling to refugees in our Contra Costa County partial outpatient clinic through refugee staff interpreters. Other counseling support is available from a licensed clinical psychologist, who is also the Director of Clinical Services at ACMHS.

These staff members provide a range of outpatient counseling and indirect services. Outpatient care consists of psychotherapy with individuals, groups, and families, and may be either short term or long term. Psychiatric consultations are available, as are monitoring

and prescription of medication. Psychological and psychiatric evaluations are provided either by a psychologist or by one of two staff psychiatrists. Overall, the bulk of services are provided by the refugee paraprofessionals.

Treatment modalities are primarily oriented toward problem solving and are prescriptive in nature, which is more culturally congruent with client expectations. Since most of our refugee clients suffer from depressive symptomatology, a more directive approach is warranted and has proven to be fairly effective. As previous reports have indicated (Kinzie et al. 1980), many refugee clients think of mental health staff as "doctors" who should prescribe a course of treatment. A common question asked initially of our staff psychiatrist and our paraprofessional staff members when services began in 1980 was, "Are you a doctor?" Furthermore, many did not think of the psychiatrist as a "real doctor" because he did not have the accouterments of a physician, e.g., a white lab coat or a stethoscope.

Unlike many clinical services offered to refugees who were surveyed by the Pacific Asian Mental Health Research Project (Egawa and Tashima 1981), an NIMH-funded research center for Asian/Pacific Islander American studies, ACMHS places emphasis on preventive interventions. Thus, refugee staff members allocated approximately 50 to 70 percent of their time to providing indirect services, including mental health consultation, education, information and referral, community organization and client advocacy, and outreach and support services.

This structuring of services results from several factors: 1) there is generally less cultural and social stigma associated with indirect help seeking via workshops or seminars, consultation, or social adjustment guidance; 2) many refugee clients are still unfamiliar with mental health concepts and resources and are not ready to utilize outpatient services; 3) there is a great need to organize refugee communities by fostering leadership and advocacy capabilities and by developing other support services; 4) initial funding instability necessitated a focus on long-range planning via prevention programs aimed at strengthening community

networks and coping resources within groups, which tend to be less costly than labor-intensive psychotherapy and counseling services; and 5) ACMHS had at its disposal several acknowledged leaders of the Vietnamese, Laotian, and Cambodian communities in the East Bay who felt that their people could benefit more from prevention-oriented programs that help strengthen the helping capacities of other providers through mental health consultation.

A key element of our indirect services is the engagement of MAAs, which are refugee-formed and administered self-support organizations, in the delivery of services. These MAAs have played a critical role in disseminating information on services and activities to their constituencies and have helped in outreach and referral for others at risk. ACMHS has actively recruited and trained identified leaders of these community groups in mental health interventions. This link has facilitated entry into the refugee community and has fostered trust between provider organizations and clients. This approach also enables clients to discuss community and social problems directly with leaders of the MAAs and with experienced refugees. More important, this relationship enables the agency to design specific interventions that are effective and well received by incorporating the ideas of leaders.

A few preventive intervention programs are noteworthy. Several years ago, ACMHS received a State contract to develop mass-media-oriented mental health promotional materials for the Asian/Pacific Islander population. Groups targeted for intervention included Chinese, Samoans, and Vietnamese. Printed and visual media approaches were developed, both with the theme, "Friends can be good medicine." The printed booklets highlighted the cultural values and strengths of each community and attempted to present favorable and accurate portrayals of Asians and Southeast Asians. The visual media consisted of 30-second public service announcements to be aired over local television stations, ensuring a large audience. The development of the visual media was based on findings that on any given day, 65 percent of Americans watch television, that most watch it for 15 hours a week (Marshall 1977), and that television is most likely to be cited as a major

source of information (Roper Organization 1979; NIMH 1982). Evaluation indicated that the materials were well received by the target communities and that more information and similar approaches were desired.

Another prevention program involves the development of conflict resolution training in local high schools. ACMHS is presently working with members of community conflict management teams or organizations in developing models to resolve conflict between Southeast Asian refugee youths and other, primarily ethnic, minority youths. There is broad-based endorsement for this project by the Oakland Police Department, the U.S. Department of Justice Community Relations Service, the Oakland Public Schools, refugee community leaders, and members of local community organizations. Thus far, a few model programs have been implemented nationwide, but we are not aware of any that specifically focus on reducing violence and conflict between Southeast Asian refugees and nonrefugee youths in primary and secondary schools. The basic model that will be developed involves identifying and training youths to be monitors and conflict management facilitators who will work closely with school authorities. This team, made up of both refugees and nonrefugees, will work to resolve conflict before it develops into open confrontation or physical violence. Rumor monitoring and control is a vital element. In addition to conflict management, the team, with an associated cadre of professional consultant from ACMHS and other ethnic minority organizations, will provide cross-cultural awareness training. It is believed that some of the hostility between ethnic groups stems from misperceptions and misunderstandings that can be partially corrected if potential combatants are sufficiently aware of the pressures encountered by, and the social sensibilities of, the other group.

RECRUITMENT AND TRAINING

Recognizing that starting mental health services for refugee communities was a difficult and challenging task, ACMHS tried to recruit applicants with demonstrated leadership abilities and experience who could function as advocates, clinicians, and preventive

service strategists. ACMHS managed to recruit and hire four refugee paraprofessionals in 1980 who met our criteria and expectations.

Training was provided in basic community mental health concepts and in the principles and practice of psychotherapy and counseling. Weekly case conferences made it possible for participants to consider cross-cultural issues in counseling and to integrate Southeast Asian cultural issues into their counseling. This integration did not mean, however, that refugee paraprofessionals applied what they knew about indigenous healing practices into their work, as they were not specifically trained in native healing arts. However, their knowledge of cultural variations in etiquette and nuances of family and individual communication styles and behavioral patterns greatly facilitated their work with refugees. This knowledge was openly shared with other Asian social work staff as a means of providing cross-training.

MATCH OR FIT BETWEEN CLIENT AND PROVIDER

Services were consciously designed for maximum fit between client needs and expectations and the resources of the organization. This was done largely by recruiting and training the refugee staff, providing bilingual and bicultural mental health services, training the non-refugee staff, and periodic evaluations aimed at improving responsiveness and effectiveness of services. But much work has yet to be done. We presently do not have a formal system of indigenous healing modalities that we can offer the refugee client. However, ACMHS is investigating the feasibility of providing acupuncture services and, possibly, making available natural healers, such as the "kru bouraan" among the Khmer, to augment clinical and prevention interventions.

RECOMMENDATIONS

Based on 5 years of providing community-based mental health services to Southeast Asian refugees, a number of possibilities for improvements suggest themselves:

1. The mental health department within each State should assume greater responsibility for allocating funds to local counties and to contractors for the provision of mental health services to refugees. States cannot rely primarily on the Office of Refugee Resettlement to address mental health needs of each State, particularly since that office has already issued a policy statement to each State emphasizing employment-related service support and stressing mental health services support only if each State can demonstrate a link between such services and the goal of increasing economic self-sufficiency.

2. Community-based agencies that are either contemplating providing or are already providing services to refugees should consider as broad a base of funding support as possible to ensure greater stability and consistency in service delivery. The acquisition of project funds, although short term, may allow the contractor to implement innovative programs not ordinarily feasible with traditional means of support, such as county or State governments, which generally prefer less experimental clinical interventions. At least one or two long-term sources should be included in the funding portfolio, one of which could be the State Department of Social Services.

3. Community-based services are best received if they include a fairly broad range of care and programs. A cluster of integrated programs can include mental health services as the core program, with augmentation of employment support services, services to the developmentally disabled, health care services, or ESL instruction. Service clusters will enable the agency to reach populations not ordinarily reached through mental health interventions alone, such as the developmentally disabled or the chronically or acutely physically ill. The service clustering also promotes the perspective that human problems are often interrelated and call for integrated approaches to problem solving.

4. There must be meaningful refugee community participation in service delivery planning and policy

formulation. Input can occur at various levels, preferably at all levels, and can include participation on boards of directors, advisory committees, and on the staff. Although staff representation alone is inadequate and potentially frustrating, it can also be meaningful if staff members are acknowledged leaders in their communities. In such circumstances, the traditional hierarchical relationships between employer and employee are not so clear cut, and communication can emulate communications among colleagues. Even if staff members are not acknowledged leaders, their positions as counselors and preventive intervention strategists give them relatively high status in their communities.

5. Organizations may consider a plan for systematically identifying and training refugee community representatives in leadership and advocacy skills. These representatives will be better prepared to assist the center in developing more effective and responsive refugee mental health services and to help their own communities in developing natural support systems. Furthermore, they will serve an important role as gatekeepers of their communities and assist in accessing target groups for preventive interventions. If there is sufficient trust, planners can also solicit more informed opinions about the adequacy of various programs and approaches and develop mechanisms for participation in service design.

6. Centers should develop an ongoing dialog with MAAs or other systems of community support. MAAs can help formulate programs and services, and can help publicize the availability of services to their constituencies. MAA representatives could also help explain the purpose of various services as a means of increasing the appropriate utilization of programs.

7. Wherever feasible or practical, the community-based service should incorporate indigenous healing practices into its armamentarium of care. Some refugee community leaders have already pointed out that traditional Western psychiatric approaches are inappropriate for and unacceptable to many refugees

and suggest a choice between indigenous and Western healers. Of course, those who are motivated to seek help from traditional healers will do so anyway, with or without the intervention of the agency. Nevertheless, the openness to consider other forms of treatment at least conveys a sense of cultural sensitivity to the refugee client that may help to create trust and minimize resistance to seeking help.

8. More research is called for to obtain much-needed information about the mental health problems of refugees. More knowledge about their attitudes toward help seeking, the impact of mental illness on refugee families, coping and help-seeking strategies, what methods work most effectively and under what conditions is needed. Further, information on what preventive interventions are most effective in reaching the community and in reducing psychological trauma and the negative consequences of resettlement would be useful.

CONCLUSION

The uncertainty of continued Federal support for mental health services to refugees (via the U.S. Office of Refugee Resettlement) and the prospects of specially designated funds being mainstreamed ought to engender considerable anxiety among community-based providers of service regarding the long-range impact on planning and service delivery. There is a strong likelihood that within a few years funds designated through the Office of Refugee Resettlement will be mainstreamed into traditional departments such as the National Institute of Mental Health. Mainstreaming or block granting will almost surely mean a reduction in total dollars for refugee mental health care.

Given these prospects, it becomes all too important for providers to plan now for the long-range continuation of basic, as well as innovative, services. Funding diversification should be the first order of business, preferably through the garnering of funding from those departments or agencies that have historically and legislatively been responsible for mental health care.

However, such support from governmental bodies may also mean that more constraints will be placed on innovation and experimentation in service delivery. The fact that we simply do not know enough about whether traditional Western treatment methods work effectively with Southeast Asian refugee clients is a persuasive argument for innovation and for incorporating indigenous cultural concepts and healing methods into the Western-oriented community mental health center.

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Southeast Asian Mental Health: Treatment, Prevention, Services, Training, and Research T. C Owan, editor
National Institute of Mental Health, 1985

INPATIENT PSYCHIATRIC SERVICES FOR SOUTHEAST ASIAN REFUGEES

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INTRODUCTION

In recent years, a variety of Southeast Asian projects offering bilingual, bicultural services has been developed through demonstration project funding from the Department of Health and Human Services, Office of Refugee Health, Social Security Administration. The projects have covered a wide range of services, such as outpatient counseling, health screening and referrals, training of paraprofessionals to assist professionals treating patients with mental health problems, consultation with health and human service facilities, linkage between social services and mental health services, and consumer education and advocacy.

Unfortunately, these demonstration projects on mental health services were aimed almost exclusively at outpatient services, with little or no attention directed to the critical need for inpatient services for Southeast Asian refugees, especially for those with severe psychiatric illness.

The purpose of this chapter is to illuminate the importance of integrating inpatient services into the overall mental health services delivery that is targeted to the Southeast Asian refugees. The discussion opens with a brief overview of our program's goals, setting, treatment philosophy, and clinical services. Characteristics of Southeast Asian refugee patients treated by our program will then be described. This chapter closes with several observations about the elements that contribute to our program's success and offers suggestions for future program planning for inpatient psychiatric services for the high-risk Southeast Asian refugees.

PROGRAM DESIGN AND ACTIVITIES

THE SETTING AND PROGRAM GOALS

Our program is located at San Francisco General Hospital, California. According to the 1980 census, 21.3 percent of San Francisco's 685,000 residents are Asian Americans. This is the largest percentage of Asian Americans within a total population of any major city in the United States. The 1980 census also indicates that there are diverse Asian subgroups in San Francisco and that there has been a dramatic increase in the number of new immigrants (Pilipino and Korean) and new Southeast Asian refugees (Vietnamese, Cambodian, Hmong, and Laotian). Collectively, they represent 32.5 percent of the 147,426 total Asian American population. According to Murase et al. (1981), the current estimate for Southeast Asian refugees in the greater San Francisco Bay area is 39,500 to 42,500. San Francisco General Hospital is the only public hospital in the city to serve urban poor, chronically ill, numerous ethnic/minority groups, and refugees. The Department of Psychiatry at San Francisco General is mandated to provide emergency, inpatient, and consultation/liaison psychiatric service to teaching hospitals of the University of California at San Francisco. The department also provides training for mental health professionals. The Asian/Pacific Islander American psychiatric inpatient program is located in one of the four locked inpatient units at San Francisco General, with 20 beds. Our program was begun in March 1980

and was believed to be the first and only inpatient psychiatric program in the United States designed especially for Asian Americans. Program activities are designed to address the following specific goals:

1. Provide culturally relevant clinical inpatient services for the Asian American residents of San Francisco

2. Provide multidisciplinary training opportunities for students and clinicians interested in inpatient services to Asian American patients

3. Provide consultation services to other departments and agencies

4. Conduct mental health clinical research on the Asian American population

CLINICAL SERVICES

Staffing

Studies have demonstrated that service utilization is greatly enhanced when bilingual, bicultural personnel are employed. Ethnic, linguistic, and cultural similarities between client and therapist decrease the dropout rate and improve the effectiveness of care (Lee 1980, 1982a; Wong 1982). During the program's first 4 years, the highest priority was to hire a bilingual, bicultural Asian staff and faculty. Currently, over 20 staff members and trainees are Asian Americans. Administrative and clinical leadership are provided by the program director and the senior attending physician, both Asian Americans. Other Asian staff consist of one physician, three social workers, six nurses, one occupational therapist, two psychologist/researchers, one unit clerk, and five Asian student interns. A majority of our staff were born, raised, and educated in China, the Philippines, or Vietnam. They are very familiar with the cultural background of the patients, since many of them are immigrants or refugees themselves. For example, five staff members lived and worked in Vietnam. Four of them were refugees who fled the war. Their personal experiences have enriched other staff

members' understanding of the emotional traumas and struggles of the refugee population in our program.

Language Coverage

Ability to communicate with monolingual Asian patients in their own languages is a vital part of our program. Currently, the program's on-site staff can communicate fluently in seven Asian languages (Cantonese, Mandarin, Shanghaiese, Chungsunese, Toisen, Pilipino, and Vietnamese). Two other programs at San Francisco General Hospital also provide language backup for our patients: A total of 6 Southeast Asian refugees are employed in the hospital's interpreter services and another 10 health workers (5 Vietnamese, 3 Cambodians, and 2 Laotians) are employed in the Refugee Medical Clinic. A training manual for interpreters working with psychiatric patients has been developed by our program to improve the quality of interpreting service. A communication skills workshop is also available for clinicians who want to improve their interviewing skills with the help of interpreters. In addition, two Asian outpatient community mental health programs, one day treatment center, and three residential programs employ a number of Southeast Asian professionals or counselors. They visit their patients during their hospitalization in the psychiatric unit and provide much-needed followup services to our patients after discharge. According to our experience, the staff's ability to speak with patients and their family members in their primary language is essential in establishing a therapeutic relationship, gathering accurate data, and formulating culturally relevant treatment plans for the patients.

Diagnosis and Treatment

In most of the acute, short-term inpatient psychiatric hospitals, mental status examination is the major form of diagnosis, and rapid stabilization with medication is the major form of treatment. Based on our clinical experience with Asian and Southeast Asian refugees, this solely biomedical approach is not sufficient and, at times, may lead to inappropriate diagnosis and ineffective treatment. In our program, we attempt to

incorporate the ethnomedical model, which is deeply rooted in the Eastern cultures, into our clinical practice. Specific approaches to diagnosis and treatment based on understanding of the cultural expression of mental illness are strongly emphasized. It is beyond the scope of this chapter to describe the complexities of evaluation and treatment in detail; however, the following therapeutic strategies may be of interest to mental health professionals:

1. When taking a thorough case history, the clinician should not concentrate solely on recent symptoms and traumatic events. A chronological approach, focusing on three major aspects of the patient's psychosocial history, is needed: 1) premigration experience: family life in the home country, education and employment status, support systems, problems and stress, war experiences, past psychiatric history, and coping patterns; 2) migration experience: the escape process and life in a refugee camp, why the patient decided to leave, who stayed behind and why, who sponsored the trip, the means of escape, and some of the traumatic events in migration and in the refugee camps; 3) postmigration experience: language, cultural, financial, and racial problems encountered in the United States; expectation and disappointments; successes and failures; and hopes and fears.

2. Southeast Asian refugees tend to retain their traditional cultural beliefs and health practices regardless of the degree of assimilation into the host society. Although there is no one set of beliefs held universally by all Southeast Asian refugees, in general their beliefs involve the concept that disease is caused by an excess or deficit of yin or yang principles. Supernatural intervention by demons, malevolent spirits, wind, etc., is still perceived by many patients as the major cause of mental illness. They frequently visit traditional herbal doctors, temple mediums, and folk healers who know little of Western medicine. In our clinical practice, it has been helpful to explore the patients' and the family members' conceptional orientation of mental illness, their health seeking behavior. and their expectations of treatment by Western clinicians.

3. Several unique assessment tools are used in the program to identify cultural expression of mental disorders. For example, we use the Vietnamese Language Depression Rating Scale developed by Kinzie et al. (1982) to evaluate the severity of depression in Vietnamese patients on a regular basis. The Diagnostic Interview Schedule and other types of psychological tests also are very helpful, especially when the tests are administrated by bilingual therapists. Because many refugees are not used to direct verbal expression of emotion and thoughts, "amobarbital interviews" are used quite frequently in the unit, especially with patients with a diagnosis of major depression.

4. A physical examination adds a great deal to the evaluation. If the primary therapist is not a psychiatrist, a physician should be assigned to perform a medical checkup and answer any questions regarding medications. Since refugee patients are usually admitted with many physical complaints, they are frequently referred to other medical units for further testing and treatment.

5. The most effective therapeutic agents for the refugee patients are the well-trained, empathetic, indigenous refugee staff members. Besides assisting in treatme ., they also serve as extended family members to the patients and their families.

6. A crisis and symptom-oriented approach is used in our program. It is not aimed at uncovering personal, intrapsychic dynamics; rather, our goal is to understand the symptoms and difficulties as perceived by the patient and to focus on symptom reduction through medication, supportive individual and family therapy, and a structured milieu therapy program.

Family Involvement

Family assessment, intervention, and education are strongly emphasized in our treatment program. Because of the traditional importance of the family in Asian culture, family members are encouraged to participate

in our family intervention program. Family assessments based on a social systems approach (Lee 1982a) are used frequently by clinicians to gain understanding of family dynamics. As most of our patients are acutely psychotic during admission, the history and information provided by family members is very important. Recent work by McGill et al. (1983) showing the importance of family education in reducing relapse in schizophrenic patients has encouraged us to increase our efforts to educate families in the management of our patients. The Department of Psychiatry has recently founded a Family Intervention and Education Task Force. We are in the process of developing family education materials in different Asian languages to enhance the family members' understanding of psychiatric disorders.

Medication

As suggested in some previous research studies, dosages of antipsychotic and antidepressant medications based on Caucasian patient populations may not be readily applicable to Asian populations (Chiess and Katz 1979; Lin and Finder 1983). For many of our Southeast Asian refugee patients, dosages of psychotropic drugs needed for target symptom remission is less than standard dosage ranges. A great number of our patients believe in Chinese herbal medicine and are unfamiliar with Western medicines and their side effects. Getting a detailed medication history, and educating the patient and family members about Western medications are essential in the treatment of refugee patients.

Milieu Program

The milieu and group activities in our program are designed to provide multilingual, multicultural diagnostic and therapeutic services in a short-term inpatient unit. Program activities can be divided into two major groups: activities offered to all patients on the unit and activities designed especialiy for the monolingual patients.

All patients are encouraged to join the general group activities, which include community meetings, self-improvement meetings, small discussion groups, patio activities, recreational groups, medication groups, occupational therapy groups, and special issues groups. Asian patients have opportunities to interact with non-Asian patients and with staff. Their participation in such activities is made possible with the help of our bilingual staff members and volunteers. For example, at community meetings, which are held three times a week, staff members simultaneously translate the discussion into several Asian languages. When monolingual Asian patients are selected as patient community meeting leaders, they conduct the meetings in their native language, while the staff leader translates simultaneously into English. Occupational therapy activities are conducted by a Cantonese-speaking occupational therapist and a Cantonese/Vietnamese-speaking assistant. Both provide Asian patients with much-needed daily support during hospitalization.

For many of the refugees and less acculturated patients, special efforts are made to create a therapeutic living environment that is more compatible with their cultural backgrounds. For example, at the time of admission, whenever possible, bilingual staff members conduct the admission procedures and orientation to the unit. Patient brochures, descriptions of patients' rights, legal forms, community meeting agenda, and unit signs and schedules are translated into several Asian languages. Small discussion groups with members who share the same language offer refugee and new immigrant patients opportunities to provide emotional support to each other and to minimize their fear and sense of helplessness about being on a locked psychiatric unit. Discussion content usually includes past life experiences in home countries, separation and losses during migration, joys or disappointments of being new immigrants or refugees, family and community perception of mental illness, past hospitalization and treatment experiences, attitudes toward herbal medicine and Western medicine, questions about diagnosis, and discharge planning. The refugee patients become much more verbal, open, and expressive in small groups that are conducted solely in their native language. They participate actively in the activities with which

they are familiar, such as table tennis, cooking, meditation, physical exercise, and English tutoring. They appreciate the availability of newspapers, books, and music from their ethnic communities or home countries. The unit has some aspects of an oriental decor, and rice and tea are routinely served to Asian patients with their regular meals. The staff frequently prepares oriental food during weekend brunches. Family members are allowed to bring in home-cooked meals during their visits.

Community Linkage

During the past few years, the program has developed extensive liaisons with posthospital care agencies. Our "improved" patients usually are referred to outpatient community mental health centers, day treatment programs, residental care facilities, and board and care homes. Patients who need long-term hospitalization are often referred to Napa State Hospital and other locked facilities, all of which are located outside San Francisco. Whenever possible, we try to place our Southeast Asian refugee patients in community settings, where bilingual, bicultural mental health staff are available. In our experience, several linkage activities have been very helpful in the facilitation of a smooth transition for both the patients and the agencies:

1. Weekly visits by our inpatient staff to an outpatient clinic and treatment program in Chinatown. Our staff has the opportunity to give progress reports on our patients and receive input regarding treatment and discharge planning from an outpatient therapist.

2. Weekly inpatient hospital visits by outpatient staff. The liaison staff attends our team rounds and visits with patients who either will be returning to the clinic or will be referred there as new patients. Other outpatient therapists are encouraged to visit their hospitalized patients and attend case conferences.

3. Preplacement visits to treatment facilities prior to discharge. Bilingual staff are available to escort our patients to the posthospital care agencies.

4. Availability of staff in a "bridge position." Staff members who work part time in inpatient care and part time in community agencies and have a knowledge of both settings have been very helpful. Currently, three Asian staff members and students are working in our program and other Asian residential facilities.

TRAINING AND RESEARCH ACTIVITIES

As one of the training sites of the Department of Psychiatry, University of California at San Francisco, our program offers unique learning opportunities for mental health p.ofessionals who are interested in working with Asian immigrant and refugee patients. Since 1980, 80 students received their training in the unit, and 50 percent of the trainees were Asian. The trainees include psychiatric residents, psychology fellows, social work students, medical students, and occupational therapy interns. Supervision is provided by experienced clinicians, the majority of whom are Asian Americans.

As one of the four units of the Department of Psychiatry, San Francisco General Hospital, our staff participates in several department-wide research projects, such as the Depression Prevention Research Project and Treatment Strategies in Schizophrenia. Current research activities with specific forms on Asian American populations include the development of a comprehensive diagnostic and treatment data base system, development of program evaluation criteria, and a research project focused on the conceptionalization of mental illness and the help seeking patterns of refugees from Vietnam. Other future activities will include a psychopharmacology study and the development of a preliminary Chinese depression scale. Consultation available from two Asian researchers has been helpful in planning such activities.

CONSULTATION SERVICES

The program faculty and staff offer a wide range of consultation services to other clinicians who are interested in improving their services to Asian and refugee patients. Consultation services are provided in the

form of individual consultation, group consultation, inservice training for staff members, workshops, program consultations, etc. Consultation services are frequently requested by the jail psychiatric ward, medical inpatient units, other psychiatric hospitals, and posthospital care agencies.

PATIENT CHARACTERISTICS

ADMISSION AND REFERRAL SOURCES

Since the establishment of the program in 1980, the percentage of patient episodes involving Asian Americans on our unit has increased from 60 patients, or 10 percent, in fiscal year 1981, to 164 patients, or 34 percent, in fiscal year 1984 (see table 1). Of the total Asian American patients in fiscal years 1982-83 and 1983-84, 71, or 22 percent, are Southeast Asian refugees.

Who are the Southeast Asian refugees in need of acute psychiatric inpatient hospitalization? The data from fiscal years 1982-83 and 1983-84 available on Southeast Asian patients' admission status provide some interesting observations.

- Sixty-nine percent of the patients are involuntarily committed due to the patients' danger to self, danger to others, or grave disability, which California law defines as an inability to provide for food, clothing, and shelter.

- Ninety-seven percent of patients are admitted with mental disorders. This percentage is slightly higher than for white, black, Latino, and other Asian populations (90, 88, 88, and 95 percent, respectively). No patients are admitted with alcoholism or drug abuse as their primary presenting problems.

- Major sources of referrals were the police (15 percent), community mental health centers (21 percent), other psychiatric hospitals (18 percent), and medical units (8 percent).

TABLE 1.--Ethnic distribution of patients by fiscal year

Fiscal year	Asian		Black		White		Other	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1980-81	60	10	186	31	312	52	42	7
1981-82	122	22	139	25	264	48	24	5
1982-83	169	30	108	19	256	46	28	5
1983-84	164	34	78	16	226	47	15	3

The following case examples illustrate the three major types of involuntary admissions:

Type A: Patients Are a Danger to Themselves

- A 38-year-old married Vietnamese man was admitted to the hospital after having stabbed himself in the abdomen three times with a very large knife. After the patient had recovered from surgery, he was transferred to a psychiatric unit. The patient has been living with his wife and their four children in San Francisco for the past 3 years. Apparently, the patient and his wife had been having increasing marital difficulties and the wife had decided to divorce him. On the day of the stabbing, the letter about the divorce hearing arrived in the mail. The patient got extremely upset and ran into the kitchen and got a knife.

- A married Cambodian woman of Chinese descent was transferred from another psychiatric hospital involuntarily as a danger to herself after she expressed suicidal ideation and made a suicidal gesture with a knife. Prior to admission, the patient had been followed by an outpatient mental health center for depression, suicidal ideation, decreased appetite, sleep difficulties, psychosomatic complaints, and decreased interest in social activities. Patient denied any auditory hallucinations. However, her family reported that she talked to her dead brother a lot.

- A 24-year-old Vietnamese man was admitted on involuntary commitment after threatening suicide. At the time of admission, he was depressed, refused to eat, was very suspicious and paranoid, and attempted to bite off his tongue.

Type B: Patients Are a Danger to Others

- A 43-year-old single Chinese male from Vietnam living with a married, younger brother was brought in by police as a danger to others. The patient was throwing sharp objects and furniture into the street and was assaultive toward his brother. The

patient was also found inappropriately laughing and talking to himself. The patient had had multiple hospitalizations since 1975 in Vietnam and the United States. Upon admission, the patient's clothing was disheveled and dirty and he appeared very frightened, extremely anxious. He was hostile, uncooperative, and assaultive toward staff. He attempted to strike at staff members twice, which resulted in his being put in seclusion and restraints.

- A young Vietnamese single man was admitted on an involuntary basis as a danger to others. The patient had been living in a temple and apparently had become increasingly agitated and aggressive. On the day of admission, he had threatened to stab the monk at the temple. In the weeks that preceded admission, the patient had been noted to be progressively incoherent, had destroyed the furniture of one of his distant relatives, and was asked to leave his relative's home.

Type C: Patients Are Involuntarily Committed Due to Grave Disability

- A single Vietnamese female patient was brought by the counselor of the Recidivism Team to the Psychiatric Emergency Services as being gravely disabled. The patient was found screaming and yelling in her hotel room at night, disturbing fellow tenants, refusing to pay her rent, cutting up her clothes, and complaining that her hotel manager was taking things out of her room. Two weeks prior to admission, she had become increasingly agitated, paranoid, and hostile, destroying property in the hotel and assaulting other tenants with a stick.

- A young Laotian woman was admitted as gravely disabled because of refusal to eat at home, muteness, and inability to sleep. Two weeks prior to admission, she stopped taking her medications. She became progressively resistant to eating food and sleeping and became mute. On the day of admission the patient began wandering outside her home and was brought back by the police.

DIAGNOSIS

In our unit, attending physicians and primary therapists diagnose patients according to DSM-III criteria. Among the Southeast Asian refugee group, the most frequent primary diagnosis is affective disorders, which is given in 37 percent of the cases; this percentage is slightly higher than in the white, black, Latino, and other Asian groups (table 2). Our finding is consistent with a recent study reporting the high incidence of depression among Hmong refugees (Westermeyer et al. 1983). Schizophrenic disorder accounts for 20 percent of the diagnoses in Southeast Asians; this percentage is slightly lower than among whites and other Asian groups. Primary diagnoses of organic mental disorders, substance use disorder, and personality disorder are not found in the Southeast Asian refugee group; this is markedly different from the black and white groups (table 3).

In summary, a majority of our patients are involuntary patients who are a danger to themselves or to others, referred by the police or by outpatient community mental health centers. Most of them are single young adult males from Vietnam, are monolingual and unemployed, and live with extended family members or roommates. Affective disorders and schizophrenia are the major diagnoses.

RECOMMENDATIONS

To overcome the major obstacles of irrelevant services targeted to Southeast Asian refugees, innovative service delivery models are being implemented in our Asian communities to provide more accessible, appropriate, and acceptable mental health services (Owan 1980). The 4-year experience in providing inpatient psychiatric services to Southeast Asian refugees at San Francisco General Hospital has yielded a number of important insights and recommendations that may be of value to the future design and implementation of inpatient psychiatric services.

1. We strongly recommend that specialized bilingual, bicultural programs be developed in major cities

TABLE 2.--Living situations of psychiatric inpatients at San Francisco General Hospital during fiscal years 1982-83 and 1983-84

Living situations	Refugee	Other Asian	White	Black	Latino	Other	Total
Alone	14	66	239	60	10	8	397
Parents/sibiings	11	70	21	36	5	0	143
Partner/spouse	8	35	33	13	3	0	92
Extended family	19	32	2	20	2	0	75
Roommate	9	8	44	6	1	0	68
Single parent	1	2	4	4	1	0	12
Institution	1	18	41	15	5	0	80
Other	2	12	50	13	2	2	81
No data	6	15	39	15	3	1	79
Total	71	258	473	182	32	11	1,027

TABLE 3.--Diagnoses given to psychiatric inpatients at San Francisco General Hospital during fiscal years 1982-83 and 1983-84

Diagnosis	Refugee		Other Asian		White		Black		Latino		Other		Total
	Numbe	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	
Infancy adolescent	0	--	2	1	2	--	2	1	0	--	0	--	6
Organic	0	--	7	3	30	6	19	10	1	3	1	9	58
Substance use	0	--	5	2	43	9	11	6	1	3	4	--	64
Schizophrenia	14	20	68	26	107	23	53	29	6	19	0	--	248
Paranoid	3	4	2	1	5	1	7	4	0	--	0	--	17
Other psychosis	13	18	46	18	54	11	34	19	6	19	0	--	153
Affective	26	37	85	33	125	26	38	21	7	22	3	27	284
Personality	1	1	1	--	26	5	0	--	1	3	0	--	29
Impulse control	0	--	1	--	1	--	2	1	1	3	0	--	5
Adjustment	5	7	14	5	33	7	3	2	6	19	0	--	61
Somatoform	1	1	0	--	1	--	0	--	0	--	0	--	2
Psychosexual	0	--	0	--	3	1	0	--	0	--	0	--	3
Dissociative	0	--	0	--	1	--	0	--	0	--	0	--	1
Anxiety	1	1	1	--	2	--	1	--	0	--	0	--	5
Factitious	0	--	0	--	0	--	1	--	0	--	1	9	2
Psycho. affect. phys.	0	--	1	--	0	--	0	--	0	--	0	--	1
No diagnosis	7	10	25	10	40	8	11	6	3	9	2	18	88
Total	71		258		473		182		32		11		1,027

or areas with a large refugee population. If necessary, these specialized services should be made available on a citywide or regionwide basis, unrestricted by catchment area boundaries.

2. Evaluation and therapy should be provided by staff members whose ethnic, linguistic, and cultural backgrounds are similar to those of their patient population. A sufficient number of bilingual, bicultural mental health personnel should be employed to permit their assignment to teams or units to maximize their visibility and impact upon service delivery systems. Special effort should be made, not only in the employment of interpreters, but in the hiring and retention of bilingual mental health professionals in major disciplines (Lee 1982b). Language coverage on a 24-hour basis is also essential in a psychiatric inpatient setting.

3. Services available in the program should be comprehensive, including emergency services, consultation and liaison services, partial hospitalization, day treatment programs, medical referrals, and case management.

4. Therapeutic milieu programs should include culturally relevant activities.

5. Family members should be actively involved in evaluation and treatment processes. Family intervention with a psychoeducational approach can be effective in reducing relapse in mental patients.

6. Strong links and good collaboration with outpatient community mental health programs and other health and human services are very important for providing continuity of care to patients. Every attempt should be made to maintain patients in the community after discharge.

7. Ongoing inservice training, supervision, and consultation, with special emphasis on Southeast Asian refugees, should be provided to clinicians to minimize transcultural misunderstanding.

8. Training opportunities for inpatient psychiatry should be available to psychiatric residents or interns who are interested in cross-cultural psychiatry. Most important, special efforts should be made to recruit Southeast Asian refugee trainees, especially in the fields of psychiatry, psychology, social work, and psychiatric nursing.

9. Research opportunities should be provided for community clinicians as well as for university researchers who are interested in inpatient populations. Research projects designed and implemented by Southeast Asian refugee researchers should be encouraged.

10. Strong links should be established with the refugee community's organizations and leaders. Their understanding and support are key factors in the success of the program.

Our special, focused program located in a general hospital has brought many new and exciting treatment possibilities to our community. It is, of course, not intended in this chapter to provide a "recipe" for the inpatient treatment of Southeast Asian refugees. Program design should be tailored to the needs of each community's unique characteristics. It is hoped, however, that the recommendations presented in this chapter can stimulate more discussion about the provision of inpatient service in the refugee and mental health communities and lead to more culturally relevant services for disenfranchised Southeast Asian refugee psychiatric patients.

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AN INDOCHINESE MENTAL HEALTH SERVICE MODEL IN SAN FRANCISCO

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INTRODUCTION

Since the initial influx of Southeast Asian refugees in 1975, a large number have settled in the San Francisco Bay area. Despite the resettlement agencies' original policy of dispersing the refugees throughout the country, the refugees themselves have demonstrated a strong preference for clustering in areas where they have family and friendship ties (DHEW, unpublished; Nguyen et al., unpublished). Because there was a highly concentrated Asian population already in place, cities such as San Francisco, San Diego, Los Angeles, Seattle, and Chicago were seen by the refugees as more desirable areas in which to settle. For this reason, the San Francisco Bay area is currently attracting, not only initial immigrants, but secondary and tertiary migrants as well. It is now estimated that approximately 45,000 Southeast Asian refugees are living in the area, representing a variety of ethnic and cultural groups, including Vietnamese, Cambodian, and Laotian.

Recognition of the serious mental health problems faced by the refugees has generally lagged behind concerns

for the more visibly pressing survival issues such as food, clothing, shelter, and jobs. However, in San Francisco there were a number of foresightful leaders who began advocating preventive and crisis intervention activities on behalf of the refugees within the first several months of resettlement. On the strength of early reports from camps and other areas where there were refugees (Cohon, unpublished a; Hoang 1976; Horowitz 1976; Liu et al. 1979; Siegel and Lurie, unpublished), the Region IX National Institute of Mental Health Office was instrumental in organizing a mental health task force, which led to the establishment of a pilot mental health resource center. Later, when a national initiative was developed by the Department of Health, Education, and Welfare (DHEW) (now Health and Human Services), the experience gained at the local level provided valuable guidance for others as well.

During the past several years, by changing Federal and State policies and support for refugee mental health activities, the commitment to serve the needs of refugees was continued in San Francisco. The focus of this chapter is a description of our effort to create a model for alternative ways of serving the mental health needs of Indochinese refugees, since the termination of Federal funding, in order to maximize the limited resources in the community. Specifically, it will describe the unique collaboration between private and government service agencies, private foundations, and State and city funding agencies.

IDENTIFICATION OF PROBLEMS

To obtain relevant data to define the nature of action needed in San Francisco, a task force was initially established by DHEW, Region IX. The task force members were representatives of various private and public agencies, including voluntary resettlement agencies (known commonly as VOLAG), county mental health services, the State of California mental health agency, community-based Asian organizations, and DHEW. The task force was to identify the extent and the scope of the refugee mental health problems. The findings from the needs assessment sponsored by the task force

identified the types of mental health problems most often experienced by Asian refugees and the etiologic factors most commonly involved. The typical mental health-related difficulties were found to be depression, ranging from general sense of lethargy and withdrawal to severe psychotic depression; anxiety reactions of various intensities; family and marital conflicts; psychosomatic illnesses; attempted or threatened suicide; attempted or threatened acts of violence against others; schizophrenic and paranoid reactions; and child or spouse abuse. Although depression, anxiety reaction, and psychosomatic cases were predominant, more severely disabling illnesses such as schizophrenia and suicidal cases caused a great deal of community and family turmoil and created more serious management problems. Our findings were corroborated by those of others (Ossorio 1979; Tung et al. 1978).

Common etiologic factors were difficulties dealing with marked cultural differences; communication difficulties; language and communication difficulties; the trauma of losing one's homeland and roots; the shock of separation from family; uncertainty about the future; unavailability of jobs, particularly jobs commensurate with previous training and experience; inadequate living arrangements; conflict with sponsors; and generational conflict between refugee parents and children, often exacerbated by differential degree and rate of acculturation.

When funds were made available to develop strategies for dealing with these problems, the task force was instrumental in stimulating the development of two refugee mental health training projects. Although Federal funding was available for a limited period of 3 years, these projects were instrumental in generating some reliable clinical data and in preparing a number of capable Southeast Asian refugees for mental health careers (Cohon, unpublished b; Nguyen et al., unpublished). The experience of the San Francisco projects, as well as that of others in other areas, has been that despite evidence of serious mental health problems in the community, the actual utilization rate of the projects by the refugee clients tended to be lower than the general American rate of service utilization. This finding was not surprising to the mental health professionals

involved with the projects, since other ethnic groups were following the same pattern. However, it revealed the need to review and analyze carefully and to develop a more effective strategy for reaching out to the refugee population in future endeavors.

