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ABSTRACT

Refugee movements impose tremendous psychological and physical trauma on survivors, making refugees a high risk group for psychopathology and psychosocial adjustment problems. This paper explores the traditional impediments to developing prevention programs for refugees and describes public mental health strategies that could be used for different refugee mental health problems. It describes and evaluates the following models for prevention programs with refugees: the classic disease prevention model; the stressful life event model; and the prevention equation model. It also reviews the substantial body of knowledge on the refugee experience and its mental health implications. It notes that experience with recent refugee groups indicates that a coordinated nationwide initiative is required for refugee mental health. Accordingly, the paper provides a series of recommendations for prevention of psychosocial adjustment problems first in refugee camps and then during final resettlement. It then provides examples of possible intervention strategies for the most common forms of psychopathology in refugees: depression; anxiety and post-traumatic stress disorders; somatization; paranoid syndromes; addictive disorders; conduct disorders; schizophrenia; psychosis; and organic brain syndromes such as learning disorders and retardation. References are included. (TE)

Prevention Programs for Refugee Mental Health

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Running Head: PREVENTION PROGRAMS

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Abstract

Refugee movements impose tremendous psychological and physical trauma on survivors, making refugees a high risk group for psychopathology and psycho-social adjustment problems. Prevention programs based on public mental health principles are needed for refugees, but few exist, and none have been evaluated empirically to determine if they lower rates of illness or other psycho-social problems. This paper explores the traditional impediments to the development of prevention programming for refugees and describes public mental health strategies that could be used for different refugee mental health problems. A necessary step towards the development of prevention programs is the recognition that a substantial body of knowledge exists about the refugee experience and its mental health implications. Experience with recent refugee groups indicates that a coordinated initiative is required for refugee mental health. Attention to prevention is important, particularly the need to evaluate empirically any prevention program's effectiveness with refugees.

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PREVENTION PROGRAMS FOR REFUGEE MENTAL HEALTH

There is a growing recognition that refugees need special prevention services in mental health. Research has demonstrated that a number of experiences inherent in the refugee process are related to increased symptoms of emotional disturbance. Severe emotional and physical stress (Dohrenwend & Dohrenwend, 1978; Lin, 1986), being in an unfamiliar environment, experiencing rapid social change, and assuming a subordinate role in society (Bloom, 1979, 1982; Cassel, 1973) all have been shown to be related to an increase in mental health problems. Furthermore, many diverse refugee groups, compared to host populations, have shown a higher incidence and prevalence of mental disorders (e.g., Eitinger, 1959, 1960; Eitinger & Grunfeld, 1966; Garcia-Peltoniemi, 1987; Lin, 1986; Mezey, 1960a&b; Pedersen, 1949; Ratnavale, 1983; Rumbaut & Rumbaut, 1976; Westermeyer, 1986; Williams, 1987). Effective prevention[1] programs could be developed to counteract the harmful effects of the refugee experience.

Certain consistencies in refugee experience and behavior transcend the superficial diversity of groups from distinct cultures and historical circumstances (Ratnavale, 1983; Stein, 1980, 1981a&b, 1986; Williams & Westermeyer, 1986) and may contribute to increased rates of mental illness (Garcia-Peltoniemi, 1987). Previous work with refugee groups demonstrates that psychological problems will increase when 1) a prolonged wait occurs between initial exodus and final resettlement; 2) refugees are separated from families and other

[1]Throughout this paper, the terms "prevention" and "promotion" refer only to mental health programs, rather than physical health programs, unless otherwise indicated.

natural support systems; 3) host and home countries are very dissimilar; 4) refugees plunge from a higher socio-economic status to a lower one; 5) the refugee flight is traumatic; and 6) massive refugee camps rob people of individuality (Harding & Looney, 1986). These findings suggest that preventive efforts should begin at the very start of a refugee crisis and that public mental health professionals should be involved at all levels of the resettlement process: international, national, regional, and local.

The goal of providing effective prevention programs for the mental health problems of refugees has not been realized yet. Only a few prevention programs for refugees exist (e.g., Cohon, Lucey, Paul, & Penning, 1986; Looney, Rahe, Harding, Ward, & Liu, 1979; Lum, 1985) and their effectiveness has not been evaluated adequately. Prevention strategies discovered during earlier refugee movements frequently have not been used for current refugees in the United States. This paper will explore some of the reasons for the difficulty in establishing prevention programs for refugees, many of which reflect general issues in public mental health. The prevention literature will be reviewed and several models for developing prevention programs for refugees will be described. Common mental health problems of refugees will be discussed, along with suggestions for preventive programs with special attention to cross-cultural issues.

Impediments to the Development of Prevention Programs for Refugees

Low Priority of Refugee Mental Health

During the first Southeast Asian refugee wave in 1975, little attention was paid to mental health issues and it was widely believed that refugee mental health problems could be prevented simply by providing adequate relocation ser-

vices including job training, English language classes, and other social services. This led to funding for social or social readjustment services (Marsh, 1980), but little priority was given to mental health services, either preventive or treatment-oriented (Lum, 1985). Information about the increases in mental health problems in previous refugee groups was not used during the 1975 refugee wave, and many have lamented that some suffering could have been prevented if that information had been used in formulating resettlement policies for the Southeast Asians (e.g., Ben-Porath, 1987a; Garcia-Peltoniemi, 1987; Stein, 1986; Westermeyer & Williams, 1986).

The available information was ignored for several reasons. One is that most scholars and government officials are so struck by the diversity of the various refugee groups that they do not even consider that there are consistencies in the refugee experience that surpass their numerous ethnic and cultural differences (Stein, 1980, 1981a&b, 1986). Refugee crises are seen as unique, atypical, historical events that, once ended, will not recur (Ratnavale, 1983; Stein, 1980, 1981a, 1986). Thus, experiences with previous refugee groups and planning for future refugee movements are seen as irrelevant in a current crisis.

However, the consistencies in refugee experience and behavior discovered after World War II became evident again during the resettlement of Southeast Asian refugees (Ben-Porath, 1987a; Garcia-Peltoniemi, 1987; Stein, 1980, 1981a, 1986; Williams & Westermeyer, 1986). The refugee experience creates immense psychological stressors that are common across diverse groups of refugees and lead to increases in the incidence and prevalence of mental disorders. That this is rediscovered with each new refugee movement certainly adds validity to the findings, yet it is quite distressing that the wheel has to be reinvented for each new group.

Reinventing the Wheel

A good illustration of the "reinvented wheel" during the Southeast Asian crisis in 1975 was the initial policy of dispersing refugees. Dispersal was intended to reduce the impact of refugee resettlement on any given area of the country (Haines, 1982; Marsh, 1980), as well as to encourage acculturation and adjustment to life in the United States. However, it resulted in the break-up of many extended families and other natural support systems. It was particularly devastating to unaccompanied minors who were separated from "unofficial foster families" in one camp and placed in American homes with no provision for interaction with other Vietnamese (Harding & Looney, 1977, 1986). This break-up of natural support systems added to the loss suffered by the Southeast Asians. Secondary migration (i.e., relocation after initial placement) became frequent as refugees sought to reunite separated families; thus, the refugees did not remain dispersed as originally planned (Haines, 1982; Marsh, 1980). These secondary migrations involved additional expense and disruption of lives that could have been prevented if earlier refugee experiences had been considered.

Mental Health Consultation After-the-Fact

Typically, public mental health professionals are not involved in the initial planning for refugee resettlement and are consulted only after problems like threats of suicide become public. Ratnavale (1983) suggests that other refugee relief workers may harbor a subtle negative attitude towards mental health professionals and their clients. A similar uncertain, and even suspicious, attitude about mental health has been attributed to public health officials (Albee, 1986). Psychiatric symptoms, even in disaster victims like refugees, may be seen as self-imposed, and sufferers frequently evoke feelings

of helplessness, aversion, fear, and hate from those not trained to deliver mental health services. Refugees in crisis may reject offers of emotional support, and their leaders may deny or conceal emotional problems because of a sense of shame and humiliation (Ratnavale, 1983).

