SOUTHEAST ASIAN REFUGEES IN IOWA

CULTURAL BACKGROUND, NEEDS, AND SERVICES

Edward R. Canda, Ph.D.

Coordinator, Refugee Training and Family Service Project
Assistant Professor
School of Social Work
The University of Iowa
Iowa City, IA 52242

Published 1988 by the Refugee Training and Family Service Project, The University of Iowa School of Social Work. This project was contracted with the Iowa Department of Human Services Bureau of Refugee Programs, under a Federal Office of Refugee Resettlement discretionary grant, October 1, 1987 to September 30, 1988.

Acknowledgements

I wish to thank the Iowa Department of Human Services Bureau of Refugee Programs for the support which made this manual possible. In particular, I am grateful to Marvin Weidner, Bureau Chief, and Wayne Johnson, Deputy Bureau Chief, of the Bureau of Refugee Programs, for their help and encouragement. Special thanks are due also to the other staff of the Refugee Training and Family Service Project who gave much insight and assistance for the preparation of this manual:

Patricia Kelley, Ph.D., Clinical Training Consultant
Monit Kam-Fong Cheung, Ph.D., Educational Consultant
CamTu Nguyen, MSW student, Graduate Research Assistant
Thitiya Phaobtong, MSW student, Bilingual Consultant
Sara Mehlin, B.A. student, Clerical Assistant
Huy Nguyen, B.A. student, Clerical Assistant

Finally, I wish to express sincere gratitude to all the Southeast Asian-American people. They have been a wonderful source of enjoyment and inspiration to myself personally and they are a rich resource of creativity and cultural diversity for this country.

Table of Contents

List of Figures

PREFACE

PURPOSE OF THE MANUAL

Since 1975, the United States has experienced a large influx of refugees from Southeast Asia. In 1975, the Attorney General authorized the admission of refugees who were fleeing the turmoil and persecution of Southeast Asian countries in the aftermath of American withdrawal from the war in Vietnam.[1] As of March 31, 1988, 1,158,456 refugees were admitted since 1975. 859,515 were from Asia. Approximately 9,200 refugees live in Iowa.[2] (See Figure 1.) Southeast Asian-Americans now comprise a variety of immigration statuses: refugees, orderly-departure immigrants, permanent residents and citizens.

This manual is intended as a convenient reference for helping professionals, paraprofessionals, and volunteers in Iowa who work with Southeast Asian refugees. The manual will be useful for helpers in settings of education, health, mental health, religious organizations, and social services. It provides four major benefits: (1) a general orientation to the cultural characteristics and service needs of Southeast Asian-Americans; (2) suggestions about strategies for delivering culturally relevant services; (3) listings of specific resources in Iowa for enhancing service to Southeast Asian refugees; (4) references cited for those who wish to extend their knowledge of Southeast Asian refugee issues and service strategies. It is hoped that this manual will enable the helper to increase the effectiveness of service to Southeast Asian refugees and also to make rapid and convenient referrals to local specialists in refugee affairs.

Due to the contrasts between Southeast Asian cultures and the predominant Euro-American culture that controls the health and mental health systems, there is often a problem of incongruity between refugee needs and services being offered as well as between the culturally variant health and mental health concepts underlying these services. This cultural incongruity and the resultant underutilization of mental health services by Asians has been documented in the professional helping literature.[3] Helping professionals have called for two general goals for reform of the service delivery system for Asians: establishment of congruence between Asian-American clients' needs and the health and mental health services, and concommitantly, abandonment of stereotypes that blur the tremendous diversity of personalities, cultures, and needs represented by the varied Asian-American populations.[4] In this regard, it is crucial to tailor services to the unique needs of each of the distinct Southeast Asian refugee ethnic groups, the most numerous ones nationwide being Vietnamese, Khmer (Cambodian), Laotian, Chinese-Vietnamese, and Hmong.

Southeast Asian refugees face the prevalent problem of prejudice confronting racial and ethnic minority groups in the United States. But their difficulties are compounded by the stresses resulting from trauma prior to resettlement, as well as culture shock after their arrival. Considering the responsibilities of helping professionals to eschew all forms of discrimination and to keep the needs of the client primary, it is logical and ethical to develop concepts and practices of furthering the well-being of refugees that match their unique characteristics and situations.[5] In effect, this results in a pluralism of mental health concepts and techniques that is appropriate for the ethnic pluralism of this nation.[6] This pluralistic approach not only benefits the clients; it also benefits American society as a whole, which can gain from acceptance of diversity as a national resource that stimulates creativity and enjoyment.[7]

Figure 1

Distribution of Refugees in Iowa*
(Estimates for March 1988)

By Ethnic Groups	Numbers
Vietnamese	2800
Tai Dam	2600
Lao	2300
Khmer (Cambodian)	900
Hmong	300
Eastern Europe/Middle East	300
TOTAL	9200

By County (All Refugees Combined)	
Polk (near Des Moines)	4250
Woodburg (near Sioux City)	1360
Linn (near Cedar Rapids)	397
Johnson (near Iowa City)	251
Scott (near Davenport)**	250
Muscatine (near West Liberty)	150
Des Moines (near Burlington)	88
Dispersed Throughout Other 85 Counties	2454
TOTAL	9200

*Estimates provided by the Bureau of Refugee Programs, Iowa Department of Human Services

**Total Quad Cities Area = 600 refugees

CHAPTER I

CULTURAL BACKGROUND

It is impossible to describe adequately the richness and diversity of Southeast Asian cultures in a brief discussion such as this. The following description is only an introductory overview. In order to provide a sense of the cultural diversity, Hmong, Khmer, Lao, Tai Dam, and Vietnamese cultures will be discussed. Please note that the cultural generalizations described in this manual are not intended to be used as stereotypes. They are intended as broad characterizations that can provide cultural orientation and starting points for the process of becoming acquainted with each client as an individual.

Hmong

The Hmong probably migrated into Southeast Asia from China in the 18th and 19th centuries. They are a distinct ethnic minority scattered in groups throughout the mountains of China, Thailand, Laos, and Vietnam. Most Hmong refugees in the United States came from Laos.[8]

Traditionally, the Hmong combined slash and burn agriculture, livestock breeding, and hunting. The society is organized according to patrilineal extended families grouped into twelve clans. The eldest household head in each clan is regarded as the highest authority.[9]

The traditional religion of the Hmong is animism. Religious specialists of healing, both male and female shamans, assist the people in rituals designed to maintain harmony between people and the spirit powers, including ancestor spirits and nature spirits. Many Hmong refugees have converted to Christianity. Yet Christian and Shamanistic practices may be combined.[10]

Although the Hmong traditionally disdained military activity, the United States successfully enlisted their support for the war. During 15 years of combat until 1975, Hmong casualities included one tenth of their entire population in Laos (approximately 30,000/300,000). Since that time, the Hmong have been singled out for systematic genocide by the Pathet-Lao and Communist Vietnamese forces.[11]

Like other Southeast Asians, Hmong values emphasize respect for elders and persons in authority, family and clan loyalty, self-sacrifice, modesty, and harmony with nature. However, the complex animistic beliefs are distinctive, including a concept that each person has multiple souls that can be afflicted or lost, thus causing illness. Also, the patrilineal clan system of kinship is of great importance to social organization. Another important distinction is that Hmong culture is nonliterate; that

is transmission of culture occurs through oral communication rather than through writing. According to a Hmong caseworker, a writing system was invented in recent history, but less than half of the Hmong are familiar with it. Many Hmong have learned to speak Lao as a second language.

One of the most puzzling aspects of the Hmong refugees' experience is the sudden death syndrome. The Hmong have the highest incidence of this affliction among refugees in the United States.[12] Sudden death occurs primarily among male adults while asleep. Victims exhibit symptoms of choking and heart failure despite a history of good health. Some who have survived or witnessed attacks described the victim as undergoing panic or suffication by a spirit. There is no clear medical explanation for the condition. Some investigators suspect that sudden death syndrome may be related to post-traumatic stress and culture shock. Some traditional healers have suggested that prevention should emphasize traditional religious and cultural supports.