CULTURAL BARRIERS TO MENTAL HEALTH SERVICE UTILIZATION

In their comprehensive review of the literature generated about Southeast Asian refugees, Nguyen et al. (unpublished) identified several factors contributing to the refugee's resistance to mental health service utilization. All of the issues identified by them are applicable to our area.

Language and Communication Problems

There are diverse groups of Southeast Asian refugees (at least five major subgroups--Cambodians, ethnic Chinese, Hmong, Laotian, and Vietnamese), all of whom speak different languages or dialects. Many of them are also unable to communicate in English well enough to discuss complex psychological and personal issues. It is difficult for more mental health agencies to maintain adequate bilingual staffing to deal with the diverse needs of the refugee groups.

Cultural Diversity

In addition to language differences, the refugee groups differ greatly in cultural orientation from Americans and from other refugee groups. Some of the areas of difference from the American orientation are attitude toward human nature, beliefs regarding the relationship between humans and nature, time and space orientation, life goals, and religion. Examples often cited as potential problems in the work of mental health treatment approaches due to these differences are emphasis on autonomy versus dependency, individualization versus family unity, and authoritarian versus egalitarian relationships.

Diversity in Migration and Resettlement Experiences

Because of a lack of sensitivity among most mental health professionals, they often fail to understand and develop the relevant psychiatric interventions for the refugee clients.

Stigma Attached to Mental Illness

Southeast Asian refugees lack experience dealing with mental health/illness concepts. Like other Asians here and overseas, Southeast Asians have traditionally felt there was a strong stigma attached to mental illness. For this reason, they are loath to acknowledge the existence of mental illness and of psychological problems, which are quickly interpreted as leading to mental illness. For this reason, coming to a mental health agency would potentially be a cause of community ostracism.

Tradition of Reliance on Kinship and Community Support Network

Southeast Asians, like other Asians, are traditionally accustomed to seeking and receiving support from their own families and kin. Despite the destruction or absence of an existing support network, the refugees, for this reason, are loath to seek outside help.

DEVELOPMENT OF A CULTURALLY RELEVANT SERVICE DELIVERY MODEL

In considering ways of dealing with the known resistance to seeking mental health care in the refugee community, we have tried to make use of the experience gained from earlier work with other ethnic groups such as Hispanics and Asian Americans. For example, Padilla et al. (1975) reviewed the experience of Spanish-speaking professionals working with their own culturally resistant clientele. They identified three promising models of mental health service delivery that seemed to minimize the inevitable community resistance among

Spanish-speaking Americans in the United States. These three models are referred to as the professional adaptation model, the family adaptation model, and the barrio service model. While it is assumed that all three models are staffed by bilingual, bicultural personnel, they emphasize different aspects of service delivery.

The professional adaptation model seeks to increase the professional sensitivity and expertise of the professional and paraprofessional staff by providing them with some form of specialized nonstandard training. Examples cited include such effects as locating the services within the community; having a comfortable, culturally appropriate decor; emphasizing prevention, consultation, and education; and offering short-term, crisis-oriented treatment.

The family adaptation model attempts to make greater use of the extended family network available in the community, as well as of culturally relevant group psychotherapy; and the barrio service model emphasizes the integration of services with those of other related human service providers, such as employment and financial assistance, housing, English classes, and recreation programs.

Similarly, in Asian American communities throughout the United States, various efforts have been made to develop mental health service alternatives that would minimize community resistance (Sue and Morishima 1982). Some of the issues critical in such an effort have been identified as:

1. Availability of bilingual, bicultural staff

2. Location within the geographically and culturally accessible community neighborhood

3. Flexibility in service operations, such as time, fees, and procedures

4. Involvement of the family and extended family network

5. Preventive outreach, consultation, and education with key community leaders

6. Adaptation of psychotherapeutic styles or themes to culturally relevant issues

The two federally funded refugee mental health projects in San Francisco did incorporate some of the ideas gained from other pioneers in the field and, for that reason, were able to make a significant impact in the community. However, one of their shortcomings was that they tended to be isolated from the existing mental health service community. Since the refugee community itself was somewhat ambivalent regarding the need for mental health services, the projects were unable to attract sufficient support to generate continued funding after the termination of the Federal support.

When pressing problems among the refugee community reached a level that could no longer be ignored, a group of concerned mental health and community representatives again formed a task force to consider new strategies.

The new task force was composed of representatives from private and public agencies, including private foundations, county health and mental health service agencies, and social service agencies. Based on experience from the earlier model, the task force was concerned with addressing the following issues:

1. Maximizing limited resources on a city-wide basis

2. Creating a bilingual, bicultural mental health service capable of aiding at least three major refugee subgroups, e.g., Vietnamese, Cambodian, and Laotian (To serve the ethnic Chinese refugees, bilingual Chinese staff were already available at key clinics.)

3. Developing effective links with various health resources to better serve the refugees, who tend to somatize their mental health problems

4. Maintaining effective ties with various refugee service organizations, including refugee-initiated self-help organizations and civic groups

5. Establishing an effective mechanism for coordination within the mental health service system

6. Emphasizing more outreach, consultation, and education than would be expected with traditional mental health services

7. Stationing of the staff in areas with the greatest concentration of each ethnic group

The task force was fortunate or skillful enough to obtain funding support from multiple sources to implement a multiethnic, multiagency mental health team with the above objectives. The funds available were far short of the amount needed to amply staff the comprehensive service system for the refugees, which would include availability of bilingual, bicultural staff in key mental health service modalities, such as outpatient, inpatient, day treatment, and transitional (halfway house) services. Within the limitation imposed by the funding level, the task force was able to organize a primarily outpatient-based mental health team consisting of three master's-level social workers, three paraprofessionals with some mental health or social science background, and one half-time Vietnamese physician. Five of these team members were Vietnamese, one was Cambodian, and one was Laotian. A year later, through a vacancy in one of the participating clinics, a part-time Vietnamese psychiatrist who had recently finished his training was hired.

Based on the needs of the community, four administratively separate agencies were chosen as participating agencies:

1. The Chinatown-North Beach Clinic, a civil service unit located near San Francisco's Chinatown, where a good number of ethnic Chinese refugees and Southeast Asian refugees are concentrated.

2. Richmond Area Multi-Services, a private, nonprofit agency with an extensive history of pioneering work in mental health training and service delivery to Asian Americans. The agency was one of the two federally funded demonstration refugee mental health training projects; it has generated

considerable community interest and support for its activities. It is located in an area that was predominantly a white, working-class neighborhood in the past but that is now changing rapidly with the influx of Asian and refugee populations.

3. International Institute, a resettlement agency with a long history of providing legal and social work assistance to immigrants. The agency was also involved in sponsoring a federally funded mental health training project. A part-time Vietnamese physician, who was unlicensed in the United States, was retained from the original project to participate on the team.

4. Tenderloin Clinic, a Traveler's Aid-sponsored program located in the heart of San Francisco's Tenderloin district. The program was targeted to serve the high-risk children and isolated single mothers in the area. Many refugee families were moving into the area, and the availability of a Vietnamese child specialist made it possible to provide timely assistance for them.

DEVELOPMENT OF A WORKING AGREEMENT

Prior to the hiring of the refugee staff at each of the agencies, the directors of the four agencies, key San Francisco community health service administrators, and representatives from key collaborative agencies were involved in the development of a working agreement among participating agencies. Key elements agreed on at the time were:

1. Participation of the four agency staff members in weekly coordination meetings. Some of the activities to take place at these meetings were problem-solving discussions on shared clinical or system issues, information sharing, intake case discussions and dispositions, mutual consultation, and training seminars.

2. Coordination of outreach relationships with key health and social service agencies. Two of the agencies, San Francisco General Hospital and the

Center for Southeast Asian Resettlement Services, were selected as sites for daily staff rotation because of their potential for the greatest amount of interface.

3. Coordination of emergency home visits and crisis interventions. The assignment of the staff was based on such factors as staff members' special skills, language needs, and geographic proximity.

4. Coordination of training, consultation, and education activities. Since the limited time for direct services of refugee staff could not be made available at many of the agencies, an effort was made to maximize the nonrefugee staff's capacity through training and consultative activities.

TEAM ACCOMPLISHMENTS

Because of the extensive publicity given to the refugee team and because of the involvement of the allied agencies in the early phases of planning and program development, the team was well received by both the refugee community and the service providers. By September 1982, the team was operational, and within the first several months, referrals were coming in regularly. By the end of the first year of operation, the total number of clients seen was 1,152 (San Francisco Department of Public Health 1983). When this figure is compared with the figure of 154 clients seen by the two training projects a few years earlier, the difference is dramatic (Nguyen, unpublished).

Although it is not realistic to expect the refugee community to change its attitude about the stigma of mental illness or mental health services, the mental health team was received with a reasonable degree of acceptance. We are convinced that our commitment to involve the community from the beginning played a significant part in minimizing community resistance.

Following are a few case vignettes describing how ongoing collaboration within the mental health team helped minimize unnecessary duplication of services and maximize treatment planning and strategies.

Case 1

A 41-year-old Vietnamese, married and the father of two children aged 10 and 7, was referred to the Chinatown Clinic by the Refugee Health Screening Clinic. He had multiple problems, including sleep disturbance and suicidal ideations, as well as visual and auditory hallucinations (e.g., saw a body lying in a bathtub, heard voices saying he was crazy). He was separated from his family at the time because of his frequent and violent attacks on his children and wife.

In addition to his psychiatric problems, it was learned he suffered from a severe, chronic neck pain, due to an injury he received in the war, and a peptic ulcer. He was a Catholic and had a sixth-grade education, was from a middle-class family, and had operated a small business in Vietnam. Now unemployed, with limited English-speaking ability, he was despondent, not only about his prospects for becoming self-sufficient, but about his separation from his family, who had left without telling him where they were going.

When his case was discussed, it was learned that his children and his wife were being seen by the Tenderloin staff. Although the children's problems were not serious, the wife was thought to be quite depressed and confused about coping with her children and having the responsibility of being a new head of household.

Through joint planning, the two staff members agreed that continued separation was needed, and they each worked to help their respective patients deal with their problems separately. With the father's behavior and psychiatric condition considerably improved, the mother was given assistance in allowing the father to visit with the children at the Children's Clinic. Although the family was headed for divorce, they were able to deal with the painful process more effectively through the intervention of the team.

Case 2

A 21-year-old single Vietnamese man was being seen at the Richmond Clinic for his suicidal tendencies and

severe mood swings. He was taken to a psychiatric emergency service by his family, who were concerned about his agitation and acutely disturbed state. He was hospitalized. Although he could communicate in English to some extent, he was so deteriorated that he could not tell the hospital staff about his link with the Vietnamese therapist; nor could his family provide helpful information about him.

The hospital staff sought the help of another Vietnamese staff member, who learned about the involvement of the other worker through the team intake discussion. Although the hospital was considering transferring the patient to a locked, subacute facility about 60 miles away from the city, the team was concerned about the disruptive impact of such a move. Instead, they were able to persuade the hospital to follow an alternative plan to arrange for a transfer to a subacute residential facility within the city.

Frequent visits by the staff and the availability of a Vietnamese house staff member enabled him to stabilize much more quickly. Following his return home, he was treated with supportive psychotherapy, medication, and day treatment. Concurrently, he was continuing to take English-as-a-second-language classes to improve his English and planned to seek vocational counseling when he was further improved.

SUMMARY

In spite of the emergence of serious mental health problems among Southeast Asian refugees, mental health service providers in various parts of the country are having difficulty establishing an effective link with the refugee community. Without question, the lack of funding and of appropriately trained, bilingual professionals are key issues. In addition, the stigma attached to mental illness and psychological problems is an additional barrier that separates mental health service providers and the refugee community.

Based on the experience of pioneer mental health leaders and on their own hunches, several groups in the United States have developed alternative ways of

dealing with the problems. In San Francisco, our decision was to create a team of multiethnic refugees within the city's community mental health system. The emphasis was placed on establishing firm coordinating ties with key health services, social services, and schools. Judging from ongoing referrals and other feedback, the refugee team has been accepted firmly within the system and provides effective assistance to many of the refugees in the community.

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TRAINING

This section addresses many of the tasks and issues involved in the training of personnel to serve the mental health needs of Southeast Asian refugees. A dominant theme of all the sections in this sourcebook is the need for sensitivity to and understanding of the Southeast Asian refugee's cultural background and life experiences. Sensitivity and understanding are relevant not only to the provision of treatment and prevention services, but are critical also in the formulation of research questions and in the development of programs to educate and train service providers.

Nidorf and Wong address the training issue from somewhat different perspectives. Nidorf, in her chapter, frames a training model for practitioners for the first phase--diagnosis and assessment--of treating refugee youths. In so doing, she employs a history-taking protocol that hones in on some basic issues relevant to the experiences of refugees. While the format has been developed for the 11- to 22-year-old age group, many of its elements are relevant to working with adults.

Nidorf's historical protocol is reminiscent of Lee's ethnomedical assessment approach. (See the services section.) Nidorf proposes the utilization of a set of 10 questions that relate to the client's premigration, migration, and postmigration experiences. The questions appear deceptively simple, but they in fact have the potential to generate rich and complex information about the young client's adaptation and functioning, as well as provide insights into the origins of psychological dysfunction. She offers illuminating discussions of the meaning, purpose, and implications of each of the questions and provides relevant case examples taken from her clinical practice. The assessment method presented will be of particular benefit to the individual practitioner.

The broader perspective of Wong's chapter, by contrast, will be more useful to policymakers and program managers than to individual practitioners. Wong addresses the issues involved in developing training for individuals, groups, and programs. Wong proposes the use of a goodness-of-fit service model for assessing and identifying training approaches. The goodness-of-fit approach essentially looks at how the needs of the client are being, or can be, met by the resources of the mental health service system. This conceptual model provides the backdrop for guiding the development of a number of training strategies. In order to increase the goodness of fit, individual, group, and system level factors are taken into account. Wong lists these factors and discusses each in terms of its impact on services. He then describes some training strategies that are directed at the individual, groups, agencies, and programs. He discusses each of the strategies in terms of successful training programs. The description and discussion of the strategies should prove useful to agency program directors and training directors in developing training efforts.

The information contained in this section presents concepts and approaches that are relevant to many of the issues and themes already raised and discussed in previous sections, and they should provide a good launching pad for further exploration and discussion.

Southeast Asian Mental Health: Treatment, Prevention, Services, Training, and Research. T. C. Owan, editor. National Institute of Mental Health, 1985.

TRAINING FOR MENTAL HEALTH SERVICE PROVIDERS TO SOUTHEAST ASIAN REFUGEES: MODELS, STRATEGIES, AND CURRICULA

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INTRODUCTION

Following a rapid and emergent resettlement process, an urgent need for mental health service providers for Southeast Asian refugees resulted in training programs that were haphazard at best. To a large extent, training programs have lacked the framework to provide a coordinated program consistent with the needs of refugee communities.

Previous chapters have defined and documented the extent and severity of mental health issues for Southeast Asian refugees. In this chapter, we will explore some of the conceptual models and concrete programs for producing mental health providers for Southeast Asian refugee mental health services. Following several cautionary considerations and a statement of our value orientation to training, we will present a conceptual model for refugee mental health training and services. A review of past and current training programs follows. Finally, recommendations and examples of exemplary training programs conclude this chapter.

CAUTIONARY CONSIDERATIONS

DIVERSITY OF GROUPS

First, the terms "Southeast Asian" or "Indochinese" oversimplify the diverse groups of people with very different histories, cultures, and languages, especially when considering training individuals to provide mental health services to this population. Even consideration of the five major ethnic groups of Cambodians, ethnic Chinese from Vietnam, Hmong, Lao, and Vietnamese as major groupings will result in ignoring vast differences within each of the groups along important dimensions such as:

- migration and relocation experiences
- rate of acculturation and assimilation
- family composition and family intactness
- area of residence in the United States
- native language facility
- identification with the "home" country
- comfort and competence with the English language
- degree of trauma in transition
- sense of rootedness
- education (years in Southeast Asia, in the United States, and elsewhere)
- age
- sociopolitical identification
- involvement in the local, regional, and national community networks (such as family associations, mutual assistance associations, and clubs)
- religious beliefs and values
- intergenerational intactness
- degree of dispersion of social and family support network
- work and vocational accomplishments and status

Sensitivity to the ethnic, cultural, and linguistic diversity of Southeast Asian refugees will be the key factor in providing successful mental health training, services, and treatment programs to this population.

RESETTLEMENT PATTERNS

Second, the migration and settlement of Southeast Asian refugees in the United States have followed closely the four easily recognizable characteristics and patterns of all refugee resettlement since 1944 (Nguyen et al. 1980): (1) multi-agency involvement in transportation, relocation, and resettlement with poor interagency coordination of efforts; (2) reliance by the refugee population on private, voluntary agencies; (3) short-term resettlement support and services based on the premise that refugee resettlement is only a temporary and crisis-generated condition; and (4) utilization of ethnic community networks, services, and organizations closely related to the refugee populations. In this light, refugees' selection of and dependency on existing services and programs may not necessarily reflect participation by choice as much as selection because of their refugee status. As such, caution is advised in interpreting the participation and utilization data as indicators of the preference, acceptability, and appropriateness of such programs in meeting refugees' needs. Sensitivity to the refugees' participation in programs as indicative of the fact that no other services are available, rather than the result of personal choice among many alternatives, may often be warranted and is an important value to consider in establishing training programs.

INAPPROPRIATE MENTAL HEALTH TREATMENT TECHNIQUES

Third, mental health concepts and techniques as they exist in current practice are foreign to the majority of the Southeast Asian groups. For example, clinical psychology and psychiatric social work as professions are almost unheard of in Southeast Asian countries. A school of social work was not established in Vietnam until 1972. Nguyen et al. (1980) noted that Vietnam had only six psychiatrists for its population of 16 million; the doctor-patient ratio in the nonmilitary population was 1 to 50,000 (Poffenberger 1971). For Southeast Asians, mental health is viewed in terms of "being crazy" and "not being crazy" (Tung, unpublished). To Cambodians, ethnic Chinese, Hmong, Lao, and Vietnamese, mental health services and practices

may be viewed negatively and with little understanding and appreciation of "talking treatment" and the value of "opening up" and self-disclosure.

The qualities and conditions of mental well-being, emotional balance, and peace of mind are as important to the Southeast Asians as they are to anyone adhering to the Western concepts of maintaining "good mental health." However, Western psychotherapy and psychological practices may not be a preferred or viable approach for achieving "mental health" for the refugee population. In their home countries, personal and interpersonal problems are solved by relying on the leaders in the community, elders in the family, religious leaders, and other community support mechanisms. What Americans view as professional interventions may appear to refugees to be the meddling of an "unwelcomed stranger" in one's midst. Training programs need to take into account the role of the "stranger" in mental health intervention (regardless of whether the provider is from that culture or not). Sensitivity to similarities in valuing emotional balance, mental health, and well-being, although the methods and practices for achieving such "health" are very different, is crucial to any program's efforts. Furthermore, the importance of preparing bicultural providers for client resistance related to the unfamiliarity and differences in perception of mental health problems is a key component of a training program.

FRACMENTATION IN PROGRAM PLANNING

Fourth, mental health services and support to Southeast Asian refugees have consisted of a hodgepodge of intervention attempts. In 1976, the Federal Government requested proposals for Southeast Asian mental health demonstration projects, and several health training projects were funded in 1978-79. Federal funding for these projects was channeled to the States in 1980-81. All funding ceased in 1981 for these projects, and the majority of the mental health trained refugees looked for non-mental-health, alternative vocations. In 1983, the Federal Government requested proposals for mental health demonstration projects again, and about a dozen demonstration programs were funded in 1984. The

government agencies, which bear the ultimate responsibility for providing adequate, acceptable, available, and effective services, have been unable to conceptualize, plan, implement, and evaluate the overall administration of programs in a coherent, coordinated, and comprehensive manner. Rather than "foresight, insight, and preplanning," we have domestic, "aftermath," and reactive solutions for problems after they have occurred. Sensitivity is needed to the fact that it is the refugees who bear the brunt of the providers' "solutions." Such solutions might be more accurately portrayed as the pieces that must be picked up by Federal, State, local, and indigenous resources as a result of the lack of a well-thought-out strategy.

TRAINING OF PROVIDERS

Fifth, many of the Southeast Asian refugees trained to be mental health providers have only recently, within a few years, experienced for themselves the traumas of relocation and resettlement. Treatment of mental health programs by these providers often required them to handle many concerns related to experiences that they had had only recently and possibly may still be experiencing. Training programs need to be extremely cautious about the ramifications of such problematic exposure to their trainees and staff and the importance of providing ongoing supervision and support.

PARTICIPATION OF SOUTHEAST ASIANS

Finally, the seeming monopoly of refugee transportation and resettlement efforts by the well-meaning voluntary agencies and other "resettlement groups" has had a serious ill-effect on the mental health and long-range development of refugee resources. Many agencies have chosen to provide mental health and counseling services through translators rather than train a pool of bilingual and bicultural personnel. Refugees in need of services end up requesting assistance from "experts" not of their own culture or ethnic background. For a population that has experienced so much of a "loss of control" in their lives, the continual lack of opportunity to control, determine, and structure their own

development and progress considerably affects their mental well-being and esteem. The exclusion of Southeast Asians and other Asian groups from making higher level decisions, planning, and administering resettlement of new refugees has been at the root of much frustration for Southeast Asian refugees and service providers alike. Sensitivity to and corrective action in bringing about Southeast Asian participation in all levels of services and program conceptualization, planning, implementation, and evaluation (in terms of agency executives, advisory and policy boards, providers, and managers) will move the Southeast Asian refugees a long way toward positive community mental health.

VALUE ORIENTATION AND APPROACH TO INCREASE BILINGUAL, BICULTURAL PROVIDERS

It is the conclusion of the author and other writers in the training field (Fujiki et al. 1983; Kuramoto et al. 1983; Nguyen et al. 1980; President's Commission on Mental health 1978; Sue and Morishima 1982; H.Z. Wong et al. 1983; N. Wong et al. 1983) that the ideal provider of mental health services to Southeast Asian refugees and other Asian/Pacific Islander American populations would be a professional with bilingual and bicultural expertise corresponding to the client's linguistic, cultural, and life experience background. The goal of all clinical training funding for this population should be to produce a pool of trained bilingual, bicultural professional personnel.

Unfortunately, at least for this next decade, there is no way to achieve such a goal. Academically prepared and qualified bilingual, bicultural individuals who can enter such training scarcely exist. Many Southeast Asian refugees in the educational system are working on bachelors degrees, and of those who are in undergraduate programs, many have career orientations in technical and business fields. Very few are interested in mental health and human services professions. Only a small number are in graduate mental health training programs in the United States.

This chapter focuses on the diversity of training programs needed to meet the mental health services needs of Southeast Asian refugees in this decade. Although some emphasis will be made on professional bilingual, bicultural training, our program descriptions and recommendations will focus more on the training of nonprofessional bilingual, bicultural mental health services providers and on professional providers not from the cultural backgrounds of Southeast Asian communities. This, however, is only a temporary measure that is far from the ideal. Future training programs will have to be implemented to achieve the goal of professionally trained bilingual and bicultural providers for this population.

CONCEPTUAL MODELS FOR VIEWING TRAINING AND SERVICE PROGRAMS

A variety of conceptual models has been advanced for the training of professional and nonprofessional mental health providers for Asian/Pacific Islander Americans and Southeast Asian refugees (Chikahisa et al., unpublished; Dong et al. 1978; Fujiki et al. 1983; Kuramoto et al. 1983; Kushida et al. 1976; Murase 1978; President's Commission on Mental Health 1978; Sue and Chin 1976; Sue and Morishima 1982; Wong 1982a,b, unpublished a,c; H.Z. Wong et al. 1982, 1983; N. Wong et al. 1983). After reviewing all of the noted training models, the qualification for any training program is that it enhance the fit between the Southeast Asian refugee's needs with the mental health resources or interventions available from the provider. We advance this notion of training and service in our conceptual model for Southeast Asian refugee training programs.

CLIENT-PROVIDER FIT CONCEPTUAL MODEL

A goodness-of-fit model, involving the refugee's needs and the mental health resources available, is proposed to clarify individual, group, and system-level issues in the delivery of mental health service to Southeast Asian refugees. Client or participation outcomes (such as improved psychological functioning, increased emotional well-being, continuing treatment, satisfaction

with services, and the like) can be viewed as a function of the goodness of fit between the client's needs and the mental health system. From this perspective, the lack of success in service delivery to Southeast Asian refugee populations is attributable to a poor fit between client systems and service systems. An adequate training program would allow trainees to enhance the client-provider fit.

Both clients and services are part of larger systems. The client system may include the individual, his or her immediate and extended family, community groups to which the client and family may belong, and other progressively encompassing structures. The mental health system includes a counterpart to each structure in the client system: the individual provider or clinician, the service unit, the agency, the service program, and so on. This model is used here in reviewing the existing mental health service and training efforts for Southeast Asian refugees and in increasing sensitivity to issues of specific importance to this population.

First, the individual and group level factors are presented followed by the broader system level factors affecting mental health training and services tailored to the needs of the Southeast Asian refugees. The President's Commission on Mental Health (1978) offered 67 general recommendations for improving mental health services, research, and training, and for moving toward a better fit between needs and resources. The Commission's report is the single best source of comprehensive recommendations for improving services to all Asian/Pacific Islander Americans, which includes the Southeast Asian refugees. For recommendations specific to refugees, The ADAMHA Role in ADM Service, Training and Research for Indochinese Refugees: Report From a Consultation (Nguyen et al. 1980) provides 21 specific recommendations to improve client-service fit. In addition, the following sources provide recommendations relevant to training and services for Southeast Asian refugees: (1) Research Priorities for Mental Health Services for Asian/Pacific Islanders (Owan 1980); (2) Minority Mental Health Conference Report (Western Interstate Commission for Higher Education 1980); and (3) testimonies before the Civil Rights Commission on Civil Rights Issues of Asian and Pacific

Americans: Myths and Realities (Lee 1979; Shon 1979; Wong, unpublished b). The reader is invited to review the proceedings from the above conferences and/or Commission for a more general idea and for a more expansive scope of the Southeast Asian mental health needs, priorities, and community sensitive areas. The individual and group-level factors and then the large system-level factors affecting mental health training and services to Southeast Asian refugees will be presented in summary form.

INDIVIDUAL AND GROUP-LEVEL FACTORS

BELIEF SYSTEMS ABOUT MENTAL HEALTH AND MENTAL ILLNESS

As noted by Lee (1982), Western-trained providers utilize the intrapsychic influences on behavior, whereas Southeast Asian refugees use such psychological explanations rarely (Tung, unpublished). For example, Chinese immigrants believe that mental health is achieved by exercising willpower and avoiding morbid thoughts (Lum, unpublished a). Sue et al. (1976) found similar results for Japanese and Pilipino Americans, for whom good mental health was perceived as being a result of avoiding morbid thoughts. Lee (1982) and Tung (unpublished) note a wide range of common etiological beliefs among Chinese and Southeast Asians including: organic disorders, supernatural intervention, genetic vulnerability or hereditary weakness, physical or emotional exhaustion, metaphysical factors such as the imbalance between yin and yang, fatalism, and character weakness. Such differences in beliefs about health and illness by clients often necessitate special efforts by the provider to ensure acceptable services. Training programs for mental health providers, of necessity, need to familiarize the practitioners with such concepts and beliefs.

STIGMA AND SHAME

As noted by Shon and Ja (1982), "The concepts of 'shame' and 'loss of face' involve not only the exposure

of one's actions for all to see, but also the withdrawal by the family, the community, and the society of their confidence and support." In seeking mental health services, not only personal shame but also personal and family stigma come into play. Training programs need to prepare the potential provider with skills and guided experiences in community education and communication efforts as well as client outreach efforts (such as services in the home) to reduce stigma and shame in Southeast Asian refugees.

FAMILY STRUCTURE AND REACTIONS TO MENTAL ILLNESS

In Eastern cultures, the family rather than the individual is considered the unit of focus and identity. Southeast Asian refugees tend to view themselves as members of an extended family with strong emphasis on family obligations, mutual dependency, and collective responsibilities and decisionmaking. As noted by several authors (Lee 1982; Shon and Ja 1982; Tung 1972, 1980, unpublished), the family structure and the family's reaction to mental illness may have much greater impact on any family member seeking and continuing with mental health treatment than does the individual's motivation to pursue treatment. Consideration of the Southeast Asian refugee family has been noted as critical in ensuring client participation. Training programs need to provide skills in a cultural orientation to the importance of family dynamics, family education regarding the mental disorders of one or more of its members, and culturally syntonic family therapy methods.

PATTERNS OF HELP SEEKING

For reasons related to their more holistic view of health and other cultural traditions, Southeast Asian refugee clients tend to seek help that emphasizes self-help and natural community resources as alternatives to mental health services. These include physical health care and other human services instead of, or as a pathway to, mental health services (Lee 1982; Leong, unpublished; Lin et al. 1979; Tung 1972, unpublished); family and friends, herbalists, acupuncturists, and

other indigenous healers are all utilized both before and during mental health treatment.

Lee (1979, 1982), using data from clinical case materials from the mental health treatment of Chinese Americans (including ethnic Chinese from Vietnam), has traced the pathway of service alternatives, programs, and agencies. Over a dozen alternatives were tried and repeated before use of the mental health system. Clients may use family and relatives, willpower and self-action, social service providers (such as teachers of English as a second language or translators), instructive readings, informal friendship networks, herbalists, other indigenous healers/helpers (such as martial arts masters), ministers and priests, providers in a health clinic, general practitioners, or specialists in medicine. Mental health services are likely to be the last alternative tried. The ability of mental health providers and programs to identify and collaborate with the full range of caregivers is critical to effective referral, entry, and continuation in treatment. Consultation and education activities with referral sources are also important (Lew and Zane, unpublished; Lum, unpublished b). Training programs need to provide some focus on the indirect services of mental health care for their trainees.

CULTURAL-SPECIFIC MODELS AND PRACTICES OF HEALTH CARE

There are differences not only in help-seeking behaviors but also in underlying models of health care. Specific community models can include traditional and folk healing methods (for examples see Kleinman and Lin 1981; Tseng and Young 1981); perception of specific Western practices as effective or ineffective (such as the Vietnamese view of injection as more effective than oral ingestion of medication); and expectations about the roles, functions, and treatment practices of providers. As mentioned earlier, training is necessary for providers to overcome the stranger-as-helper issues and the resistance of clients to the unfamiliar role of the provider.

COMMUNITY SUPPORT, LINKAGE, AND ACCEPTABILITY

For Southeast Asian refugee populations, the community is the arena for interaction and exchange; thus, it is not uncommon to see in large urban areas a concentration of Vietnamese, Cambodians, Lao, Hmong, and Chinese in specific areas of the city (for example, in San Francisco, in the Tenderloin area, and in Boston, in the Chinatown area). Since mental health concerns and mental illness are stigmatizing to the individual (and the family), the community's reaction to them plays a critical role in whether clients seek and continue treatment. Program planners and providers must engage community members and leaders in developing support for and acceptance of mental health services within the refugee community. Training programs that teach skills needed to develop community support and acceptance are critical.

DEGREE OF ACCULTURATION

Several studies (Connor 1974; Kikumura and Kitano 1973; Masuda et al. 1970; Meredith and Meredith 1966) have noted the greater similarity to white personality characteristics and the adoption of white American values by Asian Americans who have become more assimilated or acculturated into mainstream America. The greater the assimilation, acculturation, or biculturality, the more likely it is that such individuals will find Western-oriented mental health services acceptable and appropriate. Lee (1982) has indicated four variables that are related to acculturation: (1) years in the United States, (2) country of origin (more Western-like countries of origin make for easier transitions), (3) professional affiliation and status, and (4) age at immigration. To the extent that individuals remain unassimilated, special efforts must be made via such channels as mental health education, information programs, and pretherapy orientation to ensure a good match between the need for services and the availability of mental health services. Especially for refugees, the request for mental health services may be instigated by some third party--a school counselor, a family court, or a public health nurse, for example. An

accurate assessment must be made of the client system as to the degree of acculturation and the extent of receptivity and understanding of mental health treatment. Training in making such assessments is of major importance.

RELIGION

Although a limited number of religions or philosophical systems, Western or Eastern, can be said to be prevalent with Southeast Asian refugees, both Western religions (such as Catholicism and Protestantism) and Eastern religions (such as Buddhism, Taoism, and Confucianism) are practiced, depending on the degree of assimilation and acculturation to the West. In some Eastern religions, priestly functions and roles are associated with a self-disclosure inherent in verbal therapies. However, in others, the qualities of endurance, self-sacrifice, and personal suffering are admired and fostered. Strong belief in such qualities results in a stance completely at odds with the verbal expressiveness of Western modes of treatment. Thus, the client's religious beliefs can have a significant effect on participation in mental health services.

LANGUAGE

Because small nuances of speech can imply major differences in meaning and connotation, language is an important consideration. If a provider does not speak the language (or the particular dialect) of the client, the client-provider gap can be tremendous. The gap can be widened by differences in socioeconomic class, educational level, sociopolitical identification (such as coming from North or South Vietnam), age and sex, generational status in the United States, and vocational-professional standing. Linguistic, structural, and lexiconal variations in the different Southeast Asian languages provide the native speaker (most often the client) with subtle but specific cues about the provider and the nature of the treatment relationship. Few alternatives exist in the mental health treatment of monolingual or English-limited clients to language proficiency by the providers. The use of a translator

for services may be necessary, but often this only provides rough approximations of the expressed meanings of the client. Language gaps represent one of the most difficult barriers to adequate services for Southeast Asian clients. To a large extent, language constitutes an untrainable area to nonnative speakers when it comes to mental health treatment.

COST

Refugees are usually not covered by medical insurance or other third-party benefits. At the same time, cultural values governing obligation and self-sufficiency may result in conflict within families over participation in financially assisted services for which fees are not collected. Moreover, for many Southeast Asian immigrants (those who are sponsored to the United States and are not admitted as "refugees") who may want to achieve permanent legal status as residents in the United States, participation in a government-supported service, usually Medicaid or Medicare, may be at odds with their goal, because immigrants must be family sponsored and, therefore, not in receipt of federally sponsored benefits. Training for effective and sensitive handling of issues of cost determination and ability to pay constitutes a significant element in successful service delivery.

PERCEIVED RESPONSIVENESS OF SERVICES

It is important for "gatekeepers" in the mental health setting to know how to convey a sense of acceptance and willingness to help. For Southeast Asian refugees, the perception of responsiveness can be enhanced by various measures: (1) an acceptable name for the facility, (2) the general appearance and upkeep of the facility and waiting areas, (3) bilingual assistance on the first telephone call, (4) friendliness of reception personnel, (5) a pre-first-session confirming telephone call, (6) a postsession followup call, (7) willingness of providers to assist in other functions besides mental health services (such as translation services), (8) taking a more informal and less professional role, and (9) willingness of the provider to share information

about himself or herself. One of the clearest indicators of responsiveness for monolingual or English-limited refugee clients on encountering the mental health system is a staff that can speak to them in their primary language. To improve perceived responsiveness, an effective procedure is client-flow/client-entry system evaluation to identify practices associated with varying utilization. For non-Southeast Asian providers, training procedures involving role playing and stimulation of initial sessions with Southeast Asian refugee providers have been important toward sensitizing individuals to actions and nuances that come across a responsive to refugee client care.

LOCATION AND KNOWLEDGE OF FACILITIES

Kim (1978), in her study of Chinese, Japanese, Korean, and Pilipino Americans in the Chicago area, found that for a significant number of Asian Americans, especially immigrants and women, a primary reason for not seeking help was not knowing where to go. Refugees' lack of knowledge of service facilities can be corrected by good public information/education/relations programs. Problems related to location, given the need to serve a dispersed population, are not so easily overcome. For example, Sue and Morishima (1982) note that in the Seattle area, Southeast Asian refugee clients may have to travel over 100 miles before they can use the Asian Counseling and Referrals Services. In Los Angeles, some clients have to travel even greater distances in the use of the Indochinese Counseling Services.

Another barrier for refugees is the catchment or service area restrictions limiting who can be served. Since many Southeast Asians are spread much wider than one catchment or service area, their participation in one specialized mental health program, with its concentrated resources, is problematic. Training that fosters a positive attitude toward clients who come from widely dispersed areas is important for effective services to the refugee population.

HOURS OF OPERATION AND CLIENT/FAMILY WORK SCHEDULES

Southeast Asian refugee families tend to have extended work hours (sometimes two or more jobs) and multiple family members at work. Very few can get release time to utilize mental health services during normal office hours. In order to ensure accessibility, flexible scheduling (e.g., provisions for evening or weekend hours) may be necessary.

BROADER SYSTEM-LEVEL FACTORS IN CLIENT-PROVIDER FIT

COMMUNITY ORIENTATION

Services that are to be highly utilized and effective must be community based and have strong linkages, positive credibility, and a good reputation with the particular Southeast Asian community and its networks. Providers should be known within, or be members of, the ethnic community. Although sometimes affiliated with major institutions, they should be located in or near the particular Southeast Asian community. Southeast Asian community members should be active on the governing or advisory boards of such programs if there is to be a sense of pride within the community about the existence of the facility.

AGENCY ORIENTATION

The agency should have a positive "track record," based on their commitment, performance, attitudes, and longstanding services to the community. There should be a review and evaluation of the present and past and a planned perspective toward future services. Southeast Asian community members are a part of this history and expect to be a part of the future.

OUTREACH ORIENTATION

Requiring clients to come to the agency for services should be deemphasized. Rather, services should be provided within cost constraints and clinical appropriateness in the home or in more familiar settings, such as churches, schools, and community centers. Staff members should not be penalized for such work by making it lower in status--for example, by assigning paraprofessionals to outreach and more credentialed clinicians to "therapy." Rather, outreach should be considered vital and highly skilled work. Community members would then perceive providers to be a part of their community, its events, and its activities.

HUMAN RESOURCE ORIENTATION

A spirit of mutual teaching and learning pervades the environment in which service providers explore with and learn from peers and subordinates and always seek to enhance their skills. No clinician necessarily knows the diverse and complex world of Southeast Asian populations, and an open learning-growing environment contributes to the development of programs in which staff are viewed as resources for the organization. Activities to enhance the ability of the community members to help each other (such as community education forums) and to share with staff (such as training workshops) are encouraged.

TREATMENT-SYSTEMATIC APPROACH

Services should be planned, organized, implemented, and evaluated not as the sum of the various program parts and individuals that make up those programs, but as a coordinated and continuous delivery system. Thus, ethnic personnel should not be added in a piecemeal fashion; rather, selection of staff and program elements should be made for their contribution toward the total mission of the agency in providing mental health services.

CRITICAL MASS

A certain minimum number of ethnic staff and of clients appears necessary for a successful program. The actual number depends on the kind of staff (professional field, ethnicity) and the kind of programs (inpatient, partial day, outpatient, preventive). Programs that merely add single "minority specialists" do not appear to have as much impact (Wu and Windle 1980).

MULTIDISCIPLINARY SUPPORT

Programs with shared support and decisionmaking across disciplines in services, planning, and other programmatic functions appear effective. For Southeast Asian communities, with the limited number of mental health professional and nonprofessional human resources available, multidisciplinary support is a necessity.

COMMUNITY NETWORK ORIENTATION

Services and programs should be organized as a part of the total community network of human services to a Southeast Asian community. Emphasis should be put on collaborative and cooperative relationships among service programs. Interagency referrals and resource sharing should be encouraged.

INDIRECT BENEFITS

Programs and agencies organized around programs that have some preventive and indirect services (e.g., consultation, mental health education and information, community organization, and program technical assistance) appear to have their direct clinical services enhanced. Staff and programs are organized around prevention as well as direct services; interest in indirect service programs is shared by the majority of the staff.