In describing how some of these issues were handled in a refugee camp established in the United States for Southeast Asians, Harding and Looney (1977) indicated that camp administrators did not want the press to observe mental health professionals working in the camps, perhaps because they feared that mental health problems would be equated with managerial inefficiency. In fact, during a three-week period in the summer of 1975, the State Department closed all psychiatric facilities in one refugee camp for fear of negative press interpretations (Rahe, Looney, Ward, Tung, & Liu, 1978). Mental health consultants had difficulty convincing two of the federal agencies responsible for resettling the Southeast Asian refugees (the State Department and the Immigration and Naturalization Service-INS) to follow their prevention suggestions (Harding & Looney, 1977, 1986; Looney, Rahe, Harding, Ward, & Liu, 1979; Rahe et al., 1978).

A somewhat different tactic was used during resettlement of the Mariel Cuban wave of 1980, possibly due to the experiences with the Southeast Asians, but more likely because some of the Mariel entrants were former mental patients or prisoners. In addition, an established Cuban population, including a number of Cuban and other Hispanic mental health professionals from previous immigrations, could be consulted (e.g., Szapocznik, Cohen, & Hernandez, 1985). No similar resource was available for the Southeast Asian groups because of their limited immigration to the United States before 1975. Mental health professionals were consulted relatively early in the Mariel crisis and helped plan some aspects of

their resettlement (Szapocznik et al., 1985). An office at the National Institute of Mental Health (NIMH) was established to oversee mental health services to the Cuban and Haitian entrants of 1980.

Despite these efforts, mental health problems became apparent during the resettlement of the Marielitos as well. Tans (1983) provided discouraging information about events in Wisconsin after the refugee camp at Fort McCoy was closed. Because many of the unaccompanied minors at Ft. McCoy had been institutionalized in Cuba, Tans (1983) predicted long-term adjustment problems that would burden the social service delivery system for years. Much longer back-up services were needed than the 10-week transition period from camp to community life provided in the contract (Szapocznik & Cohen, 1986; Tans, 1983). Tans (1983) described other difficulties with the Unaccompanied Minors Program including inaccuracies in assessment procedures that relied mostly on self-report, frequently destructive peer interactions, the unpredictability of camp authorities (which added to the youths' mistrust of authority), and placement problems after the camp was closed.

Unfocused Efforts

By the middle of the 1980's concerns were voiced about the growth of mental health problems in refugees, primarily the large groups of Southeast Asians and Cuban entrants resettled in the preceding 10 years. Many agencies reported significant numbers of their clients had mental health impairments great enough to hamper resettlement efforts. Some states used funding from the federal Office of Refugee Resettlement (ORR) to provide mental health services to refugees (Lum, 1985).

Events in California, the state with the highest concentration of refugees, illustrate some of the funding problems for refugee mental health services.

Although mental health services for refugees initially were funded by the California State Department of Social Services from an ORR block grant in 1980, they were cut in 1982, refunded in 1983, and cut again in 1984 (Lum, 1985). Needless to say, these vagaries in funding created considerable difficulties in providing mental health services to refugees. Problems like those in California, along with the recognition of increasing mental health problems in refugees, the significant federal investment in resettlement and social service programs, and the lack of a coordinated federal initiative for refugee mental health, led ORR in 1985 to join NIMH in a $6.6 million program to improve mental health services for refugees at the state level (Bornemann, personal communication, May 12, 1987).

In this program, states competed for federal funds and set up refugee mental health offices. One of the state offices' first tasks was to complete a mental health needs assessment, and an example from this effort again demonstrated the common belief that mental health problems could be solved simply by providing adequate social services. One state office spent several months developing a needs assessment tool to evaluate the mental health status and needs of its refugee population. An initial draft of the instrument had very few items about mental health problems since members of the state's advisory board felt that items about demographic variables, English language skills and training, vocational problems, cultural differences, welfare, and so on were more important than items about symptoms of mental illness. Furthermore, the advisory board worried that refugees would be offended by questions about mental illness because of their cultural backgrounds and would not cooperate with the survey if such questions were asked. Eventually, after considerable discussion, more items that provided a needs assessment of mental health were added to the

instrument.

The Problems of Boundarylessness in Mental Health

Parallels to this diffusion of efforts in refugee mental health occurred in the general field of prevention as well. Some advocates in the community mental health movement held that almost all aspects of human behavior and social conditions came within their domain. Dinitz and Beran (1971) called this tendency "boundarylessness and boundary busting." Critics of prevention programs in mental health directed attention to the vagueness of the concepts and definitions underlying the issues (Spaulding & Balch, 1983). Zax and Cowen (1976, p. 479) pointed out that "virtually anything done to improve man's lot can also be viewed as primary mental health prevention."

Boundarylessness is evident when discussing prevention programs for refugees. As indicated above, resettlement and social services frequently are described as methods for improving the mental health of refugees. However, boundarylessness may hinder the development of effective prevention programs in mental health. Without agreement on the scope of prevention programs, "discussants will often be examining several different phenomena while thinking they are focusing on one" (Lamb & Zusman, 1979, p. 12). Boundarylessness also is likely to increase reliance on ideology rather than empirically tested procedures, and increases the likelihood that mental health professionals will promise more than they can deliver (Spaulding & Balch, 1983). For example, when funding for resettlement services is promised to decrease refugees' need for public mental health services, planners may end up having to explain why an English language training program did not help reduce psychiatric hospitalization of refugees. As in other complex areas, professionals working with refugees must be willing to take a multi-disciplinary perspective, calling upon

other professionals for assistance when leaving their areas of expertise.

Definitional Issues

Cowen (1977, 1982, 1985) concludes that because of the lack of an operational definition of prevention programs and prevention research, many diverse endeavors are inaccurately called "prevention" and this may undercut the field's most important potential contribution, that of presenting alternatives to current mental health practices. The definitional problems occur partly because the terms prevention and promotion were borrowed from the public health field and do not translate readily into the mental health field.

In public health, prevention almost always refers to illness, whereas mental health practitioners deal not only with individuals with diagnosable mental illness, but also with those who are not ill but want help with disturbing interpersonal problems and distresses of daily living (Lamb & Zusman, 1979) and with victims of stress, powerlessness, and exploitation (Albee, 1979, 1986). As described above, some mental health practitioners believe that general societal problems come within their purview and that social change and redistribution of power is needed to reduce psychopathology (Albee, 1979, 1986).

Prevention efforts traditionally are classified as primary, secondary, or tertiary. Table 1 presents definitions from the literature, along with illustrations of how these terms can be applied to refugees. Some have argued that only primary prevention should be considered synonymous with prevention, since secondary and tertiary prevention are actually treatment and rehabilitation (Goldston, 1986a&b). However, as Goldston (1986a&b) described, the field developed with this confusion of terms.

Problems with the all-inclusiveness of past definitions of prevention also were noted in an NIMH publication on Southeast Asian mental health (Silverman,

Table 1

Definitions of Prevention Terms
Used in Mental Health with Examples
Specific to Refugees[1]

PRIMARY PREVENTION

Definitions

- Lower the rate of new emotional disorders (i.e., incidence) in a population.
- Counteract irritants before they exact a toll.
- Build health and resources in people from the start.
- Perform in a mass-oriented way before trouble starts.
- Prevent diseases from ever occurring.
- Lower the rate of new cases of mental disorder in a population over a certain period (i.e., incidence) by counteracting harmful forces before they have had a chance to produce illness.
- Use techniques that seek to reduce the prevalence (i.e., total number of cases) of a disorder by reducing its incidence.
- Remove causes, known or hypothesized, of disease or disorders.

