

# COUNSELING AMERICANS OF SOUTHEAST ASIAN DESCENT:

The Impact of the Refugee Experience

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## Background

Since 1975, more than 1.5 million Southeast Asians have fled from their homes and sought refuge in the United States. The mass exodus of Southeast Asian refugees, prompted by political turmoil and genocide has caused them to become one of the fastest growing ethnic groups in the United States. This population consists of five main Southeast Asian groups: Cambodians, Chinese-Vietnamese, Hmong, Laotians, and Vietnamese. The refugees have settled in every state in the United States but are especially concentrated in California, Texas, and Washington, DC.

It is important to distinguish between refugee and immigrant status. Murphy (1977) differentiated between "forced versus free," or involuntary versus voluntary migration. According to this definition, refugees are forced to leave their country of origin and are displaced from their countries by events outside of their control, such as war or genocide, because it is dangerous to remain in their home countries and impossible to continue their customary way of life. The refugee population is therefore distinguished from other migrants such as immigrants or sojourners due to their involuntary and sudden departure. As is characteristic of refugees in general, the Southeast Asian refugees were ill prepared for the sudden departure from their familiar world and faced uncertainty, confusion, high risk for personal safety, and complete disruption of their normal lives. Such chaos often caused the loss of personal

identity as well as the loss of reference groups such as family, community, culture, and country (Bemak & Greenberg, 1994).

Southeast Asian refugees entered the United States in primarily two main waves, with each wave having different demographic characteristics and experiences before and after migration. The first wave of Southeast Asian refugees left Vietnam prior to the fall of Saigon in 1975 and entered the United States directly or from refugee camps for the next few years. During the fall of Saigon, due to their close association with the United States and/or South Vietnamese forces, these refugees were assisted by the American government and hastily evacuated by helicopters or sea-lifts. This first wave was mainly Vietnamese and tended to be relatively well educated and able to speak some English.

The second main wave of Southeast Asian refugees entered the United States between 1978 and 1980 and consisted of Cambodians, Hmong, Laotians, and Vietnamese. The second wave of refugees escaped from their homes by sea or made hazardous journeys through the jungle. Those from Vietnam left in small, overcrowded, and unseaworthy boats. The boat people frequently encountered brutal attacks by sea pirates, and many were subjected to severe violence, or were raped or killed (Chung & Okazaki, 1991). The Cambodians, Hmong, and Laotians escaped by land through the jungle, crossing mine fields and avoiding ambushes by military soldiers. They encountered tropical diseases, death, hunger, starvation, and exhaustion. Further compounding the trauma, the escape from countries of origin for many of those in the second wave did not result in an immediate resettlement to a host country. Instead these groups of refugees were forced to wait in overcrowded and unsanitary refugee camps in nearby countries such as Thailand, the Philippines, or Hong Kong for months or even years before they were permanently resettled in the United States. In contrast to the first wave, the second wave refugees generally tended to be less educated with no prior English-language skills. Furthermore, many, especially those from the rural areas, had little or no exposure to Western culture prior to arriving in resettlement countries.

The first wave of Southeast Asian refugees tended to adjust more successfully than the second wave because of the premigration differences. Because they managed to escape before the fall of Saigon, they were exposed to less premigration trauma, and they

were better educated and possessed more wealth and resources (Nguyen, 1982). As the political repression intensified in Cambodia, Laos, and Vietnam after 1975, many in the second wave experienced human atrocities and genocide and were victims of incarceration, torture, beatings, sexual abuse, rape, and starvation. Many also witnessed killings and torture or were forced to commit human atrocities themselves. These atrocities were not only confined to countries of origin but also occurred during their escape and in the refugee camps.

This chapter first discusses the psychosocial adjustment and adaptation of Southeast Asian refugees, their cultural belief systems, and their barriers to mental health services and use of traditional methods. The chapter then looks at counseling services and provides an in-depth exploration of the Multi-Level Model as an approach to psychotherapy with refugees and a case study illustrating the model's use.