Khmer (Cambodian)

The ancient Khmer-Mon agricultural society emerged from a commingling of Indonesian and Melanesian-Australoid peoples perhaps as early as 2,000 B.C.[13] Since the first century A.D., Indian Hinduism (Brahaminism) and Buddhism had a significant impact on Khmer culture. At the end of the 12th century A.D., Mahayana Buddhism was established as the state religion; but since the 14th century, Theravada Buddhism has prevailed.[14] From 1864-1953, Cambodia was held as a French protectorate. As a result, Khmer culture reflects a mixture of Indian, French, and indigenous animistic traditions.

From 1953-1970, Prince Sihanouk attempted to conduct the affairs of the independent Cambodian state according to a nationalistic form of "Buddhist Socialism." A period of economic and political turmoil in the late 1960's led to the prince's deposition by Lon Nol, who governed from 1970-1975, also according to Buddhist nationalism. The pervasive civil wars and international military interventions culminated in victory by the communist Khmer Rouge in 1975. They actively persecuted Buddhism. During Khmer Rouge rule, hundreds of thousands of Cambodian people were killed under the infamous Pol Pot regime. Under the pretext of saving the Khmer people from mass destruction, Vietnam invaded Cambodia and established an occupation government in 1979. Struggle continues between various forces in Cambodia, causing loss of life and refugee flight. Vietnam is presently considering a withdrawal of troops.

Modern Cambodia (People's Republic of Kampuchea) occupies an area of 66,000 square miles, bordered on the east by Vietnam, on the north by Laos, and on the northwest by Thailand.[15] The majority of the population lives in rural villages.

Cambodians uphold a virtue of moderation in all activities as required by the Theravada Buddhist principle of "the middle

way." The pursuit of pleasure and the expression of emotions should not take on extreme forms. Cambodians tend to be very concerned about the formal expression of politeness and the maintenance of social mores. Mores emphasize group harmony and family well-being rather than individual autonomy.[16] Many Cambodians in the United States are faced with an intense form of the psychosocial stresses, especially Post-Traumatic Stress Disorder, described in Chapters 2 and 3, because of the severity and pervasiveness of the genocide carried out under the Pol Pot regime and the Vietnamese occupation.

In their efforts to preserve their culture, many Cambodian refugees continue to utilize traditional healing methods, which combine Buddhist, Shamanistic, and Ayurvedic treatments. These include Buddhist prayer and meditation, spirit exorcism, "coining" massage, herbal medicines, and moxibustion (medicinal burning).[17] In fact, health and mental health professionals working with Khmer in refugee camps have found that an organized effort to combine the advantages of traditional healing and Western helping has provided benefits beyond what either system could accomplish alone.[18] This suggests that similar efforts should be attempted in the United States. Such a collaborative cross-cultural approach would not only enhance professional helping, it would also support a sense of dignity and respect among Cambodian-Americans for their own heritage.

Lao

The population of Laos includes ethnic Lao and dozens of other ethnic groups, including the Hmong and Tai Dam.[19] The ethnic Lao are closely related to the Thai of Northern Thailand. Laos (Lao People's Democratic Republic) occupies an area of 91,429 square miles with approximately 3.8 million people. It is bordered on the north by China and Vietnam, on the south by Cambodia, on the west by Thailand, and on the east by Vietnam.

The Royal Kingdom of Laos was established in the fourteenth century.[20] From the 17th through the 19th centuries, Laos was fragmented by internal political rivalries as well as incursions by Thailand, Vietnam, and China. France took control of Laos from 1893-1904, establishing a centralized state. In 1954, Laos won liberation from France. War, internal political rivalries and international pressures resulted in the collapse of the Royal Lao Government in 1975. The Democratic Socialist Republic of Laos was established.

The traditional model of society was founded upon a coordination between the authorities of Buddhism, the state, and the king. Ethnic Lao continue to be influenced by Theravada Buddhism. Many Lao men, and some women, make retreats at Buddhist temples in order to cultivate enlightenment, virtue and family honor. Many homes include places for Buddhist prayer and meditation. Buddhist ceremonies are performed to honor religious events, such as Buddha's birthday, celebrate important life

transitions, such as marriage, and aid in crisis intervention, such as healing of sickness.[21] Orthodox Buddhism is combined with animistic beliefs in practice. For example, a survey of traditional folk explanations of mental illness revealed the following concepts: mischievious or retributional attack by ancestor spirits, other ghosts, and nature spirits; magical curse; physical maladies; social conflict and stress; and mental frailty.[22]

The Lao extended family often includes both natal family and in-laws.[23] Parents often prefer to live with their married youngest daughter. This may result in an overlap of authority between the son-in-law and father-in-law. As in Southeast Asian cultures generally, women are expected to work primarily within the home. Men are expected to support the family by work outside the home.

Two virtues illustrate common Lao traits. Kengchai means being deferent and respectful toward others, particularly in regard to honoring social status. Piap refers to upholding family honor and pride through conformance of individual behavior to family needs and expectations.[24]

In many areas of the United States with large Lao refugee populations, the Wat (Buddhist Temple) continues to provide an important support. Lao people are helped by monks and lay leaders in Buddhist Associations through material assistance, cultural and artistic education, religious ceremonies, and recreational gatherings. Therefore, it is critical to involve the Lao Buddhist temples in the total care delivery system for refugees.

Tai Dam (or Tai)

Very little has been written about the Tai Dam people. Yet it is particularly important to become familiar with them in Iowa, because more than 95% of all Tai Dam refugees in the United States have been resettled here.[25] Most of these live in the Des Moines area. This unique situation results from the willingness of former governor Robert Ray to sponsor their resettlement here as a group.[26] Tai Dam means "black Tai" referring to the color of traditional womens' dress. Actually, a Tai Dam caseworker said that he prefers to be called just "Tai," since various subgroups of Tai people wore different dress colors and these no longer serve as important distinctions in the United States. The Tai are distantly related to the Thai of Thailand.

The Tai people originate from northern Vietnam, in an area that was an autonomous state of French Indochina from 1947-1959.[27] They lived in upland valleys, cultivating rice. From 1950-1954, the Tai assisted the French military against Vietnamese nationalists. After the defeat of the French, many Tai fled to Laos, where they lived for twenty years. After the victory of the Pathet-Lao communists in 1975, many Tai fled to Thailand from where they were resettled primarily in France and

Iowa. Since the Tai have long shared the travails of an ethnic minority group in flight from country to country, and now are concentrated in a relatively small local region, the Tai community is closely knit together by kinship and friendship.

Tai traditional religion is animistic, emphasizing family based ceremonies to honor ancestors and healing by professional shamans. Traditional healing addresses both naturalistic illnesses (e.g. herbal medicines) and supernaturally-caused illnesses (e.g. spirit possession, loss of one of a person's 32 souls, attack by spirits, or magical curse).[28] There are also Ayurvedic and Chinese medical influences, due to contact with other Southeast Asian groups. In Laos and Vietnam, some Tai have been exposed to Buddhism through Buddhist relief efforts and general cross-cultural interaction.[29] Likewise, French influence has brought knowledge of Western medicine.

In the United States, many Tai have converted to Christianity, often through their association with Christian resettlement sponsors. Yet in both the areas of religion and medicine, some Tai, particularly the elderly, combine traditional and Western practices.

Vietnamese

The Vietnamese people were subject to Chinese rule from 100 B.C. to 938 A.D. As a result, Vietnamese culture has been shaped by strong Chinese influences.[30] Independent Vietnam engaged in its own expansionist movement into Khmer territory. From the 1500's until the 1800's, Portuguese, Dutch, and other traders and missionaries made incursions into Vietnam. In 1858, the French colonized Vietnam along with the rest of "French Indochina." Nationalist resistance groups were united under Ho Chi Minh by 1930. With the German defeat of the French in 1940, Indochina came under the control of the Japanese. After the Japanese were defeated, France reasserted control. Ho Chi Minh's forces continued to struggle against the colonizers until France surrendered in 1954. Subsequently, North Vietnam, backed by China and the Soviet Union, fought with South Vietnam, supported by the United States and other noncommunist countries. The country was officially unified in 1976, after the defeat of the American backed government in South Vietnam. Vietnam, now includes approximately 130,000 square miles and 62 million people. The large majority of the population is Vietnamese. However, there are also ethnic minorities such as the Montagnards (mountain tribes), ethnic Chinese, and Khmer.[31] Vietnam is boardered on the north by China, on the south and east by the South China Sea, and on the west by Laos and Cambodia.