Refugee Examples

- Reduce time in crowded, isolated, restricted refugee camps.
- Educate refugees about the receiving culture, the psychodynamics of being a refugee, and the natural course of "culture shock."
- Facilitate continuance of familiar vocations and avocations among refugees.
- Facilitate formal organization of local refugees, as well as the development of various associations for special interest groups (e.g., Buddhist associations, former military groups).
- Aid refugees to establish their own means of communication, such as newsletters, name-and-address lists.
- Facilitate expression of grief in culturally appropriate ways (e.g., funeral rites, religious ceremonies).
- Provide grief counseling and crisis intervention services.[2]

SECONDARY PREVENTION

Definitions

- Enable a person to regain his or her normal level of functioning and prevent further development of illness after its occurrence.
- Use techniques that seek to reduce the prevalence of a disorder by reducing its duration.
- Focus on early detection and prompt treatment to prevent disorders from becoming more serious.
- Halt the progression of existing diseases.

Refugee Examples

- Educate refugee leaders, family heads, translators, sponsors, teachers, social and health workers to early signs of common mental health problems (e.g., major depression, adjustment reactions, conduct disorders in the young), as well as to culturally sensitive referral resources with the goal of providing early intervention for these problems.
- Perform psychiatric evaluation in all cases of repeated biomedical evaluation, careseeking, and ineffective treatment.
- Provide crisis intervention services during stays in refugee camps and during early resettlement.[2]

TERTIARY PREVENTION

Definitions

- Reduce the severity, discomfort, or disability associated with any disorder.
- Rehabilitate the individual.
- Prevent or reverse the aftereffects of illness (i.e., disability).
- Focus on rehabilitation of the individual during or following illness along pathways (e.g., jobs, housing, training) which lead to independent living and minimize permanent disability.

Refugee Examples

- Treatment and rehabilitation services provided by clinicians to refugees with diagnosed psychiatric disturbances. These services, provided in a culturally sensitive manner, include psychotherapy, behavioral and cognitive-behavioral interventions, family therapy, psychotropic medications, day treatment, and/or hospitalization.

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[1]The refugee examples are adapted from Westermeyer and Williams (1986, p. 243).

[2]Some practitioners classify crisis intervention as a primary prevention approach, whereas others consider it a type of secondary prevention.

1985). Prevention research is a priority at NIMH, but there is an impression that mental health research has been overly diffuse in past years and that NIMH should not place inappropriate emphasis on topics that are only tenuously related to mental health (Frazier & Parron, 1987).

Primary Prevention: Specific Protection. Primary prevention offers the greatest possibility for a new approach to mental health problems (Silverman, 1985). Primary prevention activities typically represent either specific protection or health promotion. Specific protection involves using a highly specific procedure that is effective in preventing one disorder, but does not appear effective in preventing any other disorder (Bloom, 1979). Public health programs, such as providing immunizations for smallpox or destroying the mosquito that carries malaria, are examples of specific protection in dis ase prevention. Specific protection procedures are effective for some mental disorders, particularly those arising from certain infectious or genetic processes; nutritional deficiencies; physical injuries; general systemic diseases; and environmental agents like poisons, chemicals, toxic gases, and licit or illicit drug overdoses (Bloom, 1979). For example, pellagra, a chronic disease caused by a deficiency of niacin in the diet, accounted for a significant percentage of the admissions to psychiatric facilities in the southern United States during the last cen y. Dietary improvements now prevent the occurrence of this disease in developed countries. However, refugees often come from parts of the world without adequate nutrition, general health care, or even sanitary and healthy environments. Mental health and public health officials working solely in this country may not be aware of some of these preventable mental disorders and the specific protection procedures available.

Consultation with public health professionals familiar with the conditions

in the refugees' home countries is essential to implement appropriate specific protection procedures. Particular attention should be paid to nutritional disorders that may result from the unfamiliar foods, preparation methods, and greater expense of some foods in the host country; harmful folk remedies; improper use of medications or other drugs; and endemic infectious diseases or other illnesses in the home country that may lead to mental disorders.

Primary Prevention: Health Promotion. Health promotion is the other major classification for primary prevention programs. These programs represent a variety of nonspecific practices that may improve health in general and may actually prevent some behavior disorders (Bloom, 1979). The rationale for health promotion is to enhance the individual's (or host's, to use an epidemiological term) ability to resist disease, even when the disease agents are not known or beyond control (Eisenberg, 1981). Mental health promotion techniques are generally less well-known than specific protection strategies and thought to involve a greater social, as well as economic, cost (Bloom, 1979). There are also fewer empirical demonstrations of the effectiveness of mental health promotion programs. Unfortunately, full-scale public mental health programs have been initiated in the past without adequate attention to their possible iatrogenic consequences or other contraindications (Arnhoff, 1975; Spaulding & Balch, 1983; Westermeyer, 1987). Lorion (1986) provides additional examples of prevention interventions with serious negative effects like McCord's (1978) long-term follow-up of a classic prevention effort aimed at delinquency-prone adolescents. McCord (1978) demonstrated that adolescents who were identified in the 1950's as delinquency-prone and randomly assigned to a preventively oriented counseling program had a worse outcome in adulthood than the no-treatment control group! Because of this, an empirical evaluation of program effectiveness is essential

to avoid possible ill effects, as well as to serve local populations better (Price & Smith, 1985).

Given the trauma experienced by refugees, they represent a "natural experiment" for testing the efficacy of health promotion programs designed to reduce the harmful effects of stressful experiences. Programs developed and demonstrated to be effective for refugees also may be effective for other populations, such as ethnic and racial minorities, who often share similar circumstances (e.g., cultural differences, marginal social status, and problems of racism and poverty). This adds to the attractiveness of funding prevention programs for refugees, particularly given Owan's (1985) description of the changing demographics that are making the United States a nation of minorities.

A number of primary prevention programs that are being examined empirically may be promising for refugee mental health. They include providing adequate nutrition, mitigating the effects of acute loss through social support and other procedures, providing good prenatal care, improving schooling and child-rearing practices, developing coping skills of individuals at risk for problems, bolstering social networks, family planning, and genetic counseling (see Albee, 1982; Bloom, 1979, 1982; Cowen, 1977, 1985; Edelstein & Michelson, 1986; Eisenberg, 1981; Felner, Jason, Moritsugu, & Farber, 1983; Levine & Perkins, 1987; Munoz, 1976 for descriptions of these types of interventions). Many of these examples offer both specific protection against certain diseases and general health promotion. For example, providing adequate nutrition not only will prevent specific diseases like pellagra, but also will enhance the individual's ability to resist other disorders. Of course, it remains a challenge for prevention practitioners to provide these programs in a culturally sensitive and acceptable manner.

Overcoming Barriers: Some Recommendations

This section will provide an overview of problems in the prevention field, particularly as they relate to refugee mental health. Professionals interested in developing prevention programs in refugee mental health need to be aware of the controversies in the field to avoid becoming entangled in them. An important reality is that funding for refugee programs is scarce. A prevention program for refugees has to compete with treatment services for mentally disturbed refugees, general health and social services for refugees, and perhaps even more importantly, programming for other, established minorities, not to mention the general population! All of these programs compete for limited money (Zigler & Trickett, 1979). And, unfortunately, primary prevention programs for disenfranchised minorities are often the first to be cut during fiscal crises (Ruiz, 1979), leading Bloom (1983) to suggest that prevention programs for minorities need to be self-sustaining, self-replenishing, and based on self-help concepts. Because of this, the rationale for a prevention program in refugee mental health must be compelling, and not based simply on a desire to improve refugees' emotional well-being, no matter how humanitarian that desire is.

When resettlement or other social services are labelled as mental health promotion activities, they need to be grounded in theory, with adequate attention paid to conceptual and definitional issues (Bickman, 1987). Primary prevention programs must include an evaluation component, with the ultimate goal being to reduce the incidence of mental illness in the designated population (Price & Smith, 1985; Silverman, 1985; Spaulding & Balch, 1983). Simply labeling a job training program as primary prevention does not mean that it will reduce mental health cases; it may, in fact, have disappointing results that will be used to justify terminating funds. And, if mental health professionals

do not build evaluation into their programs, others with less understanding of the issues eventually will (Zigler & Trickett, 1979).