## Psychosocial Adjustment and Adaptation

Two major factors are associated with Southeast Asian refugees' psychosocial adjustment and adaptation in the United States. One factor is the amount of premigration trauma experienced in home countries during the escape process and in the refugee camps. Mollica, Wyshak, Coelho, and Lavelle (1985) classified the different types of premigration trauma for refugees into four general categories: deprivation (e.g., food and shelter), physical injury and torture, incarceration and reeducation camps, and witnessing killing and torture. The second factor is the level of difficulties experienced after the actual resettlement in adjusting to a country with a culture significantly different from their home country (e.g., Bemak, 1989; Chung & Kagawa-Singer, 1993; Lin, Masuda, & Tazuma, 1982; Lin, Tazuma, & Masuda, 1979; Westermeyer, 1986).

The emotional survival mechanism used by the Southeast Asian refugees to cope with experiences of torture, rape, and other human atrocities prior to migration was to act "dumb" (Mollica & Jalbert, 1989). In order to survive, individuals had acted as if they were deaf, dumb, foolish, confused, or stupid. They had also learned to comply with orders obediently without question or

complaint because they knew that appearing smart resulted in a torture or execution. The fear of being killed or tortured has remained for many refugees who continued to act dumb after resettling in the United States. They continue to be afraid to speak up or show their true feelings (Mollica & Jalbert, 1989). Such behavior among the refugees, which originally served as survival skills, may appear to be aversive, antisocial, or even pathological when viewed within the culture of the host country (Stein, 1986).

Studies have found group differences among the Southeast Asian populations with respect to psychological distress. Cambodians have been found to experience more psychological distress compared to other groups (Chung & Kagawa-Singer, 1993; Mollica, Wyshak, & Lavelle, 1987). This has been attributed to the Cambodian refugees' experience of the genocide orchestrated by the Pol Pot regime. The Vietnamese and Chinese-Vietnamese have been found to be the least distressed compared to the other groups, which Chung and Kagawa-Singer (1993) found was associated with higher levels of education, better English language skills, the fact that some had managed to arrive with financial assets, and access into the already established Chinatown communities in the United States.

Resettlement in a foreign country poses additional challenges for Southeast Asian refugees. Premigration trauma may be exacerbated by hardships experienced after resettlement. For example, Amerasian refugees (often with Vietnamese mothers and American fathers) frequently experienced strong racism in Vietnam. Their hopes that such discrimination will end are often shattered as they find themselves once again facing prejudice and racism in the United States. Some Amerasian youths have responded aggressively and sometimes violently, resulting in legal problems. Taya-bas and Pok (1983) found that problems with adjustment were more accentuated during the initial 1- to 2-year resettlement period during which refugees commonly focus on meeting their basic needs of housing and employment. Bemak (1989) described a three-phase developmental model of acculturation associated with successful adjustment and adaptation to the host country. In the first phase, the refugee attempts to use skills to master the new environment and establish security and psychological safety. The second phase follows after the successful completion of phase one and is the integration of former skills that were developed in the

home country with the newly acquired skills learned in the host country. Phase three is achieved when the refugee develops a growing sense of the future. It is only after the mastery of culture, language, and a sense of psychological safety that the refugee begins to plan for future attainable goals and implement strategies to achieve those goals.

During resettlement, refugees may become motivated to recover what has been lost as they attempt to rebuild their lives. However, they may also encounter a loss of control over decision making with regard to basic life issues such as the geographical location of where they will live in the resettlement country, job opportunities, and social networks. These difficulties may hinder their enthusiasm to acculturate and create emotional and psychological problems as they begin to confront the loss of their culture and identity. Tasks such as catching a bus, handling money, and going shopping, which were routine tasks in their home countries, may become major ordeals in the process of acculturation (Chung & Okazaki, 1991).