The traditional religions of Vietnam reflect a combination of Chinese, Southeast Asian, and Western influence. Animism is most common among the Montagnards and is mixed with other traditions, especially among rural Vietnamese. Taoism, Confucianism, and Mahayana Buddhism derive from Chinese

influence. Theravada Buddhism is less prevalent than Mahayana. Cao Dai is a syncretistic religion established in 1919 which converges insights from Catholicism, Buddhism, Confucianism, and Taoism.[32] Catholicism is the largest established and most widespread Christian denomination.

In 1975, after the fall of Saigon, thousands of Vietnamese refugees fled the country. These earliest arrivals in the United States tended to be from urban, upper class, Westernized segments of the society. The later so-called "boat-people" have been much more diverse in demographic composition, including more rural, and less Westernized Vietnamese and ethnic Chinese.

A common Vietnamese trait is tanh can cu which is a combination of thrift, industriousness, patience, determination, and endurance. This trait is seen as a source of strength and resiliency in Vietnamese refugees.[33] Vietnamese also tend to have a high respect for scholarship, according to the Confucian ideal of the sage. Vietnamese emphasize a quality of "heart" over "thought," which means that feelings and personal relatedness are often given priority. This also relates to the Confucian virtues of propriety and the Taoist virtue of harmony with nature. Additional details of Vietnamese culture will be described in Chapter Two.

Vietnamese traditional healing includes a Chinese originated system of herbal treatments and acupuncture, shamanistic treatments such as exorcism, and Buddhist treatments such as meditation and blessings by prayer.[34] Traditional Vietnamese often seek help for minor health problems through extended family support (including folk healing) and professional healers of traditional systems. Vietnamese who are more Westernized, especially from urban and upper class backgrounds, will tend to seek Western style treatments from the outset. Most people will seek Western style treatment for severe acute problems in the hope of finding a rapid cure. The various approaches to healing are often mixed, depending upon the patient's understanding of the cause of the problem. For example, even if a physical symptom is relieved by Western medicine, a traditional Vietnamese person may seek further treatment for the underlying spiritual cause (e.g. disharmony with ancestors) or for a long term underlying imbalance of yin and yang (am and duong, Vietnamese) in the body.

Common Cultural Characteristics

As the preceding discussion has shown, there are many cultural variations among Southeast Asian refugees. Some groups have been closely associated as allies or enemies, and this historical background may influence current inter-ethnic relations among refugees. In addition, differences within the same ethnic group ofter relate to gender, class, education, religion, rural or urban background, occupation, length of stay in the United States, and age. In fact, every person needs to be

understood as a distinct individual. Yet, it is useful for helpers to be aware of broad cultural similarities among Southeast Asian refugees, since these can sensitize the helper to the cultural nuances of appropriate care. These commonalities derive from the widespread influence of Indian and Chinese world views, as well as from thousands of years of interaction among Southeast Asians. Some of these commonalities are outlined below.[35]

Figure 2

Common Southeast Asian Cultural Characteristics

1. Personal identity is intimately linked with group membership in extended family, clan, and ethnic group.
2. Personal well-being is a reflection of the degree of harmony between oneself, one's society, nature, and the cosmos as a whole.
3. Group loyalty is esteemed above individualism.
4. Kin elders and authority figures are to be treated with deference and respect.
5. Social relations are usually organized according to complementary hierarchical (often patriarchal) statuses and roles.
6. Direct experience and feelings are at least as important as rational logical thought.
7. Contrasting beliefs and behaviors can be combined in order to achieve complementary and harmonious relationships.
8. Maintaining proper social etiquette and personal dignity is extremely important.
9. Strong emotions are reserved for communicating with close trusted personal relations and may be indirectly expressed.
10. Nonverbal cues may signify a contradiction of verbal statement; both nonverbal and verbal cues must be understood for the message to be received accurately.
11. Scheduling is subordinate to context and relationship, so time-keeping is very flexible.
12. Health is understood to be affected by spiritual and social relational factors as well as physical and psychological factors.

CHAPTER II

SERVICE NEEDS

Health and Mental Health Problems

This chapter provides a brief overview of common problems and recommendations for helping refugees that have been identified in professional literature. These are summarized in Figure 3. Need assessments have been done on federal, state, and local levels. These have focused variously on medical, psychological, and sociological dimensions of refugee adjustment. Research methodologies include impressionistic key informant consultation, case studies, demographic and epidemiological analyses, and participant observation of service providing agencies. The author's intent is to present a convenient summary of literature for helpers who may not have time to conduct a thorough literature review themselves. The references cited can be examined for further information.

The types of problems presented here refer to the distinctive stresses that Southeast Asian refugees typically experience. These are superimposed upon the expectable tasks of development throughout the life cycle that all people face. The problems and symptoms presented are broad generalizations, however; their presence or severity varies greatly for particular individuals. Indeed, most helping professionals have been impressed by the strength, courage, and resiliency of refugees. Therefore, "problems" should be considered in positive terms as challenges for growth and creativity, rather than liabilities. The primary concern must be the unique situation of each person. Yet these generalizations about needs and services can be helpful guides for understanding and assisting the refugees. It is also important to emphasize that the problems which are distinguished and separated for the sake of conceptual clarity are actually interactive aspects of the refugees' whole situation. Biological, psychological, social, spiritual, and physical environmental conditions together compose the life situation of the whole person.

Problem types can be classified under four major categories: those related to cross-cultural transition and acculturation stress; those related to the enduring stress of traumatic experiences and the gradual resolution of traumatic feelings; those related to physical diseases endemic to Southeast Asia that continue to afflict the refugee; and those related to psychiatric disorders pre-existing transition to the United States. Although there is no reliable comparison of the numerical incidence of these problem categories, the significance of the first two categories is most emphasized in the literature. Pre-existing diseases and psychiatric disorders are important considerations, but they have been less significant problems than many refugee specialists expected.

Figure 3

Commonly Identified SEA Refugee Problems and Service Strategies

Problem Types	Symptoms of Interactive Problems	Recommendations for Prevention and Problem Solving
I. Acculturation Stress	Biological	Biological
- linguistic and non-verbal communication difficulties - status/role demotion - expectation vs. realization incongruity - unfamiliarity with cultural norms and laws - social isolation and stigmatization	- parasites, tuberculosis, anemia, hepatitis, etc. - stress related psychogenic disorders (somatization) - misdiagnosed health neglect or abuse - noncompliance with medical treatments	- medical screening and early treatment - education of both refugees and medical staff for mutual understanding - thorough communication through bicultural interpreters
	Psychological	Psychological
II. Post-Traumatic Stress	- severe depression - aggressive outbursts with risk for spouse or child abuse - anxiety - loneliness - damaged self-concept, loss of self-esteem - frustration - occasional psychosis - post-traumatic stress disorder	- culturally appropriate mental health treatment emphasizing empathy, competence, knowledge of helpers - respect of individual and ethnic uniqueness by sponsors and professional helpers: client affirmation - individual and family therapy - psychotropic medications - team work with traditional healers (for medical and psychosocial problems) - assist survival and fulfillment need satisfaction
- violent, abrupt or ambivalent separation from homeland, relatives, friends - experiencing and witnessing intense suffering and horrors of war, persecution - prolonged and often helpless wait in refugee camps	Social	Social
	- unemployment, underemployment - alienation from mainstream social participation - marital and intergenerational conflict in family - dependency upon public and private social services - underutilization of helping resources - lack of matching between client needs and social service delivery system	- English and employment training/assistance - coordination between schools, workplace, church sponsors, social service system resources - family reunification - facilitate social coping skills - encourage and fund ethnic mutual assistance associations and informal community networks
III. Pre-Resettlement Disease	- unintentional legal transgressions - occasional criminality	- advocate federal and local policy improvements for benefit of refugees (fund allocation, program development)
IV. Pre-Resettlement Psychiatric Disorders	Physical Environmental	Physical Environmental
	- housing and sanitation inadequacy - maladaptation to climate changes - drastic change of life space, e.g. rural/urban	- assist upgrading of housing - assist in climate adjustment - resettle in environments matching refugee's former life space or present desire

