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1995-04-01

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Predictors of Posttraumatic Symptom Severity
in a
Clinical Sample
of
Vietnamese Reeducation Camp Survivors

by

William P. Rhoads

B.A. (University of Pennsylvania) 1992

A thesis submitted in partial satisfaction of the
requirements for the degree of

Masters of Science

in

Health and Medical Sciences

in the

GRADUATE DIVISION

of the

UNIVERSITY of CALIFORNIA at BERKELEY

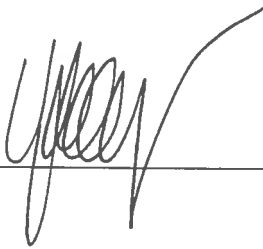
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1995

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1995

Table of Contents

I.	Introduction	1
II.	Historical Background	2
III.	Mental Health and Southeast Asian Refugees	5
IV.	Risk Factors and Resources	7
V.	Methods	15
VI.	Results	21
VII.	Discussion	28
VIII.	Treatment Implications	43
IX.	Ethical Implications of Trauma Victim Research	49
X.	Conclusion	54
	Bibliography	57
	Appendix A: Instruments	62
	Appendix B: Consent Form	81

Acknowledgements

I would like to convey my sincere gratitude to Dr. Nang Du, whose generous donation of time and expertise made this work possible. Many thanks to Jennifer Le Ly at Asian Community Mental Health Services for her help with interviews, and to Joyce Kim and the entire staff at ACMHS. Thanks to Steve McPhee, Chris Jenkins, and Don Fordham for their input regarding the study design, and to Professor Yu-Wen Ying for her input and guidance. Most of all, I express my deepest appreciation to the patients at ACMHS for sharing their experiences.

I. Introduction

In recent years, thousands of Vietnamese refugees formerly imprisoned in Vietnamese reeducation camps have arrived in the United States. This population is comprised primarily of men between the ages of forty and seventy who had served in the South Vietnamese army or government during the Vietnam War. In many cases, these former political detainees (FPDs) were separated from their families for a number of years. Some have only been reunited with their families upon arrival in the U.S. Members of this population have experienced trauma due to war, imprisonment, and torture.

Few studies of mental illness among traumatized Southeast Asian refugees have included the Vietnamese FPDs, who began arriving in the U.S. in large numbers only since 1990. Members of this population are at high risk for the development of mental illness, including depression and posttraumatic stress disorder (PTSD), as a result of their traumatic experiences.

This study investigated the interplay between past traumatic experiences, present social factors, and the mental health of Vietnamese reeducation camp survivors who were outpatients at a community mental health clinic. Specifically, the purposes of the study were 1.) To assess the contribution of past trauma, a presumed risk factor, to the development of PTSD, depression, and anxiety symptoms in

a cohort of Vietnamese reeducation camp survivors and 2.) To assess the role of two resource variables, English ability and social support, that were presumed to be protective against the development of PTSD, depression, and anxiety symptoms in this population.

II. Historical Background

In June of 1975, following the invasion of Saigon by communist Vietnamese forces, thousands of South Vietnamese were ordered to report to government authorities. The majority of them were formerly officers of the South Vietnamese (ARVN) forces and officials or civil servants of the deposed government. The new regime told those summoned that they were to travel to the countryside for a ten day "political study" period, and should bring only enough food and clothing to last for that time. Government proclamations assured them that political reprisals would be prevented as decreed under the Paris Peace Agreement (Sagan, 1989). Individuals refusing to comply with the orders were threatened with imprisonment. Thus the vast majority of those called surrendered themselves voluntarily (Freeman, 1989). Upon arriving at designated meeting sites, they were taken to makeshift prison camps in the countryside. While many low ranking soldiers and civil servants were released after ten days, higher ranking officials, officers, and

members of "subversive" political groups were detained indefinitely.

According to the limited evidence available, both the lengths of detainment and the conditions within the camps varied considerably. There were believed to be between 100,000 and 200,000 inmates incarcerated in reeducation camps in Vietnam in 1981 (Sagan, 1989). High ranking officers and other prisoners considered to be resistant to reeducation were held for six years or more. Officials of lower rank were sent to camps in the south, while those of higher rank were detained in remote camps in the central highlands and northern regions of Vietnam, where conditions were much more brutal (Freeman, 1989; Sagan, 1989).

Reeducation camp detainees also included Catholic priests, Buddhist monks and nuns, professionals, writers, and other dissidents accused of anti-communist activity. Some of these prisoners had been detained for many years prior to 1975. At some camps, families were allowed to send food and letters, and occasionally permitted to visit prisoners. However, the harsher camps forbade contact with the outside world, and, in some cases, prisoners' families were kept unaware of the prisoners' whereabouts.

Despite such variation in prisoners' experiences, some common characteristics emerged from available documentation of reeducation camp life. Prisoners were subjected to forced labor in the forest or jungle while fed on starvation rations of poor quality. Diet deficiencies, dysentery, and

other infections were common among the prisoners and appeared to have been the main causes of death. Death rates in the camps were estimated to be 10% each year (Sagan, 1989). Medical care, when available, was crude and inadequate. Prisoners were exposed to extreme weather conditions while lacking adequate shelter, clothing, and sanitation. Prisoners were forced to write and rewrite lengthy confessions of their purported crimes against the people, and were encouraged to report their fellow inmates' crimes. Punishment for infractions such as inability to work, insubordination, or attempted escape included lengthy solitary confinement, reduced rations, beatings, electric shock torture, and death (Sagan, 1989).

Upon release from the camps, a small number of former detainees were able to emigrate through the Orderly Departure Program in the late 1980s. Others attempted to escape Vietnam with varying success. In recent years, new agreements have allowed increasing numbers of Amerasians and former political detainees to exit the country.

The reeducation camp survivors represent the "fourth wave" of Vietnamese immigration to the U.S. The first wave began in 1975 with the evacuation of nearly 125,000 South Vietnamese military officers, government officials, professionals, and their families. The second wave of flight from Vietnam consisted of refugees who fled Vietnam by boat beginning in 1978. In the early 1980s, a third wave of Vietnamese immigration began as the Orderly Departure

Program was instituted to provide a safer passage for Amerasians and Vietnamese seeking to reunite with family members in the U.S. (Hinton, Chen, Du, Tran, et al., 1993). Finally, a 1990 agreement between the U.S. and Vietnamese governments allowed the former political detainees to come to the United States. As of 1992, an estimated 50,000 reeducation camp survivors and family members had resettled in the United States, and American authorities estimated that another 50,000 were eligible for immigration (U.S. Commission on Refugees, 1992).

III. Mental Health and Southeast Asian Refugees

Much has been written in the past decade about mental illness among Southeast Asian refugees. Symptom checklist studies have found symptom levels of depression, anxiety, posttraumatic stress, and somatic disturbances in the Vietnamese refugee population to surpass those in the general U.S. population (Felsman, 1990; Gong-Guy, 1988; Hinton, Jenkins, McPhee, Wong, et al., 1994; Meinhardt, Tom, Tse, and Yu, 1985; Rumbaut, 1985). Studies of refugee clinic populations revealed that Vietnamese psychiatric patients were commonly diagnosed with major depression, posttraumatic stress disorder, anxiety disorders, and psychosis (Hinton et al., 1993; Kinzie, Boehnlein, Leung, Moore, et al., 1990; Kinzie, Tran, Breckenridge and Bloom, 1980; Kroll, Habenicht, Mackenzie, Yang, et al., 1989;

Mollica, Wyshak, and Lavelle, 1987a). These studies typically used structured clinical interviews administered by psychiatrists. Such high rates of mental illness reflect Vietnamese refugees' experiences of trauma, loss of loved ones and homeland, and the difficulties of adjusting to a new country and culture.

The Vietnamese reeducation camp survivors differ from other Vietnamese refugees. Many earlier studies of Vietnamese immigrants included a disproportionate number of "first wave" immigrants, or those Vietnamese who came to the US in 1975 and early 1976 immediately following the fall of Saigon. First Wave refugees were significantly better educated and from a higher social class, had greater exposure to western culture, and were more prepared for migration than post-1978 refugees (Rumbaut, 1985). In addition, many of the first-wave refugees arrived in the United States with their families intact after relatively short stays in refugee camps (Gold, 1992).

While many of the Vietnamese educated elite, including very high ranking officers, were able to flee the country in 1975, mid-level officers remained in Vietnam and were incarcerated. Although the incarcerated former military officers may have been better educated and more familiar with Western culture than many second and third-wave refugees, they were neither economically nor culturally prepared for migration to the United States. Most importantly, while many Vietnamese refugees were traumatized

by war and migration experiences, few were exposed to the prolonged forced labor and torture endured by those in the reeducation camps.

Unfortunately, no study of psychiatric disorders among Vietnamese reeducation camp detainees has been published thus far, presumably because these individuals have only recently immigrated in large numbers to the U.S. Anecdotal evidence from specialty refugee clinics and elsewhere point to high rates of posttraumatic stress disorder (PTSD), depression, and anxiety disorder among former detainees (Goodman, 1993; Tabor, 1990; Mydans, 1992). In a prevalence study screening for depression, PTSD, anxiety disorders, and dysthymia in a San Francisco refugee clinic population, Hinton et al. (1993) found that 35% of Vietnamese reeducation camp survivors (who comprised 11% of the subject population) met diagnostic criteria for at least one major disorder.

IV. Risk Factors and Resources

This study assessed the correlation of a major risk factor (trauma) and two presumed resources (post-migratory adaptation and perceived family support) with symptoms of PTSD, depression, and anxiety in Vietnamese former political detainees. Risk factors such as high levels of traumatic experiences would be expected to leave the individual vulnerable to developing mental illness. Resources, such as

family support and ability to adapt to life in the United States, would be expected to serve as buffers protecting against the development of mental illness.