TRAINING PROGRAM STRATEGIES AND APPROACHES

A variety of training program strategies to enhance the fit between the provider and the refugee client exist. We will categorize the strategies in terms of the proposed target of training; that is, (1) individual-directed strategies, (2) group-directed strategies, or (3) agency- or program-directed and larger service-system-directed strategies.

INDIVIDUAL-DIRECTED STRATEGIES

Individual-directed strategies include, at their most important level, specific professional and nonprofessional training programs to produce qualified personnel to provide mental health services to Southeast Asian refugees. Such strategies include training bilingual, bicultural providers as well as non-Asian providers. Current professional training programs have the capacity to train bilingual individuals of Southeast Asian ethnic backgrounds for service in their respective communities (if such individuals were available). But training programs to provide such focused training primarily for professionals and targeted to Southeast Asian refugee communities do not exist. In this regard, a regional or national training center is proposed later. There have been, however, examples of training programs specifically earmarked for these communities in the training of nonprofessionals for mental health services to Southeast Asian refugee communities. The example presented below, directed by the author, provided first-hand knowledge of the processes and methods involved

The Bay Area Indochinese Mental Health Project was one of the mental health training projects funded under the Social Security Discretionary Grants in 1979. The objectives of the project were (1) to effect the existing mental health delivery systems in as many of the bay area counties as possible, (2) to increase employment opportunities for trained Indochinese refugees in the existing mental health systems through career planning and other supportive services of those trained,

and (3) to create a comprehensive community support system within the bay area counties.

To accomplish the above objectives, a multidisciplinary training team consisting of a psychiatrist, a psychologist, a social worker, a psychiatric nurse, and administrative support personnel was assembled under the direction of the author to conduct a 1½-year training cycle.

The project was conducted in five bay area counties of California. In order to impact the existing mental health delivery system in as many of the bay area counties as possible, the project was integrated into the Alameda County and Berkeley County mental health systems in the east bay and into the San Francisco County mental health system in the west bay, through the placement of six Indochinese mental health paraprofessional trainees. The same field placement agencies providing training for the year-long program agreed to serve as the sites for the second year of the project (see table 1). The training program for the second year had also been presented to 26 mental health, educational, health, and/or social service providers in the bay area with regard to their possible participation with the project.

The project had initiated dialog with 31 mental health and other human service programs and agencies to discuss services available to Indochinese refugees and the mental health needs of some of these refugees. Generally, a great deal of interest was shown about the Indochinese community and the project by these agencies at that time (1978). Many knew little about the plight of the refugees and the mental health issues involved or of services available. In terms of longer range planning of mental health services, the project met with the bay area county mental health planners (Alameda, Contra Costa, Marin, San Francisco, and San Mateo Counties) to discuss the possibility of employment for the trainees after termination of the project and to discuss the needs of the mental health projects. Staff and Community Advisory Board members had also given testimony to the Bureau of Census (on the concerns of the Indochinese) and to the United States Civil Rights Commission (on mental health issues

TABLE 1.--Field placement sites

Name and location	Public or private	Type of service/ other information
Langley Porter Neuropsychiatric Institute, University of California Medical Center, San Francisco (Crisis Intervention Unit)	Public	Inpatient mental health services (West Bay--San Francisco side)
Highland Psychiatric Emergency Services (Asian Unit), Highland General Hospital, North County Mental Health Services for Alameda, Albany, Oakland, and Berkeley, Oakland	Public	Inpatient mental health services (East Bay--Alameda side)
Gladman Day Treatment Center, Gladman Memorial Hospital, Oakland	Private	Intermediate care--partial mental health services (East Bay--Alameda side)
Chinatown/North Beach Community Care Center, Northeast Community Mental Health Services, San Francisco	Public	Intermediate care--partial hospitalization mental health services (West Bay--San Francisco side)
Adult Outpatient Service, Berkeley Community Mental Health Services, Berkeley	Public	Outpatient mental health services (East Bay--Alameda side)
Richmond Maxi-Center, District V Community Mental Health Center, San Francisco	Nonprofit, community	Outpatient mental health services (West Bay--San Francisco side
Twilight Service Center Asians for Job Opportunities in Berkeley, Berkeley	Nonprofit community	Preventive mental health services--consultation, education, and community outreach (East Bay--Alameda side)
Bay Area Indochinese Mental Health Project, San Francisco	Public	Preventive mental health services--consultation, education, information, and community outreach (West Bay--San Francisco side)

related directly to Indochinese and other Asian American groups).

Informational brochures were developed and disseminated among mental health agencies and programs and served as introductions to Indochinese mental health services and training. A slide show on the project had also been developed and shown to the staffs of mental health and social service agencies; it was used as a vehicle to educate, inform, and initiate dialog with these service providers.

Much of the project's activity revolved around the full-time training of six Indochinese persons (three Vietnamese, two Cambodians, and one Laotian who spoke Lao, Yao, Laotheun, and Hmong) as mental health professionals. Training was approached in two primary modes, field experience and classroom experience, and emphasized two major components: training in the delivery of direct clinical services, and the delivery of indirect preventive mental health services. On the average, 2½ days were spent on direct clinical services training, and 1½ days on indirect services. The remaining day of the week was devoted to classroom training that included training seminars, case conferences and practicum, and individual supervision.

The trainees were placed in inpatient, intermediate care, and outpatient settings. For inpatient and intermediate care training, the emphasis was on a general exposure to these modes of service. For the outpatient settings, the first month was also spent on orientation to this type of service delivery; however, the training following was more comprehensive. The trainees saw clients (non-Indochinese as well as Indochinese clients) under the supervision of mental health professionals provided through the staff of the outpatient settings. Training in other areas of outpatient community mental health was given (e.g., administration, outreach, and preventive services). The trainees participated in team meetings, case conferences, staff meetings, intake interviews, and recordkeeping.

Training in the indirect preventive mental health services was accomplished in two primary sites. For Alameda and Contra Costa Counties, trainees were placed

at Asians for Job Opportunities in Berkeley (AJOB) and participated in outreach, consultation, education, and information activities. AJOB provided on-the-job training in these areas and introduced community outreach techniques to Indochinese paraprofessionals. Trainees placed at AJOB developed bilingual informational and educational materials and organized the Indochinese Family Workshop that was presented to the staff of the Berkeley Community Mental Health Center, the International Institute of the East Bay, and the Berkeley Health Department.

The project site for the Bay Area Indochinese Mental Health Project served as the coordination and training site for San Mateo, Marin, and San Francisco Counties. Trainees had received training in the development of materials aimed at making an impact on the existing mental health system and informing the Indochinese community about services and mental health. Agency-centered and client-centered consultations were a focus for Indochinese paraprofessionals trained in the West Bay. Skills in community organization were fostered through activities aimed at organizing informal "block meetings" in the Cambodian community and through the coordination and organization of a television show on the Laotian community. All trainees actively participated in a number of educational and informational activities through the development of bilingual audio-visual materials.

Classroom training was an integral part of the overall program and worked hand-in-hand with field work. Utilizing a multidisciplinary approach, three of the major mental health professions (psychiatry, psychology, and social work) ere represented in the training staff. The direct services seminars and practicum/case conferences (see table 2) were primarily provided by the director of clinical training/psychiatrist and by the psychologist. The indirect services meetings and practicum (see table 3) were coordinated primarily by the psychiatric social worker. All staff, however, participated in the entire program and worked cooperatively to insure input of training materials from each discipline.

TABLE 2.--Classroom training in direct mental health clinical services

Session	Seminar (2 hours)	Practicum/ case conference (1 hour)
1	Medication: psychoactive drugs	Mental status exam (review of role play assignment)
2	Medication: psychoactive drugs	Use of psychiatric medications (symptomatology)
3	Napa State Hospital field trip	None[a]
4	Medication: review	Therapeutic interview (role play)
5	Medical issues in logical problems	Therapeutic interview (role play)
6	DHEW conference	None[a]
7	Family therapy	Global assessment scale
8	Family therapy	Global assessment scale
9	Psychoanalytic theory	Accurate translations (guest speaker)
10	Psychoanalytic theory	Psychoanalytic terminology
11	Psychoanalytic theory	DSM: test and review
12	Behavior theory	DSM: test and review
13	Behavior modification	DSM: test and review

[a]Time used for seminar.

TABLE 3.--Classroom training in indirect preventive mental health services

Session	Indirect services meeting (1 hour)	Practicum (2 hours)
1	Informational brochures	Agency site visits (sign-up), slide show (visual development)
2	Agency visits, forms, and procedures	Slide show (visual development) role play agency visits
3	Napa State Hospital field trip	None[a]
4	Consultation (review of articles)	Role play agency visit, process of interview, review slide show
5	Consultation (presentation)	Slide show, script taping
6	DHEW conference	None[a]
7	Conference discussion, consultation	Client and consultee-centered consultation
8	None[b]	Slide show (finalize script, translations)
9	None[b]	Slide show (editing)
10	Community organization	Community outreach techniques
11	Site visit to Indochinese training project	None[a]
12	Cultural workshops	Workshop format

[a]Time used for meeting.

[b]Time used for practicum.

The project facilitated a community comprehensive support system within the bay area counties (objective III) by developing bilingual mental health brochures and audiovisual slide presentations in Cambodian, Laotian, Vietnamese, and English to inform the Indochinese population about mental health and the services available in the bay area. To facilitate interagency cooperation in serving Indochinese refugees, the staff compiled, published, and distributed a resource directory of the major mental health and social service programs available to the Indochinese refugees in the bay area counties and conducted a systematic needs assessment study. Project trainees made numerous site visits to bay area mental health agencies, educational and English-as-a-second-language training programs, and medical institutions. With these activities, not only did the trainees exchange information, but interagency dialog was facilitated. The project also met monthly with the San Francisco Indochinese Refugee Forum, the project community advisory board, and the Richmond Area Multi-Services board of directors to help coordinate a regional mental health network to serve Indochinese refugees.

Numerous media organizations contacted the project to request help in organizing special shows devoted to Southeast Asian communities. For example, Laotian community leaders throughout the State met several times at the project site for one show. In addition, the project provided consultation to the Film Arts Foundation on the issues and problems of Vietnamese for a documentary film. The staff was involved in presentations of the project to the American Psychiatric Association, the Pacific Asian American Center (Santa Ana); the Training Program in Ethnicity and Mental Health (Boston); various academic institutions, including Boston University, San Francisco State University, the University of California (Berkeley), and the University of Washington; the regional Department of Health, Education, and Welfare conference; an Indochinese mental health conference held in San Diego; and the psychiatric observation team of the Peoples' Republic of China that specifically expressed interest in the paraprofessional training program.

At the conclusion of the project in 1980, six bilingual, bicultural nonprofessional providers were trained to provide mental health services to their communities. It can be seen that the training of these individuals is a time consuming and slow process. In a followup of each of these six trainees 5 years later, all of the six had remained in the mental health and human services field. One individual during the course of the project (funded by State and foundation funds after 1980) had achieved a master's degree in social work. Another trainee held a social worker position in a different county without a graduate degree. Two of the six remained as nonprofessional mental health workers (and both are trying to complete the requirements for their bachelor's degrees). One trainee is currently working as a resettlement worker, and the sixth trainee is a bilingual teacher's assistant in the public schools.

Another kind of individual approach includes programs for upgrading individuals trained in similar or related disciplines for mental health services careers. The project at Asian Community Mental Health Services in Oakland, California, funded by the Office of Refugee Resettlement, Department of Health and Human Services, that was intended to provide internship opportunities to foreign-trained Southeast Asian refugee medical doctors is an example of such a program. Other individual approaches include one-session workshop and conference programs to sensitize providers to some of the clinical issues of service to Southeast Asian refugees and multisession programs of continuing education in universities and professional schools and organizations. Also, regional workshops targeted to areas with large concentrations of Southeast Asians focus on prevention of mental health problems and development and delivery of services involving providers and consumers are considered essential to the overall training programs. These regional workshops (in California, Illinois, and Massachusetts) were successfully sponsored and conducted in 1983 by the National Institute of Mental Health in conjunction with the Office of Refugee Resettlement and the Office of Refugee Health, all of the Department of Health and Human Services.

GROUP-DIRECTED STRATEGIES

Group-directed strategies are directed at existing service- or program-related groups of providers. These strategies rest on the assumption that for training purposes there exists some built-in network or relationship for ongoing meetings among the members of the group. Such groupings could be as unrelated as a group of strangers attending a weekly class for a semester or as related as a group of the members of the adult outpatient team responsible for mental health services to the refugee population in a particular area. More ongoing group training approaches include prearranged workshops and case consultations.

The workshop and case consultation program provided by the Richmond Area Multi-Services of San Francisco under the direction of the author to the social and human service outreach workers and their supervisors in Arizona is an example of such an approach. The Richmond Area Multi-Services, Inc. (the umbrella organization for the Bay Area Indochinese Mental Health Services), established an integrated and coordinated package of workshop and case consultation training for Vietnamese and Cambodian mental health outreach workers. Two workshops, along with six case consultation sessions spread across 6 months, were implemented. A multidisciplinary, multiethnic training team that included a Vietnamese psychiatrist, psychologist, psychiatric social worker, and mental health worker, and a Cambodian outreach consultant and mental health worker provided the onsite teaching and consultation. Following an initial needs assessment, the training team, consisting of both Vietnamese and Cambodian bilingual and biliterate mental health specialists (as well as specialists in teaching and training), worked with (1) the individual outreach workers, (2) their supervisors, (3) the other members of the facility treatment team, and (4) the treatment agencies to develop mental health services for the Vietnamese and Cambodian communities in Arizona. Training involved didactic and practicum workshops in direct as well as preventive mental health services. Case consultation emphasized methods and processes that enriched and facilitated ongoing relationships in clinical supervision and expertise in the existing host mental health agencies. Following each

workshop and each set of case consultations, material presented and discussed was distilled and summarized for inclusion in a training manual. In addition to the training manual, the consultants provided suggestions for the development of a library of resources on Southeast Asian refugee mental health (e.g., videotapes, books, articles, and other materials).

Training and Consultation Objectives

The major objective accomplished through the provision of two workshops and six case consultation sessions was enhancement of the mental health skills of Southeast Asian bilingual, bicultural case workers so they could provide mental health services to the estimated 5,000 Vietnamese and Cambodian refugees in Arizona. To accomplish this objective, emphasis was placed on quickly teaching a set of skills that we had found important in over 6 years of training mental health workers. Two sets of workshops spaced 3 weeks apart provided the skills. Each workshop had staff with Vietnamese and Cambodian language expertise. However, workers were urged to express and communicate in English those mental health concepts needed to work in any current mental health system. The bilingual language used insured understanding of concepts by the workers. Between the two workshops, the training staff coordinated with the State staff to arrange for a complete rotation (for the purpose of training) of the workers in key mental health facilities and programs. The emphasis in training was to enhance and facilitate the existing support and clinical resource networks of the workers and their colleagues. Focus was on developing mutually shared and trusting collegial relationships. For the case consultations, the emphasis and focus noted for the workshops were reinforced.

Training Curriculum

Workshop I was designed to provide the Vietnamese and Cambodian mental health worker with an introduction to the diverse skills necessary for his or her work. Emphasis was placed on learning the resources within the host agency and the community. Basic

mental health skills were provided with the aim of teaching the workers how to maximize those skills through the use of consultation and supervision from their superiors, peers, and colleagues. The mental health workers were also taught to acknowledge their limitations as well as to work within the bounds of their comfort level and their newly acquired skills. Topics covered in workshop I were as follows:

- Mental health problems and practices
  - -- differences between Southeast Asian views and American views (slide show)
  - -- family and community issues in mental health
  - -- mental health services system
  - -- role of mental health workers
  - -- issues of confidentiality, ethics, and the law
- The work of mental health workers
  - -- making connections (referrals, information, education)
  - -- providing transiations (videotaped training program)
  - -- assessing problems (role play)
  - -- crisis intervention (case vignettes)
  - -- mental health treatment
  - -- health promotion and prevention
- Some critical assessment problems
  - -- suicidal behavior
  - -- violent and homicidal behaviors
  - -- gross disability because of mental disorder
  - -- family conflict involving child or wife abuse and family violence
  - -- special problems of each ethnic grouping
- Mental health worker skills
  - -- basic interviewing
  - -- understanding assessment (DSM-III; psychological testing; standard instruments, e.g., DIS, CES-D, MMPI)
  - -- explaining and translating medication issues
  - -- medical issues
  - -- cultural issues

- Services provided by the worker
  - -- setting up a treatment plan
  - -- using case management techniques
  - -- using "talking" interventions
  - -- providing activities and support
  - -- helping to explain medications
  - -- facilitating family and community support
  - -- providing information and referrals
- Knowledge of the mental health services system
  - -- national level
  - -- State and regional level
  - -- local and community level
- Other skills that will help in treatment
  - -- effective case presentation (video feedback)
  - -- using peers and supervisors
  - -- using assertiveness skills
  - -- continuing education
  - -- career strategies and planning

Workshop II was designed to enhance and further refine the skills and understanding of the mental health worker in more advanced and selected topics. Included were:

- Issues of informed consent, confidentiality, and legal considerations
- Medication effects, side effects, and cultural impacts
- Familiarity with the diverse systems of mental health treatment
  - -- psychoanalytic considerations
  - -- behavioral considerations
  - -- family therapy
  - -- group therapy
  - -- crisis intervention theory
  - -- biological considerations
  - -- community psychology
  - -- case management considerations

- Prevention interventions and health promotion
  - -- consultation
  - -- education/information
  - -- community organization
  - -- community client care
- Research and program evaluation
- Management information systems and recordkeeping

Additional workshop II objectives included:

- providing opportunities for the Cambodian and the Vietnamese case workers to communicate in their first language to better understand the content of the workshop;
- providing additional training and skill-building sessions on life crisis counseling and on family violence or child abuse; and
- providing opportunities for outreach workers, their supervisors, and other agency personnel to meet and to learn about the local, State, and Federal mental health system and select staff representatives.

Finally, three sets of 2-day case consultations provided 1 month apart focused both on enhancing the skills and understanding of the mental health worker and on facilitating the relationships of supervisors and peers at the host service agencies. In this way, a network of support and resources was developed for the workers. A facilitative model of consultation was used with a focus on the problems and concerns expressed by the worker and his or her supervisors in the course of the worker's clinical cases.

Training programs provided for refugee mental health crisis intervention training and technical assistance similar to the one documented above include: (1) Lakeview Associates, Pensacola, Florida, (2) Hunter College School of Social Work, New York, New York, (3) Child and Family Services, Honolulu, Hawaii, (4) Amherst

Wilder Foundation, St. Paul, Minnesota, and (5) Asian Counseling and Referral Services, Seattle, Washington.

Other group-directed strategies and approaches include: in-service training for staff, program and community orientation sessions for agency staff, and group supervision and case conferences using Southeast Asian knowledgeable discussants.

AGENCY- AND PROGRAM-DIRECTED STRATEGIES

Agency- and program-directed strategies and approaches include organizational efforts and resources to train individuals. Such resources include field training sites, internship training sites, ongoing clinical supervision, and in-house seminars and workshops. Although there currently does not exist any organization that is involved in the professional field and internship training of individuals for specific services to the Southeast Asian community, we propose below a model of how such an organization might function.

MODEL OF A REGIONAL OR NATIONAL TRAINING CENTER

To bring together the clinical and cultural experiences necessary to develop the training, research, and knowledge bases that are critical to professionals serving the Southeast Asian communities, we recommend the establishment of a regional or national multidisciplinary, multiethnic training center. A multidisciplinary approach would provide a sufficient "core mass" for training and knowledge development. As noted by the President's Commission on Mental Health (1978), traditional training programs in the mental health disciplines of psychology, psychiatry, social work, and psychiatric nursing have neither significantly increased the number of Asian/Pacific Islander American graduates nor adequately equipped them to serve the mental health needs of refugee populations. The vast majority of the traditional training programs have lacked the necessary expertise, interest, qualified training staff, and knowledge base. They have tended to provide

little opportunity for contact with Southeast Asian clients and communities. This situation indirectly discourages service to refugee populations and denies potential students the necessary training that should be available during critical junctures in their professional careers.

Not only is there a lack of sufficient training resources, but most Southeast Asian and other Asian/Pacific Islander American communities usually constitute much less than a majority of a catchment area's population. A larger geographic or demographic area, such as a county or metropolitan area encompassing many catchment areas, is often needed before the number of Southeast Asian and other Asian Americans becomes significant. It is therefore far more efficient and logical, from an organizational standpoint, to pool minority staff and expertise to establish regional and national multidisciplinary mental health training centers and service programs than to attempt to duplicate efforts within several community mental health centers that have limited resources or within one particular discipline that has insufficient training resources.

The typical community mental health service center employs few bicultural and bilingual staff members, which tends to discourage Southeast Asians from seeking services. Regional training/service centers are desirable because they would maximize the number of faculty members, trainees, and refugee clients within a geographic area, resulting in a more efficient and higher caliber training program. Several training centers--the San Francisco Bay Area Asian Community Mental Health Training Center, the Asian Counseling and Referral Service in Seattle, the Asian American Mental Health Training Center in Los Angeles, and the Bay Area Indochinese Mental Health Project--have demonstrated that increases in the bicultural and bilingual staff correlate significantly with increases in Asian client loads. Where there is adequate staff representation of Asians at a regional training/service center, there is a greater utilization of mental health services by Asian Americans. Conversely, the Asian American community must also utilize health services in order to provide training and research opportunities for Southeast Asian mental health professionals.

To maximize training and research opportunities and fiscal resources, regional training/service centers should be located in geographic areas with large Southeast Asian populations. One of the major objectives of these centers should be the training of Southeast Asian mental health faculty capable of providing training and mental health services for Southeast Asians in areas throughout the country. Also, these centers could bring together students from around the country for continuing education seminars.

To maintain the highest educational and training standards, the national or regional training/service centers should be affiliated with universities or other training institutions. Such programs should produce individuals academically qualified within their disciplines but not necessarily restricted to their areas of special interest or to serving only Southeast Asians. In order to better maintain the integrity of the goals and objectives of the Southeast Asian populations they serve, the centers should have significant representation from the Southeast Asian and other Asian/Pacific Islander American communities on the governing board of directors or advisors.

NATIONAL ASIAN AMERICAN PSYCHOLOGY TRAINING CENTER

The NIMH-funded National Asian American Psychology Training Center in San Francisco provides a concrete example of how such a regional or national training center for Southeast Asian refugee mental health might be organized.

The training program of the National Asian American Psychology Training Center is composed of both supervised clinical-community field work and didactic seminars. The director of training, advised by a board, coordinates three program components: (1) clinical training, (2) educational coordination, and (3) research and evolution. The core training is accomplished at field training sites, which involve at least four separate agencies that offer a broad range of mental health services to the Asian/Pacific Islander American communities in the bay area. The three agencies are the Richmond

Maxi-Center (San Francisco), the Asian Community Mental Health Services (Oakland), the Northeast Mental Health Center (San Francisco), and the Asian Psychiatric Ward of San Francisco General Hospital.

The different field sites facilitate a broad range of clinical experiences. For example, trainees are able to see Asian and non-Asian clients. Some of the sites are located in urban and others in suburban areas. Some agencies deal mainly with preventive and indirect services (e.g., consultation, education, information, and community organization), while others offer primarily direct services. The variety of sites offers trainees the opportunity to see clients of all ages and varying degrees of emotional disturbance (crisis to chronic). Furthermore, trainees who have special interests may request an assignment to Chinatown Child Development Center in San Francisco, the Counseling Center for Asian Wives (mixed marriages) in Sacramento, Vacaville State Prison, or Napa State Hospital.

All trainees attend seminars at the Richmond Maxi-Center, as well as seminars that have been made available in collaboration with other nearby training programs. Seminars address the standard issues in psychological theory and psychotherapy, but also emphasize their relevance and applicability to Asian/Pacific Islander American clients; as well they address psychological issues unique to this population. Issues such as prevention, outreach, and working with mental health systems are covered.

There are also opportunities for trainees to do research and to explore program administration and planning. Clinical supervision is provided by Asian/Pacific Islander American psychologists; however, all of the four primary sites have a multidisciplinary staff; consultation and extra supervision by Asian and non-Asian mental health staff from other disciplines are available. The establishment of the field sites and hospital sites promotes collaboration. The training program is conducted in community-based facilities that have had proven effectiveness in providing services to Asian/Pacific Islander American communities.

Although the mental health problems and concerns of Asian/Pacific Islander Americans are often interwoven with other problems--cultural, social, vocational, and medical--training in these community-accepted mental health programs allows trained professionals to work in the context of client-defined problems, with relevant and appropriate mental health service resources in an acceptable service delivery system.

Training also includes exposure to and some experience with the full range of community mental health services of each county in which the agency is located. These services are delivered through three direct treatment modes: (1) 24-hour care, which may include residential care, sub-acute care, acute hospital care, and acute nonhospital care; (2) partial day care, which may include hospital day treatment, nonhospital day treatment, sheltered workshop, and social activity centers; and (3) outpatient care, which may include individual therapy, group therapy, family therapy, assessment, medication, crisis intervention, and coliateral services. In addition, there are four modes of indirect community services: (1) mental health consultations, (2) mental health information and education, (3) community organization, and (4) community client care. Alcoholism and drug abuse programs are part of the mental health service system of the counties. Such work experience in the community mental health system allows trainees to assess and to transfer similarities and differences in treatment modalities for Asian/Pacific Islander Americans with clients of other ethnic backgrounds.

Candidates for the training program are doctoral students already enrolled in a university clinical and/or community psychology doctoral program; the training program combined with placement serves as a full-time, 1-year internship. Two students were trained the first year, and up to a maximum of six students will be trained in subsequent years of the program. Some provisions have been made for postdoctoral training as well as special summer outreach programs for master's and undergraduate students. The special programs will be aimed at emerging Asian/Pacific Islander American communities that may not at the present time have candidates ready for doctoral training.

The primary goals and objectives of the training program are as follows:

- To increase mental health service resources for Asian/Pacific Islander American communities, with special focus on underserved and unserved groups such as children, the elderly, and emerging groups:

  -- by recruiting and enrolling as trainees qualified bicultural and bilingual Asian/Pacific Islander Americans with backgrounds in clinical and/or community psychology and who have interests in developing mental health service skills appropriate to Asian/Pacific Islander American communities; and

  -- by carrying out special outreach efforts (such as summer programs and community education) in order to attract members of emerging Asian/Pacific Islander American groups to the field of psychology and mental health services. These efforts will be aimed at persons with minimal training in psychology as well as individuals who have an extensive background in nonclinical psychology.

- To increase the relevance and utility of psychological theories and research to Asian/Pacific Islander American communities by examining and/or testing the applicability and relevance of:

  -- existing psychological theories and models vis-a-vis the Asian/Pacific Islander American populations;

  -- existing research methodologies for research with Asian/Pacific Islander American communities;

  -- existing psychological intervention techniques as they relate to the mental health problems of Asian/Pacific Islander American individuals; and

  -- current psychological assessment methods for Asian/Pacific Islander American groups.

- To increase the awareness of institutions of higher learning, professional training centers, service delivery systems, professional psychologists, and mental health service providers of the issues and needs of Asian/Pacific Islander American communities and individuals:

  -- by collaborating with these institutions, agencies, and individuals in meaningful activities, such as joint seminars, colloquia, or case discussions;

  -- by helping and encouraging these institutions to implement courses that are of greater relevance to Asian/Pacific Islander American cultures, psychology, and people;

  -- by encouraging changes in their recruitment methods and admissions policies vis-a-vis Asian/Pacific Islander American applicants, students, and trainees;

  -- by establishing and maintaining systemic linkages with public and private mental health agencies, at least in the geographic area in which the training center is located; and

  -- by disseminating to these institutions and agencies and to the community at large, information about new research methodologies, intervention techniques, and knowledge about Asian/Pacific Islander communities.

- To promote support and interaction among Asian/Pacific Islander American psychologists as well as other professionals:

  -- by developing a social and informational network that will strengthen the ties between Asian/Pacific Islander American psychologists and researchers across cultures and geographic locations; and

  -- by structuring activities that promote interchange of experiences and knowledge (e.g., newletters, collaborative research, collaborative community or social action, multidiscipline conferences, workshops, and collaborative policy planning).

The National Asian American Psychology Training Center provides an example for which a regional or national training program might be similarly developed for training professionals to provide mental health services to Southeast Asian refugee communities.

SERVICE-SYSTEM-DIRECTED STRATEGIES

Service-system-directed strategies are defined as training program approaches that affect credential and licensing bodies, accreditation and certification organizations, and State agencies or regional and Federal offices. The approach of a system-directed effort in training programs is one of obtaining the legislative language and the enforcement authority to exert recommended changes to existing training programs. The expectation of this approach is that production will occur in programs targeted toward training Southeast Asian refugee mental health personnel.

RECOMMENDATIONS

The report of the Special Populations Subpanel on Mental Health of Asian and Pacific Americans (1978) and the Report of the Consultants to ADAMHA (Nguyen et al. 1980) provide the two best sources for comprehensive recommendations on mental health training and services to Southeast Asian refugees. Rather than repeat those recommendations, I refer the interested reader to those reports. I would, however, like to highlight seven recommendations of major importance. These are

(1) significant participation of Southeast Asian refugees be implemented on all levels of decisionmaking and of program implementation for programs affecting the training of refugees;

(2) adequate coordination and collaboration be effected among the multiple training and service efforts related to refugee resettlement;

(3) ongoing consultations with government agencies relative to refugee training programs be emphasized;

(4) funding be allocated to training programs for bilingual, bicultural Southeast Asian refugee professional and nonprofessional personnel;

(5) mobile and flexible bilingual, bicultural service teams be encouraged in training and in service settings;

(6) prevention intervention training programs be supported; and

(7) community-based, ethnic operated programs be supported for training and service consortiums to Southeast Asian refugees.

Finally, the following strategies and models are advanced for Southeast Asian refugee mental health training programs: (1) augment existing mental health training services, personnel, and programs with additional bilingual, bicultural refugee providers; (2) create a parallel training program specifically for refugee bilingual, bicultural trainees; (3) create a special umbrella refugee organization containing multiple service and training programs; and (4) support and fund refugee community associations, coalitions, and consortiums to establish a national or regional mental health training center in an area with a high concentration of Southeast Asian refugee communities.

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MENTAL HEALTH AND REFUGEE YOUTHS: A MODEL FOR DIAGNOSTIC TRAINING

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INTRODUCTION

The crises of the refugee condition--involuntary migration, loss of home and ancestral homeland, family separation, the trauma of escape, and the myriad stresses and demands that confront all refugees as they resettle--seriously affect their psychological adjustment (Cohon 1981). While mental health problems among refugees span all age groups, their manifestations will vary since the psychological impact and interpretation of the "refugee experience" is always dependent on the age and stage of development of the survivor. Hence, the Southeast Asian refugee's psychological experience must be grasped within the context of the refugee situation. Refugee mental health training should be guided by a contextualized theory of development that allows for the influence of specific cultural and environmental variables. This chapter is written within such a framework.

Mental health concerns affecting refugee youths are of paramount importance in the study of the Southeast Asian populations in the United States. A salient

demographic feature of the Southeast Asian refugee population in American is its disproportionate share of young people. For example, data from the Indochinese Health and Adaptation Research Project (Rumbaut and Weeks, in press) conducted in San Diego County, indicate a median age of 18. This contrasts markedly with the median age of 31 for the rest of the American population. (See figure 1 for comparative age/sex pyramids for these populations.)

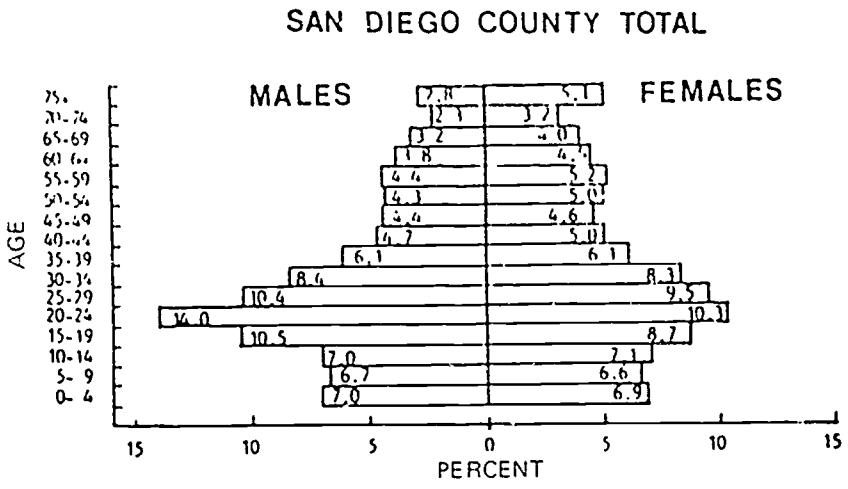
Despite their numbers, the mental health of Southeast Asian refugee youths has not been widely examined (Williams and Westermeyer 1983; Looney et al. 1979). Perhaps this is because mental health professionals have been justifiably impressed by their resilience, flexibility, and adaptability (Boothby 1983). Ironically, however, it is because of these extraordinary strengths that there is a greater danger of overlooking difficulties among these youths, and further, of misinterpreting the meaning of such difficulties.

In contrast to younger children who underwent the migration process before the age of 10, young people between the ages of 11 and 22 have been observed by the writer to be especially at risk for a range of affective, cognitive, and behavioral disorders. A plausible explanation for this observation is that refugee adolescents and young adults[1] combine in their experience concurrently, the developmental crisis of "identity formation"--which is the definitive psychosocial feature of adolescence (Eriksen 1968), with the biographical crisis of "coerced homelessness"--which is the definitive psychosocial feature of the refugee condition (Rumbaut and Rumbaut, unpublished). Thus, while there are broad cultural commonalities among all age groups of Southeast Asian refugees, there are some distinct experiential constructs (or contextual factors) influencing refugee adolescents.

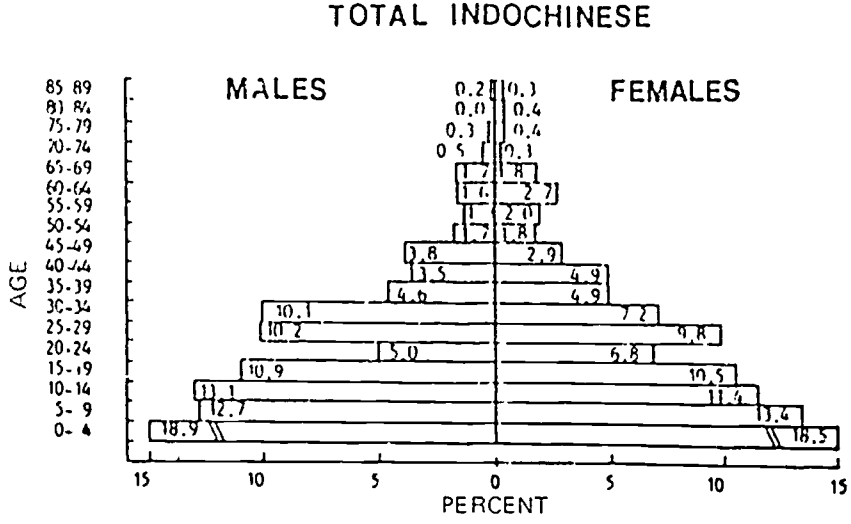
These factors set them apart and have decisive consequences for their psychosocial adjustment. Three major

[1] Also referred to interchangeably in this chapter as "youths" and defined as those between the ages of 11 and 22.

Figure 1—Age Pyramids: San Diego County Population vs. Indochinese Refugee Population



(1980 Census, N = 1,862,126)



(IHARP 1983 Household Sample, N = 2,486)

SOURCE Indochinese Health and Adaptation Research Project (IHARP) (Rumbaut and Rumbaut, unpublished)

sets of contextual factors can be identified: premigration factors; migration factors; and postmigration factors. Among the most significant of these are the following:

PREMIGRATION CONTEXTUAL FACTORS

1. The ethnicity and country of origin of the adolescent refugee and the timing of departure. Such information gives essential insight into the degree of traumatic conditions and migration processes that the adolescent may have undergone.

2. The class status of and resources available to the adolescent's family in the homeland. These include the socioeconomic status and the educational status of the parents, and an urban versus rural background. These "generalized resistance resources" (Antonovsky 1979) may affect significantly the coping capabilities of the refugee in dealing with extraordinary stress.

3. The general cultural values adhered to by Southeast Asians. Specifically, these include an emphasis on family interdependence, filial piety, "face," respect for teachers, elders, and authority, the education of children, spiritual beliefs, stoicism, fatalism, and a world view grounded in Eastern traditions. These factors affect the refugee youth's perceptions of the world and the means used to come to terms with that world.

MIGRATION CONTEXTUAL FACTORS

1. With whom did the young person leave? (i.e., with or without parents or family members). Whether or not the youngsters remain within intact family units during the migration process will affect their subsequent psychosocial development.

2. The escape or emigration experience. This includes the degree of trauma incurred in this process (e.g., attacks by pirates), especially as that trauma is subjectively interpreted by the youngster.

During the escape process there may occur an immutable transformation in the youngster's perception of others, of self, and of the larger universe.

3. The refugee camp experience. This includes the degree to which the camp provided (for some youngsters) a psychosocial moratorium during which they were able to put their flight and plight in perspective, and even muster dormant personal resources; and, conversely, the degree to which (for other youngsters) the camp experience led to increased psychic pain (sometimes culminating in psychotic episodes) and ill-made decisions (such as hastily arranged marriages) that would have long-term effects on their later psychological status.

POSTMIGRATION CONTEXTUAL FACTORS

1. With whom does the young person now live? Specifically, whether the youngsters are living with or without biologic parents, older siblings, distant relatives, or in foster homes.

2. The social ecology of the adolescent's resettlement region. The degree of "fit" or compatability between past and present environments and the lifestyles that the latter help to shape (for example, pace of life, geography, employment, size of community, density and heterogeneity of the population, and the presence or absence of established Southeast Asian enclaves in the resettlement area).

3. The reception experience in the host environment. This includes sponsoring arrangements, schools and educational opportunities, English language acquisition, vocational training, development of peer group relations and friendship networks, support from social service and health care agencies, and the degree of racism in the community.

One must recognize that Southeast Asian refugee youths often manifest the problematic behaviors of their American counterparts. For example, they may become suicidal, socially deviant, despondent, depressed, and

alienated, experience family conflict and disaffection from parents, do poorly in school, adapt an extreme manner of dress and makeup, and use drugs and experiment sexually. But for Southeast Asian youngsters, the underlying causes of these adolescent developmental behaviors are different in the way they correspond to, and are associated with, the unique set of contextual factors discussed. In their training to work with refugee adolescents, practitioners must be alerted to these differences, so that, despite surface similarities in observable behaviors, they will not misinterpret their implications.

The following section provides selected illustrations of these contextual factors, shows how they affect psychosocial development, and suggests some interpretive tools for training purposes.

The purpose of the following material is to frame a training model for practitioners engaged in the first phase of treatment, namely diagnosis and assessment. It employs a historytaking protocol format designed to sensitize practitioners to some of the basic issues relevant to the experience of Southeast Asian refugee adolescents and young adults. It does not focus on treatment interventions. Those issues are addressed elsewhere in this volume. Since refugee youths rarely utilize mental health professionals or mental health settings, the efficacy of this training model is enhanced by its easy application in other settings accessible to these youngsters--such as social service agencies, health care clinics, schools, and law enforcement and probation departments, where problem refugee youths frequently have their first contact with local agency staffs.