*Compiled by the author from literature review and professional experience

Acculturation Stress

Acculturation stress is often intense for Southeast Asian refugees, because they have usually fled their homelands without adequate preparation for adjustment to a host country. In fact, the final destination of the refugee may be beyond his or her control, determined by events in the interim refugee camp. Lack of English language skill and facility with American nonverbal communication style presents a formidable barrier to smooth acculturation, affecting everything from education to employment and establishing amiable social relations with other Americans. Often refugees who had well-established and respected social roles and statuses in their native land have been forced to accept a drastic demotion in the United States. This may be because there are no comparable roles in this society. The refugee may not have sufficient cultural familiarity to compete successfully with other Americans. Upward mobile employment may be unavailable or American racism and prejudice may lower self-esteem and social class position. Refugees who had high expectations for improvement of life style in the United States may experience particularly strong frustration and disappointment when faced with the difficult reality.[36]

Unfamiliarity with cultural norms and laws may result in unintentional transgressions that stimulate additional ostracism or punishment. The refugees often remain socially isolated minorities in the host communities because of stigmatization by the dominant society and a defensive self-containment by the refugees themselves. Also, as children adopt mainstream American values and behaviors more quickly than the elders, inter-generational conflict may begin.

These problems may manifest in symptoms of acute and chronic depression, loneliness, anxiety, aggressive tendencies, family conflict, and occasionally psychoses.[37] Incongruencies and conflicts between refugees' cultural orientations and the predominant American cultural context exacerbate these problems. If service providers impose inflexible ethnocentric approaches to care on refugees, these problems are all intensified rather than ameliorated.[38]

Just as a culturally inappropriate imposition of medical or mental health concepts on refugees can increase their distress, so also inappropriate religious indoctrination can be upsetting. Many refugees are sponsored by church-based resettlement programs. Some sponsors have a desire to convert refugees to their Christian (most often) beliefs, because they sincerely believe that the one way to salvation is through Christ. Sometimes sponsors actively prosyletize, condemn traditional Asian religious beliefs and practices, and pressure refugees to attend their church. Often the sponsor simply makes a friendly offer of Christian fellowship. Even when a noncoercive approach is taken, however, many refugees feel obligated to participate in the sponsor's religious community out of deference and gratitude.

In traditional Southeast Asian manner, the refugee may combine the benefits of Asian and Christian religions without a sense of contradiction. However, when sponsors do not undersand or approve of such combination, refugees may be made to feel that they must reject their traditions. This creates a stressful pull between religious demands, adding to confusion of roles and cultural identity. In view of these problems, it would be valuable for religious sponsors to explore the possibility of ecumenical and interreligious dialogue and cooperation as a facet of cross-cultural relations.

Post-Traumatic Stress

Many refugees have undergone traumatic experiences that few Americans can even comprehend. Mass murder, rape, warfare, torture, starvation, severance from family and friends, and prolonged anxious waiting periods in refugee camps are just a few of the commonly experienced sufferings.[39] Often refugees, unlike immigrants, have departed their homelands unwillingly and wish for an impossible return. Depression related to sense of loss, and grieving, as well as anxiety over the welfare of loved ones left behind, are common. Southeast Asian refugees may even feel guilty for having survived when so many others did not. To make matters worse, Americans who erroneously blame lack of jobs on competition with refugees can intensify feelings of guilt and social isolation. Successful resolution of trauma often requires a gradual healing of memories in a secure environment with social support for cathartic emotional release. Unfortunately, the refugees' situation in the new environment is often precarious and insecure.

When post-traumatic stress results in severe psychosocial dysfunction, it is classified as a mental disorder.[40] According to the Diagnostic and Statistical Manual of Mental Disorders (Third Edition, revised), this disorder involves symptoms lasting more than one month in reponse to a traumatic event. The traumatic event is often recalled in recurrent memories and dreams, causing great distress. The person may act as though the event is actually re-occuring in relation to delusions or hallucinations. The person typically tries to cope with this by avoidance of anything that recalls the event or by numbing emotional reactions. Difficulties in sleep and concentration, outbursts of anger, and exaggerated startle responses are typical symptoms. Post-traumatic stress disorder requires culturally appropriate psychosocial treatment, incorporating family and community support. Caution must be taken by mental health professionals not to confuse PTSD with psychotic disorders such as schizophrenia.

Other Environmental and Medical Stresses

These stressors, combined with lack of English language fluency and insufficient skills for American jobs, can make it a challenge to obtain lucrative employment or any employment. For arrivals early in the adjustment process with low earned income or dependence on public and private assistance, housing and sanitation are often deficient. Refugees from rural backgrounds may be forced to live in cities and urban refugees may be forced to dwell in rural areas by resettlement practices. Myriad pressures may lead to marital and parent-child conflict.[41] The professional helping systems, including medical and social services, are often unaware or unprepared to respond to the unique needs and expectatons of refugees. As a result, the physical and social environment may increase feelings of insecurity and alienation, making resolution of intrapsychic problems difficult. If there are also undetected or inadequately treated physiological diseases, the refugee is assailed by stressors from every direction. Under these severe conditions, it is not surprising that medical and mental health professionals have reported frequent somatization of psychosocial stress. It is clear from this summary of problems that the maintenance and enhancement or restoration of Southeast Asian-Americans' well-being depends upon the establishment of a nurturing and culturally congruent relationship with society as a whole and particularly with those who wish to assist them.

Southeast Asian Concepts of Well-Being

As the review of cultural characteristics indicated, traditional Southeast Asian religions and philosophies have an important influence on the understanding of human well-being. In all cultures, concepts of causes of illness and problems are linked with strategies for treatment and solutions. Thus, the Southeast Asian traditional perspective on well-being is linked to concepts of cosmic harmony, relations with ancestors and ghosts, nature spirits, and magic such as sorcery. These concepts contrast markedly with the Euro-American scientific understanding of well-being. Therefore it is important to consider these contrasting beliefs when designing effective service strategies.

The more a refugee is acculturated to the Euro-American world view, the more medical and secular concepts of well-being predominate. Traditional Southeast Asians recognize all kinds of natural causations (such as infection or injury) but they are considered less significant than supernatural causations.[42] It is important to keep in mind, however, that the common Western dichotomy between "natural" and "supernatural" is not upheld by traditional Southeast Asians. The cosmos is envisioned as a whole system ideally functioning with harmony among its physical and nonphysical components. Human well-being is one facet of this system. When relations in the cosmos are disrupted, illness results.

There are many variations according to ethnic group and individual idiosyncracy concerning beliefs about causes and treatments of human problems. In order to present an overview, the general common base of health and mental health cosmology derived from ancient Chinese influence will be described. Several specific Vietnamese beliefs and practices will also be presented as examples.[43]

Ancient Chinese cosmology had a tremendous impact upon the development of all East Asian cultures. Until recently, the societies of East Asia were either directly under Chinese hegemony or within an indirect sphere of influence. For example, Vietnam was controlled by Chinese rule from 111 B.C. to 938 A.D.[44] During this time, Vietnamese culture and political organizations were formed after a Chinese model. Even after this time, the fundamentals of the ancient Chinese world view persisted with variations according to historical development and ethnic differences.