Trauma

A number of studies have attempted to define risk factors for mental illness in Vietnamese refugees. History of prior exposure to trauma has been identified in nearly every study as a significant factor associated with higher symptom levels in Vietnamese refugees (Chung and Kagawa-Singer, 1993; Hinton et al., 1993; Meinhardt et al., 1985; Rumbaut, 1985). Hinton's study (1993) with a sample of 201 recently arrived Vietnamese revealed that traumatic events and veteran status were the strongest predictors of psychiatric disorder. Higher levels of trauma have been identified as a predictor not only for PTSD, but also for depression, anxiety, and dissociative symptoms (Chung and Kagawa-Singer, 1993; Hinton et al., 1993).

The category of "trauma" for Vietnamese FPDs includes not only combat exposure and the witnessing of atrocities, but also the experience of chronic deprivation and repeated stressful events related to captivity. These include torture, brainwashing, prolonged lack of food, and prolonged isolation. All of these experiences are likely to have long-term psychological sequelae. Previous studies have reported that American former prisoners of war were more

likely to experience long-term depression and anxiety (Tennant, Goulston, and Dent, 1986), and interpersonal conflicts with aggressive tendencies (Polner, 1986) than combat veterans who were not imprisoned. Physical and psychological torture often results in long-term psychiatric disability encompassing somatic, behavioral, intellectual, and emotional functioning (Allodi and Cowgill, 1982; Basoglu and Marks, 1988). Attempted brainwashing through extensive interrogation and forced confession is likely to result in shame, guilt, and self-doubt (Miller, 1992). Authors have reported that weight loss due to malnutrition during captivity was strongly associated with long-term psychological sequelae in former prisoners of war (Kolb, 1987; Thygesen, Hermann, and Willanger, 1970). It has been hypothesized that forced isolation causes a biphasic "protest and despair" response similar to the alternating hyperarousal and emotional numbing reported in posttraumatic stress disorder. This response may leave individuals more psychologically vulnerable to additional trauma (Saporta and van der Kolk, 1992).

English Proficiency

The ability of the refugee to adapt to the host society and culture is a crucial factor affecting mental health. Refugees face the dual challenges of processing and integrating dramatic losses (of loved ones, social status,

wealth, and homeland) while overcoming barriers to survival in a drastically different society (Rumbaut, 1985). If the burden of adaptation and survival in the new society is overwhelming, the refugee is less likely to reconcile past losses.

Perhaps the most important adaptational resource for the refugee in the United States is the ability to speak English. English ability greatly improves the refugee's ability to find employment, access health and social services, and develop self-sufficiency. Higher English proficiency has been shown to correlate with better social adjustment among Vietnamese refugees in the United States (Tran, 1990; Rumbaut, 1985).

Inability to speak English restricts the individual's opportunities in all areas of life in the United States, predisposing him or her to feelings of alienation and powerlessness. Low English proficiency has been shown to correlate with the development of mental illness in Vietnamese refugees (Chung and Kagawa-Singer, 1993; Hinton et al., 1993).

Family Support

Another significant resource for Vietnamese reeducation camp survivors in the United States is the family. Family support may strongly affect traumatized refugees' abilities to remain resilient amidst the chaotic events of their

lives. Studies of torture victims across different countries have indicated that measures of social support and isolation were related to presence and severity of symptoms (Allodi, 1991). Family support is apt to be particularly relevant for Vietnamese given their strong cultural emphasis on family.

Family and the Vietnamese Refugee Experience

In traditional Vietnamese culture, the family was the central institution upon which society was based (Fitzgerald, 1972). Parents, children, married sons, daughters-in-law, unmarried daughters, and grandchildren traditionally lived together (Gold, 1992). Individual rights were generally subordinate to the demands of social roles. Family responsibilities extended beyond the immediate family, creating an elaborate support system.

Numerous authors have noted that members of East Asian cultures tend to identify the "self" primarily as interacting in a social group (Chang, 1982; Tung, 1985). In the traditional Vietnamese view, the individual only existed as a function of the society, and one's identity was dependent upon maintaining one's place in society. In the view of Fitzgerald (1972),

To Vietnamese, for whom man is not an independent 'character' but a series of relationships, 'sincerity' is the accord between a man's behavior

and what is expected of him: It is faithfulness not to the inner man, but to the social role.

Such a view of the social role stands in marked contrast to the notions of individualism and self-determination espoused in American society. Upon immigration to the United States, Vietnamese families were likely to experience disruption and uncertainty as they attempted to adapt traditional roles to the demands of a new society.

In adjusting to American society, traditional Vietnamese families were likely to undergo extreme role reversals. Women who had traditionally not worked outside the home may have taken on all or part of the breadwinner role after resettlement, either because of the greater availability of "women's" jobs in relation to unskilled jobs sought by the husband, or because the new society was more permissive to women working outside the home. Men lost the power and status attendant with being the sole breadwinner, and were often forced to accept employment placing them in a lower social status than held previously in Vietnam. Children generally adapted the most quickly to the new environment, becoming more fluent in English and more familiar with American customs than their parents. The father, accustomed to having absolute authority in Vietnam, was suddenly placed in a position of dependence on his children for help in negotiating his way in the new society. (Gold, 1992)

The stress of the immigration experience on the family and social system was apt to be particularly acute for reeducation camp survivors who have been separated from their families for a number of years. Re-unification with the family was likely to compound severe adjustment difficulties for the returning refugees.

Recent arrivals may have had difficulties accepting their families' assimilation into American culture, their wives' and childrens' independence, or the stresses of feeling that they must provide for their families. Conversely, family members may have been unprepared to accept an estranged and psychologically needy individual into their lives.

A variety of social factors have been identified in previous studies as risk factors for depression among Vietnamese refugees. These include living alone (Hinton et al., 1995), a larger family size (Chung and Kagawa-Singer, 1993; Hinton et al., 1995), and having more immediate family in Vietnam (Rumbaut, 1985). The relationship of these factors to the development of PTSD has not yet been investigated.

Being married has been associated with higher levels of psychiatric symptoms in three previous studies of Vietnamese refugees (Hinton et al., 1993; Meinhardt et al., 1985; Lin, Masuda, and Tazuma, 1984), but other studies found higher symptom levels in Vietnamese who were widowed (Lin, Tazuma, and Masuda, 1979) or single (Beiser, 1988).

These results suggest a complex relationship between family interactions and the development of psychiatric disorders. Objective measures of family support such as marital status are insufficient to describe the complex relationships between survivors and their families. Vietnamese families undergo many changes as they attempt to adapt to American society, and previously supportive relationships may become sources of conflict. The overwhelming impact of trauma may diminish the ability of former detainees to benefit from their families' emotional support. Thus, it is necessary to differentiate between structural support, i.e. the presence of a potentially supportive network, and perceived support, or the ability to benefit from the social or family network that exists. The unique culture and history of Vietnamese refugees in America present a number of key adjustment issues. These issues are highly relevant to the assessment of perceived family support for Vietnamese reeducation camp survivors and their families.

It is clear that issues of respect, adherence to or deviance from traditional roles, and re-establishment of emotional connections are likely to be prominent in the families of the reeducation camp survivors. For this study, respect from children, enjoyment of time with family, the degree to which the subject felt understood by his family, whether the subject felt that he could rely on his

family, and whether the subject felt needed by his family were all assessed in measuring perceived family support.

In summary, perceived family support and English proficiency were hypothesized to be protective resources and past traumatic exposures were considered risk factors in the development of mental disorder and symptomatology in this clinical sample of Vietnamese reeducation camp survivors.

V. Methods

Subjects

Subjects were recruited from Asian Community Mental Health Services (ACMHS) in Oakland, California. ACMHS is a psychiatric outpatient clinic designed to serve the Bay Area's Asian population. 24 Vietnamese men were recruited for the study. Eligibility criteria included: 1) incarceration in a reeducation camp for at least one year; 2) age between 30 and 65; and 3) under psychiatric care at the clinic for a period of no more than six months. Eligible subjects were identified by clinic staff and invited to participate in the study. Those who agreed to participate signed informed consent forms (see Appendix B). Many of the subjects were interviewed shortly after their initial intake appointment at the clinic.

Procedures

The subjects participated in a two-part interview lasting approximately two hours. All interviews took place at the clinic. In the first part, a semi-structured psychiatric interview was conducted in Vietnamese using three instruments. This interview was performed by a native Vietnamese-speaking psychiatrist. In the second part, native Vietnamese-speaking mental health workers administered a sociodemographic questionnaire.

Instruments

1) Harvard Trauma Questionnaire (HTQ): This is a three-part questionnaire that assesses trauma and torture events experienced by the subject and screens for symptoms commonly associated with trauma and posttraumatic stress disorder (see Appendix A). The HTQ was designed by professionals at the Indochinese Psychiatry Clinic in Brighton, Massachusetts. It is available in Vietnamese and has been validated in a population of Cambodian, Laotian, and Vietnamese refugees (Mollica, Caspi-Yevin, Bollini, Truong, et al., 1992).

Section I consists of 17 items describing different traumatic experiences, including torture, illness without access to medical care, and lack of food or water. Four

categories of response are offered: "Experienced," "Witnessed," "Heard About," or "No." The original validation study revealed that the "Heard About" category was redundant due to the high levels of trauma directly experienced by Southeast Asian refugees (Mollica et al., 1992), and was consequently deleted from this study. Because of the extremely high levels of trauma experienced by all subjects in this study, the "witnessed" category was also deleted. The total trauma score was the number of experienced events reported by each subject.

Section II consists of an open-ended question asking respondents for subjective descriptions of the most traumatic event(s) experienced.

Section III assesses the presence of 30 symptoms. Sixteen of these symptoms are drawn from the DSM-III-R criteria for posttraumatic stress disorder. Fourteen additional symptoms are included in an attempt to include other symptoms associated with refugee trauma. The subject is asked about symptoms such as "difficulty concentrating" and "sudden emotional or physical reaction when reminded of the traumatic experience." Four categories of response are offered for each item, ranging from "Not at all" (score = 1) to "extremely" (score = 4). The total score is the sum of all items answered divided by the number of items answered.

The HTQ has been shown to be a valid and reliable measure of torture, trauma events, and trauma symptoms in Southeast Asian refugee patients. Reliability was assessed

in three areas: interrater reliability (.93 for Section I and .98 for Section III), test/retest (.89 for Section I and .92 for Section III), and internal consistency (coefficient alpha = .90 for Section I and .96 for Section III).