The following series of questions provide the foundation for exploring the "interiority" of the youngster. The practitioner should use informed clinical judgment to determine how much to probe the most painful events of the past, so as not to disturb the positive equilibrium of the self that may have been achieved through repression of trauma. We emphasize that these questions are not exhaustive, but rather are intended as a starting point for diagnostic assessment. Further, the questions can and ought to be used not only to

identify ego pathology but also ego strengths. (It is noted that these questions can also be usefully asked of adults, although adult responses will differ in both meaning and content from those of young people.)

The following discussion also does not address specific gender differences, age differences that correspond with the early, middle, and late adolescent phases, or ethnocultural differences as they may affect psychosocial adaptation. Rather, it focuses on the psychological experience of refugee youths generally.

There are several significant mental health problems this chapter does not address that may present themselves along with those adaptational issues that are identified. These include neurologic disorders, psychoses, developmental disabilities, and biologically determined affective disorders.

Finally, it is beyond the scope of this chapter to elaborate an analysis of the varieties of psychological theories (e.g., social learning theory, psychoanalysis, ego psychology, genetic epistemology that may be appropriate). From the writer's perspective, the work of Erik Eriksen (1959, 1965, 1968), and of Robert Coles (1967) on youth and identity, provide an especially valuable theoretical framework within which to guide mental health practice with this population.

TEN DIAGNOSTIC TRAINING QUESTIONS

The 10 questions that follow, although they may appear deceptively simple, can generate very meaningful information about refugee adolescent adaptation and functioning, as well as insight into the origins of psychological dysfunction, that can be useful in diagnosing psychological problems among Southeast Asian refugee youths.

1. When did you leave your country? Can you tell me about your life after the Communists took over and before your escape? (And as followups to question 1, (a) Back home [before the Communist takeover] were you living in the countryside or the city? (b) What kinds of work did your parents do? (c) Did you ever go to school back home?)

2. Can you tell me something about your escape? (By what means, with whom, who did you encounter along the way, etc.)

3. Was anyone in your group hurt by land or sea pirates?

4. Describe your life in the refugee camp.

5. How long have you been in the United States? And when did you arrive?

6. What is your "real" age?

7. With whom are you living now?

8. a. If you are living without your parents, what are you most concerned about? (Explore worries, fantasies, ruminations, etc.)
   b. If you are living with your parents, what are you most concerned about?

9. If it were possible, would you return home to live?

10. a. If you had one wish that could come true, what would you wish for--and why?
    b. If you could ask an American several questions about life in the United States, what would you ask?

In what follows, we present a discussion of the meaning, purpose, and implications of each question, and provide several case examples from the writer's clinical practice with Southeast Asian refugee youths in San Diego County.

QUESTIC 1.

> "When did you leave your country? Can you tell me about your life after the Communists took over and before your escape?"

Discussion

These questions provide the opportunity to understand the youngster in an historical context for the purpose

of identifying those sociocultural, political, and psychological forces that may have profoundly influenced his or her early development and coping mechanisms.

Within the past 10 years there have been two major periods of migration from Southeast Asia: in 1975, at the time of the Communist takeover; and between 1978 and 1981, after the Communist regimes were entrenched. Those who remained beyond 1977 endured many hardships unknown to those who left within the first 2 years.

In general, mention of a refugee youngster's country evokes fond reminiscences such as joyful holiday celebrations, the warmth of family gatherings, and the playful intimacy of daily life in an extended family with numerous siblings. But for those youths who fled after 1978 and were already school aged, life in the homeland is also associated with less romantic visions: i.e., of near starvation, relinquishment of the family home and possessions, forced migration through the jungle, the suspension of formal education, the disintegration of the family unit, the loss of family members to assassination squads and reeducation camps, the experiencing or witnessing of torture, forced internment in farm labor camps, and for the Vietnamese and Khmer, conscription into children's armies (Sheehy 1984).

Refugee youths presenting behavioral problems usually have experienced traumatic events in their homeland that they have been unable to forget or to resolve. By finding out the date of a youngster's departure, the sensitized practitioner may gain clues to potential traumatic experiences and begin the process of exploring these through the youngster's reminiscences of life "back home."

Case Illustration

Sang is a 16-year-old Khmer of average intelligence, presenting with a history of poor school attendance and conduct violations. He was alternately apathetic and defiant at home. Sang's married sister, with whom he lives, was furious that he would not respect the

traditional values of obedience to authority and reverence for education. Sang's and his sister's disagreements around his school performance eventually led him to threaten her new husband with a kitchen knife.

In our first meeting, I asked Sang when he left Cambodia. He replied that it was in 1979 when he was 10. I asked Sang what he remembers most about the time before he left. He replied, "I was in a labor camp. My father and my brothers had been soldiers. They were killed by the Khmer Rouge. The husband of my sister (that I live with) was also killed. Her three kids died of starvation. I saw many people die of starvation and murder. I did not go to school. I was always hungry and thought of food. One day I discovered a stream where there were fish, but I knew I was not supposed to go there. On a dark night I went down to the stream anyway because I wanted to catch a fish to eat. I was so hungry. Guards from my camp caught me. They said they would kill me. They held my head under the water in the stream for a long time and kicked me. At the last minute they told me they would not kill me because I had been a good worker. So they pulled me out."

After his near drowning, Sang became hard of hearing, and his speech became slurred. He felt ashamed and helpless. He arrived in the United States in 1981 and had several operations on his ears. His school did not know he had a hearing deficit, nor that he had not been to school before. Sang told me that he could not concentrate in school, not only because of his physical limitations, but because he could think only of killing the Khmer Rouge. He saw no value in education. He just wanted to grow up to join the military and kill the Khmer Rouge.

(Uncovering this information from Sang proved important because it is at variance with the expected norms of Khmer children who are functioning adequately, i.e., they generally do not harbor fantasies of violence as a form of revenge against past aggressors [Rosenblatt 1984; Boothby 1983]. But less well adapted Khmer children may, indeed, be plagued with intrusive obsessional ideation about the "enemy.")

FOLLOWUPS TO QUESTION 1.

> "Back home were you living in the countryside or the city? What kinds of work did your parents do? Did you ever go to school back home?"

Discussion

The purpose of these questions is to develop a more complete picture of the refugee youngster's background as an aid to anticipating "problem areas" in adaptation and acculturation.

Intergenerational conflict, confusion in identity formation, and anomie may result from an extreme disparity between youngsters' prior backgrounds and their present circumstances. For example, a 16-year-old who arrives from a small village, and whose parents were illiterate fishermen, may feel ill-prepared and ill-at-ease in an urban, computerized society. The parents, usually feeling more helpless and estranged than the child, can offer little guidance. But they also may pressure the child to achieve. Sometimes the parents will be well-educated and carry high expectations for their youngsters--who may not have attended school for a number of years and feel awkward and unsure of themselves. The socioeconomic position of refugee parents has been found to significantly affect their youngsters' capacity to function in the host country (Eppink 1979). Eppink (1979) believes that the socioeconomic status of the parents in the host country has major bearing upon their children. However, it is this writer's observation that what is more likely to facilitate or deter adaptation is the parents' former socioeconomic level.

Case Illustration

Tam is a 16-year-old Vietnamese presenting with school truancy and theft. He arrived in the United States 2 years ago and resides with his uncle. Tam's mother, still in Vietnam, was the proprietress of a food stall in Saigon. Tam finished the eighth grade in Saigon,

but was never more than an average student. His mother wanted her first-born son to advance through education in a free country, so she saved up enough gold to pay for his escape.

Once enrolled in school in the United States, Tam felt out of place. Neither could he compete with the scholastic achievements of his middle class Vietnamese peers from urban areas, nor did he feel comfortable with peers from rural areas who were less advanced educationally. His inability to meet his mother's expectations evoked feelings of anxiety and frustration. In despair, Tam dropped out of school and lost himself in television, believing if he could just absorb popular culture in appearance and manner, as taught by television, he would still have a chance to "make it" and bring honor to his mother. He began to affiliate with other dropouts, confusing their "hip" flashiness with success and adjustment. Enraged, his uncle requested him to leave his home. To support himself, Tam turned to petty theft.

QUESTION 2.

> "Can you tell me something about your escape? (By what means, with whom, who did you encounter along the way, etc.?)"

Discussion

This question provides an opportunity for the youngster to recount an event that will stand alone, compartmentalized in the consciousness for the remainder of his or her life. The telling can serve as a therapeutic catharsis of carefully selected events (some omitted because they are too painful). Remembrances evoke an assortment of images, thoughts, and emotions. For the practitioner, the (always unique) responses offer insight into the coping mechanisms specific to each survivor. Responses to this question usually illuminate causes for present dysfunction.

The experience of escape almost universally involves a confrontation with landmines, enemy solider attacks,

robbers, inhospitable weather, swollen waterways, meager food supplies, and death. Even those lucky enough to leave with their parents and siblings might eventually find themselves separated from their families after an ambush, capture, or the sinking of a boat.

Most adolescents identify "the escape" as the point at which they became consciously aware of a change in self, others, and the universe--i.e., a sudden recognition that life is dangerous, one cannot always protect oneself, and one cannot always trust others. (Their faith in the adult world takes leave when they see their adult relatives unwilling or unable to help in the face of a disabled boat or pirate attacks, or when they see adults on more seaworthy vessels pass them by, ignoring their pleas for help.)

Many of the youths presenting symptoms of chronic depression, such as sleep disturbance, or patterns of antisocial behavior, relate that they did not wish to leave their homeland. A not uncommon story is that of the widowed mother who arranged for the then pre-adolescent or early adolescent child to leave with older siblings (in their late teens or early twenties), or with unaccompanied teenage neighbors, in order that the child might have the opportunity for a better life than could be hoped for under communism. To ensure their safety, the youngsters were often unaware of the escape plans until the very end, at which time they were suddenly spirited away in the middle of the night. To this day, many feel their parents rejected them, despite acknowledging parental sacrifice for "the chosen one."

Those who, in fact, wanted to leave are susceptible to self-punishment for these desires when they later find out how hard life is back home and for their capacity to survive the escape when they recall those who were left behind or who died in flight. "The escape," then, can be associated with intense survivor guilt.

Case Illustration

Thu is a 12-year-old Vietnamese presenting with night terrors and nocturnal enuresis. She came to the United States 2 years ago with her father and developmentally delayed older brother, although she departed her country in the company of both her parents and her seven older brothers and sisters. As the youngest child, Thu was the spoiled favorite of her mother, to whom she was very close. During the early phase of the escape, the family was separated. Thu had never been told she was leaving her country forever, but just that she was going to visit some relatives. It was at sea that she awakened to the reality that she would probably never see her mother again. Thai pirates attacked the boat, but spared Thu. Nevertheless, she blamed her father for his inability to protect her from this experience, and for having lied to her about their destination and the inevitable separation from her mother. On the boat she became enraged at him and has never trusted him fully since. Sometimes now she invents stories to outsiders about his deficiencies, as a means to humiliate him. Her longing for her mother has been sharpened by a nagging sense of shame that she and her incompetent father and imperfect brother have made it to the land of freedom, while her capable and cherished mother languishes at home without food or money.

QUESTION 3.

> "Was anyone in your group hurt by land or sea pirates?"

Discussion

This question aims to shed light on what is, for the young person, often the most traumatic aspect of the escape. It provides a means to assess the way an encounter with pirates has been incorporated in the psyche and interpreted. An encounter with pirates can profoundly influence a refugee adolescent's future psychosexual development, identity formation, desires, goals, and self-expectations vis-a-vis adulthood.

For the young woman, it is likely that an encounter has meant brutal assault and repeated rape, sometimes ending with the sale of the youngster to a slave brothel. (The latter operate even in the confines of Thai refugee camps.) The horror, shame, and physical brutality wrought by these experiences leave silent, deep wounds. (Refer to reports by Tien Nhat et al. 1981 and Kim Ha 1983.)

Adolescent women who present as chronically suicidal, withdrawn, removed from social relationships, and who do not entertain the customary cultural expectations of marriage, are often responding to this past. Others, who have identified with their captors, will present as sexually promiscuous and inappropriately seductive, in defiance of culturally accepted norms.

The effect of an encounter may also be of profound significance to young men--who bore helpless witness to the victimization of their mothers, sisters, aunts, and to the murders of their male elders who attempted to intervene. Many of the adolescent males were themselves tortured. Overpowering emotions of fear, shame, and rage, and the psychic energy required to repress these events, can render them impotent psychologically and physically. Adolescent males who are either apathetic, phobic, tentative about their capabilities, obsessional and anxiety ridden in planning for the future, who manifest psychosomatic symptoms or are seemingly impulse-ridden without regard for the rights of others should be carefully and sensitively questioned about possible confrontations with pirates.

It is important to note that young people will almost never answer a direct inquiry about pirates with anything but a denial. For this reason, to elicit a response, questions must be neutralized by asking about "others" in their group. If the respondent allows that others in the group were attacked (despite he/she having been left unharmed), it is reasonable to assume he/she was also.

Case Illustration

Thuy is a 17-year-old Chinese-Vietnamese from an upper middle class background, presenting with anorexia, conversion symptoms, and impoverished peer relations. She came to the United States 3 years ago, where she was reunited with an older brother. Although unmarried, Thuy wears a wedding band so that "boys will leave me alone." Subsequent to her arrival, Thuy's brother had fallen into a deep depression that has cost him his job and exacerbated their financial worries.

In interview, Thuy never admitted that she'd been abused herself, only that during her escape and in the camp, she witnessed many young girls, including her best friend with whom she had escaped, "tortured." She recalled that the onset of her brother's depression followed her revelations of her escape experiences, which she had shared because she had felt the need to tell someone, and he was the one person she could trust not to betray her honor. A followup interview with Thuy's brother revealed excessive rumination at his failure for having not gotten word to her parents to prevent her escape unchaperoned.

QUESTION 4.

"Describe your life in the refugee camp."

Discussion

Many elements of a refugee adolescent's self-concept and coping skills can be shaped by his or her experiences in the refugee camp. This question can sensitize the practitioner to the quality of that experience as it is viewed subjectively through the eyes of the youngster.

The conditions of refugee camps within the countries of first asylum (i.e., most frequently, Hong Kong, Malaysia, the Philippines, and Thailand) vary from camp to camp and from country to country. The vast majority of Southeast Asian refugees are in Thailand,

residing in overcrowded quarters with poor sanitation, limited food, and inadequate health care. The Thai Government, reluctant to accept refugees because of its own precarious political and economic situation, has allegedly run many of the camps in the manner of punitive detention centers that are controlled by hostile military police (Stone and McGowan 1980).

Yet many refugee youths have pleasant memories of their camp experience as a supportive haven providing an opportunity to "debrief" the horrors of their former life and of the escape; rejoin friends and family; and attain a sense of inner peace achieved by greater personal and political freedom than they had known before.

In the camps, some youngsters assume serious, goal-directed behaviors, functioning as camp leaders, medics, and studying hard to acquire skills to prepare them for Western life. Others revel in the carefree atmosphere (relative to their past), grateful that they no longer must hunt for food or endure hard physical labor. They can be comforted by hearing travails of others who have suffered more than they. The camp can provide the opportunity for the youngster to regain physical and mental strength and exercise capabilities neretofore overshadowed by the daily requirements of basic survival.

A positive camp experience can nourish a youngster. But the idealization of that experience in memory can impede adaptation to the host country, because the youngster, after making comparisons, may conclude that the present life is too complex and requires too many hurdles to overcome (e.g., learning English, having enough money, developing a vocation, finding a job, supporting or sponsoring family members, etc.).

Recalling the camp experience can also conjure unpleasant memories--especially of uncontrollable anguish, since the camp represented the first major context for "processing" loss--of family, household, and homeland; of episodic and chronic illness, both physical and mental; and endless, aimless waiting (Sheehy 1983).

Sometimes, to stave off loneliness and to provide meaning to an apathetic existence, as well as to guard

against the risks of sexual assault, young girls will hurriedly marry in the camp and begin procreating--to their later regret. Young couples (usually between the ages of 20 and 30) caught up in domestic violence, gambling, and excessive drinking will often view their hastily arranged marriages and the inevitable disappointments following, as the source of their present conflicts. Sometimes the camp is associated with the time of more open and volatile dissent between those youngsters already married--especially if these were forced marriages, such as those arranged by Khmer Rouge guards. Thus, it is useful to explore the origins and onset of domestic problems in the historical context of the camp experience.

Case Illustration

Yia is an 18-year-old Hmong presenting with depression. Her 21-year-old husband, Tong, has accused her of neglecting their three children and had beaten her several times in the previous few months. Yia had countered with anger that her husband might have been seeing other women on the side.

Yia left Laos with a neighbor when she was 14. She had had little education, but was confident that her pretty looks and smart mind would ensure a bright future in a new homeland. She thought of herself, too, as brave, since she had forded the Mekong River alone during the rainy season and had found her way to a Thai refugee camp, although exhausted and half-starved, without assistance. In the camp, Yia began to attend school and teach herself English. She made many friends and helped them with their problems. She was pleased with her status and recognized her ambitions as far beyond those traditionally held for Hmong girls. Yia did not especially want to get married, but she thought perhaps it would be practical as she had no relatives within the camp. She felt inclusion in a family could provide her additional support and protection. She married Tong, who had been flattering and attentive, although she did not consider him as clever or ambitious as she. Tong wanted to start a family right away, as is his culture's custom, and within 3 years the young couple had produced three children.

But Yia was resentful. She knew that in her new country there was much to take advantage of. She felt thwarted by her husband, frustrated by child care responsibilities, and isolated and cornered in the narrow confines of apartment life in a Hmong ghetto in San Diego.

QUESTION 5.

> "How long have you been in the United States? And when did you arrive?"[2]

Discussion

These questions provide a starting point for assessing the young refugee's efforts at assimilation and adaptation to American life. According to Eppink (1979), two key factors that affect the socialization of migrant children and their chances of success in the host country are the age at which the child migrated, and the time elapsed since arrival in the host country. A 15-year-old, for example, who has been in the United States for 5 years, having arrived at age 10, who still cannot readily communicate in English, is usually expressing, either in cause or effect, learning deficits, alienation, emotional dysfunction, and the implementation of coping mechanisms less compatible with American life.

On the other hand, youngsters with a strong desire to succeed and to be accepted may push themselves to a "premature" assimilation. That is, one must take a closer look at youngsters who seem to have become outwardly Westernized and "well adjusted" in less than 2 years, for they may in actuality be at greater risk for intrapsychic disturbance. One motive more recently resettled refugee adolescents have for rapid assimilation is that their peers who arrived earlier (especially

[2]The date of arrival in the host country must be differentiated from the date of departure from the homeland, since most youngsters will have spent varying amounts of time in transit, i.e., refugee camps.

between 1975 and 1977) often look down on and even shun them. In schools with sizeable Vietnamese populations, for example, the "newcomers" often stick together, fearful of being ridiculed by their more assimilated peers. They view the "old timers" (e.g., migrants in the first wave) as of a more elevated social and economic status, and as having more cohesive, intact, and success-oriented families. They also see the "old timers" as personifying sophistication, at ease with Western lifestyle and popular culture, and with more savvy at handling their minority status as Southeast Asians.

There are no empirical guidelines with respect to optimal rates of assimilation. Such factors as previous socioeconomic level of parents, previous exposure to Western culture, parental expectations, linguistic barriers, age, intellectual functioning, and receptivity of the host environment, will influence the readiness and capacity to adapt from the new culture attitudes, beliefs, and coping skills--in essence, a new "vision"--that can be integrated with one's prior sense of identity as determined by one's cultural origins.

Case Illustration

Quy is a 13-year-old Vietnamese presenting with headaches and loss of appetite. She has been in the United States for 2 years, resides with a distant relative, is fluent in English, and receives excellent grades. Quy relates that she is tense and nervous inside because she does not feel comfortable with American friends yet. More importantly, she is fearful that she will be rejected by her Vietnamese peer group ("the highest group, who came in 1975") if they find out she has been here only 2 years. She has worked hard to get rid of her accented English, and does not let on that she can read and write perfectly in Vietnamese, as most of her Vietnamese group cannot. She is ashamed that her family is not with her in the United States. The girls in her group seem also to her to be "too free," and she is in conflict as to whether to emulate them. She is aware that her desire to create an identity or selfhood through affiliation with a high status group, and thereby bolster her social standing and

self-esteem, has led instead to a sense of self-loathing because of her own hypocrisy, secrecy, and false identity.

QUESTION 6.

"What is your 'real' age?"

Discussion

Determining the accurate age of the adolescent can be extremely beneficial to effective assessment, diagnosis, and treatment. But this question will only be answered honestly if a rapport has been established.

It is not uncommon for a young person's age as stated on official identification papers to be less than his or her actual age. The chronological age, lowered (often 2 to 3 years) on arrival at the refugee camp by the youth or by family members, is usually made plausible by the physical reality of the young refugee's diminutive and malnourished stature. The rationale for lying about age is that it might help in surviving camp life, as younger children are usually given priority for food and shelter. Parents believe this strategy will also maximize or lengthen their children's educational opportunities and welfare benefits in countries of asylum.

The restless and defiant behaviors, particularly of adolescent males as observed in the classroom, can often be traced to an age disparity--and attendant feelings of social awkwardness--with school peers. For example, the 16-year-old refugee in a seventh grade class with 12- and 13-year-olds may feel isolated, and experience humiliation and guilt at masquerading as a younger boy. The school environment is then perceived as ineffective in providing the relevant guidance or support necessary to deal with his age-appropriate developmental needs.

Case Illustration

Savanath, identified as an 11-year-old Laotian, presented with depression and refusal to attend his sixth grade class any longer. According to his physician, Savanath had become increasingly agitated and despondent, blaming minor scarring from a burn acquired as an infant as now bringing him too much pain to allow him to go to school. Upon medical examination, Savanath had the physical manifestations of puberty despite his slight build. Savanath admitted he was actually 16. He shared that as a 16-year-old he was becoming more conscious of his looks, and was now embarrassed by his scarring, as he wanted to date "American style." He felt out of place in a classroom of 11-year-olds. Savanath's parents, fearful that his welfare benefits would be foreshortened, put pressure on him not to disclose his discomfort, or confide his troubles to an "outsider." Savanath traced his emotional withdrawal to physical concerns, to his embarrassment at being forced to affiliate with a preteen peer group, and to a fear of disappointing and betraying his parents lest his benefits be curtailed.

QUESTION 7.

"With whom are you living now?"

Discussion

The purpose of this question is to understand the refugee youngster's living arrangements and the implications of those arrangements for his or her development. This discussion will focus on those living without parents, but there are other living situations which can be problematic for a youngster living with parents and worthy of exploration in assessment. For example, if the parents take in male boarders who are unmarried, in order to share the rent of already cramped quarters, the female adolescents in the household may be at higher risk for sexual molestation.

As Williams and Westermeyer (1983) have noted, children and adolescents not accompanied by close family

in their resettlement are at greater risk for mental health problems. It is the writer's observation, based on clinical experience, that adolescents who are not being provided with meaningful support from close adult family members are those most often manifesting severe depression, hysterical conversion reactions, high levels of agitation, and antisocial and acting out behaviors. These patterns are described more fully in the discussion section of question 8.

Often, unaccompanied youngsters are living with older teenage siblings who are ill equipped to offer parental warmth, guidance, and attention. Or they may be living with distant relatives, usually referred to as "brother" or "aunt," who have few emotional bonds to the young person, but are acting as caretakers out of familial duty and an opportunity to earn additional public assistance monies. These youths, called by the resettlement agencies "unaccompanied minors," usually experience intense feelings of loneliness, homesickness, and a longing for parental nurturance. They are vulnerable to feelings of confusion, shame, and generalized despair. This is because the notion of "family" and filial piety is the single most important construct binding and organizing Southeast Asian psychological experience and social reality. Lack of family brings humiliation and self-denigration--a feeling of being an outcast. These emotions are exacerbated by lost honor through real and imagined degradation by their caretakers.

It is difficult for a Westerner to comprehend the logic of this shame, for the orphaned status is through no fault of the child, but rather a circumstance either willed by parents who wanted the child to come to the United States for a better future, or a circumstance unforeseen by the parents, such as their own deaths. Despite family ties in their homeland, these youngsters feel unconnected and as if they do not belong to anyone. They often see themselves, as the Vietnamese refer to them, as "the dust of life." It is of note that the alienation experienced by refugee adolescents is imbued with a different meaning than that of an American adolescent.

Another problem of the unaccompanied youngster is the search for appropriate and acceptable placement. Williams and Westermeyer (1983) advocate placement in families from the same ethnic background. Walter (1979) endorses placement in American homes as long as they are nurturing, noting that sometimes refugee foster parents will exploit the youngsters as servants, following a common practice in their homelands. The writer has observed that unaccompanied youngsters placed in an American foster home are keenly aware of "slights" to their particular culture. For example, the American parent may be ignorant of the differences between the Khmer and the Vietnamese, or assume the youngster is from a poor family because he or she is alone--and thus relate with thinly veiled condescension, and expectations of gratitude. It is characteristic for unaccompanied youngsters who have been thusly humiliated, to disguise their feelings of shame through exaggerated modeling of American teenage behaviors, for at least this way they will have an "identity" with a clearly recognized subculture.

Regardless of ethnicity, the foster home can become the focus for the projection of internal conflicts around autonomy and identity formation, with the adolescent becoming manipulative and critical, and demanding constant changes in foster home placement. The environmental turmoil that is subsequently created further impedes the working through of the normative developmental tasks of adolescence.

Case Illustration

Chi is a 13-year-old Vietnamese from an upper middle class family in Saigon. She presents with depressed affect and suicidal ideation. In her 1½ years in the United States, she has changed foster homes three times. Her social worker is concerned about Chi's displeasure with her present American foster mother, Mrs. L., a seemingly lively and pleasant person who expresses "pity for the little dear."

An early entry from Chi's diary reflects many of the issues of adolescence such as loneliness, "face," fear of the future, control, development of identity and

self-worth, conflicts around dependence and autonomy, suicide, somatization, and conflicts around vulnerability and stoicism. But these issues are heightened and intensified within the unique context of the unaccompanied adolescent's world.

"I am sitting in my room. I am thinking about what would happen to me next. I feel miserable. I am thinking about my future. What would happen to me later in life when I leave this foster home? Where would I live? I wouldn't have any money. Where can I find a place to live in--when I am penniless? I want to leave this foster home so much but where, who would I live with? I wish that my parents were here or I am with them in Vietnam. That is my home, my very truly home. Why do I always think about things that no one in my age thinks about them. Maybe because I don't have a home like they do. I am very much jealous of them but what can I do?

"'Your family in Vietnam is very poor, you show me a picture of them without shoes,' Mrs L., my foster mother says. Well, that's really hurt me even if it's not the truth. I never did show Mrs. L. the picture of my family. Even if I did show the picture, it's still not the truth, because everybody in the picture wears sandals. Of course people in Vietnam wear sandals, because the weather is hot there. What kind of shoes does Mrs. L. expect them to wear? And the truth is my family is rich. (I really don't want to say that because I feel like that's not nice to brag about. My parents always tell me I shouldn't brag about anything, especially about family's property secrets.) But I think I have to say that my family is not poor.

"'I want you to appreciate that you stay in the United States, a good country that gives you free education. You also need to thank God, Buddha, for staying here, not in Vietnam,' said Mrs. L. 'Your family is very poor over there.' Then I asked her that, 'How do you know that my family is poor?' Then she answered that, 'You told me so." Then I started to get angry, I told her that I did not say so, I swear to God (what I meant was that I swear to Buddha). Then Mrs. L. replied by saying with a 'looking down on me' voice that, 'Don't let your imagination take over you.'

"My parents, too, why don't they write to me? What happened to them in the Far East? I am selfish, dumb, and stupid and most of all uncontrollable. Why am I crying? I am so depressed. I think that I'm dying. I'm having terrible headaches. If I have some diseases, why don't I die? Why am I living and suffering? Why am I so depressed? I really am a nobody, a nobody, a nobody.

"Why should a nobody live in this world? Why should I live in this world when I am a nobody? Mommy and Daddy, why did you make me? Why should you waste your money, your everything to have me? I am just a nobody, I know you didn't want me to be a nobody, but unfortunately I am. I am so sorry that I disappoint you. I am so sorry about everything. Mrs. L. disgraced our family. I mean that I disgraced our family because I am living with her, letting her despise our family. I am unforgivable, and I am going to die very soon."

QUESTION 8a.

> "If you are living without your parents, what are you most concerned about? (Explore worries, fantasies, ruminations, etc.)"

Discussion

While all refugee youngsters should be asked their concerns, the most compelling and often idiosyncratic responses are those of the unaccompanied minor. The special burdens and conflicts of this population increase their vulnerability to emotional problems--which easily reveal themselves through this simple question.

The unaccompanied youngster is the one most acutely aware of parental sacrifice (of money, hardships, and loss of life) in the service of his or her future. The young person's feeling of responsibility and obligation to the absent parent is an indelible part of the child's consciousness. Shortly after arrival, a major preoccupation is the quest for rapid economic viability in order

to raise money and to buy medical supplies to be sent home to the family or for the eventual sponsorship of family members to the United States. These self-imposed burdens are made heavier through conflictual feelings, such as fear of disappointing the family, confusion about American-style freedom, and resentment at having been abandoned and unprotected. The intense pressures these youngsters bear and the dread of failure are sometimes the major precipitates of more serious pathology. For example, hysterical conversion reactions (e.g., paralyses. blurred visions, etc.) and severe states of agitation have been observed by the writer to be most prevalent among those living without parents, and among those whose compulsive strivings become overwhelming as they fail to acknowledge their limitations.

It is this writer's belief that unaccompanied minors are at significantly higher risk for suicide than their peers. This is because the absence of a well-defined family structure to guide them results in their being enticed into what they consider wrongful behaviors--through which they "lose face" and shame their parents. These behaviors might include, for example, engaging in premarital sex, not achieving high enough grades, losing a job, or spending money on clothes instead of sending money home. Suicide then becomes a culturally acceptable means of resolving issues of shame. Sometimes when youngsters believe they have lost face, they will give up writing to parents and become even more estranged. The determinants of refugee adolescent suicide are usually one or more of the following: loss of face, survival guilt, and/or alienation brought about by the abrupt loss of family ties. It is noted that the typical etiology of suicide for the refugee adolescent is distinctly different than that for an American adolescent, and this has important implications for treatment and prevention.

Unaccompanied minors are also at higher risk for gang activity. Boy gangs may insure a family of "brothers," and thus an identity as expressed in the Asian way--via a family. The gang also may offer, when desired, a father figure (the godfather), who can provide the familiar role of elder and authority and reaffirm the role of "obedient son"--as institutionalized by the Asian

family--and thus contribute a key construct to the young person's identity formation. Gang life also offers the opportunity to secure a steady income so prized by the teenaged orphan.

Many of the older youths attracted to such gangs have few educational and vocational skills, having usually arrived in the United States in their midteens and from impoverished circumstances and with only limited formal education. They are cognizant that their opportunities will be restricted and delayed because of their deficiencies, and they are thus attracted to the prospect of acquiring, with immediacy, material possessions such as fancy clothes, jewelry, and cars. They are also attracted to the prospect of American-style "freedom" without adult constraints, and the possibilities for sexual experience, especially if they do not have to answer to an adult. Many youths find it more comfortable to bond to peers in a gang rather than to affiliate with adults in primary relationships.

The importance some Southeast Asian unaccompanied minors attach to gang affiliations is in large part tied to their historical experience. These youngsters often have been interned in labor camps or conscripted into the military between the ages of 10 and 14. They learned in their formative years, by their "communal experiences" under Communist regimes, to rely on a peer group as a survival mechanism. Thus, they are most likely to place faith in, and trust, strong peer group affiliations as the means for protecting themselves and their futures.

Case Illustration

Phuc is a 21-year-old Vietnamese who has been in the United States 3 years, but speaks little English. He presents with signs of agitated depression and conduct disturbances. He is currently charged with robbery and assult with a deadly weapon. He is also a member of a gang of approximately 15 Vietnamese males between the ages of 18 and 26 who reside in a two-room apartment about 20 minutes from San Diego, in the border town of Tijuana, Mexico. Phuc had previously been living with his 28-year-old brother who had sponsored

him. Phuc witnessed his father's murder by Communist soldiers. His mother remains in Vietnam with his two younger sisters. It was the realization of his mother's dream to find a way to send Phuc to the United States.

Phuc was drafted into the Vietnamese army in 1977 at age 13. Because of his father's political affiliations, he was selected to be sent to the front lines during his country's first invasion into Cambodia--as an additional punishment to his family. He was told to stick closely to his "group." Each group of boy soldiers was comprised of a dozen members of the same age. On the first day he arrived in Cambodia, Phuc saw "something I cannot describe. Heads, arms, and legs separated from bodies, death everywhere, death from war, from starvation, from Pol Pot." He had terrible nightmares the first night, but "after that I never felt anything. They told us to smoke marijuana so we would not be afraid and would be able to kill. They told us if we had to, to kill people for food. Sometimes I did that. I stayed in Cambodia for 1½ years. At the end, there was only one person left in my group. They sent me back home and later my mom helped me to escape." Upon resettlement, Phuc's older brother felt the responsibility to act as parent. On several occasions, he even used physical means to discipline the young adult. But Phuc felt he could not obey his brother. He sought out other boys in San Diego who had been through the same experiences he had. It was hard for him to concentrate in English class. He smoked a lot and could not eat. Although well on his way to being trained as an electronic assembler, he dropped out of school. He could not find a job, and he felt the need for more money than his brother could provide. He moved in with his friends, who encouraged him to "learn the ropes" from their "godfather" who had been involved previously in the Saigon underworld. Phuc's shame about his behavior was offset by his desires for excitement, girlfriends, and a car, which would be available to him if he became part of the gang.

QUESTION 8b.

"If you are living with your parents, what are you most concerned about?"

Discussion

A central issue facing many refugee youths living with their parents is a concern for their parents' own well-being. Often the youth will perceive his or her parents as despondent, the vital energy necessary for their successful coping diminished through the humiliation of exile. Thus, the young person may feel an intense obligation to compensate for the parents' helplessness, and to rectify the situation. The youth may worry about having the resources to help them in the immediate context, for example, by instructing them in English. Or, the youth may be concerned about whether he or she can incorporate fully within his or her identity the role of the dutiful child who must perfectly carry out parental wishes, as well as a commitment to a future selfhood directed toward bringing honor and protection to the family through educational and/or economic success.

It is relatively easy for the youngster to verbalize the above-mentioned concerns because they are compatible with the emphasis Southeast Asians place on family life, filial piety, and respect for one's elders. What is more difficult for the young refugee to express openly, primarily for fear of appearing disrespectful to one's parents, are worries and fears that stem from a) the reality of a growing disparity between the youth's own and the parents' values and expectations; and b) a mistrust or disregard for the parents' "advice," which may be viewed as incompatible with or irrelevant to successful adaptation to American life. When this is the case, the young person may experience emotional and/or behavioral difficulties arising from this intergenerational conflict that he or she is unwilling to own up to. These issues are often more successfully uncovered in the youth's responses to question 9, "If it were possible, would you return home to live?" An analysis of these issues and their implications for the young refugee living with his or her parents is provided in the discussion of question 9.

QUESTION 9.

"If it were possible, would you return home to live?"

Discussion

The responses of young refugees to this question often are reflective of their degree of assimilation and acculturation. Their answers also provide entree to exploring with them the newfound complexities of family relationships brought on by resettlement; and additionally, their fantasies about their own future.

Most Southeast Asian refugees view themselves as being in exile, the recipients of temporary refuge from political and economic exploitation. The adult refugee is able to maintain a sense of coherent identity in the United States by adhering to previous cultural values and beliefs, and by feeling confident that his or her future will ultimately be in the homeland, not in the country of asylum.

Young people, however, do not necessarily share these visions and expectations. They may be unclear about their roots, even perhaps embarrassed, and often are ambivalent about returning. To deal with their new environment and overcome the feelings of helplessness that often overcome their parents, they tend to become "bicultural," struggling to select from both cultures those values and beliefs that will facilitate existence.

Refugee youngsters usually feel they "owe it to their parents" to advance successfully in the American system. However, effective coping often requires them to embrace American values at the expense of values cherished by their parents. For example, in the United States we believe that the young person must develop autonomy from parents as a means toward achieving the strong sense of personal identity necessary for leading a productive life. However, the Southeast Asian youths are expected by their parents to remain indefinitely in a position of mutual interdependence with family members, their sense of self-worth and maturation established by subordinating their own

needs and by assuming increasing responsibility for meeting the needs of family members. Similarly, the American parent encourages assertiveness, "open communication," and competition as means of advancement. By contrast, the Southeast Asian parent emphasizes deference to adult authority, passivity, and a communication style emphasizing politeness and compliance with adult demands by "waiting to be told." A Southeast Asian youth who models a direct, frank, and self-initiating style of behavior, receives positive reinforcement in school and the American community at large; but the parents may view this behavior as repudiation of their cultural heritage and a betrayal of the family identity.

Thus, it is ironic that the young refugee who attempts to bring "honor" to the family through skillful adaptation to the American "system" may be perceived by his or her parents as lacking in respect and gratitude. The confusing messages received by refugee youths from their parents--i.e., "Become a success in the United States, but find a way to do it without becoming an American; be grateful for your freedom here, but don't embrace it as a way of life--and be ready to return home as soon as a favorable political climate is established"--evoke anger and resentment, and may lead to intergenerational conflict and prolonged family stress.

Case Illustration

Mr. Bounhong, a Laotian in his late 40s, who had resettled in San Diego with his family 2 years ago, contacted the writer regarding his 14-year-old daughter, Khamphet, the eldest of his children still at home. He appeared in an agitated state, indicating that his daughter was "a behavior problem" at home, and making "a big problem for the family." It was his belief that she might have a serious mental disorder.

When asked to describe his daughter's behavior, he replied, "She cut off her long hair and now wears it in a bob. She complains about going to the Lao temple on the weekend and instead joined a youth group in a neighborhood Christian church. She refused to wear

traditional dress on the Lao new year. Sometimes when my wife asks her to wash the dishes after supper, she points to her brother and shouts, 'Why can't he do the dishes sometimes; he's not helpless.' My wife is working as a seamstress, and she wants to teach Khamphet how to sew so that she can get a good job, but Khamphet is not interested. She says, 'No way. I don't want to waste my time. I'm going to be a doctor.' The girl is setting a very bad example for her younger sisters and brothers."

Khamphet, who was subsequently interviewed alone, presented as a very attractive, alert, cheerful, and energetic young woman. She reported proudly that she was an A student and had many friends in school--"Not only Laotian friends, but American friends too." She said her teachers were very fond of her. She liked her American church youth group (which included several Southeast Asian youngsters, although no others from Laos) because she was able to "see many things--like Sea World and Disneyland." Khamphet did not express overt dissatisfaction with her family. Rather, she stated that her father was old-fashioned and she was not going to accept all his ways anymore. Sometimes he made her angry, and she was no longer so afraid of disobeying him. She had learned that in the United States parents could not use physical punishment to discipline their children, as they could in Laos, because it "was against the law." She thought her father's involvement in the temple and community activities was useful for him, but that he was not being realistic when he spent his time strategizing with his compatriots about regrouping military forces in Thailand to regain Laos. Khamphet felt badly for her mother, whom she said "worked too hard for too little money." Of herself she said, "I think I want to be a doctor. Then I can help take care of my parents. But I don't think I'll ever go back to Laos. It would be hard to be a doctor there, they wouldn't have the technology I'd be used to. But if the government changes, I'll go back to visit and maybe help set up better medical services."

QUESTION 10a.

"If you had one wish that could come true, what would you wish for--and why?"