The most ancient codification of fundamental cosmological principles is found in the Chinese I Ching or Book of Changes.[44] The I Ching originated from a shamanistic-animistic context of fortune-telling based upon the reading of omens that indicate the auspicious or inauspicious character of circumstances. This prognostication system became refined and expanded into an all encompassing view of the process of change in relations between people and the universe. The underlying concepts are harmony between humankind and the universe, the complementary relationship and interactions between primary polar opposites that produce all creativity and change (ying/yang), the periodicity and cyclical recurrence of change (e.g. the cycle of the seasons), and the conversion into an opposite at the peak of development (e.g. the waxing and waning of the tides). These principles were further refined in applications to human relations by Confucianism, to relations with nature and metaphysical reality by Taoism and the metaphysical considerations (the discipline of consciousness and attainment of enlightenment) by Sinicized Buddhism. These three religious systems, inspired by the principles of the I Ching, in turn affected other East Asian and Southeast Asian cultures. Similar principles are found in Ayurvedic medicine, which influences Southeast Asia through Hinduism and Theravada Buddhism.[45]

Numerous derivative principles underlie Southeast Asian concepts of well-being. One of the most significant is that the well-being of the individual cannot be understood apart from the degree of harmony in relations with the society, nature, and spiritual powers. There is strong emphasis upon corporate, rather than individual, identity as primary. Interdependence is viewed as a necessary and valuable aspect of life.[46] Relationship within family, clan, class, state, and cosmos are the primary determinants of identity and personal well-being. Therefore, when significant social relationships are severed or disrupted, personal identity itself is at risk, since individual autonomy is not the supreme value. Accordingly, helpers must be

especially concerned about strengthening kinship and other social support systems that have been disrupted by refugee flight and resettlement.

In the context of a highly structured hierarchical social system, individual achievement is considered to be enhanced by obedience and compliance with authority figures who hopefully embody the Confucian virtues of wisdom and compassion toward subordinates. The advisory and guiding roles of elders, religious professionals, and healers are very significant to Southeast Asians. Therefore, an authoritative style of communication with clear guidelines and expectations from helping professionals is often preferred and expected rather than a non-directive approach.

Many Southeast Asians also believe in the law of karma, derived from Hindu and Buddhist sources. When a person acts incorrectly, damaging relations with others, automatic retribution is expected upon self or relatives; this may even affect the course of future rebirths. Traditional healing would therefore involve rites of expiation, acts of atonement, and purification. Helping professionals working with refugees should be alert for indications of guilt and somatization given this conception. Treatment may be enhanced by including the ritual assistance of a trusted traditional healer.

Since much Southeast Asian health care was provided by elders, religious figures, and nonprofessional pharmacists or injectionist, many refugees continue to emphasize self-care rather than the use of conventional American treatments. Unfortunately, healers who are well-qualified by traditional standards are difficult to find. Given the frequency of self-care, it could promote refugee well-being if conventional helping professionals assisted them to find well-qualified traditional healers in order to prevent medical hazard caused by unskilled application of traditional healing techniques. Since these traditional techniques often involve attempts to resolve human and cosmic relational problems that underlie physical and psychological symptoms, a holistic approach to health and mental health treatment might be appropriate, especially involving an intercultural rapport between helper and client. If this is not feasible, then an authoritative medical or problem-solving approach is often effective for symptom alleviation. In addition, ethnic community networking and traditional healing are necessary aspects of assistance for higher level need satisfaction.

Vietnamese will typically seek first a natural obvious causation for physical or mental illness, such as rotten food or brain dysfunction. Spiritual causations may be considered also, including spirit attack for transgressions, attack by sorcery, fate, or karmic retribution. Traditional treatments for these supernatural causes, especially for rural Vietnamese, often require the helping ministrations of shamans or Buddhist monks. In general, many urban Vietnamese and those who have been educated with strong French and American influence tend to prefer

Western medical approaches to health care.

A common Southeast Asian view of health involves the balancing of the hot and cold (yang and yin) polarity in the body and diet. Adjustment of food intake, herbal medicine remedies, acupuncture, and moxibustion are all based upon this notion. The intrusion of a harmful wind (phong, Vietnamese) can also cause illness. The wind may be released by forceful rubbing of the skin or "cupping " with a heated glass, which causes abrasions. Although these treatments generally pose no health threat and may have psychogenic or other benefits, they are sometimes incorrectly criticized as abuse when applied to children. Such misdiagnosis by helping professionals can cause severe family disruption and resultant mental health hazards for the Vietnamese refugees.

This overview of problems and service needs indicates that services for refugees need to address multiple social system levels (e.g. individual, family, clan, community, national, international) and service delivery institutions (e.g. legal, medical, religious, social service, educational). Further, this holistic approach must be relevant to the cultural orientations of refugee clients. The following chapter offers suggestions for providing holistic and culturally-sensitive services.

CHAPTER III

CULTURALLY-RELEVANT SERVICE

Importance of Cultural Sensitivity

Predominant service delivery systems utilize a medical, clinical, task-oriented, dichotomizing set of health or mental health concepts and therapies. The review of Southeast Asian refugees' mental health needs and concepts demonstrates that adequate service requires a holistic, spirituality-attuned approach. This incongruity can be resolved by matching the two orientations, by forming a new transcultural synthesis. Marsella and Higgenbotham present a valuable overview of current attempts to accomplish this and guidelines for the future.[47] Although they refer to application of traditional Asian healing to third world contexts, the observations and suggestions are extremely relevant to mental health practice with traditionally oriented minorities in the United States.

They advocate for a shift away from the tendency of Western helping professionals to impose their healing ideologies, techniques, and institutions upon members of other cultures and ethnic groups. In contrast to this approach, which may be exacerbating the underutilization of mental health services by Asian-American clients, there should be attempts to make helping services culturally relevant. This requires incorporation of Southeast Asian helping approaches within the philosophical and technical aspects of Western healing.

Marsella and Higginbotham point out that there is a growing discontent among contemporary Americans with the reductionist medical models that treat illness by physical manipulations. The current rise of interest in holistic medicine and Eastern philosophy and therapies among the American public makes this an opportune time to explore points of congruence and synthesis. They suggest several steps toward such a synthesis.

First, each helping professional must become aware of the all-pervasive effects on perception and behavior of culture. This involves awareness of one's own cultural limitations and the fact that world view and standards for behavior are culturally relative. Second, didactic and experiential modes of educating helping professionals must be used to gain factual knowledge and empathic understanding of clients' cultures. This includes learning about the client's concepts of illness and healing. Third, the service delivery system must be assessed in terms of its relevance and effectiveness for the client. Fourth, nonconventional helpers, such as folk healers, shamans, monks, or acupuncturists can be incorporated into the service delivery system. Finally, Western concepts and treatments for mental health must themselves be broadened to incorporate the insights of Asian perspectives.

As a prerequisite, a helping professional who is able to promote and implement such approaches needs to cultivate a professional and personal orientation that Daniel Sanders calls "multiculturalism."

> In essense, multiculturalism is an approach that affirms the reality of cultural diversity, the need for tolerance and appreciation of different cultures and the importance of understanding the dynamics of cultural diversity and interactions in work with people. Multiculturalism signifies a perspective--a philosophic approach--in which it is possible for an individual to retain a fair amount of what is distinctive and creative in his or her own cultural tradition and at the same time to be able to draw from and integrate the diverse cultural traditions of a pluralistic society.[48]

Multiculturalism views cultural differences positively and is opposed to the concept of a single dominant culture. Therefore it discredits the "melting pot" notion, which implies that cultural diversity should be leveled out and homogenized to the benefit of a supposedly dominant culture. Multiculturalism favors the development of communities free to pursue their own cultures without penalty. Interaction among such diverse groups is highly valued.

General Service Recommendations

A multiculturally oriented service system would be capable of responding to the full range of Southeast Asian-Americans' survival and fulfillment needs. As the refugee continues in the acculturation process and satisfies survival needs, there are greater possibilities to help the person maximize the opportunity to creativley benefit from the advantages of a pluralistic society. Assuming that the health and mental helath system itself achieves a multicultural orientation, it is possible to suggest a sequence of progressively expanding modes of relating with the client to enable maximum fulfillment of potential.