Validity of Section III was assessed by administering the scale to subjects with and without DSM-III-R diagnoses of PTSD. Sensitivity of the HTQ was found to be 78% and specificity of the scale was 65% (Mollica et al., 1992).

2) Hopkins Symptom Checklist-25 (HSCL-25): This is a 25-item symptom checklist that assesses the presence of depression and anxiety symptoms (see Appendix A). It includes ten anxiety items and fifteen depression items, and has been found to be a highly reliable screening instrument for anxiety and depression in American populations (Derogatis, Lipman, Rickels, et al., 1974). Four categories of response are offered, ranging from "Not at All" (Score=1) to "Extremely" (Score =4). This format is identical to that in the Trauma Symptoms component of the Harvard Trauma Questionnaire. The scale yields an average anxiety score equal to the sum of the scores of items 1-10 divided by 10. A mean depression score is calculated by dividing the sum of the scores from items 11-25 by 15. A standard cutoff point of 1.75 is generally used for both the depression score and for the total score (Items 1-25 divided by 25). A depression score greater than 1.75 is considered to indicate clinical depression, whereas a total score of greater than

1.75 indicates "significant emotional distress" (Mollica, 1987).

The Indochinese version of the HSCL-25 was also developed at the Indochinese Psychiatry clinic in Brighton and is available in Vietnamese (Mollica, Wyshak, de Marneffe, Khuon, et al., 1987b). This version has been used to assess depression and anxiety symptoms in a population of Vietnamese in a refugee camp in the Phillipines. This study yielded mean anxiety and depression scores above the cutoff of 1.75 (Felsman, 1990).

When compared to a "gold-standard" diagnosis of depression determined by a native Vietnamese-speaking psychiatrist using the Structured Clinical Interview for DSM-III-R (SCID), the HSCL-25 depression scale was found to have an 86% sensitivity and 93% specificity (Hinton, et al., 1994). Sensitivity and specificity values for the anxiety portion of the scale have not been measured in Vietnamese refugees. The Indochinese version of the HSCL-25 has also been assessed for test-retest and interrater reliability, yielding values of 0.89 and 0.98, respectively (Mollica et al., 1987b).

3) Sociodemographic Questionnaire (SDQ): This questionnaire contains a six-item scale designed to measure the subject's perception of family support. Five categories of response are offered ("Always," "Frequently," "Sometimes," "Rarely," and "Never") for each of six

statements. The statements address the subjects' perception of family life: "My children respect me as much now as they did in Vietnam," "I enjoy spending time with my family," "I feel that my family understands me," "I can rely on my family to support me," and "Members of my family rely on me." The subjects answers are given numeric equivalents (Always=4; Never=0). The sum of responses to these items divided by the number of items answered yields a mean social support score.

The SDQ also elicits basic demographic information (age, ethnicity, marital status, education, monthly income). The questionnaire covers a number of social variables (household size, number of immediate family remaining in Vietnam, number of family members migrating with the subject) and historical variables (past and present occupations, length of time spent in refugee camps, length of imprisonment).

VI. Results

A. Sample Characteristics

A total of 24 subjects were recruited for the study. Five of these subjects exhibited such severe intrusive symptoms and concentration deficits that they could not be interviewed. These patients were dropped from the study, leaving a total of 19 subjects. Tables 1 and 2 demonstrate demographic characteristics of the sample.

All subjects were men. Mean age was 51 years (SD=5.95), and ranged from 34 to 63. Subjects had been in the United States for an average of 3.8 years (SD=2.07). 78% of the subjects were married and living with their wives. All subjects were unemployed at the time of the interview.

Table 1: Sample characteristics (N=19)

Variable	Mean (SD)	Range
Age (Years)	51 (5.95)	34-63
Years in U.S.	3.83 (2.07)	1-9
Family Support Score	3.71 (1.17)	1.40-5.00
Years in Captivity	7.35 (3.52)	3-13

Table 2: Sample Characteristics (N=19)

Variable	% (N)
Marital Status	
Married	77.8 (14)
Live with Partner	5.6 (1)
Separated	5.6 (1)
Divorced	5.6 (1)
Widowed	5.6 (1)
English Proficiency	
Fluent	0 (0)
Good, not fluent	16.7 (3)
Simple Phrases	50.0 (9)
No English	33.3 (6)

Subjects had spent an average of seven years in the reeducation camps ($SD=3.52$). Individual internment periods ranged from 3 to 13 years. All but two of the subjects had been officers or soldiers in the South Vietnamese Army. The two non-veteran subjects had been civil servants for the South Vietnamese government. One third of subjects reported that they spoke no English; an additional 50% reported that they only spoke a little English.

B. Trauma

All subjects were highly traumatized, reporting a mean of 12 out of 16 possible traumatic experiences. Individual responses ranged from 9 to 16 traumatic events. Table 3 describes the frequency of endorsement of individual traumatic experiences.

Table 3: Reporting of Traumatic Events

Trauma	% (N) *
Brainwashing	100 (19)
Forced Separation from Family	100 (19)
Imprisonment	100 (19)
Lack of Food or Water	100 (19)
Combat Situation	100 (19)
Being Close to Death	94.7 (18)
Illness without Medical Care	94.7 (18)
Enforced Isolation	84.2 (16)
Lack of Shelter	84.2 (16)
Torture	73.7 (14)
Lost or Kidnapped	63.2 (12)
Serious Injury	63.2 (12)
Unnatural Death of Family or Friend	47.4 (9)
Witnessed Murder of Strangers	42.1 (8)
Murder of Family or Friend	31.6 (6)
Rape or Sexual Abuse	5.3 (1)

*Percent of subjects reporting that they had experienced the traumatic event.

All subjects reported experiencing imprisonment, brainwashing, forced separation from family, lack of food or water, and combat situations. Being close to death and illness with no medical care were reported by nearly all of

the subjects. Lack of shelter, enforced isolation, and torture were reported by most of the subjects as well. Subjects reported being held in solitary confinement for as long as six months. Torture events most frequently described included beatings, electric shock, and being bound in uncomfortable positions for extended periods of time.

C. Prevalence of Symptoms and Mental Disorders

The mean depression score for the sample was 3.14 (SD=0.62), well above the clinical cutoff of 1.75 established for the HSCL-25 depression scale (Mollica et al., 1987b). As Table 4 shows, 18 of 19 subjects had clinically significant depression as defined by this criterion. Individual responses ranged from 1.43 to 3.86.

Table 4: Prevalence of Depression, Anxiety, and PTSD

Disorder	% (N)
Depression (HSCL score > 1.75)	94.7 (18)
Anxiety (HSCL score > 1.75)	94.7 (18)
Posttraumatic Stress Disorder (HTQ score > 2.5)	89.5 (17)

Subjects exhibited high levels of anxiety symptoms as well. The mean anxiety score was 3.04 (SD=0.73). 18 of 19 subjects had clinically significant anxiety as defined by the cutoff of 1.75. Individual responses ranged from 1.60 to 3.90

17 of 19 subjects exhibited clinically significant levels of posttraumatic stress symptoms, as defined by the cutoff score of 2.5 (on a scale of 1 to 4) established in a previous study using the HTQ (Mollica et al., 1992). The mean traumatic symptom score was 3.00 (SD=0.43). Individual scores ranged from 2.10 to 3.87. Table 5 demonstrates the frequencies of the most commonly reported posttraumatic stress symptoms.

Table 5: Most Frequently Endorsed Posttraumatic Symptoms

Symptom	% of subjects*
Trouble sleeping	100 (19)
Difficulty concentrating	100 (19)
Difficulty with tasks	94.7 (18)
Avoiding thoughts or feelings that remind you of the traumatic event	94.7 (18)
Nightmares	89.5 (17)
Easily startled	89.5 (17)
Recurrent thoughts or memories of the event(s)	89.5 (17)
Sudden emotional or physical reaction when reminded of the event(s)	89.5 (17)
Feeling as if you have no future	89.5 (17)
Avoiding activities that remind you of the event(s)	84.2 (16)
Feeling on guard	84.2 (16)
Feeling irritable or having outbursts of anger	84.2 (16)

*Numbers represent % of subjects reporting that these symptoms bothered them "quite a bit " or "extremely" within the past week.

D. Predictors of Symptom Levels

Three multiple regression models were conducted using trauma level, English proficiency, and family support score as the independent variables. Given the high prevalence and

mental disorders (i.e. 94.7% of the sample met diagnostic criteria for depression and anxiety disorders and 89.5% met criteria for PTSD), the hypothesized models were tested with symptom levels as the dependent variables. In the first model, depression symptom score was the dependent variable. Adjusted R^2 was 0.26 ($F(3,14)=3.02$, $p=.065$). This model was only marginally significant. English proficiency was negatively predictive of depressive symptoms (standardized beta = $-.66$, $p=.005$, one-tailed test) (See Table 6). Trauma and family support did not significantly predict depressive symptom levels.

For the second regression model, anxiety symptom score was used as the dependent variable. Adjusted R^2 was 0.21 ($F(3,14)=2.47$, $p=.11$). This model was also only marginally significant. Again, English proficiency was negatively predictive of anxiety symptoms (standardized beta = $-.51$, $p=.02$, one-tailed test), while trauma and family support did not correlate significantly with anxiety.

In the third regression model, posttraumatic symptom score was the dependent variable. Adjusted R^2 was 0.64 ($F(3,14)=11.09$, $p=.0005$), with English proficiency emerging as negative predictor (standardized beta = $-.70$, $p=.0002$, one-tailed test), and trauma emerging as a positive predictor (standardized beta = $.66$, $p=.005$, one-tailed test) of posttraumatic symptoms. Family support did not significantly predict posttraumatic symptom levels.

Table 6: Standardized Beta Weights of Independent Variables by Disorder.