Discussion

Young refugees' responses to this question may illuminate their most pressing immediate preoccupations as well as their most cherished dreams for the future. A young person's answers often provide indications of how his or her psyche seeks to anchor itself to this new and radically different material world--the United States. The refugee adolescent lacks the cultural givens that provide, in part, the underpinnings of the usual adolescent identity formation. If one were to compare the refugee youths' responses to those of youths remaining in their homeland, one would note significant differences in context and thematic material. The experience of attempting to adapt and to assimilate into a new cultural context guides the young refugee's answers. Responses will vary, e.g.: "I wish that I would receive a letter from my family back home." "I wish I had money to send my mom medicine." "I wish I had never left my country." "I wish I could get some weights so I could work out and be big like American boys." "I wish some day soon I can buy a good stereo and a sleek sports car." "I wish that I can be a teacher so I can make my parents proud."

It is important to note that interpretations of a youth's responses are perhaps best dealt with at a more abstract level, the responses representing a challenge similar to that of interpreting the symbolic metaphors of poetry. (What does a young man's desire for a sleek sports car signify in terms of his emerging identity?) In sum, answers can provide important clues to the young person's intrinsic "psychocultural" value system, perspective on the human condition, priorities, level of self-confidence in mastering the new environment, and anxieties. They can also present a key to understanding unresolved traumatic experiences, as is illustrated in the case below.

Case Illustration

Hien is an attractive 14-year-old Vietnamese who came to the United States 2½ years ago with her mother and two younger siblings. Hien presents with depressed affect and intermittent nocturnal enuresis which had begun 1 month prior. Hien's mother could not understand Hien's problems, as before the onset of her symptoms, she had been happy, had many friends, and was a good student. In Hien's first interview, she appeared composed, but shy and reluctant to discuss anything that might be bothering her. When asked her wish, suddenly sobbing, she replied, "I wish I'd never left my country. We were poor, but we had a good life, a simple life. My dad died, but we had a big family and I always felt safe. Here there's nothing to protect us--there are lots of bad people in this country--you can't trust anybody--like my mom's boyfriend. I hate Americans. My mom's boyfriend, he hurt me. . . ." As Hien continued, she soon disclosed that her mother's American boyfriend had attempted to molest her.

QUESTION 10b.

> "If you could ask an American several questions about life in the United States, what would you ask?"

Discussion

By asking this question, the practitioner is made aware of some of the young person's less obvious inner thoughts, feelings, conflicts, and struggles that accompany the assimilation process. Concerns and observations that may appear somewhat trivial to an American or, conversely, of such deep philosophic import that they are unanswerable, can emerge: the American way of personal hygiene, work ethic, customs, politics, values, priorities, etc. "Why do Americans throw rice when they get married?" "Why do you say 'God bless you' when you sneeze?" "Why do you put your old people 'away'?" "Why are you so concerned about bad breath and underarm smells?" "Why do you always work, work, work?"

The refugee youth's questions will often serve as cogent reminders of the helper's true distance from the inner world of the young refugee, a distance that is often not apparent because these youths have, through skillful coping, often achieved on the surface a facility in communication or social interaction which is compatible with the helper's own expectations.

This question, on the other hand, may also allow the practitioner, when appropriate, an opportunity to deepen a base of mutual trust and understanding with the youth. The practitioner may evolve a new identity and a new role--as a source of "wisdom," and the cultural informant or "bridge" to the puzzles of the dominant culture. The practitioner's simple answers to the young person's heretofore secret and bewildering thoughts, perceptions, and expectations of American life may foster a new intimacy that may ultimately facilitate the exploration of less accessible personal and intrapsychic material.

CONCLUSION

This chapter has presented some of the unique historical and sociocultural factors that impact upon the young refugees' development and that must be given serious consideration in the diagnosis and assessment of their mental health problems. A training vehicle has been provided through which practitioners may become acquainted with some of the issues fundamental to working with Southeast Asian adolescent refugees. Culturally appropriate methods of gathering and interpreting diagnostic data are discussed. The purpose of this chapter is to challenge the practitioner to innovate, refine, and advance therapeutic tools for dealing with this special population.

It reflects the perspective that the Southeast Asian refugee adolescent must be viewed within the context of four cultural belief systems that are in continuous interplay with each other. These belief systems are those of the Southeast Asian: the American; the refugee; and the adolescent in a rapidly changing world.

If one is to make intelligible the singular requirements imposed on the refugee adolescents in their struggle to acquire an identity and adjust to a new society, one must become sensitized to the complexities and varying influences impacting upon their lives. The occurrence of physiological changes in the adolescent and the concomitant transformation of psychosocial roles and tasks--from that of being nurtured as a child to that of providing nurturance as an adult--are linked to the expectations, customs, and institutions of the society in which these changes take place. There is a universality to the biology of puberty, but distinct differences occur in the manifestations of adolescence. The passage from childhood to adulthood, and the psychological resolution of that passage, become comprehensible only through an understanding of the culture and background within which they are encompassed and through which they are experienced.

ACKNOWLEDGMENTS

I wish to thank Dr. Rubén G. Rumbaut for his invaluable contribution to the preparation of this paper. Most importantly, I wish to express my gratitude, with laughter and with tears, to my young friends--Chinese, Khmer, Vietnamese, Hmong, and Lao--who have taught me so much.

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RESEARCH

This section outlines areas urgently needing systematic research and discusses many of the research difficulties that may be encountered. It also provides an example of the results that can occur from well-planned and rigorously conducted research--research results that will contribute to solid programing in mental health services directed to Southeast Asian refugees.

Research into the highly specialized problems of Southeast Asian refugees is, at best, difficult. Yu enumerates some of the difficulties of conducting systematic research surveys, and her observations are supported by the findings of Liu and Cheung. Suspicions about questions and interviewers, stemming from past experiences with war and conflict, typically make research investigators feared and viewed as individuals to be avoided by refugees. Thus, building rapport with

them is very difficult. In addition, language problems compound the difficulties. There are many Indochinese terms that do not have an equivalent English meaning, and some Indochinese words when translated into English have very different meanings.

Liu and Cheung suggest a number of issues needing intensive and systematic study. For example, what is, and what has been, the role of sponsorship in the critical assimilation process? How has it affected subsequent problems, such as inadequate coping behaviors and faulty perceptions? What is the nature and significance of the refugee's social network? A careful study of the role of kinship might provide productive leads to enhancing mutual-help/self-help activities for refugees. While there are many different research agendas on refugees, Liu and Cheung stress the need for retrospective longitudinal studies coupled with prospective longitudinal followup, which, they indicate, will yield much-needed information on the adjustment of the different waves of refugees.

Rumbaut's chapter provides an example of the fruits that can be harvested through a well-designed and adequately funded research project. He describes a large project that is comprehensively examining the adaptive experiences of a random sample of families from each of the four major Southeast Asian ethnic groups--Hmong, Khmer, ethnic Chinese, and Vietnamese--residing in San Diego. Rumbaut's findings are manifold, but three conclusions stand out: (1) Southeast Asians are a highly heterogeneous population, and among them the Hmong and Khmer groups appear to be at significantly greater risk on their affective measures of happiness and depression; (2) the second year of residence in the United States appears to be a period of significantly heightened demoralization and psychological stress for refugees--a finding with important implications for preventive intervention program activities; and (3) while the psychological experiences of exiles are complex and multidimensional, they are also patterned and, to a degree, predictable.

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MENTAL HEALTH AND THE REFUGEE EXPERIENCE: A COMPARATIVE STUDY OF SOUTHEAST ASIAN REFUGEES

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San Diego, California

INTRODUCTION

Refugees are as old as human history, but it is the twentieth century that has been called the "century of the uprooted" (United Nations High Commissioner for Refugees 1981), and it has been in the post-World War II era that refugee migrations have reached massive and worldwide proportions. The Indochinese exodus--which began in 1975 with the collapse of United States-backed governments in South Vietnam, Cambodia (now Kampuchea), and Laos--is one of the largest such refugee movements in modern history. As of September 30, 1984, a total of 1,607,670 Indochinese refugees had arrived in camps and resettlement centers in Southeast Asia. Of these, 715,459 have been resettled in the United States: 461,956 Vietnamese and Chinese-Vietnamese; 109,562 Khmer (Cambodians); 89,201 Lao;

[1]This paper was written by the Indochinese Health and Adaptation Research Project (IHARP) under Grant No. R01-HD15699 from the National Institute of Child Health and Human Development.

and 54,740 Hmong (American Council for Nationalities Service 1984, p. 10). The migration has not ceased, and tens of thousands remain in refugee camps overseas awaiting resettlement. Many are relatives of refugees now in the United States and will be eligible for resettlement in this country under the family reunification provisions of the Refugee Act of 1980.[2]

There have been two broad phases, or "waves," of Indochinese refugee resettlement in the United States: from 1975 to 1977 and from 1978 to the present. There are major differences between these two phases, both in the number and characteristics of the refugees and in the timing and context (political, economic, and social) of their resettlement. Approximately 130,000 refugees, almost all Vietnamese, were evacuated to the United States in 1975. A steady but much smaller flow of refugees followed over the next 3 years. The massive increase in the number of refugees since late 1978 (most visibly the "boat people") was triggered by Vietnam's invasion of Kampuchea, the subsequent war between Vietnam and China in 1979, the concomitant exodus of ethnic Chinese from Vietnam, and the continued political conflict and the deteriorating economic conditions in Vietnam, Kampuchea, and Laos. An international resettlement crisis was created in 1979 after Malaysia and Thailand refused to accept more refugees into their already swollen camps and forced the Western countries to absorb significant numbers of this population. As a result, the rate of resettlement in the United States of these "new refugees" increased dramatically: broken down by fiscal year, 80,678 arrived in 1979; a peak of 166,727 in 1980; 132,447 in 1981; 72,155 in 1982; and 39,167 in 1983 (Office of Refugee Resettlement 1984). A total of 51,960 Indochinese refugees was admitted to the United

[2]Given their high fertility rates, as established by our research (Rumbaut and Weeks 1985), the actual Indochinese population totals are substantially greater than the number of admissions. The total Indochinese population in the United States was 895,253 as of October 1984--about 25 percent more than the number of admissions. Considered as a whole, therefore, the Indochinese now constitute the largest Asian-origin group in the United States.

States during fiscal year 1984. Compared with the first wave of Indochinese, the more recently arrived refugees include much greater proportions of Hmong, Khmer, Lao, and Chinese-Vietnamese ethnic groups and of rural and less educated persons whose economic, cultural, and psychological struggle to adapt to American society is sharply intensified.

Despite their ethnocultural diversity, all Indochinese refugees share a common predicament that may generally be conceptualized as follows. Psychosocially, refugees differ from other types of immigrants in the involuntary nature of their homelessness. Seekers of refuge, they are typically reluctant or unwilling migrants, pushed out of their homelands and caught, largely unprepared, in a maelstrom of circumstances over which they have little or no control. They tend to conceive of their exile as temporary and yearn to return to the lost homeland; yet as "guests," they feel an obligation to somehow repay the "host" who grants them what they view as generous asylum, and they tend to experience a persistent conflict of loyalties. Socioculturally, the refugee confronts, above all, what Berger (1969, pp. 19-23) has called "marginal" or "denomizing" circumstances that threaten the person's previously operative nomos--the meaningfully ordered social world from which the refugee is radically separated--and that elicit the "danger of meaninglessness" or "anomie" (a-nomos). In the process of reconstructing a social world under conditions of nomic disruption, the refugee is challenged to resolve a crisis of "loss," and a crisis of "load." The former requires coming to terms with the past; the latter requires coming to terms with the present and immediate future. The refugee loses home and homeland, family and friends, work and social status, material possessions, and meaningful sources of identity and validation; the refugee experience also often involves the deaths of significant others. At the same time, the refugee must cope with the oppressive load imposed by the sheer need to survive; to find shelter and work; to learn to speak an unknown language; and to adjust to a drastically changed environment despite the barriers of poverty, prejudice, minority status, pervasive uncertainty, and "culture shock" (Lin et al. 1982). It is a high-demand, low-control situation that fully tests the

refugee's emotional resilience and coping resources and produces severe psychological distress even among the best prepared and even under the most receptive of circumstances (Rumbaut 1977). The psychological reaction to the crisis of "loss" typically entails a long-term process of grief and mourning, as well as an "impulse to restore the past" (Baskauskas 1981); anxiety and depression are prevalent reactions to the crisis of "load." On the other hand, mastery and crisis resolution under such challenging circumstances may enhance a person's productive capacities and deepen a personal sense of efficacy and hardiness.[3]

This paper is an effort to explore empirically and comparatively the psychological adaptation of Indochinese refugees in the United States. It is one in a series of reports generated by the Indochinese Health and Adaptation Research Project (IHARP) at the University of California, San Diego. IHARP is a 3-year longitudinal study of the migration and resettlement of Hmong, Khmer, Lao, Chinese-Vietnamese, and Vietnamese refugees currently living in San Diego County, California.

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[3]A large if uneven amount of research literature has accumulated on the psychological impact of the refugee experience. Lin and Masuda (1981) and Cohon (1981) have recently provided a review of that literature, which is based largely on clinical observations of psychiatric patients, but also on field studies, community surveys, and impressionistic accounts by refugees themselves. Post-World War II refugee groups whose experiences have been documented include East Europeans (Tyhurst 1951, 1977), Lithuanians (Baskauskas 1981), Hungarians (Mezey 1960), and Cubans (Rumbaut and Rumbaut 1976). The available research on Indochinese refugees--notably the work of Aylesworth (1978), Lin and Masuda (1981), Lin et al. (1979, 1984), Liu (1979), Masuda (1980), Ossorio (1979), Rahe et al. (1978), Starr et al. (1979), and their colleagues--is more extensive, but focuses on first-wave refugees, primarily the Vietnamese. Very little is known about the psychological adaptation of second-wave "new" refugees, particularly the ethnic Chinese, Hmong, Khmer, and Lao.

The project seeks to examine comprehensively the adaptive experience of random samples of refugee families (men, women, adolescents, and school-age children) from each of the five major Indochinese ethnic groups. Interviews covering a wide range of topics--migration and family histories, economic and cultural integration, stress and life changes, social support and coping strategies, and health and mental health--were conducted with the panels during 1983 and repeated 1 year later. In-depth, open-ended interviews were also carried out with a subsample of respondents from each ethnic group to enhance and complement the quantitative data with qualitative information. This report focuses on findings from the initial IHARP interviews with the adult sample concerning their psychological reaction to the refugee experience.

In the background section, we review some of the social and demographic characteristics of the Indochinese refugees in our sample, including their present economic situation in the United States, and some of the extraordinarily stressful experiences of their migration and resettlement. We also briefly discuss the instruments used in this study to measure affective and cognitive psychological adaptation. In the analyses section, we report findings on the distribution of "happiness" and "depression" by ethnic group and gender, levels of comparative satisfaction in major life areas and the culturally distinctive satisfaction profiles of the different ethnic groups, case classifications of "low risk" and "high risk" groups for epidemiological analysis, characteristics of each of these groups, the structure of psychological adjustment, and the patterns of psychological change over time. Finally, in the accounts section, we present illustrative personal accounts of the psychological experience of exile, based on qualitative interviews with Hmong and Khmer ("new" refugee) respondents. We conclude with some observations on the implications of these findings for theory, research, service, and social policy.

BACKGROUND

CHARACTERISTICS OF THE SAMPLE

In our research, we systematically enumerated a total Indochinese refugee population of approximately 40,000 persons in San Diego County as of April 1983--one of the largest refugee concentrations in the United States. The ethnic composition of this refugee population is comparable to the total in the United States: a majority are Vietnamese (about 43 percent), followed by the Lao (20 percent), Khmer (13 percent), Chinese-Vietnamese (12 percent), and Hmong (12 percent). Of these, two-thirds are "primary" (original) migrants to San Diego, and one-third are "secondary" migrants who have moved to San Diego from 39 States plus the District of Columbia. It is a very young population, with a median age of 18 years; 44 percent are children under the age of 15. Its age-sex structure is typical of that of the populations of developing countries and reflects high dependency and fertility ratios (Rumbaut et al. 1984; Rumbaut and Weeks 1985).

For this study, random samples of adult respondents from each of the major ethnic groups were drawn from the total Indochinese refugee population of San Diego County. These respondents were interviewed at length during 1983 and again a year later by extensively trained Indochinese research interviewers (themselves refugees). In this paper, we report on first-year data from the Hmong, Khmer, Chinese-Vietnamese, and Vietnamese adult samples ($\underline{N}$ = 599).[4] Social and

[4] Data from first-year interviews of the adult Lao sample ($\underline{N}$ = 140) and of the children sample ($\underline{N}$ = 351), as well as data from the second reinterview of the entire sample conducted during 1984, will be made available in subsequent reports. Overall, the IHARP sample included 739 adults residing in 437 households that contained approximately 3,000 persons--or about 7.5 percent of the entire Southeast Asian population of San Diego County. For additional information on project methodology, contact IHARP. See also Dean et al. (1977-78), Montero (1977), Myers (1977), and Weiss (1977) for discussions of problems in cross-cultural survey research.

demographic characteristics of the first-year adult sample (N = 599) are detailed in table 1, broken down by ethnic group and immigration wave. These data in turn help provide a context within which to place the psychological analysis that will follow. The sample contains 300 males and 299 females, ranging in age from 18 to 71, with a mean age of 37.3 years.

As table 1 makes clear, in most respects there are extremely significant differences between ethnic groups--a fact that is generally concealed by the inclusive phrase "Indochinese refugees." Overall, the adults in the sample had spent a mean of 19.2 months in refugee camps overseas before being allowed entry into the United States with refugee status. Their modal year of arrival in the United States is 1980; the respondents averaged only 3.6 years of residence in the United States at the time of the first interview in 1983. The Khmer arrived most recently, while the Vietnamese have been here the longest; 22.4 percent of the Vietnamese have been in the United States for more than 5 years, in contrast to the Chinese (13.8 percent), the Hmong (13.2 percent), and the Khmer (8.1 percent). The data show that the first wave of refugees admitted to the United States prior to 1978 (primarily Vietnamese) came significantly more prepared, and under economic conditions in the United States that were more amenable to their absorption in labor markets, than those who arrived after 1979.

About 92 percent of the Hmong and 53 percent of the Khmer came from rural backgrounds, whereas about 95 percent of the Chinese and Vietnamese came from urban areas. Their premigration levels of education range from 9.8 years for the Vietnamese to 1.6 years for the Hmong, and the level of native language writing illiteracy is very high for the Hmong (70.8 percent) and the Khmer (34.1 percent). These differences are also very pronounced between men and women: the refugees' levels of education, English language proficiency (speaking, reading, and writing), employment, and job income are significantly lower for women than for men. Overall, one quarter of Vietnamese adults and more than half of the other three groups could not read or write in English.

TABLE 1.--Characteristics of the Indochinese refugee population, by ethnic group and immigration wave[a] (IHARP 1983 adult sample, N = 599)

Characteristics (mean or percentage)	Ethnic group				Immigration wave	
	Hmong (N = 144)	Khmer (N = 123)	Chinese (N = 131)	Vietnamese (N = 201)	First wave pre-1978 (N = 92)	Second wave [illegible]-1978 (N = 507)
Time and age						
Months in camps	34.8	19.8	10.3	8.2	8.3	19.1
Years in the United States	3.6	2.8	3.6	4.1	7.2	3
Age at first interview (1983)	36 8	35.6	41.8	35 9	37.9	37.
Social background						
Percent urban	8.3	46.3	95 4	94	82.6	60.5
Percent writing illiteracy	70 8	34.1	17.6	1	9.8	31.6
Years of education	1.6	5	6.7	9.8	9.7	5.5
English proficiency						
Percent cannot speak	34	54.5	55	24.9	10.9	45
Percent cannot write	73.6	61.8	61.8	30.8	25	60.6
Employment						
Percent no jobs in United States	71.5	69.1	63.4	44.8	13	68.8
Percent homemakers	49.6	42.3	33.6	26.9	21.7	39.6
Months employed in United States	6.8	7.9	9.8	16.8	44.9	4.9
Percent welfare dependent	64 8	69.9	63 1	44.5	17.4	66.2
Family income[b]						
Annual job income (dollars)	2,323	2,977	3,977	7,052	17,306	2,478
Annual welfare income (dollars)	6,223	4,607	4,706	4,716	1,797	5,806
Total annual income (dollars)	8,547	7,725	8,703	11,538	19,254	8,318
Per capita income (dollars)	1,525	2,972	2,359	3,867	5,392	2,164
Percent below poverty	93.7	81.3	81.4	57.1	28.9	84.5
Percent own car	28.7	35	61.1	74.5	93.5	45

[a] All differences between groups are significant at $p < .001$ for all variables listed, except age of respondent, which is not significantly different.

[b] Data on income are reported by family, not by individual (N = 355 households, including 55 female heads of household).

Three out of four Indochinese refugee families had 1982 gross annual incomes below the Federal poverty line. The median annual income for refugee families in our sample was $8,223 in 1982, and the median per capita income was $1,692. The poverty rate (75 percent), unemployment rate (over 40 percent), and welfare dependency rate (about 60 percent) of the refugees as a group are much higher than the corresponding rates of other groups in San Diego County or in the United States generally. These data, again, mask considerable variation: for example, annual income in our sample ranged from none to $50,000, and many refugee families achieve remarkable levels of economic attainment within a few years of arrival. On the whole, however, the Indochinese are preponderantly marginal, poor families living in crowded conditions in low-rent districts of San Diego, typically sharing their apartments with extended family members and friends (mean household size, 7.0 persons, ranging from 1 to a high of 21 persons in a 3-bedroom apartment).

While the process of forced migration, cultural displacement, and resettlement is extraordinarily stressful for all refugees, there are significant differences in the kind and degree of loss and trauma that have characterized their migration histories. For example, most respondents in the sample were separated from family members left behind in the homeland. However, principally as a result of the events of the Pol Pot period in Kampuchea, 79.5 percent of the Khmer respondents are unable to communicate with any family members left behind--and in most cases, they do not even know their whereabouts or whether or not they are alive--compared with 29.5 percent of the Hmong, 20.7 percent of the Chinese, and 4.6 percent of the Vietnamese. Half of the sample experienced no deaths in their immediate families since the exodus began in 1975; 40 percent reported one or two deaths; and 9 percent reported three to six deaths in their immediate families (most often under violent circumstances).

There are significant differences among ethnic groups ($p < .001$) in the number of losses of close family members, with the Khmer averaging by far the most (1.67 deaths per respondent), compared with the Hmong (1.03), the Vietnamese (0.63), and the Chinese (0.52).

Many of these deaths were among the respondents' spouses: 12.2 percent of the Khmer sample were widowed, as were 3.5 percent of the Hmong, 2.3 percent of the Chinese, and 1.0 percent of the Vietnamese. (Overall, 4.2 percent of the adults in the sample were widowed, 1.3 percent were divorced or separated, 8.3 percent were single, and 86.2 percent were married or remarried.) Some of the Vietnamese in the sample, on the other hand, were "boat people" who had suffered through that experience (including brutal assaults on the high seas by Thai pirates). Similarly, the data show considerable variation in the periods of time spent by the respondents in refugee camps in Southeast Asia while awaiting resettlement: the Hmong endured by far the longest stay in the camps, averaging 34.8 months--in some cases, languishing in the camps for over 7 years--followed by the Khmer (19.8 months), the Chinese (10.3 months), and the Vietnamese (8.2 months). Such life events, in turn, appear to have long-term effects on the mental health status of the refugees, as will be shown.

A NOTE ON PSYCHOLOGICAL MEASUREMENT

The psychological adjustment and well-being of the refugees was assessed through various measures, as well as through subsequent in-depth, open-ended qualitative interviews with a subsample of respondents (which were audiotaped, translated and transcribed, and selections from which are presented in the accounts section later in this chapter). One important measure that will concern us here--a Psychological Well-Being Scale--was adapted from the General Well-Being (GWB) Schedule used in the National Health and Nutrition Examination Survey (HANES) (Dupuy 1974). This scale contains indicators of the presence, severity, and frequency of significant symptoms of psychological distress or well-being experienced by the respondent over the previous month; thus, it is a measure of general affective states, as reported by the person. In our statistical analyses of this scale, we have identified two different "factors" or components, each composed of eight scale items. The results are summarized in table 2. As table 2 shows, factor 1 items reflect a vital, cheerful sense of positive well-being, and we will refer

TABLE 2.--Two measures of psychological well-being: items and mean scores[a] for "happiness" and "depression" scales (IHARP 1983 adult sample, N = 599)

Factor 1: "happiness"		Factor 2: "depression"	
Scale item	Mean score	Scale item	Mean score
1. Felt full of energy and vitality.	2.86	1. Felt sad, discouraged, hopeless.	1.67
2. Felt cheerful and lighthearted.	2.71	2. Felt under strain, stress, pressure.	1.45
3. Felt relaxed, free of tension.	2.66	3. Felt down-hearted and blue.	1.54
4. Felt emotionally stable, sure of self.	2.8	4. Thinking of something all the time.	1.79
5. Woke up fresh, rested.	3.03	5. Felt anxious, worried, upset.	1.67
6. Life full of interesting things.	2.54	6. Trouble keeping mind on activity.	2.05
7. Felt happy, satisfied with life.	2.[illegible]	7. Bothered by nervousness, "nerves."	1.49
8. In control of self, thoughts, feelings.	3.04	8. Tired, worn out, used up, exhausted.	1.4

[a] Mean scores are interpretable on a 0-to-5 scale, as follows: 5 = constantly/all of the time; [illegible]y often/most of the time; 3 = often; 2 = sometimes; 1 = rarely; 0 = never.

to this as "happiness." Factor 2 items reflect dysphoric symptoms and a sad, anxious, and depressed mood, and we will refer to this as "depression." Our data show that these are highly reliable and internally consistent measures.[5] We have found that these two factors, while related (r = .48), tap clearly different and more discriminating psychological dimensions of the broader GWB measure that tend to be concealed when the two components are aggregated into a single score. For example, we found different psychocultural profiles among the four ethnic groups for each of the two factors, and we discovered that certain stressful life events (e.g., deaths in the family) are significant predictors of one factor ("depression") but not of the other, while the fulfillment of basic social roles by men and women are significant predictors of "happiness" outcomes but not of "depression." Hence, we will deal with each factor separately in our analyses.

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[5] Reliability analyses indicated a Cronbach alpha coefficient of 0.850 for the "happiness" measure and 0.843 for the "depression" measure, providing solid evidence for their internal consistency--a particularly noteworthy result in view of the ethnocultural diversity of the respondent groups. This high level of reliability was found across all four Indochinese ethnic groups in our sample and was only slightly lower for illiterate respondents. The two measures were identified through a factor analysis (using a principal factoring method and rotating to a VARIMAX solution) performed on a set of psychological variables, including all the items from the Psychological Well-Being Scale and from a 22-item "Sense of Coherence" scale that we had previously developed for use in stress-health research (Rumbaut et al. 1981; cf. Antonovsky 1979). The aim of this analysis was to enable us to see whether some underlying pattern of relationships existed among a large set of variables such that the data could be reduced to a smaller set of factors. The "happiness" and "depression" measures were the two main factors identified, each accounting for a substantial amount of variance in the data set and each composed of items loading above a 0.5 criterion on the factor.

It is important to emphasize here that our instruments do not measure and are not meant to measure clinical entities or functional psychiatric disorders (mental illness), as determined by psychiatric observation and diagnostic judgment. Rather, they represent self-report screening scales that do measure something meaningful and consistent involving emotional and somatic distress but are related only imperfectly to clinical disorders per se (i.e., identifying groups at high risk for clinical depression). Following the work of Jerome Frank in Persuasion and Healing (1973), Dohrenwend and his colleagues have proposed calling the construct consistently measured by these scales "demoralization," in order to differentiate it from clinical-nosological categories (Dohrenwend 1980; Link and Dohrenwend 1980). Dupuy's GWB scale has been shown to be one of the leading such measures of "demoralization," and it has the important comparative advantage for estimates of prevalence and case assessment of having been applied in nationwide studies of random samples of the general United States population. To underscore the distinction between clinical disorder as such and what the scales measure, we will, throughout this paper, place in quotation marks the descriptive terms we have chosen for the two separate indices identified through our factor analysis--"happiness" and "depression." We interpret these in turn as separate components of the broader construct of "demoralization," and will reserve the latter term (or Dupuy's "distress") to refer to the aggregated GWB score in subsequent analyses.

ANALYSES

"HAPPINESS" AND "DEPRESSION" BY ETHNIC GROUP AND GENDER

Mean "happiness" and "depression" scores for the adult sample, broken down by ethnic group and gender, are presented in table 3. Note that these results are readily interpretable from the 0-to-5 scale on which they are based. A score of 2.5, for example, would mean that the respondent reported experiencing the feeling states described in the items composing "happiness" or "depression" midway between "sometimes" and

TABLE 3.--"Happiness," "depression," and "life satisfaction" mean scale scores[a] by sex and ethnic groups: San Diego County Indochinese refugee population (IHARP 1983 adult sample, N = 599)

	"Happiness"			"Depression"			"Life satisfaction"		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Hmong	2.40	2.24	2.32	1.90	1.82	1.85	3.90	3.94	3.92
Khmer	2.70	2.61	2.65	2.33	2.06	2.19	4.42	4.49	4.46
Chinese	3.12	2.56	2.83	1.19	1.36	1.28	4.18	4.10	4.14
Vietnamese	3.17	2.92	3.06	1.23	1.38	1.29	4.20	4.11	4.16
Totals	2.90	2.60	2.75	1.59	1.63	1.61	4.17	4.15	4.16

[a] Mean scores for "happiness" and "depression" are based on a scale from 0 to 5. Mean overall scores for "life satisfaction" (in nine different life areas) are based on a scale from 0 to 6.

"often" during the past month. Note also that mean scores for each of the eight items composing these measures were presented in table 2 for the adult sample as a whole. The mean scores reported in table 3 consist of the averaged scores for the overall measures of "happiness" and "depression."

There are highly significant differences ($p < .0001$) in "happiness" scores between men and women and even more so between the four ethnic groups. The mean "happiness" index score for the overall sample is 2.75. Men (2.9) are happier than women (2.6), and this pattern holds for all ethnic groups. The Hmong have the lowest score in the "happiness" measure (2.32), and the Vietnamese, the highest score (3.06). The Khmer (2.65) and the Chinese (2.83) fall between the groups. Among all refugee adults, least happy by this measure are Hmong women (2.24), and most happy are Vietnamese men (3.17).

Results for the "depression" measure reflect a rather different pattern. Again there are highly significant differences ($p < .001$) between ethnic groups, but no statistically significant differences between men and women generally. Interestingly, however, men are more "depressed" than women among the Hmong and Khmer, whereas women are more "depressed" than men among the Chinese and Vietnamese. The mean "depression" index score for the overall sample is 1.61. The Khmer--both men and women--are significantly more "depressed" than any of the other refugee groups. Mean "depression" scores for the Khmer (2.19) and the Hmong (1.85) are much higher than those of the Vietnamese (1.29) and Chinese (1.28). Among all refugee adults most "depressed" by this measure are Khmer men (2.33), and least "depressed" are Chinese men (1.19). As will be discussed in more detail later, these differences among the refugee groups in levels of subjective well-being and distress in turn reflect the objective conditions of "load" and "loss" that shape their present situation and coping responses.

COMPARATIVE SATISFACTION IN LIFE AREAS BY ETHNIC GROUP AND GENDER

A second measure used in this research was a comparative Satisfaction with Life Areas (SLA) scale that had been previously used with samples of Indochinese refugees (Ossorio 1979). This scale asked for a more cognitive appraisal from the respondent regarding nine areas of everyday life: work, money, home life, children, neighborhood, social contacts, health, religion, and leisure. In addition to individual satisfaction scores for each of these life areas, the scores may be summed to produce an overall averaged "life satisfaction" score. These scores are based on a 7-point scale, ranging from "very pleased" (scored as 6) to "very displeased" (scored as 0), with a neutral midpoint (scored as 3). Thus, a "satisfaction" score of 4.0 would mean that the respondent is "slightly satisfied" on this life satisfaction measure. The overall "life satisfaction" results are also summarized in table 3 for the adult refugee sample, broken down by ethnic group and gender.

The results show highly significant differences ($p < .0001$) between ethnic groups on current satisfaction levels but no statistically significant differences between men and women. The mean overall satisfaction score for the adult sample is 4.16 (interpretable, as mentioned above, on a 7-point scale scored from 0 to 6). Surprisingly, the Khmer (both men and women) are the most satisfied group (4.46), followed by the Vietnamese (4.16) and Chinese (4.14), with the Hmong the least satisfied overall (3.92). The Khmer, however, are also the most "depressed" group and rank below the total sample mean in the "happiness" measure. This distinctive Khmer pattern replicates an earlier finding of Ossorio in his assessment of mental health needs among "first wave" Indochinese refugees in the Denver metropolitan area. Although using a smaller, nonrandom sample (39 Khmer, 59 Hmong, and 119 Vietnamese) but the same SLA instrument, Ossorio found that the Khmer had the highest overall "negative psychological effects" score despite showing the least dissatisfaction across the various life areas (Ossorio 1979, p. 35).

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"Satisfaction" in this context, as a mode of cognitive appraisal or of a person's "definition of the situation," may be seen as a sort of "psychological thermostat" serving to adjust one's aspirations and expectations in relation to a set of past experiences and present opportunities. It is a comparative coping operation, reflecting how an individual constructs the meaning and regulates his or her wants, needs, and goals adaptively in a given context. The higher the aspirations and expectations (or ambitions) and the greater the gap between expectations and their fulfillment, the lower the level of satisfaction. "Satisfaction," therefore, requires realistic appraisals, sufficiently so to permit the feasible fulfillment of expectations. Having realistic ambitions is in turn an important subjective component in one's defense against depression and unhappiness. By lowering one's expectations realistically (one's "psychological thermostat"), one may be able to achieve or become resigned to a functional level of comparative contentment even under conditions of severe stress, which in turn may serve as a protective buffer to keep depression from deepening. In fact, in situations of acute suffering, the need for meaning may predominate over the need for contentment (Berger 1969, p. 58), and this dynamic may in turn be reflected in a "satisfaction" measure. In the case of the Khmer, our qualitative interview data suggest that there may be a complex interaction of biographical circumstances (particularly for those who survived the terror of the Pol Pot period) and culturally shaped appraisals (including, for example, the theodicies of Cambodian Buddhism that "explain" the meaning of anomic and stressful events and make the pain more tolerable), which helps to account for the distinctive Khmer pattern of high depression and high satisfaction.

We can get a more specific idea of the psychocultural differences among these refugee groups by looking at the "satisfaction" results for each of the different areas of life that make up the overall SLA measure. Current ("now") satisfaction scores for each of the nine major life areas are presented in table 4. The data are broken down by ethnic groups but not by gender, since there were no significant differences between men and women, either overall or within ethnic groups. In addition, mean satisfaction differential scores--that

TABLE 4.--Comparative satisfaction levels in major life areas, by ethnic group[a] (IHARP 1983 adult sample)

Life areas	Hmong (N = 143)		Khmer (N = 123)		Chinese (N = 131)		Vietnamese (N = 201)		Total (N = 598)	
	Now[b]	Now-then[c]	Now	Now-then	Now	Now-then	Now	Now-then	Now	Now-then
Work	2.05	-3.23	2.81	-2.06	3.52	-1.2	3.15	-1.85	2.92	-2.05
Money	2.19	-2.92	4.28	-.64	3.41	-1.4	3.31	-1.65	3.26	-1.7
Social contacts	4.17	-1.17	4.51	-.59	3.73	-1.21	3.97	-1.19	4.08	-1.06
Neighborhood	4.31	-1.19	4.65	-.78	4.49	-.55	4.41	-.92	4.45[d]	-.87
Religion	2.65	-2.83	4.98	-.52	4.13	-.17	4.57	-.06	4.09	-.85
Leisure	4.73	+.54	4.24	-.93	3.98	-.8	4.17	-.78	4.28	-.5
Health	4.77	-.04	4.5	-.6	4.49	-.68	4.43	-.71	4.54[d]	-.51
Home life	4.65	-.64	4.85	-.61	4.41	-.5	4.48	-.86	4.58	-.68[d]
Children	5.54	+.8	5.31	-.24	5.14	+.19	5.01	+.34	5.23	+.32
Overall	3.92	-1.17	4.46	-.74	4.14	-.72	4.16	-.86	4.16	-.88

[a] ANOVA. All mean score differences between ethnic groups are statistically significant at .001 or less except where noted.

[b] Now, mean present satisfaction score (scale: 0 = very dissatisfied to 6 = very satisfied).

[c] Now-then, mean difference between present satisfaction and pre-1975 satisfaction in homeland.

[d] Mean score differences between ethnic groups are not statistically significant.

is, the mean difference between the level of current satisfaction reported by the respondent and the level of satisfaction retrospectively recalled by the respondent in the homeland before 1975 ("now-then")--are also presented in table 4 for each of the nine life areas. A negative differential score indicates a lower degree of present satisfaction in the United States relative to that in the homeland; a positive score indicates greater satisfaction now relative to the homeland. The greater a negative differential score, the greater the level of comparative dissatisfaction expressed by the respondent and the greater the appraised level of loss. It should be noted that retrospective pre-1975 satisfaction scores were uniformly high for all life areas, ranging from a low of 4.78 for "recreation and relaxation" to a high of 5.38 for "housing and neighborhood," making a difference of 0.6 between the highest and lowest mean scores. This highly favorable and restricted range of opinion regarding pre-1975 satisfaction scores may reflect to some extent an idealization of the past--a dynamic that has been observed with other refugee groups.

Results for current satisfaction levels for the adult sample as a whole show that by far the areas of highest dissatisfaction are those of "work" (2.92) and "money" (3.26)--reflecting the refugees' objective economic conditions of high poverty and unemployment levels. The correlation between current "money" satisfaction scores and the dollar amount of personal income earned in the past year was 0.40 for males and 0.38 for females ($p < .001$). The Hmong in particular, whose economic situation is the most depressed of all the refugee groups, also report the highest dissatisfaction scores in these areas. All four groups rated "children" as the area of highest satisfaction by far (5.23)--probably suggesting that it is their children who provide the refugees with their best hopes for the future. Repeatedly we have heard our respondents (especially the older ones) express the view that they harbor little hope for their own generation but are satisfied that their children learn English very quickly, do well in school, and will have a much brighter future. The Hmong, who have by far the highest fertility rates, also report the highest satisfaction scores with "children" among the four groups. The difference between

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the highest (5.23) and lowest (2.92) current satisfaction area scores was 2.31, almost four times the parallel difference found in the pre-1975 satisfaction scores.

There is also general agreement among all four groups in their current satisfaction ratings for "home life" (4.58), "health" (4.54), and "housing and neighborhood" (4.45). The family remains the central institution and source of meaning in the lives of our respondents, and their neighborhoods--most often involving dense ethnic enclaves--serve important functions as sources of mutual assistance and support. Finally, despite a wide range of health problems and barriers to health care access (cf. Rumbaut et al., unpublished), most Indochinese refugees in our sample appear to be relatively satisfied with their present health status--particularly the Hmong, who tend to see their health conditions in the United States as most improved (compared with pre-1975 conditions in rural Laos and later in the refugee camps), and whose satisfaction differential score in this area (-0.04) is negligible. The correlations between current "health" satisfaction scores and our objective measure of the respondent's physical/functional health status was 0.61 for males and 0.52 for females ($p < .001$).

There are substantial differences among the four ethnic groups, however, in both current satisfaction and satisfaction differential scores in several life areas. Indeed, each group presents a culturally distinctive satisfaction profile. "Religion" is most highly rated by the Khmer (4.98), for whom Buddhism may provide an important source of meaning, purpose, and solace; and by the Vietnamese (4.57), primarily Catholics and Buddhists, who have active religious organizations locally, and for whom the Catholic Church in particular has proven an important source of social support, especially during the early years of resettlement. The Vietnamese and the Chinese, moreover, report the smallest negative differentials in this area. However, "religion" was an area of marked dissatisfaction for the Hmong (2.65), who also report an extremely high negative satisfaction differential in this area (-2.83). Our data show that the Hmong, who suffer most from culture shock, have most often changed their traditional (animist) religions since their migration, both in refugee camps and after

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resettlement in the United States (several families in our sample, for example, have become Mormons, and others have joined other Christian sects)--suggesting that their animist beliefs and practices may have proven least helpful in meeting their adaptive needs, both ideologically and socially.