It is common for refugees to experience survivor's guilt after resettlement (Brown, 1982; Lin, Masuda, et al., 1982; Tobin & Friedman, 1983). They are haunted by the guilt of successfully escaping from their home country while leaving family, relatives, and friends behind in a politically volatile country. Many refugees have little or no information regarding those they left behind. The lack of knowledge about their safety and well-being adds to the already existing guilt. Furthermore, survivor's guilt intensifies as the refugee becomes more successful in the resettlement country.

To rebuild one's life in a foreign country is a difficult task. A high percentage of Southeast Asian refugees remain dependent on welfare even after being in the United States for a long period of time (Chung & Bemak, 1995), largely due to unemployment. Acquiring a job poses particular difficulties for refugees because educational training and skills obtained in their home country are most often not transferable to resettlement countries. This may cause a dramatic change in socioeconomic status, causing some refugees to take jobs for which they are overqualified. Chung and Bemak (1995) indicated that there was a tendency for refugee men to remain unemployed and welfare dependent while waiting for a suitable position that will match their skills because taking just any employment may result in downward mobility and loss of

status. Although refugees make remarkable progress in their adjustment, only a small percentage regain their former socioeconomic status (Lin et al., 1979; Lin, Masuda et al., 1982).

English language skills play an important part in refugee adjustment and are a key to gainful employment. However, for those who are illiterate in their own language, learning English proves to be a challenge. Chung and Kagawa-Singer (1993) found that attendance in English as a second language (ESL) classes was significantly associated with distress in this population. Furthermore, emotional and mental fatigue as well as memory and concentration difficulties due to premigration trauma may also inhibit learning performance in ESL (Mollica & Jalbert, 1989).

Resettlement for Southeast Asian refugees also creates changes in the family structure. Due to high rates of unemployment and underemployment among Southeast Asian men, it is often necessary for women to work in order to provide adequate financial family support. While refugee men may experience a downward turn in their socioeconomic status, women may experience upward mobility in their socioeconomic status (Chung, 1991). Working outside of the home and community and being exposed to American culture, refugee women may begin to question their traditional cultural gender roles and seek more independence. Such shifts in roles and attitudes frequently cause marital conflicts.

Role shifts also occur within the Southeast Asian refugee family. As is common among immigrants, children and adolescents tend to acculturate faster than their parents. Attending school and having exposure to nonrefugee children through ESL or other classes, children are apt to learn the English language and the American customs faster than their parents. This often results in a shift in family dynamics, with the children assuming the role of a language and cultural translator for their parents. When this happens, the children frequently witness a transformation of their parents from previously competent, autonomous caretakers to depressed, overwhelmed, and dependent individuals. Confidence in their parents as caregivers and providers is inevitably undermined, and the traditional family structure may change dramatically as a result. Furthermore, some children may experience feeling ashamed of their parents in the resettlement country because their parents lack English language skills, dress "funny," and behave according to non-Western manners and customs. There may also be embarrassment to

speak publicly in their mother tongue with parents or family members because peers in the resettlement country may laugh at them.

Another area of change within families may be in child-rearing practices. Usual disciplinary measures used before migration such as corporal punishment may be prohibited by the different laws in the resettlement country. This issue presents a serious dilemma for Southeast Asian refugee parents, who may already feel diminished in their status as parents and constricted in raising their children in ways that have been culturally acceptable for generations. Intergenerational conflict between parents and children may also occur regarding issues such as dating, marriage, curfew, and/or parental supervision. Many refugee children face the difficult position of bridging two worlds—acculturating and adopting the customs and behaviors of their host country peer group while maintaining the role as a child in a traditional family. In attempts to keep their child from adopting patterns of behavior and values incongruent with traditional values and beliefs, some refugee parents try to maintain a strict traditional upbringing. Despite this, many parents experience the loss of traditional authority and control as their children become more outspoken and challenge their authority and the "old culture."