Disorder	Trauma	English Ability	Family Support Score
Depression	.38	-.66**	.23
Anxiety	.16	-.51*	-.22
PTSD	.66**	-.70***	.015

* $p < .05$; ** $p < .01$; *** $p < .0005$, using one-tailed tests

VII. Discussion

A. Mental illness

The subjects interviewed for this study exhibited extremely high rates of PTSD, depression, and anxiety. Interviews yielded a narrow range of symptom scores, with nearly all subjects clustered above the clinical cutoffs for each disorder. Average symptom scores for all disorders were in the upper ranges, even though five of the most overtly symptomatic patients were not interviewed. These five individuals were selectively mute and intermittently psychotic.

The severe psychopathology reported in this study is in part attributable to the relatively small sample size and the sampling bias of a mental health clinic study. A large

scale community study using the HSCL-25 revealed much lower rates (11.9 - 13.9%) of depression (HSCL score > 1.75) among Vietnamese-American men than that found in this sample (Hinton et al., 1995). Thus, these results may not be representative of the mental health status of non-patient reeducation camp survivors.

Despite these limitations, comparisons with past studies of Vietnamese patient populations suggest that the reeducation camp survivors are at greater risk of developing severe mental illness. The 95% prevalence of depression in this sample was much higher than the 50-55% prevalences found in previous samples of Vietnamese psychiatric patients (Kroll et al., 1989; Mollica et al., 1987a). The disparity between rates of PTSD in this sample compared to these previous Vietnamese patient samples was even larger (89% v. 8-11%).

B. Predictors of Symptom Levels

English Proficiency

English proficiency was an important predictor of depression, anxiety, and posttraumatic symptom levels in this group of highly traumatized patients. Most of the subjects had arrived in the United States within the past five years and were at risk for serious adjustment difficulties. It is likely that the ability to speak

English protects against significant post-migration stresses. Traumatized refugees with fewer English skills are more likely to be isolated within their new society, relying on others' assistance in many aspects of their lives. Such isolation, leading to feelings of powerlessness and demoralization, puts the individual at significant risk of developing depression.

Without language skills, the individual perceives the outside world as uncertain and dangerous. Reeducation camp survivors with poor English skills are apt to feel in less control of their lives. Resources seem non-existent or unattainable, and basic survival issues, such as employment and transportation, may seem unmanageable. For former political detainees who had previously experienced prolonged, overwhelming powerlessness, such perilous circumstances are likely to reactivate intrusive memories and other posttraumatic stress symptoms.

Trauma

Not surprisingly, the reeducation camp survivors were significantly more traumatized than Vietnamese patient groups from previous clinic studies (Kroll et al., 1989; Mollica et al., 1987a). Imprisonment, brainwashing, lack of food or water, and forced separation from family were invariable features of the reeducation camp experience. The

reporting of combat experience by all of the study subjects reflects the large proportion of military veterans in the sample. While torture and solitary confinement in the reeducation camps had been documented previously (Sagan, 1989), it is surprising that three-quarters of the study population had endured these insults. This probably reflects the bias of the clinic sample. It is likely that the FPDs who are under psychiatric care are among the most traumatized.

While the number of traumatic experiences was a significant predictor of posttraumatic symptom levels, trauma did not correlate significantly with anxiety or depression symptoms. This was a surprising finding in light of the extensive body of literature linking trauma to these disorders (Chung and Kagawa-Singer, 1993; Hinton et al., 1993). However, the regression models for anxiety and depression were only marginally significant, presumably due to the small sample size. The narrow range of symptom levels and high baseline trauma level (minimum 9 of 16 traumatic experiences) may have contributed to the lack of significant association. In addition, the Harvard Trauma Questionnaire assesses the number of different types of trauma experienced, but not the magnitude of each type of trauma (eg length in solitary confinement). Thus subjects reporting equal numbers of traumatic experiences may have actually varied considerably in their experiences.

While no previous study of Vietnamese refugees has employed the Harvard Trauma Questionnaire, a study of Cambodian refugees in Thai border camps did so (Mollica, Donelan, Tor, Lavelle et al., 1993). Overall trauma levels for the Vietnamese former detainees were comparable to those reported by the Cambodian refugee sample during the Khmer Rouge years, despite a much higher prevalence of PTSD (89.5% v. 15%) found in our study's sample. This undoubtedly reflects the bias of the mental health clinic sample examined in this study.

However, it is also possible that the reeducation camp survivors have more severe symptoms due to the specific nature of the captivity experience. The incidence of certain traumatic experiences, including torture, enforced isolation, and being close to death, were higher in the reeducation camp sample than in the Cambodian study population. In addition, the subjects in the Cambodian border camps had not faced the acculturation stresses common among refugees in the United States.

Sequelae of Trauma

In addition to generalized symptoms of depression and anxiety, most of the patients interviewed for this study suffered from debilitating symptoms clearly linked to their traumatic experiences. Nearly all were plagued by nightmares and recurrent memories of the reeducation camps,

and as a consequence invested a great deal of energy in attempting to suppress these memories. In fact, for eight of the patients, the distinction between past memories and present reality was strikingly unclear. The following case illustrates the more severe consequences of extreme trauma. the patient, DS, was one of the five patients not interviewed in the study.

Case 1

DS is a 53-year-old married man who presented to the clinic with complaints of insomnia, headaches, auditory hallucinations, and social and emotional withdrawal. He was brought to the clinic by his 21-year-old daughter, who reported that he had been unable to take care of himself.

In Vietnam, DS was a captain in the South Vietnamese army. He was sent to a reeducation camp in 1975. He refused to follow the guards' orders, and was severely tortured as a consequence. His captors broke his left arm, beat him severely, and administered electric shock torture to his head.

DS's family reported that his symptoms began mildly following his release from the camp in 1981. Later that year, DS witnessed the shooting death of his oldest son as they were caught attempting to flee Vietnam. His family reported that his symptoms worsened after this incident. His condition worsened in 1990 following his arrival in the United States, and deteriorated further after he had exhausted his Medi-Cal funds and stopped seeing his regular psychiatrist.

In therapy, DS was internally preoccupied and seemed only vaguely aware of external stimuli. He was disoriented to time and place. He exhibited marked psychomotor retardation and looked down or closed his eyes for most of the session. He admitted hearing voices of a friend telling him to "go outside" and of the "communist supervisor" threatening to hit him. He rarely responded to therapists' questions, but occasionally stated

short phrases such as, "I already disclosed everything. Stop beating me." His daughter reported that he slept only a few hours each night, and that he sometimes crawled to a corner of the room to talk and cry by himself.

A tragic feature of DS's case is the extent to which he re-experiences the horrors of his captivity long after the threat has been removed. While many trauma victims experience flashbacks, nightmares, and transient feelings that the traumatic event is re-occurring, DS's symptoms are not transient. He experiences frequent auditory hallucinations specific to his trauma and is disoriented to time and place. Persistent psychosis of this sort was seen among several of the reeducation camp survivors at the clinic, and should be examined further.

Another important feature of this case is that some of Mr. S's symptoms may be related to head trauma. Sequelae of physical injuries are common in trauma survivors, and it is not always clear whether symptoms are due to a primary psychiatric disorder or to an "organic brain syndrome." Many of the subjects interviewed in this study had sustained some type of physical injury as a result of beatings, torture, combat, or escape attempts.

The chronology of DS's illness indicates that his symptoms have repeatedly worsened in response to stressful life events. Prior to his imprisonment, DS had been a successful officer, husband, and father in South Vietnam. While the traumatic experiences sustained during his

internment resulted in mild posttraumatic symptoms initially, the stress of witnessing his son's death caused significant decompensation. Additional stresses, such as coming to the United States and running out of Medi-Cal, produced intensification of symptoms rooted in the initial traumatic events. Such a pattern of worsening intrusive symptoms during periods of heightened stress has been reported in trauma victims previously (Kinzie and Fleck, 1987).

Family Support

Family support was not a significant predictor of depression, anxiety, or posttraumatic symptom levels. While it is possible that the impact of massive trauma dwarfs the effects of other external factors in the development of mental illness, this seems unlikely in the face of evidence to the contrary. The emergence of English proficiency as a predictor of symptom levels in this study indicates that present life circumstances do influence the mental health of trauma victims. In addition, a previous study identified social support as one of the most significant predictors for development of chronic PTSD (McFarlane, 1988).

The narrow range of symptom levels and small sample size may have contributed to the lack of association between family support and symptom levels. Furthermore, the scale used to measure family support contained items adapted from

social support studies of American populations. This scale may have failed to capture elements of family support for Vietnamese refugees.

Vietnamese patients are apt to be reluctant to disclose family problems to an outsider for fear of harming the family's reputation (Tung, 1985). Despite severe mental illness and dramatic family disruptions among the patients interviewed, family support scores were clustered in the higher ranges. A possible bias towards positive responses may have distorted the measure of family support.

Given the importance of the family in Vietnamese lives, the relationship of family support to the development of mental illness in Vietnamese refugees should be examined further. In addition to its possible role as a resilience factor, family support is apt to significantly impact how the individual's illness is handled. Nearly all of the study subjects were accompanied to the clinic by family members. These family members were often indispensable in providing the patient's therapist with clinical and historical information. This is consistent with the observation that, for Southeast Asian patients,

The family structure and the family's reaction to mental illness may have much greater impact on any family member seeking and continuing with mental health treatment than does the individual's motivation to pursue treatment (Wong, 1985).

Health care providers have noted the importance of involving Southeast Asian families in treatment decisions, as family-based decision making is the norm (Lin and Shen, 1991).

The relationship between family support and trauma is complex, as the psychological impact of trauma diminishes the ability to engage in meaningful interactions. The following case illustrates how posttraumatic stress symptoms may interfere with interpersonal functioning. The patient, VL, was also one of the five reeducation camp survivors at ACMHS who were not interviewed due to the severity of their symptoms.

Case 2

VL is a 49-year-old married man who presented at the clinic with complaints of headache, sleep disturbance, low energy, depressed mood, and poor memory. When first seen at the clinic, Mr. L was sad and tearful. He exhibited marked psychomotor retardation. During therapy sessions, he was selectively mute and appeared to be preoccupied with internal stimuli.