The Hmong, on the other hand, rank "leisure" (recreation, relaxation) much more highly than the other groups, and they are the only group to report a positive satisfaction differential in that life area relative to their premigration situation in Laos. Whereas "work" is ranked lowest by the Hmong, Khmer, and Vietnamese, the Chinese express their greatest dissatisfaction in the area of "money." The Khmer, unlike the other groups and in spite of their high rates of poverty and welfare dependency, appear to be comparatively more satisfied than dissatisfied with their financial situation and with "social contacts." The Hmong, Chinese, and Vietnamese, on the other hand, all report high negative satisfaction differentials in the areas of "social contacts." And while all groups clearly rank "children" as their main source of life satisfaction, only the Khmer have a negative satisfaction differential score in this area--reflecting the fact that their pre-1975 level of satisfaction with "children" was the highest reported by far, and possibly also the fact that a significant number of Khmer respondents reported the death of some of their children in Kampuchea. Overall, the Hmong reported the highest negative satisfaction differentials (-1.17), followed by the Vietnamese (-0.86), and then the Khmer (-0.74) and the Chinese (-0.72).

CASE CLASSIFICATION INTO LOW- AND HIGH-RISK GROUPS

To sharpen our analysis of "happiness" and "depression" outcomes, we have classified cases in our sample into "low risk" and "high risk" groups along a continuum of psychological well-being and distress. The results are summarized in table 5.[b] This allows us to

[b] We employed a common statistical procedure--which is also justified on substantive grounds, as shown below--

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TABLE 5.--"Happiness" and "depression" among Indochinese refugees case classification into low- and high-risk groups (IHARP 1983 adult sample, N = 599)

Mental health measure	Risk classification					
	Low		Middle		High	
	Percent	Mean score	Percent	Mean score	Percent	Mean score
"Happiness"	14.9	1.28	69.7	2.74	15.4	4.22
"Depression"	18.6	.35	65	1.59	16.4	3.15

make some relative judgments regarding the prevalence of psychological distress and "demoralization" in the general refugee population and to examine more clearly the characteristics of both those groups who are most at risk, as well as those who are least at risk.

Put differently, we are equally interested in examining what Antonovsky (1979) has called the problem of "salutogenesis" as well as the problem of "pathogenesis." The dominant pathogenic paradigm focuses dichotomously on illness, psychopathology, disease etiology, and the high-risk groups; a salutogenic orientation focuses instead on a continuum of well-being and distress, on "symptoms of wellness," adaptive resources, and the broader process of successful coping amidst ubiquitous stressors. Indeed, in studying the adaptation of refugees, what is most remarkable is not so much the prevalence of reaction depression and anxiety (given extraordinarily depressing and anxiety-provoking circumstances), but the fact that so many manage to endure and overcome extraordinary hardship. By focusing solely on pathogenic concerns, research on refugee adjustment tends to be guided by a view of refugees as passive recipients of stressors rather than as active participants in a creative (and also stressful) social process of building a new life (cf. Lin, in press).

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to classify cases into low- and high-risk groups. Respondents scoring one standard deviation (SD) or more above the total group mean for "depression" and one SD or more below the total group mean for "happiness" are here classified into high-risk groups. Conversely, respondents scoring one SD or more below the simple mean for "depression" and above the sample mean for "happiness" are here classified into low-risk groups. The choice of a cutoff point for epidemiological studies of psychological distress and demoralization is ultimately arbitrary, although procedures based on statistical norms have been favored as more "objective" than those based on substantive or value considerations and have been widely employed with the MMPI, the Health Opinion Survey (Vega 1985), the Depression Adjective Check List (DACL) of the National Depression Survey (Levitt and Lubin 1975), and other studies of psychiatric prevalence.

Our approach to case classification into "risk" groups is strengthened by the fact that Dupuy's (1974) work on the GWB Adjustment Scale--from which our "happiness" and "depression" factors are derived--produced a continuum of grouped scores for case level assessment based on substantive consideration ranging from "suicidal risk?" for the lowest GWB scores to "euphoric mood" for the highest scores. The lowest level was based on data obtained from a community mental health center; among five patients with GWB scores within the suicidal risk category, four were on the center's potential suicide list and another committed suicide within 2 weeks of assessment. More specifically, Dupuy's 12 categories (listed in table 6) are classified into three general groups: 1) Positive Well-Being, ranging from "euphoric mood" to "marginal well-being"; 2) Problem-Indicative Distress, ranging from "mild" to "severe"; and 3) Clinically Significant Distress, ranging from "mild" to "suicidal risk?"

Given that we employed essentially the same GWB items and response sets, we made an effort to convert statistically our 17-item Psychological Well-Being Scale scores and Dupuy's 18-item GWB scores for the national HANES random sample (N = 3,380 adults) into generally comparable measures (item means) on a 0-or-5 scale. The results of our estimates are presented in table 6 and are contrasted against Dupuy's results. As expected, we found that the mean combined GWB score for our adult refugee sample (2.74) is significantly lower (indicating greater distress) than the mean for the general adult American population sample (93.62). As table 6 shows, only 23.7 percent of the Indochinese refugee sample had GWB scores in the "positive well-being" range, compared with 73.0 percent of the American population sample. Scores below that range were evaluated by Dupuy as indicative of significant distress (or "demoralization"); only one in four adults in the American sample exhibited such scores, compared with three out of four among refugee respondents. These differences are made even sharper and more consequential by looking at the percent distribution of cases found in the category encompassing the most serious levels of psychological distress, which Dupuy called "clinically significant distress." Only 9.7 percent of the American sample scored in that range, compared

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TABLE 6.--Comparative case classification of well-being or distress: The general American population (HANES adult sample, N = 3,380) versus the Indochinese refugee population (IHARP adult sample, N = 599)

Case classification[a]	Percent distribution of samples	
	American population (N = 3,380)	Indochinese population (N = 599)
Positive well-being	73.9	23.7
Euphoric mood	8.8	1
Strong positive	20.9	5
Moderately high	24.3	5.7
Low positive	10.7	4.5
Marginal	9.2	7.4
Problem-indicative distress	16.4	31.6
Mild	6.8	8.4
Moderate	5.6	12.1
Severe	4	11.1
Clinically significant distress	9.7	44.7
Mild	3.1	17.6
Moderate	3.6	18.3
Severe	2.3	7.7
Suicidal risk?	.7	1

[a]Based on Dupuy's (1974) General Well-Being (GWB) Adjustment Scale.

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with 44.7 percent of the Indochinese sample--more than four times the proportion of the general American population. This is a finding of considerable policy importance.

Let us now return to our previous statistical classification of low-risk and high-risk groups in light of these overall GWB scores. The mean GWB score for the refugees who are here classified as high risk is 2.09, a score that corresponds to "moderate, clinically significant distress" in Dupuy's classification;[7] and the mean combined GWB score for the refugees who are grouped here as low risk is 3.21, a score that would be classified as "marginal positive well-being" in Dupuy's scheme. For the total refugee sample, the mean GWB score (2.74) would be correspondingly classified as "moderate, problem-indicative distress." Broken down by ethnic group and gender, Chinese men and women have the highest mean GWB scores (corresponding to Dupuy's "mild, problem-indicative distress"), followed by Vietnamese men and women (both falling under "moderate, problem-indicative distress"), and then by Khmer and Hmong men and women (falling collectively

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[7]The mean GWB score for our IHARP high-risk group (2.09) would fall approximately two SD below the mean score for the national HANES sample (3.62). By our estimates, mean scores below 1.10 would fall into Dupuy's "suicidal risk?" category. Six respondents in the IHARP sample fell in this category (five Hmong and one Khmer). One of the Hmong respondents stated to the IHARP research interviewer during the course of the first-year interview that he could not cope any longer with a series of mounting pressures and that he intended to commit suicide by hanging himself in a nearby park. He had lost a great deal of weight recently and was unable to sleep. The interviewer (who happened to have extensive service experience in the Hmong community) was able to intervene actively in that case and successfully assist the respondent to resolve the most pressing problems. Several weeks later the respondent had regained his appetite, was in good spirits, and he and his family were very grateful to the interviewer for the assistance and support.

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under "severe, problem-indicative distress"). The Hmong (both men and women) scored lowest on the GWB measure, with their group mean scores (2.53) bordering on Dupuy's category of "mild, clinically significant distress." Overall, refugee men have a somewhat higher mean GWB score (2.77) than refugee women (2.69).

CHARACTERISTICS OF "HAPPINESS" AND "DEPRESSION" RISK GROUPS

Having established a method of case classification, our next step was to examine and compare the characteristics of Indochinese respondents who fell into low-risk and high-risk groups. Selected demographic and socioeconomic characteristics of "low," "middle," and "high" score groups are summarized in table 7 for "happiness" and in table 8 for "depression," following the case classification procedures described above. The data are broken down by gender and ethnicity to permit a clearer estimate of the relative structure and prevalence of "risk" within gender and ethnic groups as measured by the "happiness" and "depression" indexes. Our data support the often-observed finding of an inverse relationship between social class and psychological distress. Looking at social background variables, for example, we find that "happiness" scores increase as education and native-language literacy increase, and "depression" scores increase as education and literacy decrease. In general, those refugees most at risk for psychological distress are the least educated and the least proficient in English, the most dependent on welfare, the poorest and the most unemployed, the older refugees (especially between ages 50 and 64) and the widowed, those with physical health problems, and those with the most traumatic migration histories.

As table 7 shows, women (19.4 percent) are much more likely than men (10.4 percent) to be most at risk in the "low happiness" (or unhappiest) group; the opposite is true for those least at risk in the "high happiness" (or happiest) group. There are major differences between ethnic groups, ranging from 35.1 percent of Hmong women in the unhappiest group to only 4.6 percent of Vietnamese men. Women from rural areas (30.8

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TABLE 7.--Correlates of low and high "happiness," by gender:
San Diego County Indochinese refugee population
(IHARP 1983 adult sample)

Variables (means or percentages)	Male (N = 297)			Female (N = 288)		
	Low-- 10.4 percent (N = 31)	Middle-- 70 percent (N = 208)	High-- 19.5 percent (N = 58)	Low-- 19.4 percent (N = 56)	Middle-- 69.5 percent (N = 200)	High-- 11.1 percent (N = 32)
Ethnicity						
Percent Hmong	19.7	74.2	6.1	35.1	55.4	9.5
Percent Khmer	10.2	79.7	10.2	20.6	73	6.3
Percent Chinese-Vietnamese	11.1	61.9	27	14.1	78.1	7.8
Percent Vietnamese	4.6	67	28.4	9.2	72.4	18.4
Background						
Percent urban	6.9	68.6	24.5	13.1	73.1	13.7
Percent rural	17.1	73.3	9.5	30.8	62.6	6.5
Years of education	4.3	7.5	9.3	2.7	5.3	5.6
Months in refugee camps	21.8	19.2	14.7	25.5	18.9	14.9
Family and health						
Number of deaths in family	.9	1	.7	1.1	.9	.8
Number of children born in United States	1.1	.8	.5	.5	.8	1.1
Percent low health status	17.2	71.3	11.5	20.6	73.5	5.9
Percent high health status	7.6	69.5	22.9	18.4	65.8	15.8

TABLE 7.--Correlates of low and high "happiness," by gender: San Diego County Indochinese refugee population (IHARP adult sample)--continued

Variables (means or percentages)	Male (N = 297)			Female (N = 288)		
	Low-- 10.4 percent (N = 31)	Middle-- 70 percent (N = 208)	High-- 19.5 percent (N = 58)	Low-- 19.4 percent (N = 56)	Middle-- 69.5 percent (N = 200)	High-- 11.1 percent (N = 32)
Work and income						
English literacy index	2.7	4.1	4.7	2.1	2.8	3
Months in ESL	23.7	18.1	13.3	14.9	13.1	11.4
Months employed in United States	6.1	15.7	26.3	1.7	6.6	6.5
Welfare dependency ratio	.88	.65	.44	.86	.69	.62
Number of cars owned by family	.4	.8	1.2	.4	.8	.9
Personal job income (in dollars)	1,253	3,480	7,618	220	1,563	2,342
Family job income (in dollars)	1,439	4,513	9,076	1,210	4,475	6,917
Annual welfare income (in dollars)	7,513	4,851	3,719	5,868	5,450	4,952
Total family annual income (in dollars)	8,951	9,418	12,876	7,078	10,032	11,890
Per capita income (in dollars)	2,079	2,622	4,503	1,769	2,355	3,106

percent) and widows (40.7 percent) are unhappiest, whereas men from urban areas (24.5 percent) and single men (32.4 percent) are happiest. We found that age correlates negatively, but only slightly, with "happiness"; that is, older people tend to be unhappiest. "Happiness" is a function of socioeconomic status, particularly for men. "Happiness" is highest for men who are working, lowest for those on welfare; it increases with increased English proficiency, job income, and car ownership. Interestingly, one of the most significant correlates for women is the number of children born to them in the United States: the greater the number of children born, the happier the women. This finding (which persists in our regression analysis after controlling for other possible confounding factors) is probably a reflection of culturally prescribed norms validating the social role of "mother" and "woman," which in turn tend to diminish a sense of purposelessness and pessimism and to enhance self-esteem among female respondents. Equally interesting, this correlation is reversed for men: the greater the number of their children born in the United States, the unhappier the men. Perhaps increasing family size adds to the burden of the perceived "provider role" for men.

Table 8 shows that nearly equal proportions of men (17.1 percent) and women (15.6 percent) are at risk in the "high depression" group. Perhaps the most significant finding concerning the prevalence of reported depressive symptomatology in the refugee population is that 35.6 percent of Khmer men and 27.0 percent of Khmer women are in the "high depression" category, as are 23.9 percent and 20.8 percent of Hmong men and women, respectively. The extremely elevated levels of "depression" among the Khmer are underscored by the fact that only 1.7 percent of Khmer men and only 4.8 percent of Khmer women are in the low-risk category, compared with Vietnamese men (31.8 percent) and women (23.9 percent), and with Chinese men (33.3 percent) and women (16.4 percent). Men and women from rural backgrounds (29.5 and 24.5 percent, respectively) and having disrupted marriages (40.0 and 27.6 percent, respectively) are also most at risk for "depression." The relationship between age and "depression" is curvilinear, but persons over 50 years of age are most at risk (31.8 percent of men and 22.7 percent of

women). There is a strong negative association between functional health status and "depression"; that is, the lower the health status level, the greater the "depression" score. That association is weaker for the "happiness" measure. There is also a significant association between "depression" and number of deaths in the family--although that variable was not significantly correlated with "happiness." In addition, the longer men (but not women) stayed in refugee camps, the greater the current level of "depression." For women, the main socioeconomic variable correlating with "depression" is car ownership, which may indicate degree of isolation. For men, socioeconomic status affects "depression" more directly, especially employment status and level of welfare dependency. "Depression" among men increases as current occupational prestige decreases and as occupational status loss increases. And the longer men (but not women) attend English-as-a-second-language (ESL) classes, the greater their level of "depression," probably indicating a vicious cycle of frustration and demoralization.

To clarify these complex multivariate relationships and to control for possible confounding factors among predictors of "happiness" and "depression," we have conducted a series of path analyses and multiple regression analyses. It would take us beyond the bounds of this chapter to provide a detailed discussion of these separate regression models and results for men and women. It will suffice to suggest tentatively the following: The degree of "satisfaction" as a form of cognitive appraisal of the person's situation is a principal "predictor" of the affective states of "happiness" and "depression." "Depression" is especially influenced by the extent and intensity of stressful life events involving loss over which the person has little or no control (including deaths of the spouse and close family members, separation from family still in the homeland, divorce, prolonged stay in refugee camps, and physical symptoms and dysfunction). "Happiness," on the other hand, tends to be influenced by the degree of fulfillment of major social role obligations (as indicated for men by welfare dependency ratios and for women by number of children), and by other types of appraisals and coping responses (such as humor). All are variously affected by the refugees' sense of self-worth,

TABLE 8.--Correlates of low and high "depression," by gender
San Diego County Indochinese refugee population
(IHARP 1983 adult sample)

Variables (means or percentages)	Male (N = 299)			Female (N = 295)		
	Low-- 22.7 percent (N = 68)	Middle-- 60.2 percent (N = 180)	High-- 17.1 percent (N = 51)	Low-- 14.9 percent (N = 44)	Middle-- 69.5 percent (N = 205)	High-- 15.6 percent (N = 46)
Ethnicity						
Percent Hmong	16.4	59.7	23.9	11.7	67.5	20.8
Percent Khmer	1.7	62.7	35.6	4.8	68.3	27
Percent Chinese-Vietnamese	33.3	57.1	9.5	16.4	77.6	6
Percent Vietnamese	31.8	60.9	7.3	23.9	65.9	10.2
Background						
Percent urban	28.4	61.6	10	20.1	69.3	10.6
Percent rural	12.4	58.1	29.5	6.4	69.1	24.5
Years of education	8.9	7.7	4.9	6.1	4.8	3.6
Months in refugee camps	15.2	16.5	30.4	15.8	19.9	23.7
Family and health						
Number of deaths in family	.5	.9	1.5	.6	.9	1.4
Number of children born in United States	.7	.8	.8	.6	.8	.6
Percent low health status	10.2	61.4	28.4	11.4	61.4	27.1
Percent high health status	28	59.7	12.3	18.1	76.8	5.2

TABLE 8--Correlates of low and high "depression," by gender
San Diego County Indochinese refugee population
(IHARP 1983 adult sample)--continued

Variables (means or percentages)	Male (N = 299)			Female (N = 295)		
	Low-- 22.7 percent (N = 68)	Middle-- 60.2 percent (N = 180)	High-- 17.1 percent (N = 51)	Low-- 14.9 percent (N = 44)	Middle-- 69.5 percent (N = 205)	High-- 15.6 percent (N = 46)
Work and income						
English literacy index	4.4	4.3	3	2.8	2.7	2.3
Months in ESL	16.8	16.6	23.7	10.7	14.5	10.3
Months employed in United States	18.4	17.6	10.8	9.6	5.2	3
Welfare dependency ratio	.58	.64	.74	.64	.72	.74
Number of cars owned by family	1	.8	.5	1.1	.7	.4
Personal job income (in dollars)	5,453	4,008	2,238	2,410	1,258	959
Family job income (in dollars)	6,581	5,116	3,017	6,406	3,759	3,304
Annual welfare income (in dollars)	4,558	4,868	5,694	5,339	5,513	5,045
Total family annual income (in dollars)	11,209	10,015	8,819	11,762	9,449	8,427
Per capita income (in dollars)	3,970	2,686	2,432	2,781	2,318	1,834

of cultural estrangement and anomie, and of confidence and comprehensibility (or helplessness/hopelessness) in a context of restricted opportunity, economic hardship, and severe "load." These mediating variables, in turn, are influenced by the urban/rural background of the person, the level of education and literacy, occupational skills, age, and ethnicity. All such causation, in any case, is multiply determined--and psychological well-being or distress can, in turn, influence the ongoing adaptation process as "independent variables" in their own right. Rather than focusing further on lifeless variables, a deeper understanding of the human elements involved may be gleaned from selected passages taken from qualitative interviews with refugee respondents themselves concerning these issues, which are presented in the accounts section below.

TIME AND THE PROCESS OF PSYCHOLOGICAL ADAPTATION

So far, we have identified some significant characteristics of groups at low and high risk for mental health problems, i.e., of the structure of Indochinese refugees' psychological adjustment. But how does this picture change over time? Are there temporal as well as social patterns of refugee well-being and distress?

Our data suggest that there is such a general temporal pattern or sequence for each of our measures of "happiness," "depression," and "satisfaction." The findings should be taken as tentative at this point and will need to be tested longitudinally with our sample before more definitive conclusions can be drawn. Nevertheless, a general outline of this pattern is suggested in table 9. The table lists the percent of adult respondents in our sample who scored above the total group mean in "happiness," "depression," and "satisfaction" per year of residence in the United States.

During the first year in the United States, 75 percent of respondents in the sample scored above the mean score for "happiness"--the highest level of "happiness" recorded during any one year of residence. At the same time, first-year respondents scored the lowest

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TABLE 9.--Percent of respondents scoring above the mean in "happiness," "depression," and "satisfaction" by length of residence in the United States (IHARP 1984 adult sample)

Number of years in United States	Percent scoring above mean for psychological variables on GWB scale		
	"Happiness"	"Depression"	"Satisfaction"
1 (N = 24)	75[a]	37.5[b]	66.7[a]
2 (N = 91)	42.2	67[a]	64.8
3 (N = 117)	52.3	43.5	41.9[b]
4 (N = 212)	52.9	47.9	44.8
Over 4 (N = 154)	55.3	43.1	53.2
Total sample (N = 598)	52.6	48.3	50.3

[a] Highest percentage of respondents scoring above the total sample mean for the dependent variable.

[b] Lowest percentage of respondents scoring above the total sample mean for the dependent variable.

levels of "depression" and the highest level of "satisfaction." Scores in all three measures peak during that first year and are not surpassed thereafter. If the first year appears to be a "high," or relatively euphoric, period, the second year is a "low," or primarily dysphoric, period. The highest rates of "depression" were found among second-year residents (67 percent scored above the total sample mean in "depression"), as well as the lowest rates of "happiness" (only 42.2 percent scored above the mean). More precisely, the lowest "happiness" scores were recorded 12 to 18 months after arrival in the United States, and the highest "depression" scores were

recorded 18 to 24 months after arrival. "Satisfaction" scores, however, declined only slightly during the second year. During the third year, "satisfaction" scores hit their lowest level (only 41.9 percent were above the group mean), but there appears to be a substantial psychological rebound in both "happiness" and "depression." There is a slight increase in "depression" during the fourth year in the United States, but rates of "happiness" and "satisfaction" remain essentially stable. Finally, respondents who have been in the United States for over 4 years show small improvements in all three psychological measures relative to fourth-year levels. The most remarkable psychological changes appear to take place primarily and predictably during the first 3 years.

These findings generally support the recent clinical experience of a 10-month Indochinese refugee mental health project carried out through the Gifford Clinic of the University of California, San Diego, during 1983-84. A total of 901 Indochinese refugees were screened through this project, and it was found that 652 did not need mental health services--most of them consisting of newly arrived refugees. Another group of 134 were seen more than once by an ethnic paraprofessional worker, and the rest were seen by a mental health professional. Data from the latter group on onset of the symptoms that brought the patient to the clinic show a few patients with symptoms occurring during the first year in the United States and a few in the fourth or fifth year; onset of symptoms for most of the patients occurred during the second year, with the next largest group having symptoms during the third year. Problems most often started to surface after the first 18-month period in the United States. Most patients were diagnosed as "affective disorder/depression," followed by "adjustment disorder (with depressed mood)." Only three patients were diagnosed as "psychotic disorder" (Hineman and Onstatt 1984).

Three decades ago, Tyhurst (1951) reported on a clinical study of 47 "displaced persons" from Eastern Europe (42 of them women) who were seen as patients at a psychiatric institute in Montreal. He distinguished two characteristic periods of psychological reactions: an initial "incubation period" lasting about 2 months

after arrival, marked by a subjective sense of well-being and euphoria and a time perspective concerned with the immediate past and an "attitude of escape"; and a "period of psychological arrival" during which the person increasingly realizes the harsh demands, cultural differences, and personal losses he or she must face, and retrospectively idealizes a "happy past." During this period, psychiatric reactions reportedly reach their peak within 6 months of arrival, mainly involving suspiciousness, anxiety, and depression, and somatic complaints such as fatigue and disturbances of sleep and appetite.[8] In a more recent paper, Tyhurst (1977) has referred to this pattern as the "social displacement syndrome." Our data, based on a random sample from the general refugee population rather than on psychiatric patients, largely support Tyhurst's description but would emphasize the range of individual variation and lengthen the time frame of psychological reactions (cf. also Lin et al. 1982). In a similar vein, we have proposed earlier the concept of "exile shock"--as opposed to the familiar "cultural shock"--to refer to the delayed realization of the refugee that almost everything that matters is beyond control: separation from family, culture, job, and significant sources of self-validation; length of exile; return to the homeland; availability of choices (Rumbaut and Rumbaut 1976, 1984). The general process is described succinctly by an elderly Khmer widow in our sample.

> I was feeling great the first few months. But then, after that, I started to face all kinds of worries and sadness. I started to see the real thing of the United States, and I missed home

[8] White (1974, p. 62) has similarly described the time dimension of coping behavior during major life transitions and in patients with severe injuries. Of the latter he writes: "For a while, the depressing impact of the event must be controlled, and this is often accomplished by extensive denial of the seriousness of the illness. As time goes on, there is an increase of cognitive clarity, but this is usually achieved at the cost of an increase of depression, which now is better tolerated. The dismal truth is perceived only as rapidly as one can stand it."

more and more. I missed everything about our country: people, family, relatives and friends, way of life, everything. Then, my spirit started to go down; I lost sleep; my physical health weakened; and there started the stressful and depressing times. But now [almost 3 years after arrival] I feel kind of better, a lot better! Knowing my sons are in school as their father would have wanted, and doing well, makes me feel more secure. . .

ACCOUNTS[9]

You know being a human being in this world, everybody does only want to live and does not want to die; and everybody does only want to be rich and not want to be poor. But I don't understand why when it comes to my turn or my life cycle, I have to be homeless, poor, worthless and forced to depend on somebody's help. I used to be a real man like any other man, but not now any longer. Things I used to do, now I can't do here. I feel like a thing which they say drops in the fire but won't burn and drops in the river but won't flow. So I feel like I have no goal, nothing in the future. . . . We only live day by day, just like the baby birds who are only staying in the nest opening their mouths and waiting for the mother bird to bring the worms. Because we now are like those baby birds who cannot fly yet. . . .

The words are those of a Hmong refugee in his mid-fifties, about 2 years after his arrival in the United

[9] This section presents excerpts taken from extensive transcripts of qualitative interviews conducted with a subsample of Hmong and Khmer respondents. The interviews were conducted and translated, respectively, by two superbly skilled IHARP staff research associates, Mr. Tong Vang and Mr. Chanthan S. Chea. We specifically wish to acknowledge their vital contribution to this research.

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States. He lives with his 8 children and 10 grandchildren in a low-rent, three-bedroom apartment in San Diego. They had first been resettled in Oklahoma but moved after a year since there were no available ESL classes (and, he felt, everyone in the family was "still stupid like a buffalo" because no one had learned a word of English). If an American came into their house, some family members would hide in the bedroom until the visitor left, he said, acting like the "yellow leaf people" who live like hermits in the jungle in Laos, never wanting to see or meet other people. He is now attending ESL classes 9 hours a day--mornings, afternoons, and evenings. He and his family are still "eating welfare." Although illiterate, he had been the respected head of a village of over 500 people in Laos.

The above selection was drawn from transcripts of translated open-ended interviews conducted with a subsample of 10 respondents from each ethnic group. These interviews were intended to provide a more in-depth qualitative assessment of coping strategies and psychological processes. The following themes are salient: security, anxiety, dependency, control, loss, grief, meaning, self-worth, hope, and depression. Consider the following illustrative depiction (also by an illiterate respondent from rural Laos) of what we have called the problem of "load:"

> Coming to live in this new country, my heart always thinks that as we lived in our old country, whatever we had was made or brought in by our own hands; we never had any doubts that we would not have enough for our mouth. But from now on to the future, that time is over. Now we don't know what we should do to have enough for our mouth. We are so afraid and worried that there will be one day that we will not have anything for eating or paying the rent, and these days these things are always in our minds. Some nights the sleep hardly comes to me at all. . . . I myself am too dumb/ignorant; any jobs they have require a literate person to get. We have the arms and legs but we can't see what they see, because everything is connected to letters and numbers. . . . We are not born to earth to have somebody give us

feed; we are so ashamed to depend on somebody like this. When we were in our country, we never ask anybody for help like this. . . . In this country everything is money first. You go to the hospital is money, you get medicine is money, you die is also money and even the plot to bury you also requires money. So you see, when you think all of this over, you don't want to live anymore . . . so we have to organize a clan group so when we have problems we know how to seek help. . . . Money is the worst part of my life that I have to think about, all the time. . . . You know these days I only live day by day and share the $594 for the six of us for the whole month. Some months I have to borrow money from friends or relatives to buy food for the family. I don't really know what to do. I'm very worried that maybe one day the welfare says you are no longer eligible for the program and at the same time the manager says that I need more money for the rent, then we will really starve. . . . I've been trying very hard to learn English and at the same time looking for a job. No matter what kind of job, even the job to clean people's toilets; but still people don't even trust you or offer you such work. I'm looking at me that I'm not even worth as much as a dog's stool. Talking about this, I want to die right here so I won't see my future. . . . How am i going to make my life better? To get a job, you have to have a car; to have a car you have to have money; and to have money you have to have a job, so what can you do? I think for my generation, it's it. No way to rebuild it because I am too dumb/ignorant. Don't know how to read and write, don't know how to speak the language. . . . Language, jobs, money, living and so on are always big problems to me and I don't think they can be solved in my generation. So I really don't know what to tell you. My life is only to live day to day until the last day I live, and maybe that is the time when my problems will be solved.

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The respondent quoted above is a middle-aged Hmong refugee who arrived in the United States in 1980 after spending 5 years in refugee camps in Thailand. He lives with his wife, two children, and two grandchildren. The theme of depressive self-accusation--which can be analyzed as amounting to a search for a vocabulary of meaning in the face of an overwhelmingly frustrating situation (Becker 1962, 1964: Freden 1982)--recurs throughout these interviews. The following excerpt is from an interview with a younger Hmong refugee with six children who also arrived in 1980 after 4 years in the refugee camps:

> I'm so worried that I am a dumb/ignorant person who came to live in their country and still didn't get a word of English. . . . It remains in the heart always for every single day. . . . None of these problems [language, jobs, etc.] can be solved unless there is no me on this earth. I don't think they can be solved if my life is not ended, because not the problems came to me, but I am the one who cause to have the problems. . . . No one would feel in need of a dumb person like me now. Nothing I can help anyone with. What can people count on me for? Don't know the language, have no knowledge how to help others, I even can't drive. . . . It is not like in the old country where you can use your energy to help if others need it. Here you can't do that, or even if you can, nobody would need it. So I really feel helpless. . . .

The three previous respondents all came from rural backgrounds and are illiterate. The following excerpt, by contrast, is from a younger Hmong refugee from urban Laos, who has lived in San Diego since 1976 with his wife and (now) seven children and holds a full-time job at an electronics plant. The objective differences of their situations do not necessarily dissipate a common subjective despair:

> I know that life is something very worthwhile to a human being. But what can a person like me do? I think that my life is worthless, really. You can't do anything. You are like a blind

person, even though you have two eyes but you can't really see what knowledgeable people see. You have two ears but you can't really hear what knowledgeable people hear. And also you may have good health, good legs, good arms, but you can really do nothing, you see. . . . How can you feel secure? Nothing on your hands now. . . . The house you live in belongs to its owner. No land, no properties. Not only that, but you can't even raise your own family. When the welfare pulls its hands off we [the Hmong] probably will go and live under the bridges or whatever because there is no jungle for you to go. Really, in our homeland, you don't have electricity in the house, no TV, no car, no jobs in a company, but you felt secure really. Because there, you have your own home, no need to pay the rent to anybody else; you have your own land to raise crops, raise animals. Even you have no money, but no worries. I don't want to talk about this much; the more you talk the more discouraged you will become. Your eat will not have appetite, your sleep will not come. . . .

Finally, the following two excerpts are taken from interviews with two Khmer women. The first respondent is 65 years old, arrived in 1981, and lives with three teenage sons in a two-bedroom apartment. Six members of her family were killed in Kampuchea, including her husband and three oldest children. The second respondent is in her mid-forties, arrived in 1982, and lives with her mother and three children in a two-bedroom apartment. She is also a widow, and two other close family members were killed in Kampuchea. Both respondents receive welfare assistance, both are illiterate in their native language, and both attempt to make sense of their situations in terms of their Buddhist beliefs:

I'm too old. My mind and courage are not there. It's no use. I'd rather stay home and do all the household chores for my children so they can concentrate on their school and do whatever is vital for their future. If I have any time left from this, I would just dedicate it

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to worshipping the Lord Buddha and promoting Buddhism in our community. I think that's all I can and must do. . . . Sometimes I can sleep, sometimes I can't. Sometimes I can eat, sometimes I can't. I'm in no condition to go out there and face the world like the younger people can. . . . It's a hopeless situation, and I don't know how to deal with it, really. I feel terrified, scared. I wonder if my boat will reach the shore or not. According to Buddhism, this is my fate. I have to accept it, learn to live with it, deal with it. . . . You know, only my body is here. The rest of me including my soul and my way of thinking/seeing things are still back there. It comes down to one thing: I don't feel secure, and I have no control of our daily needs, not today, not tomorrow. Anything could happen in the future. As it seems right now, it's bound to go wrong more than right in the future.

* * *

Buddhism helps me accept my fate more easily. Buddhist teaching taught us to do good deeds which later will be returned to us by someone else. So whatever has happened to me so far is a reflection of a deed that I had done in the past. It's my fate/destiny, and it has been planned that way. There is nothing you can do to change what you had done in the past. . . . But I lost my husband, I lost my country, I lost every property/fortune we owned. And coming over here, I can't learn to speak English and the way of life here is different; my mother and oldest son are very sick; I feel crippled, I can do nothing, I can't control what's going on. I don't know what I'm going to do once my public assistance expires. I may feel safe in a way--there is no war here, no Communist to kill or to torture you--but deep down inside me, I still don't feel safe or secure. I feel scared. I get scared so easily. . . . Still, I believe no matter what happens, life has to go on; and there will always be good and bad in life, in the past as well as

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> in the present. One must feel the need to continue on living, otherwise if life doesn't make sense, nobody would want to live. For me, sense is being a mother taking care of the responsibility to raise my children. . . .

These are profoundly moving and thoughtful statements. They reveal, beyond the respondents' subjective expression of despair and disconsolateness amidst objectively depressing circumstances, a complex humanity and a "psychological eloquence" that belies the often uncritically accepted (and just as uncritically disseminated) notion of "somatization"--i.e., the claim sometimes made in the clinical and research literature that non-Western cultures, less educated people, and ethnic minorities in the United States tend to deny or suppress emotion and to experience or express psychological suffering in somatic terms. It is beyond our purpose here to enter into a thoroughgoing discussion of the merits of the arguments involved (but see Cheung 1982; White 1982). In general, however, our experience and findings in IHARP--and indeed, the accounts just presented--strongly dispute such contentions. Instead of illuminating our undertanding of affective processes, the "somatization" concept seems to us to function more as a superficial and prejudicial mode of dismissing complex psychocultural realities and of discrediting the experience of human suffering of different social classes. While the expression of emotional pain may be socially stigmatized or culturally proscribed in particular situations, the emotional experience of human suffering--certainly as reflected in the refugee experience we have studied--emerges as transcultural and universal.

CONCLUSION

All of us have fundamental human needs to strive for self-esteem and to avoid anxiety, to find meaning and security in our lives (cf. Becker 1962; Adler 1977). What we somewhat amorphously call "mental health" may be understood as a measure of the extent to which we fulfill those basic needs. For Freud, similarly, mental health meant "the capacity to work and to love"--to act and to enter into significant social

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relations that validate a person's identity and sense of self-value. Self-esteem--and meaning itself--is engendered by the experience of control over actions, by the establishment of dependable means-ends relationships that permit ego mastery and satisfying action; and it ensues when aspirations are not too far removed from the opportunities for fulfilling them (see Becker 1964; Brisset 1972; Freden 1982). One's sense of worth and meaning in life is undermined when those goals--including the wish to be valued and loved, to be secure and useful, "to work and to love"--are perceived to be unattainable and when the means of attaining them are perceived to be uncontrollable (cf. Bibring 1953). Depression,[10] in turn, may be explained as the result of such threatened or impaired self-esteem--an emotional expression of powerlessness and helplessness, a demoralized feeling that life lacks meaning, a sense of failure and worthlessness that is accounted for through self-accusation and an attempt to compensate for lost self-worth (see especially Bart 1974; Blaney 1977; Coyne 1976; Freden 1982; Levitt and Lubin 1975; Seligman 1975).

Refugees epitomize people who are plunged into "denomizing" circumstances that seriously threaten both security and self-esteem and over which they have little control. The refugee experience involves profound losses of meaningful sources of self-validation. Further, although the level of their preparedness and reception may vary greatly, refugees must act in a structurally and culturally marginal situation in which the gap between aspirations and opportunities--even if they adaptively lower what we called their "psychological thermostat" and their expectations--may be experienced as ultimately unbridgeable. The psychological reactions of refugees to these circumstances--to

[10]For a discussion of the unitary-binary classification "muddle" of depression, and the controversy between "reactive/psychogenic" versus "endogenous/biochemical" diagnostic definitions of depression, see Levitt and Lubin (1975).

the crises of "loss" and "load"--typically involve grief,[11] anxiety, and depression.[12] This formulation, of course, is intended heuristically to help identify the essential features of a refugee process that empirically is far more complex and resists the theoretical closure imposed upon it by any such formulation. With that understanding, we would here argue further that grief and anxiety are the prototypical responses to the crises of "loss" and "load," respectively. Depression--including what Jerome Frank (1973) has termed "demoralization"--may ensue in either case when the person's sense of worth is overwhelmed. These themes are vividly illustrated by the personal accounts of refugee respondents in our research and are supported by the data presented here.

This chapter reports preliminary findings from a longitudinal study of the resettlement of Indochinese

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[11] In his classic formulation, Freud distinguished between mourning (grief) and melancholia (depression). In normal grief there is object loss (e.g., death of a significant other) but no self-accusation or fall of self-esteem. On this point see Freden (1982).

[12] Rumbaut (1977), in a psychiatric study of migration and depression, concluded that "depression, as one of the most prevalent forms of human suffering and ill health, will never be clearly understood if we conceptualize it as an exclusive product of either 'something wrong with the patient' or 'something wrong with the environment.' The emotional reaction . . . of the patient to an accumulation of negative and rather precipitous life events conveying loss and social undesirability seems in essence to constitute what we call a clinical depression. Migration is the epitome of change, and the refugee is the epitome of the migrant. The kinds of life events that accumulate the stresses of change, loss, and social undesirability weigh most heavily upon the person who moves from one stable cultural niche to another. In consequence, depression, open or masked, is the most prevalent psychiatric condition in migrants and others who are subjected to massive alteration of accustomed life circumstances." (p. 125).

refugees in the United States, including data on the psychological adaptation of the more recently arrived "new refugees," regarding whom systematic research has previously been unavailable. The research literature on migration and mental health has repeatedly suggested that refugees experience significantly greater psychological distress and dysfunction than other immigrants. It is, of course, axiomatic that unhappiness is a natural consequence of human misfortune, and refugees by definition tend to experience a much greater share of such misfortune. What has not been so clear are the specific dimensions, duration, and distribution of psychological distress and dysfunction among different refugee groups and their impact on other facets of adaptation (e.g., English proficiency and economic attainment). Moreover, from a "salutogenic," rather than a "pathogenic," perspective, an equally important question is how, despite the hardships of the refugee experience, so many refugees manage to endure and cope effectively without serious psychological dysfunction. Such knowledge has important theoretical and policy implications for research, service, treatment, training, and prevention.