Paralleling the home experience are the difficulties faced in schools by many refugee children and adolescents. They may experience racial tension manifested in being punched, mimicked, harassed, or robbed by non-Asian students (Huang, 1989). The norms regulating classroom and school behavior are usually different than those in their home countries. Children wishing to participate in extracurricular activities may have difficulties because their Asian refugee parents see educational success as a tool for upward mobility and can not understand this "foreign activity" that does not emphasize studying or the relevance of extracurricular activities. These issues, combined with the desire to belong socially, may generate both internalized and externalized tensions and conflicts for refugee children and adolescents.

## Cultural Belief Systems

Studies suggest that Southeast Asian refugees express depression and other psychological problems in a manner that is consistent

with their cultural belief systems (e.g., Chung & Kagawa-Singer, *in press*; Lin et al., 1979). These studies have indicated that Southeast Asian refugees, like other Asian populations, tend to express psychological distress as neurasthenia, which is comprised predominantly of somatic symptoms (e.g., headaches, weakness, pressure on the chest or head) but with some depression, anxiety, and psychosocial dysfunction. Mental illness is highly stigmatized in most Asian cultures, and the expression of neurasthenic symptoms may be a culturally sanctioned method of expressing psychological distress (Cheung, 1982; Chung & Kagawa-Singer, 1996; Kleinman, 1982). In many Asian cultures, mental illness is seen as a reflection on the entire family line, including ancestors and future offspring. If it is known that an individual within a family has a mental health problem, the individual's family is seen as undesirable, and the marriageability of family members is dramatically reduced. The manner in which Asians express psychological distress through somatic symptoms may allow the individual to seek help regarding physical complaints, thereby avoiding the stigma of seeking help for mental health problems. However, it is important to acknowledge that although many Southeast Asian refugees exhibit distress through somatic channels, they are also capable of discussing their problems in psychological terms (Cheung, 1982; Kinzie et al., 1982; Mollica et al., 1987).

Southeast Asian refugees' conceptualization of mental health differs from the Western framework. Refugees' help-seeking behavior reflects their perception of the problem, which in turn influences expectations for treatment. How can a Western psychotherapist be effective with this population if there is disparity regarding the conceptualization of mental illness between therapist and client? It is critical for the psychotherapist to be aware of and understand the client's conceptualization of problems within the context of the client's culture, and employ culturally sensitive therapeutic interventions and skills (Kagawa-Singer & Chung, 1994; Kleinman, Eisenberg, & Good, 1978; Kleinman & Good, 1985; Pedersen, 1988). Furthermore, the psychotherapist must acknowledge the fact that many Southeast Asian refugees are unfamiliar with Western mental health concepts because few had ever been exposed to mental health treatment in their home countries (Lin & Masuda, 1983). Indeed, there were no psychiatrists in Laos, South Vietnam had only a handful in 1975, and it is doubtful that

there were mental health professionals in Cambodia. Consequently, when Southeast Asian refugees seek help from Western psychotherapists, they expect a medical approach and quick symptom relief. Given their view of mental illness as akin to physical disorders, they often request injections or medication (Chung & Okazaki, 1991).

Even so, many Southeast Asian refugees reject Western practices and prefer traditional healing practices that involve belief in possession, soul loss, and witchcraft. Rituals for exorcism, performed by shamans and Taoist priests in Vietnam (Hickey, 1964) and by Buddhist monks in Laos and Cambodia (Westermeyer, 1973), consist of calling back the soul of individuals believed to be suffering from soul loss and asking local guardian gods for protection. Fortune-telling with cards and coins, the Chinese horoscope, and physiognomy (palm reading and reading of facial features) are also popular methods of treatment.

A major influence on the Southeast Asian belief system is Chinese medical practices. Cambodians, Hmong, and Vietnamese regularly use Chinese folk remedies, including herbal concoctions and poultices, forms of acupuncture, accupressure and massage, and the dermabrasive practices of cupping, pinching, rubbing, and burning (Nguyen, Nguyen, & Nguyen, 1987). Because mental illness is seen as a disturbance of the internal vital energy, acupuncture is often used as a remedy for depression and psychosis.