As is the case in evaluating treatment programs for refugees, reliable and valid methods of psychological assessment are needed to help identify mental health problems in the refugee population to target for prevention. These procedures also are needed to evaluate the outcome of prevention efforts. Unfortunately, the development of reliable and valid methods of psychological assessment continues to lag behind their need (Ben-Porath, 1987b; Butcher, 1987a&b).

Models for Prevention Programs for Refugees

Given the problems detailed above and the scarcity of resources for refugee mental health programs, planners should approach the development of a prevention program for refugees in a systematic fashion. Consultation with individuals knowledgeable about refugees, mental health, public health, and cross-cultural psychology/psychiatry is essential. Several models that can be useful for refugee mental health planners are described below.

Classic Disease Prevention Model

The original 200-year-old classic disease prevention model has been effective in preventing numerous infectious and nutritional diseases including cholera, smallpox, malaria, scurvy, and dental caries. The classic disease prevention model assumes that a disease has one "cause" that can be eliminated to prevent the disease from developing. Bloom (1982, p. 381) described the classic model in the following manner:

1. Identify a disease of sufficient importance to justify the development of a preventive intervention program. Develop reliable methods for

its diagnosis so that people can be divided with confidence into groups according to whether they do or do not have the disease.

2. By a series of epidemiological and laboratory studies identify the most likely theories of that disease's path of development.
3. Mount and evaluate an experimental preventive intervention program based on the results of those research studies.

However, for a number of disorders, including mental illness, cardiovascular disease, and cancer, Bloom (1979, 1982) suggests that the classic model is less effective, perhaps because these conditions are chronic and do not appear to have a single identifiable precondition or "cause." Despite these problems, the classic model is particularly relevant for specific protection programs like those developed to prevent mental health disorders with known etiologies, such as those resulting from encephalitis, rubella, or phenylketonuria.

Stressful Life Event Model

Bloom (1982, p. 385) suggested an alternative model for the prevention of mental disorders that has direct relevance for developing prevention programs for refugees:

1. Identify a stressful life event, or set of such events, that appear to have undesirable consequences. Develop procedures for reliably identifying persons who have undergone or who are undergoing those stressful experiences.
2. By traditional epidemiological and laboratory

methods study the consequences of those events and develop hypotheses related to how one might go about reducing or eliminating their negative consequences.

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

Conditions 1 and 2 of this new model have already been met in refugee mental health, but very few intervention programs have been evaluated. Silverman (1985) indicates that refugees and other immigrants are recognized as having experienced high levels of stress, and it is relatively easy to identify refugees. Studies of previous refugee groups suggest ways to reduce the negative consequences of the refugee experience.

The Prevention Equation Model

One further model that is useful for developing a primary prevention program for refugees is Albee's (1982, p. 1046) prevention equation:

$$\text{Incidence} = \frac{\text{organic factors} + \text{stress}}{\text{coping skills} + \text{self-esteem} + \text{support groups}}$$

An effective primary prevention program should reduce the incidence of a disorder (or the left side of the equation) by either decreasing the numerator or increasing the denominator. Preventive efforts designed to lower organic factors or stress or increase coping skills, self-esteem, or support groups should lower incidence.

There are several advantages to using the prevention equation as a model for program development. Albee's (1982) formula demonstrates the multicausal nature of the incidence of psychopathology, which requires multiple levels of interven-

tion. It is an easy way to communicate mental health concepts to others (e.g., legislators, community leaders, foundation directors) less familar with the area (Swift, 1987). A disadvantage of the equation is the difficulty in making its terms operational because some of the concepts overlap (Swift, 1987). For example, using support groups can be considered a type of coping skill and so perhaps should not be listed separately in the model. Despite this, refugee mental health planners can use this model to organize their preventive efforts.

Structural Requirements for Primary Prevention Programs

As in other populations, primary prevention is seen as the most meaningful mental health alternative and it seems particularly compatible with the lifestyles of Southeast Asian refugees (Owan, 1985). However, the prominent definitional issues must first be resolved. For this reason, Cowen (1982, p. 132) proposed three structural requirements for a program to be considered primary prevention:

1) It must be group- or mass-, rather than individually-oriented (even though some of its activities may involve individual contacts).
2) It must have a before-the-fact quality, i. e., be targeted to groups not yet experiencing significant maladjustment (even though they may, because of their life situations or recent experiences, be at risk for such outcomes).
3) It must be intentional, i.e., rest on a solid, knowledge-base suggesting that the program holds potential either for improving psychological health or preventing maladaptation.

Owan (1985) recommended that primary prevention programs in refugee mental

health meet these structural requirements.

Importance of Secondary Prevention for Refugees

Although primary prevention is viewed as more likely to improve mental health care for the general population, secondary and tertiary prevention become more important with a traumatized group like refugees. Advocates of primary prevention for refugees recognize that effective treatment services should not be ignored (e.g., Owan, 1985). Tertiary prevention will not be addressed in this paper since it is related to traditional mental health treatment and is covered in detail elsewhere (e.g., Kinzie, 1985, 1986; Tung, 1985). However, secondary prevention should be considered in prevention planning for refugees.

Because of the trauma they have experienced, a significant number of refugees already will show some signs of mental disorder upon arrival in the host country. Secondary prevention strategies, aimed at early identification and treatment, are needed in addition to primary prevention for survivors of extreme disasters (Klingman & Eli, 1981) One secondary prevention strategy is to employ public mental health professionals with experience in cross-cultural work to provide ongoing consultation to infant care programs, schools, resettlement agencies, welfare departments, job training programs, and English language programs, where they can identify early cases of mental illness, mental retardation, and physical illness (Looney et al., 1979). A second strategy is to train non-mental health professionals (e.g., social workers, nurses, physicians, public health officials, teachers, refugee paraprofessionals, and indigenous leaders) to recognize early symptoms of psychopathology and use appropriate referral sources (Westermeyer & Williams, 1986).

Crisis theory and crisis intervention (Bjornson, 1971; Bloom, 1979; Caplan, 1964; Levine & Perkins, 1987; Lindemann, 1944) provide a useful framework for

developing successful primary and secondary prevention programs for refugees (Muncy, 1985; Rahe et al., 1978; Ratnavale, 1983; Silverman, 1985). The key to these programs is to identify quickly the developing signs of disorder and provide a culturally sensitive intervention to restore individuals to their previous level of functioning within a short time. Crisis intervention requires an active therapist who helps the individual focus on solving immediate problems, an approach that seems compatible with the expectations of refugees described by Owan (1985). Crisis intervention has been used with other disaster victims, and Klingman and Eli (1981) describe a program that was developed in Israel for children immediately following a terrorist attack, using existing resources in a school setting.

Summary of Models for Prevention

Numerous existing models can guide the systematic development of prevention programs for refugees based on previous research and experience. Epidemiological research, as well as information from a needs assessment, can help the planner pinpoint the most common problems in a group. If a primary prevention program is indicated, either a specific protection or health promotion activity can be chosen. If no specific protection procedure exists, information from previous refugee groups can be used to formulate hypotheses about potentially effective intervention strategies. Research on the effectiveness of any primary prevention program developed to address the problem is essential.