Early in the acculturation process, the refugee is highly vulnerable to the stresses depicted in Figure 3. He or she will be struggling to adapt his or her present monocultural abilities and lifestyle to the demands of the new cultural environment. At this phase, it will be particularly important for the service system to assist the refugee's medical and subsistence problem-solving by well structured directive interventions. Simultaneously, secure support in an ethnic community network will be crucial. Ethnic elders and traditional healers should be included in the refugee's support network. At this phase, the service system and refugee client system will be unfamiliar with each other, or even incongruent. Therefore, the problems of

ethnocentrism reviewed earlier must be avoided by careful planning on the part of the service system.

Gradually, the client may become more familiar with American society. Ideally, acculturation will proceed to the point of the refugee's attainment of bicultural competence. This does not mean conformity to Anglo-American standards, but rather a capacity to operate flexibly within both the ethnic subculture and the mainstream cultural contexts. Each person attempts to work out satisfying degrees of integration and synthesis between cultures. As this process progresses, mutual understanding and cooperation between the mental health system and the refugee will be much easier to establish. The service system can maximize the potential of this phase by making more in-depth psycho-social therapies available. Insight oriented therapy may become more feasible and desirable for the client, especially as a means to resolve the lingering effects of post-traumatic stress. The client should be made aware of a wide range of service options ranging from medical-pharmacological to psychodynamic and traditional. The client can also be assisted to achieve a clear sense of identity that includes bicultural competence and various degrees of synthesis between traditional and conventional American world views.

As the person achieves a greater psychosocial resolution of survival, self-concept, and fulfillment issues, the client can be assisted to explore possiblities of multicultural awareness and life style. At this phase, the service system can offer a holistic approach that synthesizes the advantages of a biopsychosocial health view with the advantages of traditional Asian concepts and practices that derive from a nondualistic and spiritually attuned world view. A synergistic relationship of traditional helpers with helping professionals can maximize the benefits of both. Finally, refugee and non-refugee helpers trained in each other's traditions of healing can cooperate and inspire each other within a converged, mutually embracing service system. Implementation of these recommendations would require long range planning, taking into account both service delivery development toward multiculturalism and also the refugees' descendants' acculturative adjustment. This process involves a mutually beneficial relationship between client and helping professionals--the needs of refugees prompt continued growth and creativity in service delivery, which in turn benefit the clients. The societal context as a whole is thus enriched by these innovations of services and the cultural contributions of the new Southeast Asian Americans.

Specific Service Recommendations

Most physiological problems can be corrected and prevented by careful medical evaluation and early treatment.[49] Medical professionals must be alert for the possible presence of endemic Southeast Asian diseases. Yet treatment is often complicated by

a language barrier and contradictory assumptions about the causation and correct treatment of disease between medical professionals and refugees. This means that bicultural/bilingual translators must be utilized during important medical communications. Further, both patient and medical professional must be educated about each other's healing systems and agree to mutual understanding and cooperation. This would likely increase patient compliance and reduce will-intentioned mistakes by service staff, such as when Vietnamese parents are accused mistakenly of child abuse for employing the traditional folk treatment of abrasive rubbing (coin rubbing) on the child's skin.

Psychosocial treatment must be culturally appropriate. Southeast Asians may be reluctant to express deep emotions to professionals in an impersonal clincial setting. Practical needs must be attended to first, establishing a basis for trust and confidence. Through empathic communication, geared to minimal English or mediation by an interpreter if necessary, refugees may be helped to ventilate painful feelings.[50] Psychopharmacology may be useful in treating the biochemical aspects of depression, anxiety, and psychotic disorders. In fact, an authoritative medical model approach may be congruent with some patients' expectations and increase compliance.[51] An alternative approach, which can be complementary, is to incorporate traditional refugee concepts and techniques of treatment in psychotherapy or to establish a team cooperation between traditional healers and Western style helping professionals. In general, survival and task-centered needs may be served best by a practical, well-structured problem-solving approach. Higher level fulfillment needs may be assisted by innovative therapies and cooperation with ethnic support systems, such as mutual assistance associations and traditional healers.

Self-esteem of refugees must be encouraged by client-centered and affirming behaviors on the part of sponsors and helping professionals. Ethnic variation must be understood and considered in all assistance programs. Further, the individual should always be considered as a valuable and unique person.

The complex web of potential psychosocial problems must be treated by helping activities that extend to interpersonal relations. English as a Second Language training and preparation for employment are crucial programs for all refugees. Family reunification efforts can also help alleviate anxiety and grief while restoring the supportive network of kin relations. Family therapy may be necessary in cases of severe marital or intergenerational conflict. Ethnic mutual assistance associatins and informal ethnic mutual support networks also deserve strong support. At the same time, opportunities for social mainstreaming, especially in schools and employment, can be encouraged to lessen social isolation and augment the acculturation process. Ethnic integrity can be promoted together with interethnic integration and harmony. Public education programs to counter racist and ethnocentric attitudes in the general community may help prevent mutual antagonism. Federal

and local policies must be promoted which provide funding, staff, and program development necessary to implement these services. Helping professionals can also serve as advocates who coordinate and monitor the provision of services from many sectors--schools, church sponsors, community organizations, public welfare, hospitals, and other social service systems.

All of these recommendations for assistance depend upon the establishment of connections and congruence between contrasting ethnic orientations. At the foundation of this matching effort is the need to form connections between world views and life styles. This requires fundamental realignment of Western helping professionals' assumptions about the nature of reality as linked to concepts and practices of helping and healing.

Multi-Cultural Teamwork and Interpretation

It is impossible for any one person to provide the complete range of services recommeded for refugees in this manual. No one has the time or multi-lingual, multi-cultural competence to meet the needs of all refugees from all the ethnic groups. For this reason, Dr. Quan Cao recommends a multi-cultural teamwork approach.[52] The multi-cultural team would include experts in various languages and types of service within an agency as well as ongoing inter-agency collaborators. For example, an English-only speaking psychotherapist might do counseling with the assistance of a staff bilingual interpreter in consultation with the client's resettlement sponsors. Ideally, intra- and inter-agency teams would establish on-going strategies for cooperation and cross-referral.

When helper and client do not share the same language, service can be delivered only through the mediation of an interpreter. Since this is often the case in refugee services, it is important to utilize interpreters carefully.[53] An interpreter should be fully bilingual and bicultural, particularly with regard to the specific problem being addressed. For example, a Lao and English speaking interpreter is not necessarily fluent in psychiatric or medical terminology. The interpreter needs to receive training appropriate to the interpretation setting. In addition, relatives and friends of the client should be avoided as interpreters, since the interpersonal dynamics often complicate accurate interpretation and the protection of confidentiality. Children, in particular, should be avoided as interpreters for adults, since they lack appropriate maturity and social status.

It is best for a service provider to establish a long-term collaboration with specific interpreters, so that mutual understanding and teamwork become well-developed. Before each interpreting session, the service provider should brief the interpreter on relevant aspects of the case. A plan for interviewing, goal attainment and role-cooperation should be established. After the interview session, the provider and

interpreter should meet to de-brief each other on nuances of the communication that may not have been explicit or clear during the interview. Planning for future sessions should be conducted.

Within the interview session, three styles of interpreting are often used: simultaneous, summary, and consecutive.[54] In the simultaneous style, the interpreter attempts to convey all information to all parties at the same time as they are speaking. The speed and complexity of communication often makes this unfeasible. In the summary style, the interpreter attempts to convey only the most salient contents of brief sections of dialogue to each party in alternation. This style is easier, but it may sacrifice valuable information. The consecutive style combines the virtues of the other two: it attempts to convey all information to all parties while pacing the dialogue according to brief, alternating communications.

The bicultural interpreter can be a valuable source of information for both the client and the service provider. In bicultural mediation, the interpreter establishes mutual understanding about cultural information as well as linguistic information. The bicultural mediator can alert the service provider to aspects of the client's socio-cultural context that are significant for effective service delivery. Likewise, he or she can help the client to understand the cultural and professional context of the service being delivered. Such bi-cultural mediation should occur within the plan of the overall service strategy devised in cooperation between the primary service provider, the client, the interpreter, and other relevant members of the multi-cultural team.