VL was a soldier in the ARVN forces prior to 1975. From 1975 to 1981, he was incarcerated in a reeducation camp. He came with his wife and two young children to the United States in 1992. He speaks no English.

At home, VL was sleeping one to two hours each night and was disturbed by darkness. He was bothered by nightmares about the reeducation camps, waking several times each night in a panicked state. His wife and brother reported that he spent most of the night wandering around the house as if he were looking for something. VL reported hearing the voices of his fellow reeducation camp inmates at night.

VL spent most of his day sitting at home in one place, rarely speaking to family members. He expressed no interest in food, and he

had to be encouraged by his wife to eat. He was quite irritable, and he had occasional outbursts in which he would hit furniture and yell at his wife and children. Mr. L's family needed to arrange for two people to drive him to the clinic for every appointment because his unpredictable behavior required constant attention.

Mr. L's sadness, appetite disturbance, and insomnia are all consistent with Major Depression. He also suffers from nightmares, transient hallucinations, irritability, and inability to connect with family or therapist. These represent the triad of intrusive symptoms, hyperarousal, and emotional numbing commonly seen in posttraumatic stress disorder. Similar combinations of posttraumatic stress and depressive symptoms were seen in all of the subjects interviewed. These symptoms are likely to interfere with the individual's ability to interact with friends and family and maintain social relations.

Mr. L's family acts as a crucial support in his life. However, although the family is able to provide for his practical needs, Mr. L is unable to connect with his family emotionally due to the severity of his symptoms. Mr. L's emotional withdrawal is probably due not only to depression, avoidance behaviors, and emotional numbing, but also to the nature of his captivity experience.

Trauma and torture at the hands of others often result in guilt, shame, and pervasive mistrust of friends, relatives, and neighbors, as well as authority figures and institutions (Allodi, 1991). Significantly for reeducation

camp detainees, posttraumatic stress disorder is in many cases more severe and longer lasting when the original trauma was of human design. (American Psychiatric Association, 1987) Thus Mr. L's inability to relate to loved ones may be intimately linked to his emotional experience of the trauma and his relationship to his captors.

Mr. L's case also illustrates the tremendous strain on families who must care for severely distressed reeducation camp survivors. Whereas Mr. L had been in a leadership role within his family and society prior to his imprisonment, he is now entirely dependent on his family. His severe functional impairment requires that he be cared for daily. Were his wife and brother not present or willing to provide daily care, he would most likely be either institutionalized or homeless.

Families of traumatized reeducation camp survivors must adjust to being reunited with a family member whose personality and level of functioning have changed dramatically. In addition, as is evident in Mr. L's case, family members often bear the brunt of the trauma victim's irritability, frustration, and anger.

In addition to suffering from traumatic sequelae, many families of former political detainees have experienced extensive disruption. The following case illustrates common themes of separation, conflict, and loss for Vietnamese former political detainees and their families:

Case 3

TN is a 54-year-old former ARVN soldier who was referred to ACMHS with complaints of headache, insomnia, nightmares, and sadness.

Mr. N was imprisoned in a reeducation camp in southern Vietnam between 1975 and 1978. In the reeducation camp he was subjected to forced labor and lengthy interrogations. He did not experience torture, beatings, or solitary confinement.

After two of his children escaped from Vietnam in the mid 1980s, Mr. N feared that he would be imprisoned again. In 1988 he and his 17-year-old daughter fled Vietnam by boat. During their escape, the boat nearly sank in a storm, and the passengers went without food or water for several days. Upon reaching the United States, Mr. N was reunited with the son and daughter who had fled several years earlier.

Mr. N now lives with his children in the United States. His wife and three more children remain in Vietnam. When he first came to the clinic, he was experiencing nightmares every night about his imprisonment and his traumatic escape experience. In addition, he was extremely depressed about his home situation and about having to leave his wife in Vietnam. His 26-year-old daughter, who had come to the United States four years earlier, was not speaking to him. Mr. N was opposed to her lifestyle and yelled at her frequently. He felt that she did not respect him or care about him.

Mr. N spoke no English, and depended on his children to help him with his affairs. He never left the house and spent most of his time in his room. When he received letters from his wife in Vietnam, he became more depressed and preoccupied with his family in Vietnam.

Mr. N's case is typical of refugees who have rather mild PTSD but clear depressive symptoms. Although Mr. N suffered from nightmares related to his traumatic experiences, much of his distress is a result of his present life circumstances and acculturation difficulties. Mr. N

had experienced less severe trauma and was less severely impaired than most of the other subjects.

Mr. N, like most refugees, was forced to flee under extreme conditions. His forced separation from his wife and children is a source of great sadness and worry, leaving him very vulnerable to developing depression.

Mr. N's difficulties at home reflect the different levels of acculturation resulting from family members immigrating at different times. He expects his adult children to respect him as they did in Vietnam, but in the United States he cannot command this authority. Mr. N's unmarried daughter came to the U.S. several years previously and adapted to the more permissive American culture in the absence of her parent's support and authority. In the U.S., she was not only permitted to establish an independent identity, but needed to do so in order to function in the new society.

In Vietnam, an unmarried daughter would most likely remain dependent on her family until she married. In times of crisis, the Vietnamese father could always threaten to disown his child, which would result in the child losing her social place. (Fitzgerald, 1972) In America, where Mr. N finds himself dependent on his daughter, the threat of disownment is an empty one.

Coming from a culture in which identity is dependent upon status within society and within the family, reeducation camp survivors have faced dramatic changes in

virtually every arena in which their identity is determined. Having lost his place in the society of his home country, Mr. N now finds that his role has changed within his own family. At the same time, he must confront his new status as a refugee in America while reconciling the loss of his homeland and separation from his wife.

The importance of family support in influencing mental health and treatment decisions for Vietnamese reeducation camp survivors is magnified by a number of factors. Unfamiliarity with American social and mental health services, language barriers to services, and prevailing stigmatization of mental illness in the Vietnamese community are significant barriers to treatment. In the absence of family help, Vietnamese refugees generally seek help from friends, community leaders, religious leaders, or healers, with American mental health professionals regarded as a last resort (Owan, 1985; Wong, 1985). Kinzie (1985) observed that Cambodian and Vietnamese families were often reluctant to admit the existence of a "crazy person" within the family. Negative attitudes within the Vietnamese- American community regarding mental illness cause families to fear that they will be shamed and ostracized if a family member's mental illness becomes public.

VIII. Treatment Implications

The severity of posttraumatic, depressive, and anxiety symptoms seen in this patient sample of traumatized Vietnamese men indicates a desperate need for effective intervention in this population. Most patients' lives and personalities remained affected many years after their imprisonment, indicating that their impairment was chronic in nature. This is consistent with the findings of Hauff and Vaglum (1994) that, in a group of Vietnamese refugees with PTSD, reeducation camp survivors were most likely to suffer from chronic PTSD of more than three years' duration. Treatment of severe, chronic posttraumatic stress disorder is notoriously difficult (van der Kolk, 1994), and cultural differences and life stresses are likely to hinder the treatment process.

The available literature on treatment outcomes for Southeast Asian refugees is sparse. A study of Asian American mental health service use and treatment outcome found that although Southeast Asians had the highest rate of service use, they showed the least improvement from treatment (Ying and Hu, 1994). Studies examining PTSD treatment outcomes in this population show mixed results. One study reported significant reduction in depressive symptoms but an increase in somatic anxiety symptoms over the course of treatment (Mollica et al., 1990). Another study with a similar patient population showed initial

improvement in intrusive symptoms (nightmares, sleep disorders, startle reactions, while symptoms of avoidance, emotional numbing, and shame were much more refractory to treatment (Boehnlein, Kinzie, Ben, and Fleck, 1985). Kinzie and Fleck (1987a) reported that the stress of life events such as economic hardship, intrafamilial changes, and various reminders often caused reactivation of intrusive symptoms even after initial improvement.

Cultural factors complicate the treatment process for Vietnamese refugees. Unfamiliarity with Western treatment methods and a language barrier between patient and provider are enormous obstacles to traditional psychiatric treatment. Psychotherapists working with traumatized Southeast Asian refugees must consider that the concept of healing through discussing intimate thoughts with a stranger has little precedent in Vietnamese culture.

Medications are an essential aspect of depression and PTSD treatment, and are generally better accepted by Vietnamese patients than "talk therapy." However, a number of providers have observed that many Southeast Asian patients regard Western medicines as too powerful (Kinzie, 1985; Tung, 1985). Psychopharmacologic treatment involving long-term maintenance and delayed onset of symptom reduction may be in conflict with Southeast Asian patients' expectations of western medicine (Lin and Shen, 1991). As a consequence, patients may reduce the dosage or take medications only when they feel bad (Muecke, 1983; Ong, 1994).

Previous studies of drug compliance among Southeast Asian refugees indicate that inadequate adherence to treatment regimen may be a major barrier to effective treatment (Kinzie, Leung, Boehnlein, and Fleck, 1987b; Lin and Shen, 1991)

A logical first step in the treatment of PTSD is to ameliorate overwhelming intrusive symptoms. Flashbacks, nightmares, and intrusive memories, often accompanied by intense physiological arousal, may be precipitated either by specific reminders of the trauma or by physiologic arousal itself. Psychobiological findings suggest that memories formed during intense stimuli are inherently different than normal declarative memory. Images of trauma appear to be strongly linked to states of physiologic arousal and conditioned stress-response behaviors (van der Kolk, 1994). As a consequence, the memories of trauma do not feel like memories; the vividness of the traumatic images, accompanied by a physiologic response out of proportion to incoming stimuli, make the trauma victim momentarily feel that the traumatic event is re-occurring.

Such a psychobiologic approach would explain the resistance of PTSD to a cure by talk therapy alone. A psychodynamic perspective regards the flashbacks, nightmares, and reexperiencing of the traumatic event seen in PTSD as attempts by the individual to work through and understand an unresolved loss. Freud (1920) postulated that this "war neurosis" represented an unconscious process by

which the trauma victim repeatedly attempted to master overwhelming and uncontrollable events.