Although religious beliefs differ among Southeast Asian refugee groups, health and mental health practices are influenced by religious and medical practices. For example, Vietnamese religious beliefs combine Buddhism, Taoism, and Confucianism. Further, Vietnamese values share commonalities with Chinese cultural concepts such as filial piety, ancestor worship, interpersonal relationships based on hierarchical roles and reciprocal obligations, high regard for education, a strong family orientation, and loss of face. Theravada Buddhism, in which the attainment of spiritual enlightenment is valued over the achievement of material success, plays a central role in every aspect of a Cambodian's life. Laotians strongly believe in animism (the belief in supernatural, gods, demons, and evil spirits) as an essential part of everyday life. Illnesses are commonly treated by the shaman through practices such as string tying, in which a cord is tied around the wrist to enable a person to communicate with the spirit of deceased ancestors, or

to prevent the loss of a sick person's soul. The string may be perceived as a symbol of a patient's spiritual wholeness and his or her social and familial support system (Muecke, 1983).

## Barriers to Mainstream Mental Health Services and Use of Traditional Methods

Due to premigration trauma, many Southeast Asian refugees are at high risk for developing severe psychological problems. Many studies have stated the serious need of mental health services for this population (e.g., Gong-Guy, 1987; Kinzie & Manson, 1983; Mollica et al., 1985), and some studies have revealed a high incidence of depression and posttraumatic stress disorder (PTSD) (Kinzie, Frederickson, Ben, Fleck, & Karls, 1984; Mollica et al., 1985). A number of older Cambodian refugee women have reported incidences of nonorganic blindness in which the degree of subjective visual impairment was found to be significantly related to the number of years the women experienced in the internment camps, starvation, physical and sexual abuse, forced labor, and witness of the execution of significant others (Rozee & Van Boemel, 1989). Although the need for mental health services is great, only a small percentage of this group utilizes mainstream mental health services or even those services targeting Asian clients (Sue, Fujino, Hu, Takeuchi, & Zane, 1991).

The main reason for the low utilization of mainstream mental health services is that these services are not culturally responsive (Kagawa-Singer & Chung, 1994; Sue et al., 1991). When refugees enter mainstream mental health services, the environment is unfamiliar to them. There may be not only a language barrier between the client and psychotherapist but also cultural differences in both verbal (e.g., tone and volume of the speaking) and non-verbal (e.g., eye contact and personal space) behaviors. For example, if the therapist should happen to put his or her feet up on a stool with the sole of the feet facing the Southeast Asian refugee client or pat the head of a child, it will be considered extremely offensive. The therapist may not be aware of the effect of this nonverbal behavior. Poor accessibility may also be a hindrance to

Kleinman, & Womack, 1982). Clinics and private offices are often located in places that can not easily be reached, and using public transportation to get to these places may be a difficult task for Southeast Asian refugees, especially those individuals with poor English skills. Simple tasks such as working out a bus timetable, finding a bus route, or the payment may be highly stressful. Furthermore, many refugees may be unaware of the types and availability of mental health services (Van Deusen, 1982).

When considering or providing mainstream mental health services for Southeast Asian refugees, the cultural frame of reference must be kept in mind. Southeast Asian refugees' help-seeking behavior is influenced by culturally based attitudes (Van Deusen, 1982; Vignes & Hall, 1979). For example, traditional beliefs, superstitions, and the belief in the supernatural are common barriers to mainstream mental health care (Tung, 1983). This population instead often relies on indigenous healers and folk medicine (Egawa & Tashima, 1982; Muecke, 1983; Yeatman & Dan, 1980). Chung and Lin (1994) found that many Southeast Asian refugees reported concurrent utilization of both traditional and Western mainstream health care methods. This population of refugees in Chung and Lin's study reportedly preferred to use traditional methods, and their utilization of mainstream services in the United States was a reflection of the unavailability of traditional methods. Such behavior may suggest a desperate need for health and mental health services in this population.