Prevention and Refugee Mental Health

Using Key Information from Past Refugee Movements

An essential preventive strategy for refugee mental health is to ensure that key information about mental health needs of previous groups is used in planning

any future refugee resettlement programs. Although this may seem to be a fairly straightforward recommendation, it may not be that easy to implement for several reasons. Effective resettlement requires the cooperation of many different professionals and organizations who have little, if any, experience working together. The military, State Department, and INS have initial responsibility for resettling refugees and little experience with mental health professionals. In fact, as discussed earlier, other professionals may feel some antagonism towards mental health workers (Ratnavale, 1983). When working with other organizations, mental health professionals enter a new social structure and must realize that their work may not be understood or accepted. Furthermore, mental health professionals may have to learn a new role if they move from being "in charge" to being only one of several consultants (Cohen, 1985). Less effective consultation can result when mental health professionals do not recognize the true power structure of the organizations with which they are working (Rahe et al., 1978).

In addition to the government agencies, a number of voluntary resettlement agencies (VOLAGs) assumed responsibility for refugees through a system of sponsorship (Marsh, 1980). Many of the VOLAGs were affiliated with churches, like the U.S. Catholic Conference, Church World Service, and the Lutheran Immigration and Refugee Service. Although some of the sponsors were groups, over three-fourths were individuals or families (Marsh, 1980). Sponsors were expected to provide reception services to refugees (e.g., lodging, food, clothing, pocket money), inland transportation in the U. S., and interim services to facilitate adjustment (e.g., language, educational, and vocational training). Sponsorship was such a key component of the refugee resettlement strategy that the dispersal policy was adopted partly because the number of sponsors in any given area was

limited (Marsh, 1980). During the Southeast Asian refugee movement, sponsorship also increased the number of agencies and individuals responsible for refugees, which resulted in further logistical problems when developing mental health services. In fact, Westermeyer & Williams (1986) suggested as a preventive strategy changing the sponsorship system so that more careful screening will eliminate sponsors looking for cheap labor, religious converts, sexual partners, or other similar victims.

As has been demonstrated in the past, consultation with knowledgeable mental health professionals will not occur spontaneously during a refugee crisis, but must be encouraged at the highest levels. Many organizations and individuals are required in any large refugee resettlement program. A coordinated effort is required to make information about refugee mental health available for planning resettlement policies.

Coordinated Nationwide Effort

This coordinated effort even may require a federal initiative in order to affect the mental health of refugees resettled in the U.S. The potential for meeting refugee mental health needs increased with the creation of the Office of Refugee Resettlement (ORR). As described earlier, ORR recently collaborated with NIMH to improve the mental health services provided to refugees. However, further progress also is necessary. Mental health has not been a major responsibility of ORR, and Lum (1985) described some of the ORR funding problems for refugee mental health services in California. Refugee mental health services are among the first to be cut during budget crises.

ORR's main objective is to insure that refugees achieve economic self-sufficiency as quickly as possible (Hohl, 1980). Frequently, low unemployment rates among different refugee groups are used as measures of successful

resettlement. However, simple unemployment figures do not give a complete picture of the economic adjustment of refugees, since many are significantly underemployed and suffering the harmful emotional consequences of this (Ben-Porath, 1987a; Haines, 1982).

States can choose to ignore refugees and their needs, without a coordinated, federal effort for refugee mental health. Even today in some parts of the United States, refugees are living in unhealthy and even unsanitary environments, without the benefit of adequate medical, educational, or social services. The children, many of whom are U.S. citizens by virtue of their birth in this country, suffer the most, and a significant amount of preventable mental disorders develop because of malnutrution, disease, injuries, abuse, and inadequate pre- and post-natal care. Haitian entrants are among those who face the most difficulties, impeding their healthy adjustment in their new environments (Biamby & Nachman, 1985; Stepick & Portes, 1986).

Without federal leadership, public mental health programs for refugees will remain unstable, and some states can choose not to address the issues at all. The federal government can insure adequate attention to public mental health concerns, for example, by maintaining a cadre of mental health consultants. Hopefully, this will insure that the wheel will not have to be reinvented with the next (inevitable) refugee wave.

Refugee Flight: Implications for Prevention

Chaos and crisis typically precede refugee flight. In the midst of wars or other political upheavals, refugees frequently have little time to think about decisions which place them in physical danger and separate family members. Although these events are beyond the interventions of public mental health professionals, they are extremely important to understanding refugee mental health.

Tyhurst (1982) suggests that symptoms such as paranoid behavior, somatization, anxiety, depression, and sleep disturbances are manifestations of premigratory stress.

Therefore, prevention efforts must be made in the context of what precedes the refugee flight. Mental health professionals must be educated about these events to develop effective prevention programs. Fortunately, there are good summaries of the antecedent stressors and theories about refugee behavior (e.g., Ben-Porath, 1987a; Keller, 1975; Kunz, 1973, 1981; Stein, 1980, 1981a&b 1986).

Refugee Camps: Possibilities for Prevention Programming

True prevention programming first can be developed in refugee camps. The classic disease prevention model can be used to develop primary prevention programs for nutritional, genetic, and systemic diseases that may lead to mental illness and cognitive impairments. Adequate screening is essential for these programs and they must be developed with sensitivity to cultural issues in order to gain acceptance from the refugees. Public health officials familiar with the disorders prevalent in the refugees' home countries are good resources for the development of specific protection programs in refugee camps.

Mental health professionals knowledgeable about cross-cultural issues and minority mental health are also essential consultants. For example, research with other minority cultures in the United States and other developed countries suggests important implications for primary prevention strategies. Manson's (1982) volume on mental illness prevention with American Indians and Alaskan Natives illustrates many potentially useful approaches, including recommendations for prevention research.

The need for mental health consultation in refugee camps is not always recognized. For example, both Simmonds (1980) and Gaydos, Ashmore, McNeil,

Minc, Bertsch, and Eisen (1978) advocate a public health approach in refugee camps, yet fail to address mental health concerns. However, several examples of prevention and mental health programs developed in refugee camps both in Asia (e.g., Muncy, 1985; Sughandabhirom, 1986) and the United States (e.g., Harding & Looney, 1977, 1986; Looney et al., 1979; Rahe et al., 1978; Szapocznik & Cohen, 1986; Szapocznik et al., 1985) have been described.

Three noteworthy refugee groups need special prevention programs in camps: women, the elderly, and children. While special nutritional programs are available for pregnant women and nursing mothers, very few programs are developed for women's special mental health needs. In many of the traditional societies from which refugees come, women are socialized to be submissive and dependent on men. Single, divorced, and widowed women in refugee camps do not have a male protector, and may not have learned to compete with men for the resources their families need (Ben-Porath, 1987a). When they get access to special training in the camps as a head of household, they may not participate fully in classes with men. This puts women at a further disadvantage when they finally reach their resettlement countries. Separate programs are required for these women.

The elderly and children suffer most during disasters like refugee movements (Ratnavale, 1983). The elderly frequently lose the status they held in the home country. Efforts to enhance their status in refugee camps through active consultation with them about camp policy likely would have a positive mental health effect. A study in the United States demonstrated positive effects for both the paraprofessionals and the targeted community when older adults were employed as paraprofessionals in a primary prevention program (Gatz, Barbarin, Tyler, Mitchell, Moran, Wirzbicki, Crawford, & Engelman, 1982).

A spiral of anxiety is created in refugee camps when the emotional distress and fears of parents and other adults are transmitted to the children, who react with panic and helplessness, which in turn further distresses the adults (Ratnavale, 1983). Today's major refugee groups contain large numbers of children, so their special needs must be considered. Providing educational and recreational programs for the children is crucial.

A program in a Khmer refugee camp at Phanat Nikhom (Thailand) entitled "Preparation for American Secondary Schools" is an example of cultural preparation to smooth the transition for refugee adolescents and their parents (Munnell, 1985). Since many Khmer have little or no experience with formal education, this program introduces the American school system to the refugees. One part of the program deals specifically with parental involvement with their child's education since their role is so different from what is expected in Asia. Although this is a good example of a preventive strategy, Munnell (1985) presented no evaluation information upon which to judge the program's utility.