We have documented in this report the fact that, based on comparable IHARP and HANES measures, Indochinese refugees as a whole do experience significantly greater levels of distress than the general population. Further, we have shown that there are many significant differences and levels of need among the refugees themselves with respect to both objective and subjective aspects of their adaptive experience. They are a highly heterogeneous population, and among them the Hmong and Khmer groups appear to be at significantly greater risk on our affective measures of "happiness" and "depression." Our findings on comparative life satisfaction suggest that the refugees' cognitive appraisals or "definition of their situation" are important mediating variables in the duress distress relationship and that there appear to be culturally distinctive satisfaction profiles for each ethnic group. We have also attempted to show that while the psychological experience of exile is complex and multidimensional, it is also patterned and predictable: we have found identifiable correlates and "predictors" of "happiness" and "depression." The structure of psychological adjustment is temporally

patterned as well, and our data (still to be tested longitudinally) point to an identifiable pattern in the timing of unhappiness and depressive symptoms. A period of "psychological arrival" and "exile shock," occurring during the second year of residence in the United States, appears to be a period of significantly heightened demoralization and psychological problems--a finding with potentially important implications for intervention and prevention.

Finally, we have shown that it is possible to systematically measure and study the mental health and subjective experience of these new ethnocultural refugee groups. We noted at the outset that, taken as a whole, the Indochinese may now constitute the largest Asian-origin population in the United States--a phenomenon that has occurred over less than a decade. Our findings suggest that there are serious and pervasive adjustment problems--economic, sociocultural, and psychological--affecting large sectors of this population, especially the more recently arrived groups. There is an urgent need for rigorous prevention-oriented and policy-relevant research, including mental health research, commensurate with their numbers and levels of need. Like other refugee groups before them, they too have much that they can contribute--not least, perhaps, in the lessons we can learn from their extraordinary struggle to overcome adversity and rebuild their lives in a largely indifferent and frightening world.

ACKNOWLEDGMENTS

The results reported in this paper are based on a large-scale research study funded by the National Institute of Child Health and Human Development (grant No. HD-15699). Hundreds of Indochinese respondents gave generously of their time to share their personal experiences at great length and in great detail. Their stories, in turn, could not have been gathered without the highly skilled work of more than three dozen multilingual research interviewers and translators, nor without the cultural expertise provided by the Chinese, Hmong, Khmer, Lao, and Vietnamese members of the project's Community Advisory Board.

The Indochinese Staff Research Associates coordinated the research process in the field and themselves conducted many of the interviews: Chantan San Chea, Duong Phuc, Nguyen Van Nghi, Dr. Vithaya Sourinho, Darouny Thammavong, Dai Truong, and Tong Vang. They also taught us much about the history, culture, and migration experience of their communities. Dr. John P. Anderson, the coprincipal investigator of the study, gave a careful critique of an earlier version of this manuscript. Dr. Keh-Ming Lin, Dr. William T. Liu, and Dr. William Vega made many helpful suggestions during the preparation of this paper.

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INTRODUCTION

The analysis of refugee movement and integration into a host society is beset with a myriad of thorny issues that researchers must address. These issues include escape, transition, arrival, economic and occupational adjustment, and cultural integration. Researchers studying refugee issues encounter several difficulties in arriving at a satisfactory level of generalization, the foremost of these centering around the conceptual and definitional confusions that arise in dealing with refugees as a social type. Other major difficulties result from the quality of data available in refugee research. Related to these problems is the fact that

researchers have thus far failed to understand the various stages of change in ethnic and social realities that play a role in refugee resettlement.

It has been our intent in several previous papers over the course of a decade to call to the attention of policy-makers, particularly those who deal with migration and refugee legislation, that it is the human group, rather than the individual, that is the central element of migrations (Liu et al., 1979, unpublished; Liu, unpublished). Recent migration studies have focused on refugee research related to such events as the 1975 Saigon evacuation; the 1978 migration of the "boat people"; and the Palestinian, Ugandan, Rawandan, Soviet Jewish, Haitian, and Salvadoran tragedies. Most of this research has, however, been limited to fact-finding reports in which assessments of situations involving refugees are based largely on data representing cohorts, events, lists of international relief agencies, and movements--the distribution and flow of refugees. While these reports are valuable historical documents, they do little to help in the understanding of the refugee phenomenon.

Refugee migration is not simply a movement of people responding to political, economic, and social opportunities, but a complex transition that involves major changes in basic human groups such as the nuclear family, friendship circles, and kinship entities. As groups adapt to these crises and to economic exigencies, new forms of social relations may emerge. Most uprooted individuals cannot handle such complex changes very well without some sort of enduring cooperation and interdependency with their other primary group members.

This chapter proposes no formal theory of integration and social change or of inherent constructs relevant to refugee movement. Its goal is to point out where some of the conceptual and research problems are and to illustrate the importance of primary groups and how they continue to function even after abrupt damage to their original forms.[1]

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[1]Materials presented are based upon interviews with evacuees from Saigon in Camp Pendleton in 1975 and

DEFINING THE REFUGEE

Inasmuch as refugees are a result of military or political events or both, "refugee" as a concept has been largely defined in legal terms.[2] A legal definition of a refugee was, for example, given by the United Nations in its 1951 Convention on Refugees. This definition has been revised several times; it states:

> . . . . a person who as a result of events occurring before January 1, 1951 and owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, is outside the country, and is . . . unwilling to avail himself of the protection of that country.
>
> Winter 1982, pp. 4-5

This definition is inappropriate and inconcise. It limits refugees to those who are of a certain race or religion or are members of a particular social group. It limits refugees to those who are afraid of being persecuted and are already outside the country, thus excluding people in similar situations who remain in the country but who would escape if opportunities existed--the "internally displaced" persons.

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again, 2 years later, in southern California in 1978 and 1979. These studies were supported by two separate grants from the National Institute of Mental Health, Center for Minority Mental Health Programs. The second wave of interviews was conducted and directed by Elena Yu, Associate Professor of Psychiatry, University of Illinois at Chicago.

[2] Here we tentatively argue that there are no purely economic refugees (even though many refugees have aspirations to improve their economic situations), because to include economically motivated persons in the definition of refugees would confuse "refugees" with "immigrants." As well, some people become refugees as a result of natural disasters such as earthquakes or floods. We prefer to define refugees from natural disasters as "victims."

Once a refugee is resettled in the country of asylum, he or she ceases to be a refugee and, in theory, becomes an immigrant (Kunz 1973); but since the law itself does not define who is and who is not "resettled," resettlement becomes a complex issue. Holborne (1978) has also suggested that refugees are a temporary phenomenon resulting from unexpected circumstances under which they were created, and once they are resettled, refugees essentially become immigrants. While this assumption is accepted by many policymakers and investigators in refugee research, there are two major flaws in it. First, it is difficult to arrive at a commonly agreed-upon point of time when refugees become immigrants and are no longer refugees. Liu, for example, pointed out that the proliferation of special work manuals and refugee aid programs and the extension of appropriations for services for refugees have inadvertently created an enduring image of the Indochinese in America as permanent refugees (Liu et al., unpublished). The second, perhaps more important, flaw from the viewpoint of refugee behavior, is that movements of refugees are typically not "motivated." Their destination is frequently unknown to them. Furthermore, as Kunz (1973) pointed out, there is always a period of "transition to nowhere," an important point well documented in Liu's work on the first wave of Camp Pendleton evacuees (Liu et al. 1979). In contrast to refugees, immigrants most commonly identify their destinations and always make careful preparations for their resettlement; some even design their life structure for a long time to come. It is not uncommon for an immigrant to plan such a move well in advance.[3] By contrast, 85 percent of the Vietnamese who evacuated Saigon in 1975 had, at most, 2 days to make the decision to flee (Liu et al. 1979).

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[3]In an ongoing study of immigrant Chinese families from Taiwan living in Monterey Park, California, we found the majority of newly arrived middle-aged and elderly immigrants made their initial preparation a decade before the actual movement. One family, through chain-like migration, took 17 years to complete migration.

The differentiation between immigrants and refugees is theoretically important. The combination of circumstances of motivation--movements without destinations, lack of control of destinations, and fear of political persecution--is cumulative and interactive, producing statistical variations and uniformities of refugee behavior that cannot be compared with those of immigrants.

Some authors distinguish between a refugee and an expellee by suggesting that the refugee is one ordinarily created by political or religious ideals who suffers from bitter agonies because he or she departed voluntarily instead of remaining to fight for ideals. Contrariwise, the expellee is one whose departure from home was involuntary.

Kunz (1980) proposed several major factors affecting refugee adjustment: the situation surrounding the creation of refugees, the refugees' attitudes toward displacement, the ideological orientation abroad, and the receptivity of the host country. From this complex combination of factors, nine types of refugees were suggested, arising from a total of five flight situations (Kunz 1980, 1981). Kunz argued strongly the theoretical importance of taking into consideration refugees' unique pasts, the transit experience, and the host elements, which together create the refugee. In Kunz's own defense of such a complex scheme:

> If we want to come to grips with the meaning of being a refugee, we have to learn to identify and understand the differences between the composition, predisposition and predicaments of refugee groups. Of course, while sub-types abound there are certain para-types which appear on the scene of history more often.
>
> Kunz 1980, p. 120

Despite the painstaking details of Kunz's classification, the complex model may not be too cumbersome to be workable although his fine delineation of refugee types may further aggravate the unwieldy task of doing empirical research on refugee groups.

What we can see from this cursory survey of past works on the subject is that there are real difficulties in

defining the term "refugee." On the one hand, we have treated refugees as a special type of immigrant. On the other, we have an overzealous treatment of unique historical events that do not make for a very readily usable typology.

DATA LIMITATIONS

SOURCES OF REFUGEE INFORMATION

There are two general sources of refugee information upon which most reports are based. The first, though not the most reliable or comprehensive, is from agency and governmental records, based on forms filled out by refugees themselves at reception centers or refugee camps. These are not reliable because refugees, for fear of being persecuted, often withhold information that might reveal their identities or their connections with relatives or close friends in similar situations. Moreover, refugees are aware of the fact that sponsoring countries or private organizations may have hierarchies or use selective criteria in offering sponsorship and that, therefore, they should disclose only information that may be in their favor.

A second source of information comes from surveys taken during or after the refugee flight. This source of information is limited either by restrictions imposed by governmental agencies or by ethical considerations involved in asking refugees for information beyond the basic medical and demographic information that is useful to service providers when refugees are in transition. Often, under these circumstances, investigators are under pressure to collect as much information as possible in a very short time in one camp and then move on to the subsequent waves of incoming refugees. Their questions may be ill prepared due to a lack of knowledge about the context of the refugee's experience. Information may either be contaminated by post-traumatic stresses or be sketchy, at best. Previous studies of the use of survey research methods in non-Western nations have indicated that people who have had no previous experience answering survey questions

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often give answers that reflect their desire to please the survey interviewers (Hurh and Kwang 1982; Yu 1982).

Survey research in many major works has encountered problems with sample design, as well as inadequate percentages of mailed returns. Many of the problems of response validity and methodology in telephone interviewing are glossed over in these reports. Results of most of the studies of small samples, the majority of which are not randomly selected, leave much to be desired with respect to estimates of various ratios and percentages.

RANDOM SAMPLING

Finally, perhaps the most important problem in data collection is the difficulty of random sampling. Very often those who allow themselves to be interviewed, or those whose names are found on many of the community lists of refugees, are more successfully adjusted. They are joiners, owners of telephones and real estate. At the other end of the spectrum are those who are on the welfare rolls, are clients of social and health agencies, or are in programs funded by Federal, State, or local governments. Since refugees are scattered throughout the country, the area probability sample procedure is neither practical nor feasible. When a final list for selection is available, frequently more than half of the people on the list will have moved away, and names will have been duplicated because different lists will have Asian names spelled differently, or they will have reversing of the order of first names and surnames from one list to the next.

Problems of survey interviews have been discussed extensively in the literature (Daniel 1975; Ellis et al. 1970; Fuller 1974; Hanson and Marks 1958; Schuman and Duncan 1974, 1977; Sudman et al. 1977). It is not the purpose of this chapter to elaborate on these points, but to provide sufficient documentation to illustrate how information, if not carefully validated under refugee-related conditions, can be misleading. In spite of the various historical conditions that have led to the refugee phenomenon and the wide spectrum of refugee experiences, all refugees have one experience in

common: they all have been in captivity at some time, even if for just a short stay in a reception camp (Segal et al. 1976). Captivity is a unique experience that, when added to the fear of persecution, the severance from close kinship ties, and the feeling of uncertainty about the future, leads refugees to remain quiet about who they are and where they came from. If the response validity under unusual conditions is questionable, the level of confidence in data based on the survey method must also be questionable.

One additional problem about the quality of survey data deserves particular attention; namely, the use of interviewers. The usual preference for a homophilic interviewer-interviewee situation may need to be reexamined when it comes to the refugee situation, particularly among Hmong and Cambodian respondents. Even under normal circumstances, respondents, who would not hesitate to disclose information to an unfamiliar, professional interviewer if anonymity were assured, can be expected to refuse when the interviewer is an acquaintance from the neighborhood. Often the only bilingual speakers are members of the same refugee group, and their presence during an interview can hinder obtaining truthful information in selective areas of inquiry. These and other sensitive issues must be given considerable attention in terms of both assessing the quality of the data and handling the ethical problems of doing research on refugee groups (see Yu 1982).

THE OFTEN UNDERSTATED SIGNIFICANCE OF SPONSORSHIP

Sponsorship as a legal requirement for immigrants wishing to settle in the United States has had a long history, going back to the first American immigration legislation in 1882, the Chinese Exclusion Act. Such legislation still exists and has attracted wide public attention in recent years as a result of the refugee phenomenon. For the most part, immigrants from Europe used the sponsorship system well, and waves of newcomers came into American communities in the first two decades of the present century.

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Catholic churches and other religious organizations provided a well-oiled machine to handle new arrivals. This was a period of great urban expansion and of the establishment of multiethnic neighborhoods. The cultural "fit" between new immigrants and American society was, in a sense, mediated through the immigrants' own ethnic institutions. The dominant philosophy was to keep the primary group intact, and this was reinforced by various ethnic institutions. This emphasis was balanced by the homogenizing public school system and the social ideal of the "melting pot." In more recent years, both Cuban and Hungarian refugee groups have used the system of sponsorship to become resettled in the United States.

In the case of Indochinese refugees, there was considerable confusion about the requirements of sponsorship, particularly in regard to what the responsibilities were, and for how long. The sponsor was the first person refugees contacted in American society. The sponsor was therefore the key to transition, and could set the tone for subsequent adjustment in occupational, cultural, and mental health areas. It comes as a surprise that research on refugee adjustment has not traced the impact of initial contact with an American sponsor on the subsequent range of refugee options (Yu 1982). Although most people during the first wave of evacuation in 1975 could choose their sponsors, the majority of the post-1978 refugees could not. From refugee data, we learned that sponsors varied widely in socioeconomic status, personal motives, family structure, household relations, and previous experience in dealing with refugees. Sponsors' attitudes toward and understanding of sponsorship also varied greatly, and this defined the development of the relationship.

The evacuees in the first wave group, those who came from Saigon in 1975, had, in theory, someone in the United States to whom they could turn as a sponsor; many sponsors were relatives or former American employers. However, the voluntary agencies that were contracted by the Inter-Agency Task Force in 1975, and later by the State Department, were caught without any uniform definition of the concept of sponsorship, and each interpreted the legal provisions in its own way (Liu et al. 1979). Information about the

prescribed role of the sponsor as found in the Inter-Agency Task Force on Refugees Handbook (Department of State 1975) stated:

> Sponsors may be individuals or organizations who agree to help you become self-supporting. They will help you find a home, a job, and schools. They will also help you get acquainted with American customs and laws, will help you find where and how to get necessary services such as doctors, and will introduce you to people in your new community.
>
> (p. 10)

In contrast, a more comprehensive description was given by the U.S. Department of Health, Education, and Welfare (now Health and Human Services), which says:

> In resettling a refugee, the resettlement agency and the sponsor undertake certain responsibilities as a moral commitment. These include receiving the refugee and his family; providing shelter, food, clothing, and pocket money; providing assistance in finding employment and in school enrollment for children; and covering ordinary medical costs. Once employment is obtained, the sponsor assists the refugee to locate permanent housing, acquire minimal furniture, and arrange for utilities. Sponsors are also expected to help refugees with some of the less tangible aspects of adjustment to a new culture.
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> Department of Health, Education, and Welfare Interagency Task Force for Indochina Refugees 1975, p. 73)

Both descriptions are specific about the responsibilities but do not specify a definite period of termination of such responsibilities, though implicitly such assistance would be terminated if and when the refugees themselves decided that they no longer wished to depend on their sponsors. The lack of a precise meaning of "sponsorship" resulted in two unanticipated developments. First, many refugees expected sponsors to take the responsibility for supplying food, shelter, clothing, schooling for children, medical services,

employment, and spending money. In addition, the refugee families expected the relationship to be affectionate, interdependent, diffused, and reverent/deferent. Further, refugees initially thought that their socioeconomic status would be largely determined by the status of their sponsor.

Research that relates sponsorship to refugee adjustment is totally absent. This is unfortunate because the former obviously serves as a context for the latter in the interpretation of adjustment data. The interaction between a favorable or unfavorable sponsorship experience and a refugee's psychological functioning and attitudes toward the host society may be reflected in that refugee's capacity to adapt to the majority of changes with which he or she is faced.

The sponsorship experience seems an attractively simple issue to study, as pointed out in the thoughtful essay of Van Esterik (1981), but surprisingly, no one else appears to have given it much thought. Perhaps most investigators simply take sponsorship as a given not to be questioned. Consequently, research has been directed toward the refugees, not the agencies that serve them (Mortenson 1981). The resulting gap in knowledge will not be filled until we know more about sponsorship as a critical linking element in the refugee phenomenon. Longitudinal data starting from the time that a refugee is sponsored out of a reception camp would provide much-needed information about the effects of sponsorship, permitting us to observe how sponsorship is related to the emergence of life problems later.

Sponsor-refugee relations are essentially interpersonal experiences, and many of the problems that refugees experience arise in their encounters not only with the sponsor, but also with employers, neighbors, and agency officials. The effect of interpersonal experience on coping behavior is readily apparent in the web of relationships that exists within the family, but it is also present in other settings such as in the workplace or the place of worship.

If the sponsorship experience is negative, there is a traumatic effect that leads to a greater vulnerability

to life circumstances, which are capable of maintaining or exacerbating the effects of the initial trauma. It is important for researchers to realize that the sponsorship experience may be a vulnerability factor, and one that may not immediately surface.

RESETTLEMENT ISSUES

ASSIMILATION AND ADJUSTMENT

Many writers have assumed that such standard sociological concepts as "assimilation" and "adjustment" are immediately applicable to Indochinese refugees. A problem in measuring assimilation is that we often do not know what it really means. When the earlier European immigrants came to America, language adaptation, employment mobility, the nuclearization of the family, religious conversion, residential mobility, and so forth were all elements of the Americanization process. Inasmuch as European nationalities did not include the element of "race," assimilation could be simply measured by cultural and social indexes.

There are two major problems in describing the assimilation of Indochinese refugees. First, social scientists in the past few decades have been conditioned to view assimilation as a social ascendency process, but when post-1965 immigration legislation opened the floodgates for many professional and technical immigrants a new phenomenon occurred: the social descendancy of many new immigrants from Asia, whose major motivation in coming to the United States was the lure of unlimited opportunities for themselves and for their children. The adjustment of these highly educated immigrants to the experience of downward social mobility received no sociological attention.

Second, from the beginning of the evacuation of Saigon in 1975, various pieces of Federal legislation, including the 1980 Refugee Act, have not "delabeled" Southeast Asians as "refugees." In the past 9 years, the words Vietnamese, Laotian, and Cambodian have been synonymous with the word "refugee" in the minds of welfare providers and the general public.

These historical and situational factors have made it difficult to reap much of an intellectual harvest from recent studies on the assimilation of Indochinese refugees. One might simply argue that the assimilation of Indochinese refugees should be measured by the disappearance of refugee status. It is more important, however, to find out whether refugees have gotten off welfare and unemployment rolls, a more measurable indicator of self-sufficiency.

Periodic reports of employment and welfare statistics may be important in an agency's planning for continuation of material aid to refugees. There is a problem of deciding whether or when such aid should be discontinued or altered. Employment data can be useful to delineate relationships between various cohort age groups, time of resettlement, and match (or mismatch) between previous employment and employment after resettlement. Such analyses may provide evidence of the extent to which a refugee may need additional support to meet the occupational and economic demands of the new environment. However, the value of employment and other economic data must not be overestimated. It is often taken for granted in private and public sectors that economic self-sufficiency is the solution to many other problems such as housing, education for the young, health and mental health care, and crime and delinquency. For the refugees from Indochina, however, employment statistics have a number of limitations when they are used as proxy measures of "adjustment" to American society. First, having a paid job tells little about the nature of the job relative to expectation. Downward mobility and underemployment have been reported as two common features in the occupational profiles of Vietnamese refugees. Second, multiple job holdings have been reported as being common in certain parts of the country. Third, and this deserves considerable discussion with regard to policymaking, the determinants of labor force entry are not necessarily related to the goals or results of refugee job retraining programs.

When refugees arrive in the United States, they are faced with a concrete situation that may result in their working, undergoing training for employment, or receiving welfare. The distribution of jobs and programs

and the clustering of refugees, differ from one State to another, and this influences individual refugee families' choices of work versus other available alternatives. It is reasonable to assume, from our interview materials, that there is an element of choice in the use of public assistance by refugees. Our file materials on the 2-year followup of the families interviewed at Camp Pendleton reveal that there are competing ways for refugee families to maintain themselves. Public assistance and job retraining programs are two of these, and working is another. It is, therefore, reasonable to assume that using employment data alone or as a major index for assessing economic self-sufficiency may distort the total picture of current or future refugee adjustment.

LANGUAGE DIFFICULTIES

Language difficulties may be an important factor in underemployment, and the frustration of prolonged underemployment could affect the choice to use public assistance. Thus, education and work history prior to refugee status are two important elements affecting job-related choices. In addition, family-related variables have been identified as relevant to the work experience of women. For refugees, especially in the initial period of resettlement, family or familial factors have been found to be extremely important for both men and women in determining their motivation to work.

EMPLOYMENT AND WELFARE DATA

The short history of occupational rehabilitation of the current refugee population from Indochina does not permit us yet to see the entire picture. For the refugee group, both wage levels and welfare-benefit levels interact with cultural and labor force variables to affect the income-producing actions of newcomers who have a different language, background, and family structure. Other variables, such as the attitudes of the community, may be important factors in the eventual occupational adjustment of refugees. This was shown in a well-documented paper by Starr (unpublished) in which he described the problems of refugee fishermen on the gulf coast of Texas.

An attempt to maximize family welfare benefits may skew employment data. If some family members are entitled to multiple benefits, it might be better for the family if those members continue to receive such benefits even if work were to become available. The pooled income system could free younger members or women to return to school, while family members living in isolation might find it difficult to do so.

For the present time, at least two issues warrant a careful reexamination of available data and a change in the type of data to be collected if employment and income data are to be used as proxy measures of resettlement adjustment. First, questions about income and work, ordinarily used in survey research with the general population, need considerable revision. In order to measure the economic well-being of the family, cash income and reciprocal exchange of services and gifts (sometimes with nonrefugee neighbors and/or coworkers) must be considered for their economic effect on the overall household and the individuals within the household. Second, it is also clear that we need clarification of the role of the family in individual resettlement adjustment, which has so far been largely neglected in refugee study reports.

MENTAL HEALTH, STRESS, AND THE ROLE OF SUPPORT GROUPS

MENTAL HEALTH AND STRESS

Because of the suddenness of events that create refugees, the need for immediate assistance, and the political situation surrounding their creation, refugee movements have become the subject of international media coverage. The ensuing public attention produces a demand for immediate action that precludes a thorough assessment of the mental health needs of the refugees. It is, consequently, difficult to collect mental health data on refugees until at least a year or two after they have been relocated. Mental health data on refugees nearly always suffer the inadequacy of being either incomplete or based only on reports of severe cases by clinicians. Events occurring in Asia in 1977 and

1978 provided sufficient grounds to assert that the major life event traumas experienced by refugees would, sooner or later, lead to greater risk for mental health problems (Burton 1983; Liu et al., unpublished; Webster 1979) (especially events such as mass rape and physical assaults by Thai pirates on the women and elderly en route to Thai camps, the so-called "boat people"). The expected large number of breakdowns and suicides has not become reality, but many service providers and researchers claimed that human suffering remained hidden as refugees individually and collectively found ways to cope with the new demands of life.

In short, we have two contradictory views about the mental health status of Indochinese refugees. One view is that the many stresses produced by flight and uncertainties about the future, the loss of close family members, the guilt feelings evoked by leaving someone behind in order to gain personal freedom, the experience of downward mobility for some, the severance of strong primary network ties, and the like, would invariably produce the stress symptoms commonly identified in clinical manuals but would not be reported to medical and service personnel. A second view argues that, though they are subject to higher stresses, this does not necessarily lead one to conclude that refugees suffer from higher rates of mental disorders; refugees have developed a resilient response to crisis and possess a flexible and effective mode of tension management and adaptation. This view is based on earlier studies of survivors of Nazi treatment during World War II (Antonovsky et al. 1971) and a longitudinal study of the community population in Chicago that suggests, among other things, that critical life events do not necessarily produce stress in spite of the tension (Pearlin and Schooler 1978); successful tension management can serve as an effective immunization against the impact of traumatic events. Our own research supports this finding. We found that refugees who experienced the 1954 Dien Bien Phu evauation adjusted much better after the 1975 Saigon evacuation than did those who had not experienced the earlier evacuation.

THE ROLE OF CULTURE IN MENTAL ILLNESS

Most recent research reports on the mental health issues of Indochinese refugees have focused on the impact of culture shock and the lack of culturally appropriate mental health prevention facilities (Aylesworth et al. 1979; Tung, unpublished; Pacific/Asian American Mental Health Task Panel 1978; Wong, unpublished). The role of cuiture in mental illness is a classic controversy, involving the differential goals of psychiatrists and cultural anthropologists (Leighton 1981), the former traditionally seeking uniformities in clinical symptoms regardless of cultural variations in defining mental illness, and the latter seeking peculiarities of behavioral disorders in cultures other than their own. The complex problem of the role of culture in mental illness exceeds the scope of this chapter. However, with respect to Indochinese refugees, there are generally four types of stressors that may explain mental disorders that result from the refugee experience. 1) There are universal adjustment reactions to stresses and critical life events that are common to all people. 2) The refugee experience is a combination of several important single events: residential movement, violence, death of family members, loss of job, and changes in family structure (Antonovsky 1974; Bowlby 1977; Brown and Harris 1978; Dohrenwend and Dohrenwend 1981). 3) There are posttrauma syndromes that may be peculiar to refugee populations who have gone through such experiences, but such stress is not clinically significant enough to warrant medication or professional attention (Rahe et al. 1978; Tung, unpublished; Tyhurst 1981). 4) These people are stigmatized as refugees, which places them in the category of needing mental health services (Wong, unpublished; Liu, unpublished). Beyond these four possibilities, there are the true clinical breakdowns, in which the flight is merely a provoking agent that causes preexisting mental health problems to surface.

SOCIAL NETWORK SUPPORT

Extrapolating from studies conducted in the United States on the role of social network support in moderating stress (Caplan 1974; Cobb 1976; Dean and Lin 1977;

Hammer, unpublished; Henderson 1977; McKinlay 1973), a strong argument for the clustering of refugees, as opposed to the dispersion policy, was that network support is a strength of Asian communities and should be preserved to prevent mental breakdowns. Network support is so universally advocated in every policy paper on Indochinese refugees that there is no need to list such papers here. However, it is surprising that, aside from a set of papers on Vietnamese culture and kinship, giving what social scientists called the description of ideal norms, we have yet to uncover a single empirical study on the changing refugee kinship structure in the United States. Such a study would enable us to assess the strength of such network relations in mental health prevention.

KIN, NONKIN, AND FICTIVE KIN SUPPORT GROUPS

Furthermore, there is a conspicuous lack of distinction between kin, nonkin, and fictive kin support groups in the literature, which often blurs the issue of the importance of support groups during crisis and during periods of inconvenience. For example, the Indochinese Mutual Aid Association project, reported by Bui (unpublished), is merely an attempt to reformulate small groups to aid individual refugees by using various regional and functional criteria; these associations should be discussed separately from kinship groups.

Work done in the 1950s on mutual help and interactions among families dealt with groups rather than individuals. The unit of analysis was the household. This is a legitimate way to study interactions among several nuclear units but is a problematic method to study kinship (Liu, unpublished). In view of difficulties such as these, Loudon (1961, p. 135) used the egocentered approach, focusing on the individual and his or her relationship with other relatives. By using this approach, it is possible to delineate the differences between men and women, among people of different ages, and between parents and their adult children on levels of formal and informal obligations other than major life events such as ritual vistation on the occasion of a birth, death, graduation, or wedding, or

semireligious observations. The culturally prescribed kinship interactions may not be synonymous with continual and reciprocal assistance and contacts among kin, even though they may involve similar functions (Rosow 1965, p. 375).

For example, the very low level of interaction among extrafamilial kin, as reported by several investigators, is probably the reason that sociologists, in the absence of special obligatory norms to report, must rely upon the lowest denominator as the unit of measurement of such interactions. The units of accountancy often resorted to are frequency of contacts by telephone or in person, and the amount of cash assistance received by the relative (Hill 1970). To use the lowest common denominator has methodological advantages in describing the profiles of American family behavior through sample surveys, but the variability of norms of different interkinship relations will be overlooked, which may account for our failure to come to grips with this issue. For example, Cummings and Schneider (1961) dramatically demonstrated the wide range of behavior among kin by reporting that the number of kin their informants reported varied from 34 to 280, and the informants failed to agree on the relationship between genealogical distance and degree of intimacy. Similar findings have been reported by Adams (1968), Schneider (1968), and Gibson (1972).

While research has consistently shown that interactions occur among kin beyond the basic nuclear unit, the problem has been that of identifying the particular set of kin relations that have the highest sense of obligation, as well as those factors that explain the variability of kinship relations. Studies on class variations in kinship interaction have at least touched upon some aspects of the issue (McKinlay 1973; Shanas 1968; Sussman 1965). We can expect to be misled if we try to use the American norm of kinship relations to delineate a support system for refugees from Indochina. In America, kin ties outside the immediate domestic group often do not constitute a concrete and boundary-clear group of relatives with binding obligations upon one another, nor are they a constituent unit of a social structure, except for certain ethnic groups with rather selective sets of experience. If the same methods that

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are used to study the American family are used to study Indochinese refugees, we fear the results would more reflect poor methodology rather than the reality of the situation.

KNOWLEDGE GAP: THE REFUGEE COMMUNITY

Few research designs have touched upon the refugee community as a social group. Individual refugees have an enormous capacity to adapt to a new culture in a short time, particularly to the external signs of behavioral conformity that make them more acceptable in the community, raise their employability, and generally make their lives easier. A good starting place for understanding the assimilation of refugees, however, is to look for answers not in the individual but in the persistence and metamorphosis of the refugee community itself.

DIFFERENCES BETWEEN IMMIGRANTS AND REFUGEES

It is frequently true that the structural characteristics of the ethnic community provide the best evidence of the differences between immigrants and refugees. Refugees, under the duress of fear of persecution and subjected to unplanned movement, are forced to depend on each other for support and care. The normative guides to behavior in tension management and in interpersonal relations are transported from the society of origin.

We submit here that there are variations in the motivation of immigrants, and some undoubtedly come closer to the refugee type than others. Immigrants, who are more inclined to move for economic rather than for political reasons, generally move across borders in small bands or as isolated individuals, depending almost exclusively on the local community to meet their needs. They are under greater pressure to adjust to the norms of the host community as they struggle to play a more active economic role after resettlement.

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We accept the consensus of many earlier writers that labor relocation in relation to resources is the basis for many historical large-scale individual movements across national boundaries (Ravenstein 1974; Sjaastad 1962; Wolpert 1965; Zipf 1949; Zolberg 1979). The economic motive tends to cause interpersonal relationships to be restructured on a more open form, based on functional utility rather than ascriptive attributes. It is now a historical fact that both immigrants and refugees tend to cluster after resettlement. It is at this point that the similarities end. Immigrant communities tend to form secondary ethnic groups, whereas refugees tend to form primary ethnic groups, a distinction made clear by Francis:

> By primary ethnic groups we understand variable corporate units which, after their transfer from the parent to the host society, tend to continue to function in the host society as close subsocieties able to satisfy the basic social needs of their members. . . . Participation of their members in the host society accordingly tends to be indirect in all dimensions.
>
> (Francis 1976, p. 397)

The primary ethnic group is structurally closed; that is, there is strong cohesion among members within the group and little direct communication with members of the host society. It is not limited to refugee groups: peasant immigrant groups and religious minorities have historically formulated such primary ethnic groups in America (Francis 1955a,b, 1976; Thomas and Znaniecki 1927). However, refugees as a rule tend to formulate primary ethnic groups, in contrast to voluntary immigrants, and are, as a result, structurally closed (Lauman 1983).

On the other hand, Francis described the "secondary ethnic group" as one--

> whose members participate directly in the host society in some dimensions, particularly on the level of commercium, but indirectly through the mediation of the ethnic group in other dimensions, particularly on the level of commensalitas and connubium.
>
> (Francis 1976, p. 393)

Francis' concept of connubium means the readiness to establish affinal kinship ties through intermarriage. By commensalitas he means such activities as visiting, eating, and feasting together and associating for recreation. On the other hand, commercium means purely functional cooperation for practical reasons.

The relationship between individual motivation and group structure should be kept in mind as the key to understanding refugee behavior as compared with immigrant behavior.[4] The persistence and change of refugee communities are invariably the reflection of refugees' progressive adjustment to the host society.

For those who are uneasy about the secondary migration of Indochinese refugees, which goes against the original plans of the Federal Government for their resettlement, these secondary migrations are simply the result of natural tendencies of refugees to form into new primary ethnic groups. The resettling agencies and the Office of Refugee Resettlement of the Federal Government must recognize the important role such refugee communities play in maintaining the well-being of the Southeast Asian refugee.

EPILOG

There are many different research agendas on refugees. Individual investigators while limited by resources, set their own priorities. In most cases, their inquiries are confined to areas such as immediate crises, services planning, and legislative demands, and, as a result, they do not follow the path of refugee adjustment over time. It is clear that refugee life is subject to transitions and, expectedly and understandably, is unstable;

[4] This analysis is similar to Edwin Lauman's paper on the isomorphic relationship between Roekesh's closed mind and the closed structure of the Durkheimian concept of society characteristic of altruistic suicide, or a closed society. (See Edwin Lauman, Bonds of Pluralism: the Form and Substance of Urban Social Networks, New York: Wiley & Sons, 1973.)

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circumstances are continually changing. Finding themselves in an economy of abundance, refugees are confronted with new and attractive opportunities. They are expected to respond to these opportunities, but often at the expense of maintaining family cohesion. It is during unsettled periods that refugees are often studied, surveyed, and interviewed. These cross-sectional surveys uncover neither the process of adjustment nor the emerging structure of the future refugee community. Therein lies some of the major weaknesses often found in refugee research.

Refugees almost always arrive in multiple waves as the events in the home country develop. Each refugee wave may be different from the last. To sample the different waves of refugees in a cross-sectional study is like sampling the moving waters in a river, which poses enormous methodological problems. Therefore, for research on refugees to be useful, it must utilize a longitudinal approach, tracing each family or individual over time regardless of whether they change residence and are on the move. Such studies require painstaking care to execute and more financial support than normally required for research involving the study of ordinary populations.

One need not be pessimistic, however. A decade has elapsed since the arrival of the first wave of refugees in 1975. The trauma of the sudden turn of events in Southeast Asia, the shock of their migration to the host country, the long periods of transition, their bittersweet experiences in dealing with their sponsors, and their initial dreams all have had profound effects on the refugees' quest for places in American society. A retrospective, longitudinal study design coupled with a prospective longitudinal followup will yield much needed information on the adjustment of the different waves of refugees. Similarly, it would be good if samples of each of the major refugee cohorts arriving at different times could be drawn. Cohort analysis of the refugee experience would be a most powerful source of valuable data on refugee adjustment and behavior. It is not very useful for many cross-sectional studies on small numbers of refugees at different locales to continue to be undertaken. The resources commmitted to many such fact-finding exercises could be better

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spent on a few well-designed, indepth, longitudinal studies.

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STUDYING VIETNAMESE REFUGEES: METHODOLOGICAL LESSONS IN TRANSCULTURAL RESEARCH

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INTRODUCTION

Besides the existence of two divergent methodological approaches in sociology--qualitative field work and quantitative survey research--there is a debate between those researchers who advocate and those who question the universal applicability of survey techniques developed in the American context. On the one hand, some sociologists--particularly Mitchell (1965; p. 665)--have argued that "perhaps the vast majority" of the materials collected in developing countries "are of such questionable quality that they cannot be used for research on numerous topics." As supporting evidence, Mitchell has cited the difficulty of estimating sampling errors in developing countries; questioned the competence and honesty of indigenous field staff in interviewing or sampling respondents; noted the noncomparability of sampling frames and interviewing situations in cross-cultural research; and pointed to the danger that the courtesy bias and the "sucker bias" may "pull" certain

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responses in different directions, depending upon the prevailing norms and values of the society being studied. In addition, those who have conducted interviews with ethnic minorities in the United States have questioned the value of absolute adherence to the conventional research methods taught in standard textbooks, against which the "scientific merit" of a piece of research is judged (Couchman 1973; Durham and Wortham 1968; Fein 1971; Schwartz 1970; Williams 1964). Among the most frequently encountered difficulties are unusually high refusal rates, community suspicion, high mobility, irregular layouts of ethnic ghettos, and language barriers, combined with status differences between interviewers and interviewees that can hinder the establishment of rapport and the collection of valid data.

On the other hand, other social scientists have argued that survey research can be used successfully to study ethnic communities. Freeman (1969), for example, stated that, in his study of Mexican Americans in Tucson, Arizona, his research staff encountered minimal difficulties with language problems. They dismissed as "exaggerated," if not "imaginary," the possible obstacles of cultural disparity between Anglos and Mexican Americans and of reluctance on the part of respondents to submit to interviews on account of their illegal immigration status. Obviously, much remains to be learned about the specific context in which a piece of research is conducted and the circumstances under which respondent cooperation is obtained.

Mainstream sociology, through its unchanging treatment of survey technology in virtually all of its standard research methodology textbooks and through its embarrassing silence on the sensitive issues surrounding the realities of research on special populations, has inadvertently lent support to the misguided notion that survey techniques developed in middle America can be applied with equal success to all groups, including populations in Third World countries. Our experiences in doing research with Indochinese refugees tend to cast doubt on this widely accepted notion.

This chapter draws upon field notes of my research experiences with Vietnamese refugees to examine the

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universal applicability of survey strategies to a special population, an area in which few studies have hitherto been conducted in this country. The research experience on which these notes are based was possible only because some Vietnamese refugees were willing to overcome communication barriers created by cultural prescriptions of politeness toward outsiders. Due to space limitations, this chapter focuses on only two objectives: first, to describe some of the critical methodological problems encountered in a Vietnamese refugee study in California and to examine them against the backdrop of standard procedures presented in most survey research textbooks; second, to discuss ways of coping with these difficulties, some of which are unique to studies of refugee populations per se, others of which are common to all research on small ethnic minorities.

By and large, the methodological insights gained from our studies of the Vietnamese refugees have led us to question the value of a blind application of survey techniques to a population by whom the concept of research is not well understood. Following closely the discussion of methodological problems in the study of Korean immigrants by Hurd and Kim (1982), the materials in this chapter are organized according to four topics: 1) contextual differences between a war-torn country and a society at peace; 2) conceptual equivalents and linguistic differences between Vietnamese and English; 3) specific cultural problems in social interaction with refugees; and 4) sampling difficulties unique to refugee populations, especially the Vietnamese.