## Counseling Refugees

In view of the cultural beliefs and preference for the traditional health care methods, it is crucial that psychotherapists work cooperatively with bilingual/bicultural mental health professionals, community leaders, elders, and traditional healers (e.g., spiritual leaders, monks, priests, herbalists, and shamans). Bilingual/bicultural mental health professionals are not just interpreters or translators but serve as specialized mental health professionals who are familiar with both Western models of mental health and the unique medical and psychological worldview of Southeast Asian cultures. Bilingual/bicultural mental health professionals play a

important role because they not only bridge the language gap and interpret subtle cultural messages between clients and therapist but also help establish a culturally sensitive treatment environment.

Because language differences pose a major barrier to help seeking for Southeast Asian refugees, using trained translators and interpreters is essential in areas where bilingual/bicultural mental health professionals are not available. Training of translators and interpreters is imperative to facilitate effective interventions and to minimize inaccuracies in communications. For example, an untrained Southeast Asian translator may be too embarrassed to tell the Western-trained psychotherapist that certain questions may be culturally offensive to the Southeast Asian client. Sometimes inadequately trained translators may answer for the refugee client, interpreting what they believe to be the "right" answer or a respectful response. Problems can also arise due to confidentiality, poor paraphrasing of questions, and inadequate translation of problems and psychological terms into the client's language.

Even with accurate translations, misdiagnoses may occur because of cultural misunderstandings. In one instance, a Southeast Asian man was committed to a psychiatric institution and was heavily medicated because his sponsor reported that he kept referring to seeing dead relatives and speaking with them. What the sponsor failed to realize was that referring to the dead is a common and accepted behavior among people from Southeast Asian cultures (Chung & Okazaki, 1991).

Many of the principles for counseling Asian Americans also apply to Southeast Asian refugees. In order to be effective, psychotherapists need to maintain both ascribed and achieved credibility with their clients in order to continue with the counseling process and avoid premature termination (Sue & Zane, 1987). Ascribed credibility is determined by the psychotherapist's status (e.g., age, education, or gender), whereas achieved credibility or gaining the trust and confidence of the client is determined by the psychotherapist's competency in the therapy sessions. Therefore, if the psychotherapist initially has a low ascribed credibility, he or she can acquire credibility by being culturally aware and sensitive. To achieve trust and credibility, psychotherapists need to be aware of the Southeast Asian refugee client's premigration history, postmigration adjustment issues, cultural belief systems pertaining to

health and mental health, and the potential concurrent use of traditional and Western methods of health care.

Refugee clients are frequently preoccupied, especially in earlier sessions, with resolving problems associated with basic needs and services rather than with working on more serious mental health concerns. This may result in refugee clients requesting help for social services such as an assistance with housing, employment, and welfare. Responding to these requests rather than discounting them as inappropriate in the process of psychotherapy will develop trust and credibility. Psychotherapists should be aware that the client's need to address these problems may be associated with personal desperation and fear concerning basic needs, which may overshadow other therapeutic issues. Because these social problems about daily living are often presented to psychotherapists rather than to other social service providers, there is a need for a linkage between existing resettlement programs, social and human service providers, and the mental health and counseling services. It is important that psychotherapists understand the refugee client's unfamiliarity with the Western psychotherapeutic method of talk therapy and the low credibility ascription of talk therapy. Subsequently, one way of beginning counseling sessions with the refugee client is to discuss everyday survival issues, such as asking clients about their employment situation, housing, and income. These discussions over critical life issues are natural ways to lead into the pressing psychological problems, which are often associated with premigration trauma and postmigration adjustment issues. The general aims of a psychotherapist working with Southeast Asian clients should be to (a) alleviate hopelessness, (b) instill in clients faith in themselves and hope for the future, (c) identify existing coping strategies, (d) explore new alternative coping strategies, and (e) help clients attain a sense of mastery and confidence over their lives.