The attitudes of workers in refugee camps are also extremely important for the overall morale of the camp. Rahe and his colleagues (1978) described the positive interactions of refugee children and adolescents, with the Marine guards stationed at Camp Pendleton, California. Furthermore, the military personnel's familiarity with Vietnamese culture was beneficial. For example, when a civilian catering service took over food preparation for the camp, its dieticians substituted macaroni and other starches unknown to the Vietnamese for rice, resulting in food refusal and waste. Cultural training for refugee relief workers is essential to avoid such misunderstandings and potential conflicts.

Prevention programs for workers in refugee camps are also important since they, like other disaster workers, must function under highly stressful con-

ditions. Ratnavale (1983) describes problems of refugee relief workers, some very similar to what the refugees experience, including feelings of being overwhelmed, uprooted, and alienated. Psychosomatic illnesses, depression, suicidal thoughts, anxiety attacks, sleep disturbances, loss of appetite, and obsessions may occur in refugee relief workers during times of stress. Needless to say, these problems would interfere with the quality of care given to the refugees. Teaching relief workers how to recognize and cope with these feelings in themselves might make them more receptive to such interventions for the refugees they serve. Anticipatory guidance, based on the assumption that preparing for stress will make adaptation easier, has been suggested for those about to go through a stressful experience (Bjornson, 1971). Leavitt (1976) described the need for special group sessions for University of San Francisco students after they volunteered to provide direct emergency care to Vietnamese children during Operation Babylift.

Another method of prevention for refugee relief workers would be to screen volunteers for such work to identify those with a propensity for stress-related illnesses, much as the Peace Corps does. Adequate educational programs could help eliminate any naive notions about working in a refugee camp, possibly decreasing uncompleted tours of duty. The average tour of duty at Pulau Bedong in Malaysia is eight months, even though relief workers are expected to stay two years. The effectiveness of these programs could be evaluated by comparing rates of uncompleted tours of duty or studying the incidence of stress-related disorders in relief workers participating in prevention programs compared with those who do not.

The work of Rahe and his colleagues (1978) provided a useful example of public mental health programming based on sound methodological procedures.

Their initial ecommendations were based on a needs assessment using a key informant technique. This was followed by an epidemiological survey of the mental health status of the refugees using standardized questionnaires and a random sample. Consultants familiar with cross-cultural assessment procedures were used to select and develop the questionnaires. The resulting data identified subgroups of the population more likely to report psychological problems. This combination of preventive interventions with an empirical determination of mental health status is exemplary as an indication of what can be done by mental health professionals with a public health perspective in refugee camps.

Rahe and his colleagues (1978) also report on problems their team encountered. First of all, they were consulted only after a report predicting mass suicides among the refugees was released, so that their work began in a crisis situation (Harding & Looney, 1977). Secondly, they were unable to identify those with the most administrative power in the camp and elicit their trust, which resulted in several important recommendations being ignored (Harding & Looney, 1977; Looney et al., 1979; Rahe et al., 1978).

Prevention of Psycho-Social Adjustment Problems During Final Resettlement

Bloom's (1979) stressful life event model (see page 19) is perhaps the most useful for developing prevention programs to alleviate psycho-social adjustment problems during resettlement. Using this model, the refugee experience is the stressful life event demonstrated to have negative consequences in a significant percentage of the refugee population. Ben-Porath's (1987a) review identified several stressors common to refugees: familial stressors, occupational concerns, and cultural barriers. The next step in the stressful life event model, the development of hypotheses about how to reduce or eliminate the negative consequences of these stressors, is presented in the next several sections.

Cowen's (1982) three structural requirements (see page 21) for a primary prevention program must also be kept in mind when considering interventions in these areas.

Familial stressors. Uprooting and migration have been identified as problems for healthy family functioning (David, 1980; Heller, 1975; Morschauser & Chescheir, 1982; Sluzki, 1979), even though the family offers considerable support to refugees. Ben-Porath (1987a) identified two main areas of family stress: different rates of acculturation by various family members and loss and separation of family members. In the stressful life event model for prevention, strategies to reduce differential rates of acculturation and separation from family members could be the basis of an intervention program.

Children tend to acculturate faster than other groups of refugees, perhaps because they have less experience with the home culture and also because of the pressures to adapt in schools. Schools are a logical place to intervene to eliminate the differential rate of acculturation between parents and children. Programs that encourage daily, or at least weekly, participation by parents would help expose the parents to the mainstream culture. Teaching children about their home countries and customs also would be important. Active involvement of mental health professionals in these programs could serve as secondary prevention by allowing prompt identification and treatment of individuals showing initial signs of emotional disorders.

Mass media programs in the refugees' native language could be developed for adults to encourage understanding of the mainstream culture and introduce the values taught in schools. The growth of cable television programming and videocassettes offer exciting potential for reaching large numbers of people. Both Owan (1985) and Lum (1985) give examples of different mass media

approaches. Of critical importance in developing such programs is to provide for evaluation of their impact.

Mutual Assistance Associations (MAAs) are another likely resource for reducing differential rates of acculturation. These self-help organizations can teach the young about the home culture as well as help adults understand the host culture. Hundreds of these organizations exist across the country for various purposes and they have been identified as potential resources for community development activities (Barger & Truong, 1978) and prevention programming (Bliatout, Ben, Do, Keopraseath, Bliatout, & Lee, 1985; Borman, 1984; Vinh, 1981).

Differential rates of acculturation also have been noted for husbands and wives (Ben-Porath, 1987a). This frequently occurs because women are more willing to take a lower status job like a maid. When a woman thus becomes the family's sole provider, it disrupts traditional family roles and can lead to problems. Family stress can increase and erupt into violence. When this has happened, some women have been counseled into hasty divorces. An alternate approach would be to teach the spouses other coping or conflict resolution skills. This would result in fewer family separations and fits with Albee's prevention equation (see page 20) of increasing coping skills. A program such as this, combined with job placement or training for the husband, may prove useful.

Refugees may become overwhelmed by the deaths of family members, the loss of family members left behind, and the separations caused by resettlement policies. The importance of keeping family members together cannot be overemphasized as a prevention strategy. Providing adequate means to mourn the dead, including relevant cultural and religious ceremonies, is also of paramount importance.

The growing literature on grief can be used as a guide for prevention program development (Gullotta, 1982). Secondary prevention, particularly crisis intervention, is important for individuals whose grief is so pronounced that they are unable to cope with everyday life.

Some refugees make up for the loss of natural family members by creating "artificial" or "unofficial" families. Among Vietnamese refugees at Camp Pendleton (California), many of the unaccompanied minors were "adopted" by Vietnamese families. Despite the recommendations of mental health professionals, these "unofficial foster families" were broken up and the children were placed in American homes, with no provisions for interaction with other Vietnamese (Harding & Looney, 1977, 1986; Looney et al., 1979). From a mental health promotion standpoint, it seems most appropriate to maintain these natural sources of social support, and even to help create these "unofficial" families, rather than to destroy them. This would be in keeping with Albee's (1982) equation of enhancing social support as a prevention strategy. Adler (1985) described some methods for placing unaccompanied minors in ethnically similar homes. American Indians also recognized the importance of developing child care programs under tribal sponsorship and community control as a primary prevention effort (Shore & Nicholls, 1975).

Proponents of placing unaccompanied minors in American families argue that a refugee family is already so stressed that adequate care of the minor is less likely. Furthermore, children are thought to learn the new culture better in foster families from the majority society. Baker (1982) described some of the issues in placing unaccompanied minors in cross-cultural homes. Monitoring the care of minors in any foster family is essential. An empirical evaluation of various options of foster placement is crucial, given the controversies outlined

above, noted by Ben-Porath (1987a), and described in the American Psychologist about Operation Baby-Lift (McCrohan & Wetterer, 1977; Zigler, 1979).

