



Psychiatric Treatment Of Southeast Asian Refugees

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Along with the soldiers, the Vietnam War has had long-term effects on the civilian populations of Cambodia, Laos, and Vietnam. Many refugees who left Southeast Asia after 1975 continue to re-experience and suffer from their war, escape, concentration camp, and prisoner-of-war experiences. They suffered great losses of family members, livelihood, and cultural traditions. Vietnamese saw family members killed, possessions confiscated, and villages destroyed. The Laotians, Mien, and Hmong had significant and irreversible damage done to their social structures and cultures. Cambodians experienced the brutal rule of Pol Pot from 1975-1979 when an estimated one million people died of disease, starvation, torture, and execution. No individual or family was spared, directly or indirectly, the trauma of this period.

After the war, many Vietnamese escaped to other countries of Southeast Asia via small boats on the high seas, braving hostile elements, pirates and shortages of food and water. Cambodians fled to crowded refugee camps on the Thai border, where they often spent years in substandard and dangerous living conditions. Finally, millions of refugees were resettled throughout the world, especially in the United States, France, and Australia.

Besides coping with the memories of loss and trauma, these refugees faced pressures of acculturation such as employment and financial stressors, intergenerational change and reconcile traditional cultural values and traditions with those of the host country.

Indochinese Psychiatric Program

Our program at the Oregon Health Sciences University for psychiatric assessment and treatment of Indochinese refugees began in 1978 (1,2). Over the past 17 years, the clinic has treated more than 1000 refugees: from Vietnam, Cambodia, and Laos (including ethnic Laotians, Mien, and Hmong), and 550 are currently enrolled in treatment. Clinic staff has grown to over 20 professionals, including 5 psychiatrists, a psychologist, a nurse practitioner, 3 masters of social work, and several licensed mental health counselors from each ethnic group represented in the clinic. Each psychiatrist heads his or her own treatment team, working with the counselor who is case manager for a specific group of patients. Patients are seen by their psychiatrist every one to three months for medication management and psychotherapy, and many have weekly group therapy (3) and participate in our Indochinese Socialization Center program to learn language, daily living, and work skills.

The most common diagnoses given to these patients are major

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depression and posttraumatic stress disorder, most commonly together. Approximately ten percent of the patients meet diagnostic criteria for chronic schizophrenia, with much smaller percentages of patients receiving diagnoses of dementias or bipolar disorder. The highest percentages of patients with PTSD (over 90%) are found among the Cambodians and Mien (4-6), and our clinic was the first to report the presence of PTSD among Cambodian refugees (7,8). We have found depression to be quite treatable initially and when it reoccurs, but like others (9-11), have also found that PTSD is more chronic and treatment resistant.

Research data are mixed in relation to the differential effects of pre-migration, migration, and post-migration trauma on subsequent refugee distress. Some have noted the primacy of premigration traumatic experiences such as war, torture, or family loss (12-14), but a number of factors in the host country can contribute to the reactivation of traumatic responses, such as exposure to crime, accidents, or anniversary reactions to traumatic events. The complexity of traumatic responses and the challenges of understanding them cross-culturally can be difficult for even experienced clinicians. We take a biopsychosocial approach to assessment and treatment, including the effect of culture on the person's experience and understanding of their trauma within their own cultural and social system. The clinician must be aware of the historical and sociocultural heritage of each population with whom they work, and that includes an awareness of family and political structure, norms and values, and religious traditions. Since the recovery of a sense of purpose and meaning in life is a primary task of all trauma survivors regardless of ethnicity or culture, the clinician must be aware of specific cultural determinants of meaning, such as secular values and religious beliefs, that may affect psychotherapeutic interventions.

The effects of trauma and the refugee experience are both chronic conditions. From a treatment perspective, there is no short-term fix, as much of the time the comprehensive treatment of refugees must be considered long-term and supportive. A longitudinal relationship in patient care provides security and hope while individuals and families encounter the ups and downs of an often difficult life. As an example, the following is an outline of the key elements to our psychiatric treatment program for Southeast Asian Refugees.

Specific Treatment Elements

1. Education. Teaching patients about the effects of trauma and the fact that the majority of those who undergo severe trauma will have symptoms helps patients feel more accepted. It helps break down their self-perceived stigma of being "crazy".

2. Symptomatic relief of comorbid conditions. Depression is often present with PTSD. We have had a good experience with tricyclic antidepressants (e.g., imipramine, desipramine, and doxepin) and serotonin reuptake inhibitors (e.g., fluoxetine, sertraline, paroxetine). With the reduction of depression, nightmares and sleep disorders often improve.

3. Reduction of intrusive symptoms. We have found that clonidine often reduces irritability, startle reactions, and nightmares. We typically give it in conjunction with an antidepressant, but many patients take it alone. About half of our Cambodian patients are on clonidine and the rate of their acceptance of this medication is high.

4. Reduction of other stresses. Having the resources and staff to insure adequate finances, housing, and medical care gives great security to patients and reduces anxiety about the realistic concerns refugees often face.