### *The Multi-Level Model (M1.M): An Approach to Psychotherapy With Refugees*

In order to provide psychotherapy for Southeast Asian refugees effectively, the psychotherapist must be culturally sensitive and

understand the individuals' and families' worldview, premigration history and experience, and the extent of identification with their culture of origin. This requires not only the knowledge of Western counseling and psychotherapy techniques but also the ability to incorporate such theories into a multicultural counseling framework. To work effectively with refugees, it is also necessary to understand the factors associated with severe trauma and to take a multidisciplinary approach that incorporates constructs in psychology, counseling, anthropology, psychiatry, public health, social work, and sociology.

In order to address the complexity of these diverse bases of knowledge and skills, Bemak, Chung, and Bornemann (1996) have designed a comprehensive approach to counseling refugees called the Multi-Level Model. The MLM takes into account the intricacy of the refugee's historical background, past and present stressors, the acculturation process and the psychosocial ramifications of adapting to a new culture while providing a psychoeducational approach that includes cognitive, affective, and behavioral interventions. Cultural foundations and their relation to community and social processes are critical in this model. The MLM includes the following four levels: Level I—Mental Health Education; Level II—Individual, Group, and/or Family Psychotherapy; Level III—Cultural Empowerment; and Level IV—Indigenous Healing. The four levels are interrelated, and there is no fixed sequence for their implementation, so that they may be used simultaneously or independently. Although each level can be viewed as an independent unit, working with a client on all levels is essential to attain the desired goals of psychotherapy. The treatment planning emphasizing or using any one level or combination of levels must be based on the assessment of the psychotherapist. Use of this model does not require additional funding or resources, but rather the model allows the psychotherapist to assume different and more diverse roles as a helper.

In Level I—Mental Health Education, the focus is on the psychotherapist educating clients about mainstream mental health services. Many refugees are not familiar with the types of services available or with the process of mental health treatment. Thus the psychotherapist must educate the client about issues such as the norms of behavior in the physical environment of the mental health clinic, the purpose of the intake assessment, the roles and

expectations for the client and the psychotherapist, the role of the interpreter, the types and use of medications, and the appointment system. Such information helps the Southeast Asian refugee client understand the nature of a therapeutic relationship and formulate expectations for psychotherapy.

Level II—Individual, Group, and/or Family Psychotherapy builds on the traditional Western techniques of psychotherapy. The psychotherapist must make an assessment about the individual's needs and then determine which type of psychotherapy (individual, group, or family) will be most suitable for the particular client. Although traditional Western techniques are foreign to Southeast Asian refugee clients, these traditional methods of individual and family therapy are also effective with Asian clients (Zane & Sue, 1991). In particular, some specific techniques have been identified to be effective in working with this population. For example, the psychotherapist may take a more directive and active role during counseling sessions with Southeast Asian refugees (Kinzie, 1985). Cognitive-behavioral interventions have also been recognized as being helpful with Southeast Asian refugees (Bemak & Greenberg, 1994; Egli, Shiota, Ben-Porath, & Butcher, 1991), and both De Silva (1985) and Mikulas (1981) have suggested that cognitive-behavioral intervention may be effective with refugees because of its compatibility with Buddhist beliefs. However, Beiser (1987) maintained that cognitive-behavior interventions are helpful to this population because the techniques assist them to reorient to the present rather than to maintain a painful preoccupation with the past memories or to worry about an uncertain future.

Other techniques that can be incorporated into MLM Level II are storytelling and projective drawing. Pynoos and Eth (1984) described how these techniques can assist children who have experienced trauma regain control over their response to the traumatic event. Bemak and Timm (1994) demonstrated the efficacy of employing dream work in the therapeutic process with refugees. Other techniques that may be used in individual counseling include gestalt, relaxation, role-playing, and psychodrama.