Psychiatric Diagnostic Cautions

The assessment of psychopathology in refugee clients is complicated by linguistic, cultural, and socio-economic variables. Since it is not possible to address these issues in detail here, the reader is encouraged to examine the relevant literature. However, a few words of caution are appropriate.

Standard mental health assessment tools must be used with caution since they seldom take into account cross-cultural variability. Some tools have been designed specifically for use with refugee clients, translated into their native languages.[55] These tools should be used in the context of thorough, culturally-sensitive evaluations and treatment planning.

Many mental health settings are required to use the DSM III-R for psychiatric diagnosis and classification. This poses a problem since, as the authors of DSM III-R point out in the introduction, the categories have not been scientifically tested for cross-cultural reliability and validity. The DSM III-R authors state emphatically that it should be used with caution in cross-cultural settings. Behaviors that are considered normative in specific religious or cultural contexts, such as visions of spirits in shamanistic cultures, should not be considered signs

of psychopathology. Likewise, there may be culture-specific syndromes that are not listed in the DSM III-R manual. It is critical, therefore, that bicultural mediation and interpretation occur in the process of psychiatric diagnosis.

Given the service considerations of this chapter, the following specific guidelines are recommended for evaluating and implementing services. These guidelines are especially important to consider in the case of crisis intervention with Southeast Asian refugee clients, since the need for rapid response must be combined with maximum use of available community resources. Specific local resources which can be utilized in implementing these guidelines are listed in Chapter Four, Refugee Services Directory. In general, the Bureau of Refugee Programs (Iowa Department of Human Services) in Des Moines is an excellent source of referral information, since it coordinates refugee services throughout the state. The Bureau Chief is Marvin Weidner; the Bureau Deputy Chief is Wayne Johnson.

Figure 4

Guidelines for Service Delivery

Every contact with a Southeast Asian refugee client needs to include the following considerations. For culturally sensitive assessment and treatment:

1. Obtain sufficient knowledge about the client's cultural background to determine how to conduct culturally-relevant assessment and service.

2. Determine client's needs as stated by the client and the client's significant others.

3. Assess client's needs according to professional criteria.

4. Examine possible differences between client self-assessment and professional's assessment, especially with regard to cultural differences.

5. Establish helping approach that is congruent with the client's personal and cultural orientation; where there are irreconcilable differences, clearly explain the reasons to the client and attempt to maximize client self-determination.

6. Utilize a skilled bilingual/bicultural interpreter in cases in which the helper and client do not share the same language. Interpreters can be located through the Iowa Department of Human Services Bureau of Refugee Programs in Des Moines, the Language Bank of the University of Iowa Hospitals Interpreter Services, or other resettlement agencies.

7. Identify and cooperate with the refugee client's resettlement agency and sponsors. This information and consent can be obtained from the client during initial assessment.

8. Consult with relevant resource persons who are knowledgeable in refugee services and cultures pertaining to the client's specific needs. These can be identified from the Refugee Services Directory or the Iowa DHS Bureau of Refugee Programs.

9. Incorporate the support of ethnic community systems such as family, friends, elders, religious figures, traditional healers, and mutual assistance associations. These can be identified through interviews with the client and consultation with mutual assistance associations listed in the Directory.

10. Coordinate the service being provided with the total range of services the client may be receiving through other agencies.

Implementing culturally sensitive service often requires a willingness to relate to the client in his or her own life space; rigid adherence to formal office and hospital visits may increase the risk of client drop-out.

Culturally sensitive helping is founded upon recognition of all persons' common human needs and dignity, as well as each individual's distinctiveness. A sincere, empathic, and skillfull helping relationship that takes into account both these dimensions is likely to be most beneficial for the client and most satisfying for the professional helper.

CHAPTER V

REFERENCES CITED

FOR A MORE COMPREHENSIVE ANNOTATED BIBLIOGRAPHY, SEE:

An Annotated Bibliography on Refugee Mental Health, Carolyn L. Williams, Refugee Assistance Program: Mental Health-Technical Assistance Center, University of Minnesota. Published by National Institute of Mental Health, 1987. For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402.

References Cited

1. Metropolitan Human Services Commission, Refugees in Franklin County: An Overview (Columbus, Ohio: Metropolitan Human Services Commission, September 1983), p. 5.

2. U. S. Department of State, Bureau of Refugee Programs, "Summary of Refugee Admissions," Fiscal Year 1988.

3. For example, see: Stanley Sue, Ph.D. and Herman McKinney, MSW, "Mental Health Care System," American Journal of Orthopsychiatry, 45:1 (January 1975): 111-118; and Man Keung Ho, "Social Work with Asian Americans," Social Casework, 57:3 (March 1976): 195-201.

4. Ibid. See also: Nazneen S. Mayadas, "Psycho-Social Welfare of Refugees: An Expanding Service Area for Social Work," International Social Work, 26:1 (1983): 47-55, and Hideki A. Ishisaka and Calvin Y. Takagi, "Social Work with Asian- and Pacific-Americans," in Cultural Awareness in the Human Services, James W. Green (Englewood Cliffs, New Jersey: Prentice Hall, Inc., pp. 122-155.

5. Delegate Assembly of the National Association of Social Workers, NASW Code of Ethics, 1980, in 1983-84 Supplement to the Encyclopedia of Social Work, 17th ed., Scott Briar et al., ed. (Silver Spring, Maryland: NASW, 1983), pp. 257-262. The concept of matching client needs with environmental circumstances for mutual benefit was well developed in: William Gordon, "Toward a Social Work Frame of Reference," Journal of Education for Social Work, 1:2 (Fall 1965): 19-26 and "Basic Constructs for an Integrative and Generative Conception of Social Work," in The General Systems Approach,

ed. Gordon Hearn (New York: Council on Social Work Education, 1969), pp. 5-11.

6. Leona Grossman, "Ethnicity and Health Delivery Systems," in The Diverse Society: Implications for Social Policy, Pastora San Juan Cafferty and Leon Chestang, ed?. (Washington, D.C.: National Association of Social Workers, 1976), pp. 129-148.

7. Andrew M. Greeley, "Why Study Ethnicity?" in The Diverse Society, Cafferty and Chestang, pp. 3-12.

8. Janey Egawa and Nathaniel Tashima, Indigenous Healers in Southeast Asian Communities (San Francisco: Pacific Asian Mental Health Research Project, 1982).

9. Vang Tou-Fou, "The Hmong of Laos," In: Bridging Cultures: Southeast Asian Refugees in America, Special Services for Groups, ed. (Los Angeles: Asian American Community Mental Health Training Center, 1987), pp. 73-82; Glenn L. Hendricks et al., eds., The Hmong in Transition (New York: Center for Migration Studies, 1986).

10. Egawa and Tashima, Indigenous Healers.

11. Vang Tou-Fou, "The Hmong of Laos."

12. Ronald G. Munger, "Sudden Death in Sleep of Laotian-Hmong Refugees in Thailand: A Case Control Study," American Journal of Public Health, vol. 77 (1987): 1187-1190.

13. Carole Chan, "Aspects of Khmer Culture and Cambodians in America," In: Bridging Cultures, pp. 91-102. Egawa and Tashima, Indigenous Healers.

14. Yang Sam, Khmer Buddhism and Politics (Newington, CT.: Khmer Studies Institute, 1987), p. 1.

15. Edward R. Canda, ed., Southeast Asian Refugees: Needs and Service Approaches (Columbus, Ohio: Columbus Area Refugee Task Force, 1986).

16. Chan, "Aspects of Khmer Culture."

17. Egawa and Tashima, Indigenous Healers.

18. J.P. Hiegel, "Collaboration with Traditional Healers: Experience in Refugees' Mental Care," International Journal of Mental Health, vol. 12, no. 3, (1984): 30-43. Anne Langford, "Working with Cambodian Refugees: Observations on the Family Practice Ward at Khao Dang," Journal of Transpersonal Psychology, vol. 12, no. 2 (1980): 117-126.