However, it would appear that in many instances repeated recall of the trauma does not lead to an appropriate integration of the past experience into the patient's psyche. In fact, working through the traumatic events with patients may result in decompensation rather than the healing catharsis that the clinician may expect. In describing the treatment of Cambodian victims of war trauma, Kinzie and Fleck (1987a) reported that when patients were able to recount their experiences under the Khmer Rouge, a "healing effect" rarely resulted. Instead, recall of the traumatic experience seemed to induce intensified anxiety. Mollica, Caspi-Yavin, Lavelle, Tor et al. (1991) also observed this phenomenon in Southeast Asian trauma victims:

Clinical experience and research findings indicate that once an account is given, both an increase in memory and an intensification of symptoms is likely to occur.

Attempts to "work through" massive trauma prematurely may simply increase the patient's focus on a past that when viewed in its overwhelming totality can neither be resolved nor integrated.

The trauma, loss, and social upheaval experienced by reeducation camp survivors present a massive challenge to the individual's cognitive ordering and understanding of the self and the world. Prolonged powerlessness at the hands of

other humans leads the individual to question previously held assumptions about his or her identity, strength, and social role. This dynamic points to another focus in the treatment of PTSD. If intrusive symptoms can be relieved through medication, the role of psychotherapy may lie not in helping patients to "work through" their trauma, but in aiding them in the search for identity and meaning in their present lives. X

In examining PTSD in Cambodian victims of war trauma and torture, Boehnlein (1987) noted the many similarities of PTSD to chronic, unresolved grief. The presence of insomnia, nightmares, and preoccupation with thoughts of the dead seen in his patients led Boehnlein to examine PTSD as an extremely intense grief response which would require a culturally appropriate mourning period to resolve. For Vietnamese, successful coping with death is considered to be achieved not through the expression of grief to a professional, but through the fulfillment of rituals and services appropriate to the family's religion (Chung, 1990). The practice of rituals and familiar customs may help reinforce long-held cultural beliefs and restore some order to trauma victims' lives (Boehnlein, 1987). Rituals may include the use of traditional healers and the conduct of ceremonies to honor one's ancestors. ✓

For Vietnamese former political detainees, cultural bereavement, personal loss, and disruption of the traditional family structure make the completion of such a ✓

mourning period very difficult. Ingrained avoidance behaviors and inability to form meaningful attachments with others seen in chronic PTSD further isolate trauma victims. While avoidance and numbing behavior serve to hold recall and intrusive symptoms at bay, they also prevent the individual from becoming reintegrated into society and maintaining positive social relationships.

Treatment of traumatized Vietnamese FPDs requires a multi-faceted approach involving medication, supportive psychotherapy, and social service intervention. Patient's families should be educated about the patient's illness as well as the treatment approach, as family members are often instrumental in encouraging compliance. Boehnlein and Kinzie (1992) argue that the initial reduction of intrusive symptoms through medication is a crucial prerequisite to further healing:

Lessening intrusive PTSD symptoms can also allow the patients to benefit more from psychotherapy, tolerate interpersonal intimacy in their social environment, and participate in culturally sanctioned activities... that enhance the grieving process occurring in a culturally valued social context.

Helping patients and their families to access social services can help to reduce the financial stresses and feelings of isolation that may trigger posttraumatic symptoms. For less severely impaired patients, emphasis on social reintegration may speed patients' recovery. While Vietnamese patients are apt to be averse to sharing their

emotional problems with others, therapy groups may be helpful in validating FPDs' experiences and allowing them to relearn social skills. Groups with activities and practical skill teaching (e.g. English skills) can help FPDs to become less isolated, begin to live in the present moment, and rediscover the world around them.

IX. Ethical Implications of Trauma Victim Research

A major concern in conducting this study was that the interview process would reactivate posttraumatic stress symptoms in the subjects. The recall of traumatic events during therapy may be exceedingly distressing for trauma victims (Kinzie, 1985; Mollica et al., 1991). Kinzie and Fleck (1987a) have warned against the possibility of triggering decompensation when eliciting a trauma history:

Many apparently asymptomatic patients reported a return of nightmares, intrusive thoughts, and startle reaction following the interview when the histories were first taken. For some, these symptoms lasted several months.

Although the interview process was designed to be as unintrusive as possible, the study involved a risk of unnecessarily distressing very vulnerable subjects.

There were several instances in which the fragility of the patients' defenses became apparent. In the early stages of the study, potential subjects were invited to a meeting at the clinic at which the study was explained and

informed consent forms were given. Several of the subjects became very distressed during this meeting and had to leave. The principal investigator, a psychiatrist, reported,

We learned that the clients were unable to tolerate being in a closed, small room with fellow former detainees. Some, especially the new ones, rapidly decompensated and could not continue ...

In retrospect, the reason that this experience was upsetting for these patients seemed obvious. A large group of reeducation camp survivors were called to a meeting, held behind closed doors, in which they were addressed by a Vietnamese professional and asked to sign a written statement. The meeting may have recalled for some individuals the arrest procedure or the political study sessions of the reeducation camps.

The occurrence of this incident early on in the study underscored the need for caution and sensitivity in conducting research with this population. A number of elements of the research process may be upsetting to trauma victims. Informed consent forms, drug consent forms, and other paperwork may remind subjects of being forced to sign confessions. Extensive interviewing may recall previous interrogations and arrests. Questions regarding the family are particularly sensitive for victims of political violence who have feared for their relative's safety (Yu, 1985).

Given their histories, it is not surprising that silence should seem the safest option for traumatized

refugees. Ong (1994) observed that Cambodian refugees' traumatic experiences had taught them to reveal as little information as possible:

Khmer refugees have survived war, labor camps, and flight by becoming masters in the contest between self-willed silence and forced confession... Silence and opacity become a shield of defense in the face of authority.

Thus, extensive questioning in treatment or research settings may create anxiety for the subject and yield little information for the practitioner.

The challenge of eliciting a trauma history unintrusively was addressed by Mollica in the development of the Harvard Trauma Questionnaire. After conducting a pilot study with the scale, Mollica et al. (1992) reported,

Contrary to initial concerns, (the HTQ) was well accepted by patients. This finding is consistent with the cultural acceptance by Indochinese refugees of checklist questions as a "medical test," the greater ease for highly traumatized patients in sharing their life experiences through neutral interview formats ..., and the overall clinical impression that torture survivors appreciate having their health providers acknowledge their trauma/torture events and symptoms. ✓ ✓ ✓

While the HTQ was generally well tolerated by the reeducation camp survivors in this study, the traumatic events checklist was difficult for some subjects.

Four of the 20 subjects interviewed for the study became distressed during the administration of the HTQ. These subjects reported experiencing somatic symptoms such as sweating, headache, and dizziness. In all four cases these reactions occurred during or shortly after the administration of the traumatic experiences portion of the HTQ. The interviews were halted by the clinician and completed at a later date. These findings support previous observations that being asked to consciously recall traumatic experiences may induce symptoms in some survivors.

Asking trauma victims to recall and describe their experiences is a common, albeit controversial, component in the treatment of PTSD. But what is the responsibility of the researcher who may attempt (as we have done here) to elicit a fairly comprehensive history of the subject's traumatic experiences? The patient who painfully details his or her experiences in therapy is participating in a process in which (it is hoped) every exercise is in the service of helping the patient become well. The research subject, on the other hand, submits to potentially distressing questioning in which his or her interests may be secondary to the goals of the researcher and the study.

Because those who do research in this field are typically psychiatrists and other mental health workers, treatment and research goals may overlap. The importance of involving trained personnel who are sensitive to the needs of trauma victims cannot be overemphasized in studies of

this type. Mental health workers who have cultivated a therapeutic relationship with research subjects can minimize the intrusiveness of the research process and serve as advocates for the interests of the patient. Information obtained through clinical research can be quite useful in the treatment of individual patients.

However, the involvement of clinicians in the research of vulnerable subjects also presents a potential conflict of interest. If treatment and research agendas are not clearly demarcated, the interests of the individual patient may be obscured amidst the broader goals of the study. Mental health professionals wield substantial power; their decisions with regard to individual patients may affect not only the course of treatment, but also whether patients receive the documentation and referrals necessary to access various social services. Even though mental health professionals often do regard the patient's interests as primary, the involvement of the health care provider in research is potentially coercive.

Patients may be hesitant to disappoint their providers, and may fear that refusal to participate in research will compromise the quality of their care. This is particularly relevant for the Vietnamese reeducation camp survivors involved in this study. Due to cultural dictates regarding respect and social status, refusing the request by a physician to participate in a study may not feel like an acceptable option for these patients. This is complicated

by these patients' unique histories, in which forced submission to authority and fluctuating social status were important components. In some cases, severely traumatized individuals may be incapable of making informed decisions independently. The informed consent process designed to protect human subjects is inadequate if other factors conspire (as in this case) to limit options for potential subjects.

It is clear that severely traumatized individuals are a highly vulnerable population, and that research involving trauma victims should not be undertaken cavalierly. Southeast Asian refugees are likely to perceive limited options due to cultural factors, a language barrier, past experiences of persecution, their alien status in this country, and psychological distress. Researchers conducting studies with this population have the responsibility to be sensitive to these factors and to design studies to minimize discomfort for the subjects. Clinicians and mental health workers must serve a crucial role as advocates for their patients.

X. Conclusion

Vietnamese former political detainees are a highly traumatized group and are at great risk for developing mental illness. This study examined a mental health clinic sample of Vietnamese men who had been imprisoned in

reeducation camps. All patients were found to have experienced multiple traumatic events, including starvation, brainwashing, torture, and enforced isolation. The patients were highly symptomatic, with 90% of patients having clinically significant levels of depression, anxiety, and posttraumatic stress symptoms.

The emergence of English proficiency as a significant predictor for depression, anxiety, and posttraumatic stress symptoms suggests that postmigration factors strongly influence traumatized refugees' vulnerability to psychological distress. Enhanced ability to adapt to the host society, as measured by English ability, appears to be a protective factor against the development of symptomatology for reeducation camp survivors.