CONTEXTUAL DIFFERENCES

When a total of 130,000 Indochinese refugees, mostly from Vietnam, started to arrive in the United States in April of 1975, their flight was but one of a series of evacuations and relocations the Vietnamese had made in the past 30 years or so. Perhaps the best known forced migration was the refugee movement of over 1 million North Vietnamese civilians and military dependents across the 17th parallel as a result of the Geneva Accord, which formally ended the French-Indochina War (1946-1954) and marked the beginning of American

involvement in Vietnam. Since then, displacement of the civilian population has been an integral part of the Vietnam War, first initiated by the Diem regime as early as 1961 and continued later by the ARVN (South Vietnam's army) and United States forces. By the mid-1960s, experts estimated that approximately one-eighth of the Nation's population of 16.1 million was composed of recently displaced persons (Smith et al. 1967, p. 59). The majority of the population was rural, although as a result of their forced relocation, many had to crowd into urban centers in search of subsistence and protection from constant guerrilla harassment.

Contrast that situation with what has happened in the United States over the last 30 years, where gunfire has not filled the skies at night, buildings have not toppled from bombing attacks, and armies have not been stationed a few miles from one's home. Forced relocation of the populace has been infrequent and has occurred primarily because of natural disasters in confined geographic areas, such as flooding in the Northwest, tornadoes in the Midwest, or such events as the nuclear scare at Three Mile Island. The contextual difference between a war-torn country and one at peace is self-evident.

Furthermore, while most Americans have become accustomed to public opinion surveys since the end of the second World War, some Vietnamese had never been interviewed. A few had their first experience of being interviewed for research purposes only as recently as 15 years ago, when a group of Harvard-affiliated scholars and students was under contract with the Department of Defense to assess the impact of United States-sponsored relocation movements on the morale of the populace. Since then, there have been no systematic large-scale surveys of the Vietnamese until their arrival in this country.

As a result of over 30 years of conditioning in a war-torn country, terms such as "principal investigator" or "co-investigator" had to be avoided whenever researchers were introduced to the Vietnamese. This is because the Vietnamese translation, "Khao sat vien chinh," immediately conjures the image of secret police investigators, many of whom are perceived by the

Vietnamese as corrupt officials who thrive on bribery and the exploitation of innocent citizens.

Furthermore, the simple enumeration of household or family members, a standard practice in United States censuses and sociological surveys on the family, becomes problematic when applied to the Vietnamese. In a society whose kinship structure gives preference to sons over daughters, the Vietnamese government demand for males to fight the war led many frightened parents to hide the existence of male offspring or to send them away, under whatever disguise and at whatever price, to save them from being drafted into the armed forces. Others have been so hounded by their previous activities in various military operations in Vietnam that they are easily threatened by any research questions into their family composition. In our interviews in San Diego, one refugee with minimal education began to suspect that two of our interviewers were Communist agents when they asked whether some of his family members were left behind during the evacuation from Vietnam. Although the respondent answered the question during the interview, his spouse surreptitiously phoned a relative to come and force the interviewers to the nearest police station and file charges there. No amount of assurance could convince the respondent that the interviewers were not Communist agents. Two months after that incident, the respondent and his family sold their house and moved, leaving no forwarding address. Whether the move was precipitated by their fear of being followed by the Communists cannot be determined. What is evident, however, is the fear that responses to survey questions in this country may cause some harm to relatives left in Vietnam.

Questions on income and occupation, normal topics in daily conversations between Asians, become problematic in the refugee context, especially since some refugees have had to sell valuable personal properties (gold, diamonds, jewelry) to survive.

Another common question for which reliable answers are difficult to obtain from refugee populations is marital status. The instantaneous decisions made during the evacuation rendered family separations inevitable. The uncertainty surrounding the whereabouts of loved

ones, combined with the insufferable loneliness of individuals thrust into an alien environment, easily led some refugees to cohabitation or other types of living arrangements that are not socially acceptable or legally appropriate (e.g., bigamy). Some refugees avoid any contact with other persons from their country for fear that their new lifestyles will be known to others and that their relatives back home will be hurt by the knowledge of their new living arrangements or marital status. Some respondents gave two or three confusing answers to the question regarding their marital status, switching from single to married to widowed in different sections of the interview section, rendering it impossible to determine the precise information for research tabulation purposes.

The question has been raised as to what we, the researchers, can do to remedy the problem created by the contextual differences between the life experiences of the Vietnamese and the Americans. Unfortunately, the problem is not immediately solvable. Just as it will take the Vietnamese years to forget the trauma of war and its aftermath and to acquire a realistic assessment of the threat of communism, it will also take them a long time to accept that their survey responses will have negligible effects on their relatives remaining in Vietnam. In our complacent acceptance of surveys, we have nearly forgotten that the American public was once as suspicious of interviewers as the Vietnamese are today. Hyman et al. (1954, p. 147) provides us with ample documentation that in 1948, 1950, and 1952, some National Opinion Research Center interviewers in different parts of the country reported that they had encountered undue resistance among uneducated Americans, some of whom believed that the interviewers were "commie spies."

The subsequent refinement of survey techniques in this country has gradually educated Americans and taught them to be more responsive to research inquiries. However, the vast majority of the Asian ethnic minorities in this country, especially Indochinese refugees who fall outside of the mainstream of American life, are not yet informed of the concept of social surveys, nor do they fully understand the role of research interviewers. While the first few investigators who came

in contact with the Vietnamese refugee population may not have gathered as much data as they had expected, a consolation is that the process of research has a cumulative and positive socialization effect on the population studied, thereby making the collection of survey data much less difficult for future researchers.

CONCEPTUAL AND LINGUISTIC PROBLEMS

Recognition of conceptual and linguistic problems is a necessary step in transcultural research. Unfortunately, insofar as the study of Vietnamese refugees is concerned, our knowledge base regarding such problems has yet to be built. In general, there are two approaches to instrument translation in transcultural research. The first argues that the items in a particular instrument can be used for different populations and that differences in the answers can be explained by cultural variations rather than by differences in research methods. However, other researchers have posited that the items chosen for inclusion in an instrument derive their meanings from the culture of origin and may sometimes have a different meaning--or no meaning at all--in another culture, even though perfect linguistic equivalence is assured in the process of translation and back-translation. These two approaches have come to be known as the "emic-etic" problem in research (Brislin 1980; Davidson et al. 1976; Hunter and Whitten 1976, p. 142, p. 152; Pike 1954; Stone 1976; Sturtevant 1964). Briefly, the emic approach "attempts to describe items of behavior occurring in a particular culture utilizing only concepts employed in that culture" (Davidson et al. 1976, p. 1), whereas the etic approach describes behavior by using external criteria imposed by researchers. But, of course, the validity of the measurements based on these criteria comes into question immediately: a combined emic-etic approach must be devised to resolve this problem.

In our study of refugees, even simple terms such as "full time" versus "part time" work were difficult to translate, because the concept is foreign to the Vietnamese culture. Full-time comes out in translation as "toan thoi gian," which literally means "complete time,"

while part-time was translated at "ban thoi gian," or, literally, "one-half time." But in the American occupational setting, part-time is not the same as half-time; it carries a broader meaning than just 50 percent-time.

To ask a respondent whether he has any marital problems is not as clear-cut as one might think, because the words "marital problems" can be translated into Vietnamese in two ways. The first, "tro ngai hon nhan," literally means "obstacles in a marriage," such as incompatible horoscopes or religious or regional differences. The second, "bat hoa giua vo chong," means discord between husband and wife. Since both Vietnamese constructs are back-translated as "marital problems" in English, we had to take great care in differentiating between these two meanings.

Indeed, such differences inherent in the two languages carry broad ramifications in interviews. To illustrate further, Vietnamese has a distinctive system of personal pronouns and "classifiers" that are used in place of the English "I" and "you." These classifiers reflect the important social hierarchies in Vietnamese culture by denoting the age, sex, marital status, social distance, personal achievement, and official rank between the speaker and the person addressed. Even in face-to-face conversation, the speaker must constantly refer to the person addressed as if he or she were a third party and use the third person pronoun most appropriate for the social status of the person addressed. In short, there is no second-person pronoun in Vietnamese. Thus, when talking to a married woman, one says "Ba," a kinship term used in addressing one's grandmother. To an unmarried woman, one says "Co." To a man without any title, married or unmarried, one says "Ong," a term used in addressing one's grandfather. When calling his own child, a Vietnamese man would say "Em." To a teenager, he would say "Cau"; to a young adult, "Chu"; but to a friend's child, "Chau." To a man of his father's age or older, he would have to use the word "Bac," but to a most venerable elderly person (regardless of sex), he must use the word "Cu." For kings and other exalted persons, he may only use the word "Ngai." There are, all in all, more than 40 such classifiers in Vietnamese in lieu of the one English pronoun "you." Failure to

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use the appropriate term constitutes a serious breach of etiquette.

When referring to himself, a Vietnamese man must also use the appropriate terminology that pairs with the term of address used for the other person. Thus, to someone addressed as an "aunt," he must refer to himself as "Chau," meaning nephew. To someone he calls "older sister," even though she is not really related to him, he must humble himself by calling himself "younger brother," and so on. The Vietnamese word, "Toi," which is frequently used as a generic "I" nowadays, etymologically means "servant" or "subordinate." If used in the presence of relatives, it suggests displeasure or an intention to deny kinship ties.

When an adult Vietnamese speaks in English with other people, therefore, it is inevitable that the other party will seem impolite, since the traditional classifiers of social hierarchy are absent in English. This became quite apparent one day when one of our interviewers noted the following comments:

> Here you say "you, you." Everyone is "you." I call people in Vietnam according to [their] age, rank, and [according to whether they are related] mother's side, father's side. I think that our culture is more polite than the American culture. . . . When I go to other people's homes, everyone calls me "Hey [first name] or "you." I hate that. When people say: "Where are 'you guys' going?" I don't answer. I think Europeans are more polite than Americans.

Using recently immigrated Vietnamese refugees both as translators and as interviewers was one of several strategies employed to resolve the conceptual and linguistic problems encountered in our study. As bilingual, the research interviewers were able to make a contribution by examining both Vietnamese and English versions simultaneously, working back and forth between the two languages to eliminate as many cultural and linguistic biases from the instrument as possible. Whenever there was a lack of consensus as to appropriate terminology, a combination of random probe and

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it--not even by some of the educated leaders--misconceptions were unavoidable. There were unrealistic expectations that participation in research would bring instantaneous benefits. Refugees were disappointed quickly when better housing could not be found, working conditions did not improve, or family problems remained unresolved--even though such promises had never been made. Some leaders failed to understand the concept of sampling and harbored resentment for not being included in our study. Was their opinion not important? One leader whom the author invited to dinner--to demonstrate that his exclusion from the study was not for personal reasons--sadly inquired as the evening came to an end: "Did you forget your questionnaire?"

INTERVIEWER RECRUITMENT AND TRAINING

Interviewer recruitment and training were perhaps the least worrisome aspects of our field work. Unlike Hurh and Kim's experience in studying Korean immigrants in Chicago and Los Angeles (1982), we had more applicants for interviewer positions than our budget allowed us to hire.

A set of selection criteria was applied to recruit 7 potential interviewers for training out of about 30 applicants who filed through our office in 2 days. Each applicant was given a written description of our research project before being interviewed and was rated independently by three project officers. The following criteria (in order of importance) were considered: 1) technical ability in social surveys; 2) length of employment at previous jobs; 3) availability of means of transportation; 4) references; 5) fluency in Vietnamese and English; 6) ability to handle a test situation; 7) age and sex; 8) pleasant, extroverted, confident personality; 9) what the applicant thinks the project is about; and 10) background variables such as previous military activities or social prominence.

Eliminated from possible recruitment were persons who were too young or too old, exhibited introversion, had a history of unstable employment or a dubious past, were too prominent socially, did not own or were unable

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A set of selection criteria was applied to recruit 7 potential interviewers for training out of about 30 applicants who filed through our office in 2 days. Each applicant was given a written description of our research project before being interviewed and was rated independently by three project officers. The following criteria (in order of importance) were considered: 1) technical ability in social surveys; 2) length of employment at previous jobs; 3) availability of means of transportation; 4) references; 5) fluency in Vietnamese and English; 6) ability to handle a test situation; 7) age and sex; 8) pleasant, extroverted, confident personality; 9) what the applicant thinks the project is about; and 10) background variables such as previous military activities or social prominence.

Eliminated from possible recruitment were persons who were too young or too old, exhibited introversion, had a history of unstable employment or a dubious past, were too prominent socially, did not own or were unable

to borrow a car, could not provide a single reference, knew little Vietnamese (some were students from wealthy families sent to study in the United States since grade school), appeared blank when given the test situation ("How would you handle a respondent who cried in the middle of an interview?"), or mistook the project to be some kind of welfare program. None of the applicants fit the first criterion of having technical skills in survey research or even any previous training in the social sciences. Studying such subjects was a luxury in war-torn Vietnam. Certainly, none of the applicants had any experience in interviewing.

Furthermore, despite our impressive criteria for recruitment, we did not have the best possible candidates. Those who fit our criteria had no problem in finding better employment and were in fact already employed elsewhere. Many of the candidates were those who were not qualified to find alternative sources of livelihood or were not firmly committed to working for others. Among the latter group were former military bosses and upper or upper-middle class housewives who had never actually worked in Vietnam, had been pampered by having servants around the house, and found the idea of working for others distasteful.

Our budget allowed us to hire and train only three full-time and two part-time interviewers, but we trained and hired two additional persons in case some of those trained could not work on the project. Only one of the interviewers was male, a former engineer and plant manager. Interviewer training took a week to complete, and another week was spent rehearsing the interview procedures with pretest subjects. During this second week, the research instrument was revised, based on new insights acquired from the pretest experience.

When the time came to leave the field office and drive to respondents' homes for interviews, the female interviewers began to exhibit their fears of driving alone to strange places. After all, properly raised Vietnamese women do not roam around in unfamiliar places. For many, driving on superhighways was a newly learned skill. The interviewers insisted that they were not ready to go out and knock on doors. A few more days were spent to reassure them that there was nothing to fear.

How the interviewers would be paid was a subject of discussion. The idea of paying them on a per-interview basis was rejected because refugee respondents are unpredictable and, in the end, the interviewers were paid on a salary basis, twice a week. However, midway through the survey, the interviewers complained that the task of interviewing was "more than they had bargained for." A request for higher salary was granted--despite the fact that the interviewers were already paid competitive wages--because the cost of training new interviewers would have been prohibitive. One interviewer became disillusioned because beyond charitable donations and referrals to social service agencies, the researchers were unable to alleviate the sufferings of the refugees. In her other job and daily social life, she could not avoid interacting with some of the respondents we interviewed. Their constant queries as to what good the research had done for the refugees nagged her endlessly. Unable to cope with this kind of cognitive dissonance and beset with problems of her own, she failed to show up for work one day and some interviews that she supposedly completed were never found. Notwithstanding this one sad case, we had excellent cooperation from the rest of the interviewing team.

OBTAINING WRITTEN INFORMED CONSENT

As part of our research procedure, letters were sent to prospective respondents, followed by telephone calls to set up appointments for interviews. Written informed consent from the respondent was required before an interview could take place. However, this routine survey procedure became an obstacle, because many refugees were fearful of signing their names on any documents. This problem merits discussion.

Since the promulgation of a number of statutes and Federal regulations in 1974 to protect the use of human subjects, the use of a consent form has become a requisite part of any research involving human subjects. Regardless of the kind of sponsorship or funding, prospective investigators must obtain written, informed consent from their respondents prior to initiating any research. Before such consent is obtained, the

researcher is required to inform the respondent of the study objectives; the research procedure and question content; and the voluntary nature of the respondent's participation, emphasizing that he or she has the right not to answer any question and the right to terminate the interview. In addition, the respondent is entitled to be informed as to whether any risk, cost, or reward is involved as a result of participation in the research. If so, the nature and amount of such risk, cost, or reward must be stated.

Obviously, then, the concept of informed consent refers to a person's ability to consent freely to participate in a study in which he or she adequately understands both what is required and the "cost," or risk (Wolfensberger 1967). Under normal conditions, and with Americans who have had 30 years of exposure to polls and surveys, the task is a routine procedure. But when dealing with special populations such as the poor, the uneducated, and recent refugees, it may become a complicated and meaningless exercise executed merely to satisfy the letter of the law. For these special populations, chances are great that, for one reason or another, a sizable number of individuals are unable to absorb the information necessary for them to grant informed consent meaningfully, even when the interviewers are racially and ethnically matched with them. Moreover, any experience they may have had in which someone informed them of their "right to remain silent"--which is what we are really saying when we say that they do not have to answer any of our research questions--probably took place in the context of arrests and interrogations by law enforcement agencies. What assurances, then, do we have that the poor and the uneducated are able to analytically and experientially differentiate researchers from law enforcement officers?

The gravity of this problem is compounded when it is related to Vietnamese refugees. For these people, freedom of political expression existed in their country only in name, and the threat of communism--real or imagined--was the substance of much of their government's propaganda against the enemy from within and without. The field of survey research was underdeveloped, sociologists were unheard of for the most part, and government statistics were not always obtained by

interviewing. Not accustomed to expressing their opinions outside close circles of family and friends, unfamiliar with polls and surveys, and overwhelmed by the complex legal structure of this country, refugees could not help but feel confused and frightened when asked to sign a consent form. Indeed, our experience in the study of Vietnamese refugees attests to this fact. Refusals to sign the consent form were commonly encountered, even though the respondent was genuinely willing to participate in the study. In one case, a respondent signed the consent form but became so frightened by the thought of it that, minutes later, she broke off the interview. Another respondent completed the interview, but suffered some sleepless nights because her friends and neighbors--all Vietnamese--were horrified to learn that she had signed a paper for a "stranger." Our interviewer learned of her intense anxiety when she phoned a few days after the interview to give her some information she had requested. Sensing that the consent form had injured rather than benefited the respondent, the author had the consent form and the interview protocol returned to the respondent.

Thus, a practice intended to protect human subjects in research may inadvertently cause psychological injury to them because of their previous political, social, and cultural experiences. Furthermore, if one assumes for a moment the role of a respondent, one may well question having to give consent in writing before submitting to a simple question-and-answer session. Affixing one's signature signifies that one could be held legally liable for any statement made. Individuals who suffer guilt, real or imagined, or have made decisions or taken actions that are unknown to others would be well advised not to affix their signatures to anything. Regardless of assurances that research investigators give to respondents, the law in fact has the right to subpoena research data, especially when violations of criminal laws are suspected.

Furthermore, the assurances of anonymity that interviewers give to respondents are contravened by the signature, which constitutes legal evidence in court. The concept of anonymity in research, it has been suggested, exists in fiction only.

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There are, unfortunately, no remedial steps one can take in this respect. We thought of trying to explain the consent form through the mass media. Several Vietnamese refugee leaders discouraged us from doing so because they felt that this would confuse the people and might bring them harm if, in the future, others attempted to obtain signatures under the guise of "research." Until the Indochinese refugees are better informed about research and their life experiences cease to be threatening, the use of the consent form will continue to be a major biasing factor in the selection of research samples from this special population.

SAMPLING DIFFICULTIES

Obtaining a sample of refugee populations in the United States is another lesson in patience. The difficulties of conceptually differentiating the different waves of refugees from one another and from other nonrefugee ethnic populations, of obtaining a roster of names with correct addresses, and of locating the persons included in the sample were the three major stumbling blocks we encountered in our study of Vietnamese refugees in San Diego.

IDENTIFYING WAVES OF REFUGEES AND DEFINING ETHNIC MEMBERSHIP

Identifying the appropriate ethnic refugee population for research was not as easy as we had thought. Even though the majority of the Vietnamese in California arrived after 1975 and are classified as "refugees," it was not possible to identify, without a costly screening process, those who evacuated after the fall of Saigon, as opposed to those who had come to this country earlier as visitors or students. There was, furthermore, much ignorance at the time about the characteristics of different "waves" of refugees--the rich who had a foreboding of things to come and fled prepared just prior to the fall of Saigon; the ones who were fortuitously saved by helicopters and naval ships in the scamper after the Communist forces claimed South Vietnam; and the later waves of "boat people," each worse off than the previous ones--many of whom turned out

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to be ethnic Chinese--who paid all they had in exchange for freedom. Obviously, the kinds of assistance required by each of the different waves of refugees varied from one to the other, and the kinds of meaningful questions one could ask in a research context varied accordingly. Moreover, how does one classify a Chinese who grew up in Vietnam but attended Chinese school and cannot speak Vietnamese fluently? Does it matter to the Chinese to be perceived as Vietnamese and to the Vietnamese to be perceived as Chinese? Is self-definition of ethnic identity preferable to racial or biological definitions of identity? These are questions that are difficult to answer. Ultimately, the reluctance of Vietnamese colleagues and staff members on our project to include Vietnamese of Chinese descent finally led to their exclusion from our study. That, however, did not make sampling the Vietnamese refugees any easier. The resettlement policy employed by the United States Government and VOLAGs (voluntary agencies) effectively scattered the refugees to all parts of the United States, including its territorial possessions (e.g., Puerto Rico and the Virgin Islands). Secondary migration among the refugees resulted in their gravitation to California, where about one-half of the Vietnamese in the United States are now located. Nevertheless, implicit in the housing referral policies of all but one of the VOLAGs in San Diego at the time was the concept of residential dispersion. Systematic efforts were made to relocate the refugees as far away from one another as possible in the belief that this would hasten their assimilation. The VOLAG that encouraged the refugees to concentrate in one area for mutual support was criticized by the others, and the area in which the refugees resettled came to be called a "ghetto," even though it did not have the attributes that are often associated with ghetto living, such as high crime rates and dilapidated housing.

DELINEATING A SAMPLING FRAME

Our second stumbling block was obtaining a roster of names with correct addresses. A number of sources were available at the time we began our study: the telephone directory, the city street directory, the Immigration and Naturalization Service (INS) record of

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aliens who register every January, and the mailing lists of various VOLAGs and voluntary associations in San Diego. However, the following problems were encountered in the attempt to use these sources. First, because the telephone directory lists names in alphabetical order, considerable manpower would have been needed to identify and write each name and corresponding address on an index card, to determine the ZIP code, and to file the cards by ZIP code for area sampling purposes. For a telephone directory with over 1,100 pages, the entire process would have taken 3 months to complete and given us addresses that were a year old from which to draw our sample. We estimated that by the time we finished drawing the sample and had contacted the individuals, another 4 months would have passed; also, the project would have involved high labor costs.

Second, although the city street directory was available, we faced the problem of determining which of the names were Vietnamese surnames. Ngo and Hoang may be either Vietnamese or Chinese surnames. Ng, the Vietnamese abbreviation of Nguyen that some refugees used in their telephone listings, is also a Chinese surname. Furthermore, most Vietnamese women who were married to Americans and, therefore, listed under non-Vietnamese surnames would have been missed. The fact that the city street directory, like the telephone directory, was at least a year old by the time we were prepared to draw a sample presented an equally serious problem.

Third, the INS is said to have the most comprehensive list of aliens in this country. However, an inquiry yielded the following information: records submitted in January of every year are apparently not processed by the INS computer system until the end of that year. Some refugees, for reasons not known to the INS, either did not record their complete addresses or used false addresses. These facts made the INS record no better than the city street directories for our sampling purposes.

Finally, the mailing lists of social service agencies and the VOLAGs whose specific functions were to resettle refugees were considered as a possible resource for

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sampling purposes. Unfortunately, these agencies initially ignored our requests for cooperation. We finally succeeded in establishing personal contacts with key personnel in these offices and obtained permission to use their mailing lists, only to discover a number of complications. Not all agencies had lists of addresses, since not all of them mailed out newsletters to the refugees. Some of the agencies admitted that they simply did not have the manpower to follow up their clients, or even to update their addresses. For some of those agencies that had mailing lists, we soon found that because their funding depended heavily upon the size of their clientele, numbers--or the impression of a large clientele--were important to assure continuous funding. As a result, they updated their mailing lists by the most convenient procedure--that of adding new addresses without removing old ones. The same person often appeared on their mailing list four or five times, with surnames and first names interchanged, thereby giving the appearance of several different persons. Within a household, more than one person was often listed. Since the newsletters were mailed at a bulk rate, no one ever knew how many of the intended recipients were non-Vietnamese residents. One agency in San Diego that we contacted repeatedly assured us that their mailing list was only a month old and under the strictest restrictions, gave us access to it--only for us to discover that several indivioauals that we knew of were still in the current clientele file even though they had moved away from San Diego 3½ years before!

Next, we explored the idea of using the membership and mailing lists of various Vietnamese voluntary organizations in San Diego. However, a careful assessment of the 12 associations in the area revealed that appearances are indeed deceptive. One of these voluntary organizations had only 2 members, the founder and his spouse, although they claimed to have a membership of "at least 200." Another incorporated organization claimed that their membership reached "thousands of refugees." An independent check with some of their former "members" revealed that they actually had a membership of no more than 12 persons, all of whom were listed on their stationery as officers of the organization in one capacity or another. The rest of the

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organizations, insofar as one could determine, were not substantially different. Requests for their membership lists were denied on grounds of confidentiality.

Faced with the challenge of obtaining a current roster of Vietnamese surnames, we finally resorted to a public source available in California: a special street directory published by the Pacific Telephone Company every 6 months and available only by lease. To test the accuracy and recency of their listing, our staff had to first obtain a total enumeration of streets within a postal zone. We selected 92111, which is Linda Vista, because that area had the largest Vietnamese population in San Diego at the time. It took five staff members 3 weeks to complete the task of selecting and recording all possible Vietnamese names. Letters were mailed out to prospective respondents. To our dismay, approximately 60 percent of the Vietnamese we tried to contact in this way had already moved elsewhere. We soon discovered that it was not unusual for many Vietnamese refugees to move six times in 7 months, especially unattached individuals, who constitute a sizable proportion of the refugee population. Some refugees would move across the street if only to save $10 a month in rent. Others would move to another district and pay more for rent, just to live close to someone from their country whom they liked. Still others would move without leaving any forwarding address, either out or fear or ignorance. In the end, we had no choice but to use as survey respondents the remaining 40 percent of the population listed in the telephone company's street directory.

LOCATING THE PERSONS FOR INTERVIEWS

Locating a potential respondent turned out to be another formidable challenge. We had thought that the refugees residing in postal zone 92111 exhibited a high mobility rate only because they were primarily apartment dwellers and not homeowners. However, our attempts to contact the refugees who were homeowners and who were residing in more expensive residential areas revealed a similar problem of an ultra-high mobility rate. Oddly enough, the reasons were different, although the outcome was the same. For these

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upwardly mobile refugees, overly ambitious attempts to purchase properties just barely within their reach often resulted in their subsequent inability to meet the monthly payments. Their financial difficulties were exacerbated by several factors. First, there was a high degree of unemployment in San Diego, a city that has very few industries besides tourism and a greater frequency of layoffs among those refugees who were fortunate enough to be employed. Second, many refugees had an insufficient credit history to make large legitimate loans through a bank; thus, it was not uncommon for refugees to pool their meager resources with friends, Vietnamese or non-Vietnamese, and to underwrite a large down payment on their house to get a small bank loan. However, interest--in cash or in kind--has to be paid to both friends and banks alike, with the result that one or the other does not always receive the payments on time. Third, some refugees admitted falsifying their income to secure loans in the amount they needed. They did this sometimes with the tacit understanding of their employers. The cumulative effect of these "wheel and deal" practices was an extremely heavy financial burden for some of the less well-to-do refugees. If they met their monthly payments, they did so by working at more than one job, by not purchasing household furnishings and other nonessential products, or by eating less expensive food. In a very expensive residential area in San Diego, we saw the windows of two houses owned by refugees covered with newspapers rather than drapes. In another case, a refugee family fed their baby nothing but rice porridge--which upset the interviewers.

We found that many refugees were not easily accessible for interviews because they frequently had more than one job or worked odd shifts to meet the payments on their property. Those on night shift disconnected their telephones during the day; those on day shift needed to rest at night. Unless our interviewers were willing to conduct interviews at 11 o'clock in the evening or 7 o'clock in the morning, we had to forego interviewing some of those originally designated for our study. Weekends were not necessarily a better time since that was when some of the refugees assumed their second or third part-time job by working, for example,

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as department store clerks, waiters, third chefs, accountants, bookkeepers, or typists. Among our own staff, two female interviewers at one time each had three jobs. In one case, husband and wife together held five jobs, without counting the husband's involvement in property speculation. With such a research population, even the best sampling design would produce an imperfect sample outcome, since those included in the sample would not always be available for interviews.

CONCLUSIONS AND RECOMMENDATIONS

For the purpose of this chapter, emphasis has been given to the methodological problems encountered in a study of Vietnamese refugees in southern California. Due to space limitations, little has been said about those aspects of our research that were problem-free. This omission in the description of the data collection process is deliberate. It is because I wanted to address myself to the applicability of survey techniques to Vietnamese refugees under the circumstances in which they came to the United States. These issues are barely touched upon in most standard textbooks on survey research methods.

By choosing to highlight the contextual differences between the society that was South Vietnam and the United States today and by contrasting the experiential differences between a refugee and a middle class American, I wish to call attention to the dissimilarity in meaning behind the methods we use to collect survey data from special populations. Research across ethnic lines is replete with the pitfalls of noncomparable meanings and nonequivalent contexts, even though the same concepts may be translated and back-translated without apparent changes and the same method of eliciting data applied. As Hurh and Kim (1982, p. 75) put it, "What we are striving for is a transcultural methodology which we do not yet have." Indeed, rigid adherence to survey methodologies developed from studies of white middle class respondents even when studying a deprived and captive population presents unique problems in research ethics that deserve more intensive discussion than we can possibly offer in this chapter.

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As a result of the insights gained from involvement in the research project described here, this author is convinced that the problems in sampling and obtaining written informed consent and the nagging questions as to what benefits research has offered the refugees can only be resolved if research activities are conducted in conjunction with the delivery of social services and treatment to those who need it. Better still, these series of activities should be integrated into a comprehensive prevention program for Indochinese refugees. Such a suggestion has broad ramifications for the organization of research, treatment, and service delivery in this country. These functions are currently perceived, by researchers and providers alike, as incompatible and perhaps impossible to combine in a single proposal to any funding agency. Changes in the training of social workers and clinicians need to be made to increase their appreciation for rigor in research and for better measurements of their treatment or service approaches. Likewise, far more immersion in applied settings than now exists is necessary in the training of survey researchers to broaden their perspectives and develop a better understanding of the issues inherent in transcultural research, especially in surveys of refugee populations.

ACKNOWLEDGMENTS

The field notes presented in this chapter are based on a research project funded by NIMH's Center for Minority Group Mental Health Programs under grant No. RO 1 MH 29102. The author is most grateful to William T. Liu (Principal Investigator) and Tran Minh Tung (Co-Investigator) for giving her the opportunity to participate in their study of the Vietnamese refugees in California and for encouraging her to keep a record of field observations. Phyllis Flattery's helpful suggestions and Cita Orendain's perceptive comments on an earlier draft are gratefully acknowledged. To Nghiem Xuan Phu, Quynh Ngoc Trinh, Hanh Thi Tran, Tuan Quang Pham, Phuong Thuy Nguyen, Oanh Tran Hoang Phuong Thuy Le, and Le Thi Lieu, the author owes a debt of gratitude for the valuable insights gained from hours of discussion. Thanks are also due to our

refugee respondents whose participation in the project has enriched our knowledge of Vietnamese in America.

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APPENDIX

These tables are reprinted from Report to Congress, Refugee Resettlement Program, Office of Refugee Resettlement, Social Security Administration, U.S. Department of Health and Human Services, 1985. Available from the Superintendent of Documents, U.S. Government Printing Office.

TABLE 1

Southeast Asian Refugee Arrivals in the United States:
1975 through September 30, 1984

Resettled under Special Parole Program (1975)	129,792
Resettled under Humanitarian Parole Program (1975)	602
Resettled under Special Lao Program (1976)	3,466
Resettled under Expanded Parole Program (1976)	11,000
Resettled under "Boat Cases" Program as of August 1, 1977	1,883
Resettled under Indochinese Parole Programs:	
August 1, 1977—September 30, 1977	680
October 1, 1977—September 30, 1978	20,397
October 1, 1978—September 30, 1979	80,678
October 1, 1979—September 30, 1980	166,727
Resettled under Refugee Act of 1980:	
October 1, 1980—September 30, 1981	132,454
October 1, 1981—September 30, 1982	72,155
October 1, 1982—September 30, 1983	39,167
October 1, 1983—September 30, 1984	52,000
TOTAL	711,001

Prior to the passage of the Refugee Act of 1980, most Southeast Asian refugees entered the United States as "parolees" (refugees) under a series of parole authorizations granted by the Attorney General under the Immigration and Nationality Act. These parole authorizations are usually identified by the terms used in this table.

TABLE 2

Refugee Arrivals in the United States by Month:
FY 1984

Month	Number of Arrivals		
	Southeast Asians	All Others	Total
October	2,961	401	3,362
November	4,400	1,275	5,675
December	3,495	1,792	5,287
January	3,729	1,339	5,068
February	4,202	1,385	5,587
March	4,947	1,916	6,863
April	3,501	1,544	5,045
May	3,058	1,914	4,972
June	7,024	1,587	8,611
July	3,628	1,539	5,167
August	5,885	1,947	7,832
September	5,170	1,952	7,122
TOTAL	52,000	18,591	70,591

FY 1984: October 1, 1983—September 30, 1984.

TABLE 3

Southeast Asian Refugee Arrivals by State of Initial Resettlement:
FY 1984

State	Country of Citizenship: Cambodia	Laos	Vietnam	Total
Alabama	96	43	145	284
Alaska	0	6	9	15
Arizona	159	40	419	618
Arkansas	9	54	104	167
California	5,202	2,211	9,305	16,718
Colorado	197	153	263	613
Connecticut	331	73	159	563
Delaware	0	0	15	15
District of Columbia	48	36	135	219
Florida	335	55	506	896
Georgia	566	100	472	1,138
Hawaii	24	82	185	291
Idaho	60	76	80	216
Illinois	907	273	671	1,851
Indiana	60	45	137	242
Iowa	161	190	197	548
Kansas	126	108	449	683
Kentucky	88	14	76	178
Louisiana	193	71	675	939
Maine	248	5	40	293
Maryland	444	66	398	908
Massachusetts	1,371	110	801	2,282
Michigan	77	85	299	461
Minnesota	635	500	498	1,633
Mississippi	0	9	99	108
Missouri	156	85	360	601
Montana	0	11	17	28
Nebraska	25	11	74	110
Nevada	67	24	173	264
New Hampshire	81	7	17	105
New Jersey	95	27	393	515
New Mexico	82	46	63	191
New York	843	135	1,152	2,130
North Carolina	326	77	143	546
North Dakota	30	7	30	67

State	Country of Citizenship			
	Cambodia	Laos	Vietnam	Total
Ohio	532	90	227	849
[illegible]homa	160	79	407	646
Oregon	273	215	465	953
Pennsylvania	866	130	660	1,656
Rhode Island	341	148	42	531
South Carolina	35	26	49	110
South Dakota	0	16	21	37
Tennessee	303	134	124	561
Texas	1,525	512	2,473	4,510
Utah	455	78	325	858
Vermont	77	14	14	105
Virginia	781	151	632	1,564
Washington	1,405	451	787	2,643
West Virginia	5	2	10	17
Wisconsin	49	343	107	499
Wyoming	0	0	9	9
Guam	0	0	16	16
Other	0	0	0	0
TOTAL	19,849	7,224	24,927	52,000

TABLE 9

Estimated Southeast Asian Refugee Population by State:
September 30, 1983 and September 30, 1984a/

State	9/30/83	9/30/84	9/30/84 Percent
Alabama	2,300	2,600	0.4%
Alaska	200	200	c/
Arizona	4,600	4,300	0.6
Arkansas	2,900	2,300	0.3
California	244,200	285,100	40.1
Colorado	10,100	10,700	1.5
Connecticut	6,000	6,600	0.9
Delaware	300	300	c/
District of Columbia	1,100	1,400	0.2
Florida	11,700	11,500	1.6
Georgia	7,800	8,300	1.2
Hawaii	6,800	6,200	0.9
Idaho	1,300	1,300	0.2
Illinois	23,500	23,400	3.3
Indiana	4,200	3,800	0.5
Iowa	8,100	8,300	1.2
Kansas	8,700	9,400	1.3
Kentucky	2,300	2,000	0.3
Louisiana	13,300	13,500	1.9
Maine	1,300	1,600	0.2
Maryland	7,300	8,500	1.2
Massachusetts	15,400	19,300	2.7
Michigan	10,000	10,000	1.4
Minnesota	21,000	22,600	3.2
Mississippi	1,500	1,700	0.2
Missouri	6,200	6,200	0.9
Montana	1,000	800	0.1
Nebraska	2,300	1,900	0.3
Nevada	1,900	1,900	0.3
New Hampshire	600	700	c/
New Jersey	5,900	6,300	0.9
New Mexico	2,400	1,800	0.3
New York	22,700	24,800	3.5
North Carolina	4,800	5,000	0.7
North Dakota	800	800	0.1
Ohio	9,800	9,600	1.4
Oklahoma	8,500	8,200	1.2
Oregon	16,200	17,200	2.4

State	9/30/83	9/30/84	9/30/84 Percent
Pennsylvania	23,000	23,900	3.4
Rhode Island	6,200	5,100	0.7
South Carolina	2,400	2,100	0.3
South Dakota	1,000	900	0.1
Tenneasee	4,100	4,500	0.6
Texas	53,600	51,300	7.2
Utah	7,900	7,800	1.1
Vermont	500	600	c/
Virginia	20,300	21,000	3.0
Washington	30,400	32,600	4.6
West Virginia	500	400	c/
Wisconsin	9,600	10,300	1.5
Wyoming	300	200	c/
Guam	200	200	c/
Other Territories	b/	b/	c/
TOTAL	659,000	711,000	100.0%

a/ The September 1983 estimates were constructed by taking the January 1981 INS alien registration, adjusting it for underregistration, adding persons who arrived from January 1981 through September 1983, and adjusting the totals so derived for secondary migration. The September 1984 estimates were constructed similarly by using the known distribution of the population in January 1981, adding arrivals from January 1981 through September 1984, and adjusting those totals for secondary migration. Estimates of secondary migration rates were developed from data submitted by the States. Figures are rounded to the nearest hundred and may not add to totals due to rounding. No adjustments have been made for births and deaths among the refugee population. Percentages are calculated from unrounded data.

b/ Less than 50.

c/ Less than 0.1 percent.

TABLE 12

States with Largest School
Enrollments of Refugee Children: March 1984 a/

State	Refugee Children	Percent
California	29,601	31.5%
Texas	6,394	6.8
Florida	4,706	5.0
Massachusetts	4,125	4.4
Illinois	4,101	4.4
New York	4,043	4.3
Pennsylvania	3,710	4.0
Virginia	3,657	3.9
Washington	3,473	3.7
Rhode Island	2,281	2.4
Minnesota	2,252	2.4
Oregon	1,857	2.0
All Others	23,720	25.3
TOTAL	93,920	100.0%
By Levels		
Elementary	40,778	43.4
Secondary	53,142	56.6
By Groups		
Southeast Asian children	74,597	79.4
All other children	19,323	20.6

a/ Elementary school children are counted if they have been in the U.S. for less than two years; secondary school children if they have been in the U.S. for less than three years.

Source: U.S. Department of Education

SUBJECT INDEX

DHHS Publication No. (ADM) 85-1399
Printed 1985

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