In the recent wave of the Mariel entrants, the decision to separate minors from the main camp seemed to be a more appropriate mental health strategy. In the case of the Marielitos, many adults were former prisoners. Most were single males, not family units as in the case of the Vietnamese. Minors were separated from adults to avoid victimization of the children. Children in the Cuban entrant camps were grouped in "families" of 10, who met daily with counselors, ate together, and attended recreational activities together, all in an attempt to help build a social support network (Szapocznik & Cohen, 1986). These two examples indicate that a single "cookbook" method can not be used as a mental health strategy.

One final note of extreme importance for unaccompanied minors is the fact that most of them are not orphans, but frequently have parents or other close relatives in the home country or in a refugee camp (Adler, 1985). Anecdotal reports indicate that some of these parents, after several difficult years, finally are able to join their children in the United States. Unfortunately, in some cases these reunions are quite painful as the children have become so "Americanized" and integrated into their American families that they reject the natural parents. Programs anticipating such problems must be developed.

Occupational concerns. A natural outcome of the refugee experience is substantial downward mobility in occupational readjustment in the host country (Rogg, 1971; Stein, 1979, 1986). This loss of status frequently is accompanied by emotional distress. Whereas unemployment lessens with time, underemployment remains quite significant for a number of possible reasons: the differences in technology between the home and host countries; lack of familiarity with busi-

ness practices in the host country (e.g., competitive capitalism in the U.S.); and biases against "foreigners" or other forms of racism (Ben-Porath (1987a). However, the most significant problem Ben-Porath (1987a) identified was difficulty with the English language.

An obvious preventive strategy involves improving refugees' English speaking abilities. However, English-as-a-Second Language (ESL) classrooms also could teach refugees how to cope with some of their negative experiences. Cohon and his colleagues (1986) developed an instructional manual for an ESL program that also served as a mental health promotion program. This program used a number of the strategies suggested in Albee's equation (1982), including reducing stress and increasing coping skills, self-esteem, and support groups.

The program evaluation revealed that teachers' attitudes towards mental health problems changed after this training and that the teachers said they would continue to use the primary prevention activities learned in the workshop in their classrooms. However, several questions remain. Were the teachers able to change their instructional styles after a one-day workshop? Can a teacher make such behavioral changes after simply reading the manual? How much consultation and training from mental health professionals are required for success? Once the teachers have demonstrated a change in instructional style, do these new procedures help improve the mental health status of refugees exposed to them? Are there any unintended or iatrogenic effects? These questions should be addressed before the widespread adoption of this manual in ESL classes.

Rogg (1971) revealed another potential preventive strategy for the psychosocial stressor of downward mobility. Her findings indicated that Cuban refugees in the late 1960s and early 1970s were able to cope with their loss of

occupational status because they lived in an area with a strong Cuban refugee community and could measure their success compared to their ethnic peers rather than to Americans. Cluster resettlement (i.e., keeping groups of refugees intact rather than dispersed) of refugees is a preventive strategy for dealing with these occupational issues, as well as for other mental health problems. Cluster resettlement programs for Southeast Asian refugees in New England have been described (Burton, 1983; May, 1981).

Cultural barriers. Although culture often protects the individual against natural disasters, social anarchy, and psychological isolation (Dubreuil & Wittkower, 1976), cultural barriers can contribute to refugees' emotional distress in a number of ways (Ben-Porath, 1987a). These problems increase with greater dissimilarity between host and home countries, as in the case of the Southeast Asian refugees (Stein, 1986). Prejudice and racism can be a part of the problem. Furthermore, there may be considerable cultural variation within one nationality, such as Haitians, because of social class differences. Programs could be developed to restore the primary prevention functions of culture described by Dubreuil and Wittkower (1976).

Cultural heritage programs are possible prevention strategies. Lefley (1982) described a program for American Indians that could be used as a model for refugees. Providing cultural training to educators, health and mental health practitioners, and other service providers is just as necessary for refugees as for Indian populations (Lefley, 1982). Hiring refugees to work in school and Head Start settings gives children appropriate role models, thus enhancing self-esteem. Again, these suggestions require empirical demonstration of their effectiveness.

Preparing the receiving culture for the refugee influx is another possible

preventive strategy that is rarely considered. Certain aspects of refugee behavior contribute to difficulties between the refugee, the sponsor, and the resettlement agency. Refugees tend to have high expectations of life in the new society, as well as a strong belief that they are owed something (Stein, 1981a, 1986). They frequently become demanding of sponsors and agencies, which causes frustration and bitterness on both sides. Although May (1981) provides a generally positive description of the sponsorship system in Vermont, she also describes the need to prepare sponsors for their work. Stein (1986) also suggests programs to prepare sponsors and agency personnel for likely areas of conflict.

Not everyone is appropriate to sponsor a refugee, nor are there adequate supplies of sponsors during large crises. Stein (1986) notes that very few personal friendships developed from sponsor-refugee relationships in the United States. Others have pointed to further significant problems with the sponsorship system used for the Southeast Asians (e.g., Chan & Lam, 1983; Westermeyer, Vang, & Lyfong, 1983; Williams & Westermeyer, 1983). which suggest the system must be reevaluated before it is used in another refugee crisis.

Training members of the majority culture, refugee groups, and minority groups in the host country in interpersonal problem-solving skills, such as perspective-taking skills (Durlak, 1983; Spivack, Platt, & Shure, 1976), is another intervention that may decrease problems with racism and conflicts. For example, officials at one high school reported a decrease in racial tensions after a program that included a showing of the film The Killing Fields. Seeing this film apparently helped others understand the refugees' perspective.

Prevention of Psychopathology During Final Resettlement

This section provides examples of possible intervention strategies for the more common forms or symptoms of psychopathology that occur in refugees. Some of the interventions suggested for psychosocial adjustment problems also may be relevant as health promotion strategies for the different types of psychopathology. The suggestions primarily focus on aspects of the refugee experience that could be changed to prevent mental illness, based on research in the general prevention literature. This is done to highlight refugee-specific interventions. However, prevention programs developed for the general population are also relevant, especially if care is taken to present them in a culturally accepted fashion so that refugees will use them. The suggestions provided in this section should be viewed as a starting point for planners. A more detailed review of the prevention literature for each specific disorder would be the next step in designing a program.

When developing prevention programs for specific types of disorders, it is essential to have reliable and valid assessment tools to determine the presence or absence of a disorder. Unfortunately, few assessment procedures have been evaluated adequately for the current refugee populations in the United States (Ben-Porath, 1987a; Butcher, 1987a&b). The development of appropriate assessment devices is essential not only for tertiary prevention or treatment, but also for primary prevention. Butcher (1987a) lists assessment devices that could be used in a prevention program.

Depression. Depression among refugees is so common that it is recognized as a problem by general health workers, not just mental health professionals (e.g., Muecke, 1983). Suicide can be a fatal consequence of depression, which adds to the need for prevention programs. Albee's (1982) prevention equation, as well

as past experience with refugee groups, suggests that programs designed to decrease stress and/or increase coping skills and self-esteem, and/or develop support groups should lower the incidence of depression in the targeted group.

The stressful life event model also can be used to develop intervention strategies for depression. As described earlier, the refugee literature suggests that techniques designed to decrease experiences of loss, provide social support, and provide effective grief counseling are all possible types of intervention. Research with the general population suggests that cognitive-behavioral procedures, such as those described by Hollon and Beck (1979), might also work. However, Cowen's (1982) structural requirements must be used for any primary prevention program. Since these procedures are adapted from treatment research and would be applied in a different population, evaluation is essential.

Anxiety and Post-Traumatic Stress Disorders. Symptoms of anxiety and post-traumatic stress disorders are so common in refugee groups that a mass-oriented intervention strategy is appropriate. Several behavioral and cognitive-behavioral procedures, such as relaxation training and other stress management techniques, could be taught through group instruction or possibly even mass media presentations (Meichenbaum & Jaremko, 1983). These techniques are likely to be effective for sleep disturbances as well. Instead of presenting them as mental health treatment, they can be described as educational programs to help refugees cope with the stressful experiences they have suffered. However, these techniques cannot be considered completely benign. They require an active mental health consultant w extensive training in the appropriate use of cognitive-behavioral techniques to monitor any possible iatrogenic effects. As always, an evaluation of any program using these techniques is essential.