Not surprisingly, levels of trauma predicted posttraumatic symptom levels in the sample. For many, the horror of the captivity experience was still very much a part of their present lives. Additional research into the effects of different types of trauma may be useful in understanding of the psychological mechanisms of posttraumatic stress disorder.

While family support did not emerge as a significant predictor of symptom levels, families played a significant role in individual patients' lives. Further development of measures of family support and isolation in traumatized refugee populations is needed.

While the impairment seen in the patients was rooted in the degree of trauma they had experienced, life circumstances had enhanced their vulnerability to chronic mental illness. The approach to treatment for the reeducation camp survivors is complicated by the severity of trauma, cultural and language barriers, and the presence of significant life stresses for these recent immigrants. Future studies of treatment efficacy in this population are desperately needed. An intensive treatment approach should involve medication, supportive psychotherapy, family education and involvement, and an emphasis towards community reintegration. With great effort by patient, family, and provider, it is hoped that victims of massive trauma can slowly begin to reconstitute their lives in their new country.

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Appendix A: Instruments

Sociodemographic Questionnaire

Client's Name: _____
ID# _____

Interviewer: _____
Interview Date: ____ _

1. (Code Sex)

Male	1
Female	2

2. What is the date of your birth?

____	____	____
mon	day	year

3. Do you consider yourself: (read all)

Vietnamese	1
Chinese-Vietnamese.	2
Mien	3
Cambodian	4
Chinese-Cambodian	5
_____ Other (specify).	6
refused	9

4. What language do you speak at home?

Vietnamese	1
Chinese	2
Mien	3
Cambodian	4
refused	9

5. Can you read Vietnamese/Cambodian?

no	1
yes	2

6. Can you write Vietnamese/ Cambodian?

no	1
yes	2

7. On what date did you enter the USA?

____	____	____
mon	day	yr

8. Please give the year you entered the refugee camps. _____
9. Please give the year you left the refugee camps. _____

(Questions 10 and 11 For Vietnamese Only):

10. Please give the year you entered the reeducation camps. _____
11. Please give the year you left the reeducation camps. _____
12. In Vietnam/Cambodia/Laos, did you live in a
 city 1
 rural setting . . . 2
 both 3
 refused 9
13. Education: In total, what is the highest grade you completed?
 No education 0
 Elementary School (K-8) 1
 Some High School (9-12) 2
 1st baccalaureate/ high school
 graduate/ GED certificate 3
 2nd baccalaureate/ technical
 school graduate 4
 Some university 5
 University graduate 6
 Post graduate/ professional school . . 7
14. How well do you speak English?
 Fluently, like an American 1
 Well (can converse but not fluent) . . 2
 Can speak simple phrases 3
 Cannot speak English 4
15. Who is your primary source of financial support?
 self 1
 sponsor . . . 2
 _____ other 3
 refused . . . 9
16. Please estimate your monthly household income:

(17-19). Occupational history:

17. current: -----

18. prior to migration: -----

(Q. 19 For Vietnamese):

19. prior to imprisonment: -----

- | | |
|---------------------|---------------------------------|
| 1) unskilled labor | 2) skilled labor |
| 3) clerical/ sales | 4) semiprofessional/ managerial |
| 5) professional | 6) housewife |
| 7) military officer | 8) military (non-officer) |
| 9) civil servant | 10) student |
| 11) unemployed | 12) disabled |
| 13) retired | 14) self-employed |
| 15) other: _____ | |

20. Are you: (read all)

- | | |
|--|---|
| married | 1 |
| separated | 2 |
| live with partner (skip to Q. 23) | 3 |
| divorced (skip to Q. 23) | 4 |
| widowed (skip to Q. 23) | 5 |
| never married . . (skip to Q. 23) | 6 |
| refused | 9 |

21. Does your spouse reside in the US?

- | | |
|---------------------|---|
| no (skip to Q.23) . | 1 |
| yes | 2 |
| refused | 9 |

22. When did your spouse arrive in the US?

year

23. Was your sponsor in the U.S.

- | | |
|---------------------------|---|
| a family member | 1 |
| a friend. | 2 |
| someone else | 3 |
| refused | 9 |

24. How many other family members were in the US when you arrived?

25. How many other friends were in the US when you arrived?

(26-34.) Who accompanied you to the US?:
(Specify Numbers)

26. came alone (code '1')	#	_____
27. spouse	#	-----
28. children	#	-----
29. mother/(in-law)	#	-----
30. father/(in-law)	#	-----
31. grandparents	#	-----
32. sister(s)	#	-----
33. brother(s)	#	-----
34. friends	#	-----

35. Did you leave family members behind in Vietnam/ Cambodia/Laos?

no (skip to Q. 42-49) . 1
yes 2

(36-41). Who were the family members left behind?

36. mother	#	-----
37. father	#	-----
38. brother(s)	#	-----
39. sister(s)	#	-----
40. children	#	-----
41. grandparents	#	-----

(42-49). Who lives in your house?

42. lives alone (code '1')	#	-----
43. spouse	#	-----
44. friends	#	-----
45. parent(s)	#	-----
46. siblings	#	-----
47. children	#	-----
48. extended family	#	-----
49. other	#	-----

- (50-56). Do you take part in
50. a church group?
- no 1
yes 2
51. a social or recreational group?
- no 1
yes 2
52. a group at work?
- no 1
yes 2
53. a neighborhood group?
- no 1
yes 2
54. a group involved in refugee resettlement or advocacy?
- no 1
yes 2
55. a senior citizens group?
- no 1
yes 2
56. any other groups or organizations?
- no 1
yes 2
57. What is your religion?
- None 0
Buddhist 1
Christian 2
Moslem 3
Confucian/ ancestor worship 4
other 5
refused 9
58. How important is religion in your life right now?
- not important 1
somewhat important 2
very important 3
not sure 4
refused 9

59. Disagreements are very common between people who live together. Do you consider there to be many arguments at home?

no 1
yes 2
refused 9

60. When arguments do take place at home, are these arguments mainly between (read all)

you and your spouse 1
you and your children 2
spouse and children 3
you and other relatives 4
you and your friends 5
other parties, not involving you . . . 6
refused 9

Please indicate whether you agree or disagree with the following statements:
(read all options)

61. (If subjects' children are living in USA): My children respect me as much now as they did in Vietnam/Cambodia/Laos

always 1
frequently 2
sometimes 3
rarely 4
never 5
refused 9

62. I enjoy spending time with my family

always 1
frequently 2
sometimes 3
rarely 4
never 5
refused 9

63. I feel that my family understands me

always 1
frequently 2
sometimes 3
rarely 4
never 5
refused 9

64. I can rely on my family to support me

always 1
frequently 2
sometimes. 3
rarely 4
never 5
refused 9

65. Members of my family rely on me

always 1
frequently 2
sometimes. 3
rarely 4
never 5
refused 9

66. Did you experience the loss of a loved one before the age of 10?

no 1
yes 2
refused 9

Harvard Trauma Questionnaire

Vietnamese Version

Developed by Indochinese Psychiatric Clinic Brighton Marine Public Health Center
Department of Psychiatry, St. Elizabeth's Hospital

Please indicate whether you have witnessed, experienced, or heard any of the following events.

Xin cho biết nếu quý vị có chứng kiến, kinh nghiệm, hoặc nghe tới những sự việc sau đây

W: Witnessed
: Chứng kiến

E: Experienced
: Kinh nghiệm

H: Heard
: nghe tới

N: No
: Không

	W	E	H	N
1- Lack of food or water Thiếu đồ ăn hoặc nước uống				
2- Ill health without access to medical care Đau bệnh mà không có phòng tiện y khoa				
3- Lack of shelter Không có nhà ở				
4- Imprisonment Bị bắt giam				
5- Serious injury Bị thương nặng				
6- Torture Bị tra tấn				
7- Brainwashing Bị tẩy não				
8- Rape or sexual abuse Bị hiếp dâm hoặc bị bạo hành dâm dăng				
9- Enforced isolation from others Bị cô lập				
10- Being close to death Bị nguy hiểm gần kề sự chết				

	W	E	H	N
11- Forced separation from family members Bị ép buộc phải tách rời khỏi gia đình				
12- Murder of family or friend Người thân thích hay ruột thịt bị giết hại				
13- Unatural death of family or friend Người thân thích hay ruột thịt bị chết bất dật kỳ tử*				
14- Murder of stranger or strangers Người không quen thuộc bị giết				
15- Lost or kidnapped Bị lạc hay bị bắt cóc				
16- Combat situation Tình thế iữa đạn				
17- Any other situation that was very frightening or you felt your life was in danger (please specify) Hoàng cảnh khiếp đảm nào khác đem tới sự đe dọa cho tính mạng.				

Please indicate the most hurtful or terrifying events you have experienced, if any. (Please specify when and where these events occurred).

Xin ghi ra những biến cố nào đau đớn hoặc ghê sợ nhất quý vị đã trải qua (xin cho biết kỹ lúc nào và ở đâu những sự việc này đã xảy ra).

Please indicate the most hurtful or terrifying events you have experienced, if any, in this country.

Xin ghi ra những biến cố nào đau đớn hoặc ghê sợ nhất quý vị đã trải qua, nếu có, tại nước cử ngụ

The following are symptom that people sometimes have after experiencing hurtful or terrifying events in their lives. Please read each one carefully and decide how much the symptoms bothered you in the past week.

Sau đây là những triệu chứng có người sẽ bị sau khi trải qua những biến cố đau đớn hoặc khiếp đảm. Xin đọc kỹ từng triệu chứng và nghĩ xem quý vị đã bị những triệu chứng nào và đến mức độ nào trong tuần vừa qua.