19. Karen Olness, "Cultural Aspects in Working with Lao Refugees," Minnesota Medicine, December (1979): 871-874. Lutheran Immigration and Refugee Services, Laos: The Land and the People. Supplement No. 4-5/78.

20. Marcello Zago, "Buddhism in Contemporary Laos," In: Buddhism in the Modern World, Heinrich Dumoulin and John C. Maraldo, eds. (New York: Collier Books, 1976), pp. 120-129.

21. Joseph Westermeyer, "Lao Buddhism, Mental Health, and Contemporary Implications," Journal of Religion and Health, vol. 12, no. 2 (1973): 181-188.

22. Joseph Westermeyer and Ronald Wintrob, "Folk Explanations of Mental Illness in Rural Laos," American Journal of Psychiatry, vol. 136, no. 7 (July 1979): 901-905.

23. Bounlieng Phommasouvanh, "Aspects of Lao Family and Social Life," In: Bridging Cultures, pp. 83-90.

24. Ibid.

25. Sue E. Bell and Michael B. Whiteford, "Tai Dam Health Care Practices: Asian Refugee Women in Iowa," Social Science and Medicine, vol. 24, no. 4 (1987): 317-325.

26. Jack Lufkin, ed., Refugee Oral History (Des Moines, IA.: Tai Studies Center, 1987).

27. Bell and Whiteford, "Tai Dam Health Care," p. 317.

28. Ibid., p. 318.

29. Lufkin, Refugee Oral History.

30. Joseph S. Salzberg, Vietnam: Beyond the War. (Hicksville, NY: Exposition Press, 1975).

31. World Almanac and Book of Facts 1988 (New York: Pharos Books, Scripps Howard, 1988).

32. Salzberg, Beyond the War. Pierro Gheddo, The Cross and the Bo Tree: Catholics and Buddhists in Vietnam (New York: Sheed and Ward, 1970).

33. National Indochinese Clearinghouse Center for Applied Linguistics, "Perspectives on a Cross-Cultural Problem: Getting to Know the Vietnamese," In: Bridging Cultures, p. 57.

34. Egawa and Tashima, Indigenous Healers. Sandra L. Schultz, "How Southeast-Asian Refugees in California Adopt to Unfamiliar Health Care Practices," Health and Social Work, vol. 7 (1982): 148-156.

35. This summary is influenced by the following sources: Paul B. Pederson, "Asian Personality Theory," In: Personality Theories, Research, and Assessment. Raymond J. Corsini, et al., eds. (Itasca, Ill.: F. E. Peacock, 1983), pp. 537-582. Thinh van Dinh, The Indochinese Refugees: An Introduction to Their Cultures (Salt Lake City: Indochinese Refugee Assimilation Program, 1981).

36. Joseph Westermyer, M.D., Ph.D., Tou Fu Vang, B.S., and John Neider, M.A., "Refugees Who Do and Do not Seek Psychiatric Care: An Analysis of Premigratory and Postmigratory Characteristics," Journal of Nervous and Mental Disease, 171: 2 (February 1983): 86-91.

37. Robert Smither, "Psychological Study of Refugee Acculturation: A Review of the Literature," Journal of Refugee Resettlement, 1:2 (March 1981): 58-63.

38. Westermeyer, Vang, Neider, "Refugees."

39. Lammone Khamsouk, "Indochinese Refugees and Depression," Indochinese Assessment and Planning Program, Institute of Human Design, University of Wisconsin-Oshkosh.

40. San Duy Nguyen, M.D., "Psychiatric and Psychosomatic Problems Among Southeast Asian Refugees," Psychiatric Journal, University of Ottawa, 7:3 (September 1982): 63-172.

41. Tran Minh Tung, M.D., "Health and Disease: The Indochinese Perspective," in Working With Indochinese Refugees: A Handbook for Mental Health Workers and Human Service Providers, Nancy Lee Koschmann and Joseph Jay Tobin, eds. (Chicago: Travelers Aid/Immigrants Service League of Chicago, no date), 42-51; Antonio Catanzaro, M.D., Robert John Moser, Ph.D., "Health Status of Refugees from Vietnam, Laos, and Cambodia," Journal of American Medical Association, vol. 247, no. 9 (March 5, 1982): 1303-1308.

42. George Peter Murdock, Theories of Illness: A World Survey (Pittsburg: Univ. of Pittsburg Press, 1980). For summary comparisons of SEA views, see: John Vandeusen, et al., "Southeast Asian Social and Cultural Customs: Similarities and Differences, Part 1," Journal of Refugee Resettlement, vol. 1, no. 1 (February, 1981): 32; Staff of the Indo-Chinese Mental Health Project, Mental Health and Illness: Similarities and Differences Between Vietnamese, Cambodian,

Hmong (Pennsylvania: Office of Mental Health, Penn. Dept. of Public Welfare, 1980).

43. This discussion is based upon cited literature as well as information obtained by the author as a Graduate Fellow of Oriental Philosophy at Sung Kyun Kwan University in Seoul, Korea, 1976-1977, and ongoing field study of Asian religions.

44. Richard Wilhelm and Cary F. Baynes, trans., The I Ching or Book of Changes, 3rd ed. (Princeton: Princeton University Press, Bollingen Series XIX, 1967).

45. Paul B. Pederson, "Asian Personality Theory," In: Raymond J. Corsini, et al., Personality Theories, Research and Assessment (Itasca, Il.: F.E. Peacock Publishers, 1983), pp. 537-582.

46. Tran Min Tung, "Health and Disease: The Indochinese Perspective," In: Working with Indochinese Refugees: A Handbook for Mental Health Workers and Human Service Providers, Nancy Lee Koschman and Joseph Jay Tobin, eds. (Chicago: Travelers Aid/Immigrants Service League of Chicago, no date), pp. 42-51.

47. Anthony J. Marsella and Howard N. Higgenbotham, "Traditional Asian Medicine: Applications to Psychiatric Services in Developing Nations," in Mental Health Services: The Cross- Cultural Context, Paul B. Pedersen, Norman Sartorius, Anthony J. Marsella, eds. (Beverly Hills: Sage Publications, 1984), 175-97.

48. Daniel S. Sanders, "Multiculturalism: Implications for Social Work," International Social Work, 23: 2 (1980): 9-16.

49. Antonio Catanzaro, M.D., Robert John Moser, Ph.D., "Health Status of Refugees from Vietnam, Laos, and Cambodia," Journal of American Medical Association, 247:9 (March 5, 1982): 1303-1308.

50. Richard M. Sanders, "Mental Health and Treatment Strategies with Indochinese Refugees," Monroe, New Hampshire, 1980.

51. San Duy Nguyen, M.D., "Psychiatric and Psychosomatic Problems Among Southeast Asian Refugees," Psychiatric Journal, University of Ottawa, vol. 7, no. 3 (September 1982): 63-172.

52. Quan Cao, Ph.D., Workshop on Refugee Mental Health, Des Moines, Iowa, October 18, 1988.

53. Nicholas G. Baker, "Social Work Through an Interpreter," Social Work, vol. 26 (September 1981): 391-397; Anna O. Freed, "Interviewing Through an Interpreter," Social Work, vol. 33, no. 4 (July-August 1988): 315-319.

54. Ozzie F. Diaz-Duque, Ph.D., Presentation at "Cultural Diversity: The Impact on Health Care," The University of Iowa Hospitals and Clinics, Iowa City, Iowa, October 28, 1988.

55. R. Mollica, "Indochinese Version of the Hopkins Symptom Checklist-25: A Screening Instrument for the Psychiatric Care of Refugees," American Journal of Psychiatry, vol. 144, no. 12, 1567-1572; Joseph Westermeyer, Models of Assessment, Treatment, and Prevention for Social Adjustment and Mental Health of Refugees (St. Paul, Minn.: Refugee Program-Technical Assistance Center, University of Minnesota, 1986).