5. Supportive psychotherapy. Predictable, empathic, reality-based ongoing psychotherapy with a psychiatrist every one to three months is a central element of our treatment model. Continued contact and appreciation of the refugee's experience and discussion of current issues and stresses are very affirming and comforting to the patients. Treatment sessions often include spouses and other family members. Modification of, and education about, medication is also accomplished in these sessions. Helping the refugee process current and past experiences, dream content, and difficulties in interpersonal relationships often reduces symptoms and enhances their perceived control and self confidence. In addition, patients often have their primary case manager (a social worker or licensed mental health counselor) between clinic visits for supportive counseling sessions focusing on family problems or financial and housing issues.

6. Socialization groups. Group activities (led by Southeast Asian born mental health counselors) have been very useful in providing the patients with a sense of community and shared experiences. These usually are bi-cultural, including activities from the culture of origin, such as New Year's celebration, and sharing in American events such as Christmas and Thanksgiving. Practical matters of transportation, insurance, housing, and learning English are often discussed. Group therapy with a more process orientation has been conducted with Cambodian groups. The earliest themes that emerged, lasting up to two years, were related to the affect-laden Pol Pot trauma and losses. Another important theme has been the problems of raising children in America. An additional recurrent theme is related to aging and death, and the provision of appropriate ceremonies to ensure a good afterlife. With children less willing to follow traditional ways, patients feel that the necessary rituals will not be carried out. For parents, traditional expectations of respect from their children and deference to authority can conflict with the imposed reality of a more passive position due to illness or poor English language skills. Women in single parent families who have lost their husbands during war or migration are required to function as both father and mother. An important task may be to help each generation to understand and accept each other's new beliefs and roles as the family evolves through the life cycle. The clinician must approach the family with respect for the strengths that allowed its members to survive individually and as a unit.

7. Indochinese Socialization Center. At a separate location, a socialization center has been developed to provide increased social activities and an expanded experience with American volunteers. This has been a popular activity with sharing of cultural traditions, and now

has expanded to include vocational rehabilitation and job training.

8. Refugee opportunities to give back and participate. Throughout the treatment program, the refugees contribute in many ways. All the groups offer ethnic meals to the hospital staff at times of their culture (origin's New Year's or other celebrations). Several groups (particularly the Mien) make craft items, such as embroidery, that represent their culture to the community. An advisory board for the Socialization Center includes many refugee members. The activities by the refugee patients are greatly appreciated by the staff and undoubtedly increase the self-esteem of the patients.

Treating these traumatized patients has at times been difficult and the psychiatry staff has been greatly changed by the experience. Our countertransference feelings have been challenging and complicated (15). We have learned that assessment and treatment must always be offered within a broad context that integrates ethnocultural factors, problems of language, metaphors and symbols, and with an awareness of adaptation and acculturation pressures (16).

Some Closing Thoughts

The cross-cultural diagnosis and treatment of PTSD remains an area of opportunity and controversy. Not only must techniques, skills, and conceptual frameworks be available for evaluating a patient who may not share the same culture as the clinician, but diagnostic classification is a key step in pursuing cross-cultural factors related to epidemiology, etiology, prognosis, and treatment (17). Understanding the entire sociocultural milieu in which the patient functions is also crucial in distinguishing psychopathology from culture bound beliefs or behavior (18).

The process of reconstructing meaning and purpose in life after trauma through bereavement is highly culturally determined, but the search for meaning itself and the struggle with grief (which includes the reconstitution of self-concept and comfort in interpersonal relationships) are universal experiences for all groups of people who have experienced severe trauma. For example, although American veterans of the Vietnam War returned to their country of origin, many have struggled with issues that are analogous to bereavement in refugee groups - a loss of social structure, cultural values, and self identity. Culturally constituted symbols, communication patterns, and healing approaches vary tremendously within the process of posttraumatic recovery, but cognitive disruption and existential pain remain a universal human response to traumatic events. The treatment of the broad spectrum of veterans in Vet Center therapy groups, of American Indian veterans with indigenous healing approaches, or of Southeast Asian refugees in socialization group settings all have a great deal in common through their focus on group healing in a social context.

As long as they are applied in the proper cultural context, biomedical interventions have the potential to diminish PTSD symptoms cross-culturally and can enhance and complement sociocultural interventions. For example, the treatment of insomnia and nightmares with medication

can enhance daily functioning and improve subjective well-being, thus optimizing role functioning as spouse, parent, student, or employee. Reducing intrusive PTSD symptoms can allow the patient to benefit more fully from psychotherapy, tolerate interpersonal intimacy in their social environment, and participate in culturally sanctioned activities that enhance the grieving and recovery process.

Working with refugees who have experienced immense trauma is challenging for the clinician. A clinician's store of cultural knowledge should serve primarily as a general template against which an individual or family is assessed.

Although the DSM diagnostic criteria are severely limited in regard to placing illness or suffering in a sociocultural context, they should not be limiting to the astute and experienced clinician. The DSM taxonomy is merely a scaffold upon which the clinician constructs a multilayered picture of the biological, psychological, and sociological effects of severe trauma upon the individual, family, and the culture at large. A therapeutic relationship within a biopsychosocial framework can serve as an important catalyst in assisting the traumatized refugee.

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