	1 Not at all Không hề có	2 A little Có chút ít	3 Quite a bit Có khá nhiều	4 Extremely Có rất nhiều
1- Recurrent thoughts or memories of the most hurtful or terrifying events Bi ám ảnh bởi những ý tưởng hoặc kỷ niệm về các sự việc đau đớn hay khiếp đảm đã trải qua				
2- Feeling as though the event is happening again Cảm tưởng như chuyện ấy đang tái diễn lần nữa				
3- Recurrent nightmares Thường bị ác mộng				

	¹ Not at all Không hề có	² A little Có Chút ít	³ Quite a bit Có khá nhiều	⁴ Extremely Có rất nhiều
4- Feeling detached or withdrawn from people Thấy như mình cách biệt hay không muốn giao thiệp với người khác				
5- Unable to feel emotions Không có thể xúc động được				
6- Feeling jumpy, easily startled Tâm trí căng thẳng, dễ bị giật mình				
7- Difficult concentrating Khó tập trung tư tưởng				
8- Trouble sleeping Khó ngủ hay ngủ không yên				
9- Feeling on guard Cảm giác đề phòng				
10- Feeling irritable or having outburst of anger Cảm thấy khó chịu hoặc có những cơn giận dữ				
11- Avoiding activities that remind you of the most traumatic or hurtful events Tránh các sinh hoạt nhắc lại những sự việc đã gây ra đau đớn hoặc xúc động				
12- Inability to remember parts of the most traumatic or hurtful events Không thể nhớ lại chi tiết các việc đã đau đớn hoặc xúc động				

	1 Not at all Không hề có	2 A little Có chút ít	3 Quite a bit Có khá nhiều	4 Extremely Có rất nhiều
13- Blaming yourself for things that have happened Tù trách mình về những việc đã xảy ra				
14- Feeling guilty for having survived Cảm thấy có tội lỗi vì đã sống sót				
15- Feeling ashamed of the hurtful or traumatic events that have happened to you Cảm thấy xấu hổ vì những sự việc đau đớn hoặc xúc động đó đã xảy ra cho mình				
16- Spending time thinking about why these events happened to you Suy nghĩ mãi tại sao những sự kiện ấy đã xảy ra cho mình				
17- Feeling that people do not understand what happened to you Cảm thấy người khác không hiểu việc gì đã xảy ra cho mình				
18- Difficulty performing work or daily tasks Khó làm công việc hằng ngày ở sở hay ở nhà				

	1 Not at all Không hề có	2 A little Có chút ít	3 Quite a bit Có khá nhiều	4 Extremely Có rất nhiều
19- Avoiding thoughts or feelings associated with the traumatic or hurtful events Tránh những ý tưởng hoặc cảm giác làm mình nhớ tới những biến cố đó				
20- Less interest in daily activities Không thiết tha mấy tới cuộc sống hằng ngày				
21- Hopelessness Cảm giác tuyệt vọng				
22- Feeling as if you don't have a future Cảm thấy như mình không có tương lai				
23- Sudden emotional or physical reaction when reminded of the most hurtful or traumatic Đột nhiên xúc động mạnh tâm lý hoặc có thể khi nghe nhắc đến các biến cố đau thương				
24- Feeling as if you are going crazy Có cảm tưởng như mình sắp điên				
25- Feeling that you are the only one who has suffered these events Cảm thấy rằng chỉ có mình là người duy nhất đã qua bấy nhiêu đau khổ				

	¹ Not at all Không hề có	² A little Có chút ít	³ Quite a bit Có khá nhiều	⁴ Extremely Có rất nhiều
26- Feeling others are hostile toward you Cảm thấy kẻ khác có ác ý với mình				
27- Feeling that you have no one to rely on Cảm thấy không có ai dễ dàng nhờ được				
28- Finding out or being told by other people that you have done something you cannot remember Được biết hoặc nghe người khác nói lại rằng mình đã có những hành động mà nay mình không nhớ gì hết				
29- Feeling as if you are split into two people, and one of you is watching what the other is doing Tưởng chừng như mình phân thành ra hai người và một trong hai người đó ngắm coi người kia làm gì				
30- Feeling that someone you trusted betrayed you Cảm thấy người mình đã tin tưởng phản bội mình				

HOPKINS SYMPTOM CHECKLIST 25



VIETNAMESE
VERSION

NAME _____ DATE _____ CLINICIAN _____

DATE OF BIRTH _____ SEX _____ MARITAL STATUS _____

ARRIVAL DATE _____ PSYCHIATRIC DIAGNOSIS _____

Instructions

Listed below are some symptoms or problems that people sometimes have. Please read each one carefully and decide how much the symptoms bothered or distressed you in the last week, including today. Place a check in the appropriate column.

Sau đây là những triệu chứng hoặc vấn đề mà con người thỉnh thoảng cảm thấy, xin vui lòng đọc cẩn thận và coi những triệu chứng đó đã gây khó chịu cho bạn đến mức độ nào trong tuần vừa qua và hôm nay. Xin ghi vào những cột thích ứng.

PART I ANXIETY SYMPTOMS		1	2	3	4
		Not at all	A little	Quite a bit	Extremely
		Không hề có	Có chút ít	Bị khá nhiều	Bị rất nhiều
1.	Suddenly scared for no reason <i>Bỗng dưng lo sợ mà không lý do</i>				
2.	Feeling fearful <i>Cảm giác sợ hãi</i>				
3.	Faintness, dizziness, or weakness <i>Gần ngất xỉu, ngất xỉu, chóng mặt, suy yếu</i>				
4.	Nervousness or shakiness inside <i>Run sợ hoặc hồi hộp trong lòng</i>				
5.	Heart pounding or racing <i>Tim đập mạnh, hoặc nhanh</i>				
6.	Trembling <i>Trem run các bắp thịt bị giật, run (run rẩy)</i>				
7.	Feeling tense or keyed up <i>Cảm giác căng thẳng</i>				
8.	Headaches <i>Bị nhức đầu</i>				
9.	Spells of terror or panic <i>Bị những cơn hoảng hốt, lo sợ ngất xỉu ra</i>				
10.	Feeling restless, can't sit still <i>Cảm giác bồn chồn, lo lắng khó thể ngồi yên một nơi</i>				

PART II DEPRESSION SYMPTOMS		2	3	4	
		Not at all	A little	Quite a bit	Extremely
		Không hề có	Có chút ít	Bị khá nhiều	Bị rất nhiều
11.	Feeling low in energy, slowed down <i>Cảm giác yếu ớt, uể oải</i>				
12.	Blaming yourself for things <i>Tự trách mình về mọi việc xảy ra</i>				
13.	Crying easily <i>Bất khóc dễ dàng</i>				
14.	Loss of sexual interest or pleasure <i>Mất hứng thú trong việc sinh lý</i>				
15.	Poor appetite <i>Ăn không biết ngon</i>				
16.	Difficulty falling asleep, staying asleep <i>Khó đi giấc ngủ, khó yên giấc ngủ</i>				
17.	Feeling hopeless about the future <i>Cảm giác tuyệt vọng về tương lai</i>				
18.	Feeling blue <i>Cảm giác âm-u, buồn rầu</i>				
19.	Feeling lonely <i>Cảm giác cô đơn</i>				
20.	Thoughts of ending your life <i>Có ý tưởng muốn kết liễu cuộc đời mình</i>				
21.	Feeling of being trapped or caught <i>Cảm giác mắc kẹt hoặc không lối thoát</i>				
22.	Worrying too much about things <i>Lo lắng thái quá về mọi việc</i>				
23.	Feeling no interest in things <i>Cảm giác không ham thích gì nữa, bất cứ việc gì</i>				
24.	Feeling everything is an effort <i>Cảm giác, việc gì cũng khó khăn đòi nhiều cố gắng</i>				
25.	Feelings of worthlessness <i>Cảm giác mình là kẻ bất tài, vô dụng</i>				

SCORING

Responses are summed and divided by the number of answered items, to generate three scores:

$$\text{ANXIETY} = \frac{\text{ITEMS 1-10}}{10} \rightarrow \boxed{}$$

$$\text{DEPRESSION} = \frac{\text{ITEMS 11-25}}{15} \rightarrow \boxed{}$$

$$\text{TOTAL} = \frac{\text{ITEMS 1-25}}{25} \rightarrow \boxed{}$$

Individuals with scores on anxiety and/or depression and/or total > 1.75 are considered symptomatic.
See Manual for additional information.

developed by
INDOCHINESE PSYCHIATRY CLINIC
BRIGHTON MARINE PUBLIC HEALTH CENTER
DEPARTMENT OF PSYCHIATRY
ST. ELIZABETH'S HOSPITAL
AND
THE HARVARD PROGRAM IN PSYCHIATRIC EPIDEMIOLOGY

Funded by the U.S. Office of Refugee Resettlement

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Appendix B: Consent Form

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO CONSENT TO PARTICIPATE IN A RESEARCH STUDY

A. Background and Purpose:

Doctor Nang Du and his colleagues are doing a study to evaluate the prevalence, the severity of Post Trauma Stress Disorder (PTSD) symptoms and the impact of social and family supports on the development of these symptoms among the Vietnamese, Cambodian and Mien psychiatric patients at the Asian Community Mental health Clinic.

B. Procedures:

If I agree to participate in this study

1- I will answer four short questionnaires about how I have been feeling.

2- I will be interviewed by two different clinicians on two different days in a periods of one week.

C. Risks/Discomforts:

If I should become uncomfortable during any part of the interviews, I can stop at any time.

D. Benefits:

There will be no direct benefit to me as a result of this study.

E. Confidentiality:

The investigators have taken a number of steps to ensure the results of the questionnaires remain as confidential as possible. The questionnaires will be kept in a locked filing cabinet that only the research team will have access to. After the study is completed all the questionnaires will be destroyed.

F. Alternatives:

I am free to choose not to participate in this study.

G. Questions:

If I have any questions about this study, I should first talk to the doctors doing the study. They can be reach at (415) 206-5065. If I do not wish to do this, I may contact the Committee on Human Research which is concerned with the protection of volunteers in research projects. This committee can be reached between the hours of 8:00 AM and 5:00 PM, Monday through Friday, by calling 476-1814, or by writing to committee at suite 11, Laurel Height Campus, Box 0616, University of California, San Francisco, California 94143.

H. Consent

Participation in this study is voluntary. I am free to decline to be in the study or to withdraw from it at any point. my decision about whether or not to be in the study will have no influence on my present or future status as a patient at the Asian Community Mental Health Clinic. I have been given a copy of this consent to keep.

Signature _____ Date _____

Person obtaining consent _____