Somatization. Health professionals must be trained to recognize that somatic symptoms are frequently an expression of emotional distress in refugees. Westermeyer and Williams (1985) recommend a secondary prevention strategy of psychiatric evaluation for repeated biomedical evaluation, care seeking, and ineffective treatment. Primary prevention programs can be built using the behavioral and cognitive-behavioral interventions described for depression and the anxiety disorders.

Paranoid Syndromes. Suspicion, anger, distrust, and paranoid behavior are characteristic of refugees (Garcia-Peltoniemi, 1987; Stein, 1981a, 1986). These reactions are so established that relief workers, sponsors, health providers, educators, and others working with refugees should be educated about their likelihood to prevent misunderstandings. Knowledge of these symptoms can be used in planning daily living. Differential treatment of refugees and camp personnel, particularly with regards to drinking water and food, should be discouraged as suspiciousness among the refugees may grow. Sensitivity to this aspect of refugee behavior is a relatively easy intervention strategy to implement and may result in fewer problems.

Isolated migrant and refugee groups have been known to develop more serious paranoid disorders such as shared delusions within families or other close-knit groups (Westermeyer, 1986). Although folie en famille and mass suicides fortunately are rare (Westermeyer, 1986), their often severe consequences make them likely targets for prevention. Again, providing social supports and decreasing isolation are likely to be effective interventions.

Addictive Disorders. Information about rates of addictive disorders in refugees have been inconsistent: some groups have a higher reported number of disorders and other groups have lower reported rates than the host population

(Westermeyer, 1986). Need exists for epidemiological studies in this area. Although rates for the Southeast Asian refugees at first were reported to be low (Westermeyer, 1986), problems have been identified in opiate addicts from Laos who continue their addictive behaviors in this country. Secondary and tertiary prevention are needed for these individuals. Furthermore, effective treatment of these addicts might well serve as primary prevention for their kin, friends, and neighbors, who would then be less likely exposed to the addictive substances. Botvin (1986, 1987) and Milgram and Nathan (1986) describe interventions for these disorders in the general population that may be relevant for refugees.

Conduct Disorders. Certain groups of refugee children and adolescents may be more prone to display or develop conduct disorders. Many of the Cuban unaccompanied minors during the 1980 entrant wave came directly to the United States from delinquent or psychiatric institutions. Tans (1983) describes a group of these refugees resettled in Wisconsin whose behavior is suggestive of long-term problems that will require tertiary treatment. Behavior management programs are needed for these young people since many do poorly in foster homes. Obviously, individuals institutionalized in their home countries will require extensive treatment upon resettlement, regardless of whether their problems are due to inherent personality characteristics or behaviors learned during inappropriate institutionalization.

Conduct problems also have been noted in some Southeast Asian refugee adolescents. Williams and Westermeyer (1983) described some cases that predated the refugee crisis. Apparently, some families may use a refugee crisis as a means of solving problems with a difficult adolescent. They may have the belief, sometimes founded, that a more permissive society may tolerate the adolescent's behavior better than the home country. Some families may also send the most

assertive or even aggressive son to a resettlement countr in the hope that he will ease the way for the family's eventual journey or acquire needed financial resources. For whatever reasons, it is apparent that unaccompanied minors are a risk group for conduct disorders.

Two other refugee groups constitute high risk groups as well. Amerasian refugees (usually children of American GI's and Asian mothers) were often looked down upon in their home countries (Ben-Porath, 1987a). Many, in fact, became street children, living with no adult supervision and often surviving through lying, cheating, stealing, and prostitution. Former street children are in great need of long-term tertiary care. One final at risk group are sons in single-parent homes, usually headed by widows. Many of these children are unable to fulfill culturally-dictated responsibilities to their families after resettling because of cultural and educational differences in the home and host countries. Caught between two cultures, each with different expectations, they may develop conduct problems. These youngsters may benefit from primary and secondary interventions, perhaps like those described by Gelfand, Ficula, and Zarbatany (1986), Nietzel and Himelein (1986), or Kornberg and Caplan (1980).

Schizophrenia/Schizophreniform Psychosis/Brief Reactive Psychosis. Most preventive strategies for schizophrenic disorders involve intervening in high risk groups, like the children of psychotic parents, because the disorders are so rare in the general population (Watt, 1986). Refugees may be another high risk group for testing prevention strategies for schizophrenia. In addition, as a secondary prevention strategy, mental health professionals should be educated about the increased likelihood of a brief reactive psychosis in highly stressed populations Misdiagnosing individuals with brief reactive psychoses as schizophrenic and institutionalizing them may lead to further debilitation.

Appropriate diagnosis is also important for tertiary care, because the wrong medication may be administered if a refugee is diagnosed as schizophrenic, when in fact he or she is suffering from a bipolar affective disorder (Garcia-Peltoniemi, 1987). Finally, specific protection procedures are useful to eliminate any psychotic disorders due to nutritional, infectious, or other known causes.

Organic Brain Syndromes/Learning Disorders/Retardation. Specific protection procedures designed to eliminate disorders caused by infections, poor nutrition, or injuries are important here as well. Medical and nutritional evaluations and care of individuals suspected of having these disorders are essential secondary prevention strategies that may have primary prevention potential if, for example, a nutritional deficit is causing the disorder. Culturally sensitive psychological and psycho-educational assessments are also important secondary prevention strategies, because interventions will vary depending upon the reasons for a learning problem. For example, learning difficulties may be due to a specific learning disorder or mental retardation, but also can be the result of anxiety, depression, or another type of psychopathology. Reviews of prevention strategies used in developed countries for these disorders are useful to consult when designing a prevention program for refugees (e.g., Kornberg & Caplan, 1980; Lloyd & DeBettencourt, 1986; McCluskey-Fawcett, Meck, & Harris, 1986; Ornitz, 1986). These reviews describe appropriate care during pre-, peri-, and neonatal periods, secondary prevention techniques for developmental disorders, day care and preschool programs, and parent-directed programs.

Concluding Comments

A first step towards preventing mental illness in refugee populations involves recognizing that there is a substantial body of knowledge about the

refugee experience and its mental health implications. Knowledge from previous refugee groups can be used to develop prevention programs for current refugees. This knowledge was not used systematically for planning resettlement strategies during most of the recent refugee movements to the United States. Recent resettlement has occurred in a crisis atmosphere with very little coordination or consultation with refugee and public mental health experts. Fortunately, the federal government is taking more initiative in coordinating refugee mental health efforts.

Many of the important issues in refugee mental health are parallel to those in the general field of prevention of psychopathology. These issues must be considered when developing prevention programs for refugees. Definitional issues are of paramount importance. Several definitions and models of prevention can be used by those interested in refugee mental health, including the classic disease prevention model, the stressful life event model suggested by Bloom (1979), Albee's (1982) prevention formula, and Cowen's (1982) structural requirements for primary prevention. Both specific protection and health promotion techniques are available for refugee mental health. Examples of how to apply these models and definitions are provided in this paper.

Whichever prevention approach is used, a careful, critical evaluation of the program must be included to avoid the mistakes of the past. Frequent mistakes in prior prevention efforts include overselling a particular program's potential, which frequently results in disillusionment and the cut-back of funds. Even worse are the iatrogenic effects that can occur when unevaluated or poorly evaluated procedures are introduced on a large scale. Although the ideas proposed in this paper stem from the literature on refugee mental health, they are hypotheses upon which to base a program which then should be evaluated to deter-

mine its effectiveness. This review found no prevention programs for refugees with sufficient empirical demonstration of their effectiveness. A prevention program empirically demonstrated to reduce psychopathology in refugees could be used as a model for work with other stressed groups in our society.

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