Although group therapy has not been used extensively as a therapeutic intervention with Southeast Asian refugees, several studies have pointed toward its effectiveness with this population. Friedman and Jaranson (1994) have indicated that highly traumatized refugees find solace in group therapy. Kinzie et al. (1988)



have instituted a 1-year therapy group for Southeast Asian refugees that incorporates discussions about somatic symptoms, cultural conflicts, and loss, with the group structure allowing for flexibility with therapy session times and duration. The group approach may naturally lend itself to include psychoeducational information sessions (MLM Level I), traditional group psychotherapy (MLM Level II), and cultural empowerment group meetings (MLM Level III).

For Southeast Asian refugees, family is an important part of the culture and all aspects of the individual's life. This suggests that family therapy is a natural means of focusing on systemic rather than individual problems. It is important to note that given the emphasis on extended rather than nuclear family, family therapy for this population may include members of the extended family. Mental health professionals have stated the importance of family therapy with refugees, explaining that the roots, experiences, and subsequent family system problems with acculturation make family counseling an ideal intervention strategy (Bemak, 1989; Lee, 1989). Psychotherapists who use family therapy must have a clear understanding and knowledge about the cultural background and traditional relationships in the family.

Level III—Cultural Empowerment provides another important dimension in the healing of the refugee client. Cultural empowerment consists of assisting Southeast Asian refugee clients gain a better sense of environmental mastery. Frequently, the psychotherapist unfamiliar with a multicultural framework may focus exclusively on mental health concerns and neglect basic issues of adaptation in daily life. But many psychotherapists find themselves faced with refugee clients who are initially more interested in working on survival issues, such as housing and employment. The refugees may be trying to understand and make sense of their new environment, rather than discussing psychosocial adjustment and interpersonal issues. As mentioned earlier, it is important to address these issues as fundamental concerns before exploring other psychological problems. Cultural empowerment directly addresses these adjustment issues. Psychotherapists must therefore be sensitive to the difficulties inherent in adjusting to a new culture and provide case management through assistance and guidance that will lead to a sense of empowerment for the refugee clients. In MLM Level III—Cultural Empowerment, the psychotherapist is

not expected to be a case manager for the client but rather to assume the role of cultural guide in order to provide the client with relevant information about how the American social service system works, and answer questions about the host culture. In addition, by serving as a cultural broker, the psychotherapist may educate the refugee client about the legal system governing certain practices that may be misunderstood by social agencies. For example, school teachers and police have often mistaken coin rubbing, an Asian traditional medical treatment method that leaves bruises on the skin, for child abuse (Nguyen, Nguyen, & Nguyen, 1987). The practice of coin rubbing is believed to bring negative energy, the cause of physical and emotional problems, out of the body and restore balance to body, mind, and spirit.

In Level IV—Indigenous Healing, the psychotherapist integrates Western and traditional healing methodologies. The World Health Organization (1992) described how an integration of indigenous healing with Western traditional healing practices resulted in more effective outcomes. Such integration may be best accomplished in cooperation with indigenous healers who are known to refugee community members. As indicated previously, Chung and Lin (1994) found that Southeast Asian refugees prefer to utilize traditional methods of healing rather than Western psychotherapy and that a large percentage of this population concurrently use both traditional and Western methods. Psychotherapists working with this population must not only acknowledge that their clients may prefer traditional practices or want to combine traditional and Western methods, but also must be willing to integrate the refugee clients' healing methods with the Western treatment techniques. To this end, the psychotherapists of Southeast Asian refugees will benefit from approaching and working cooperatively with healers or community elders in the treatment (Chan, 1987; Hiegel, 1994). Note that not all traditional healers are legitimate, and that it is important to use community members to assist in identifying legitimate healers.

### *The Case Study of Mrs. N*

The case study and sample treatment plan using the MLM presented here illustrate the complex issues involved in counseling Southeast Asian refugee clients.

Mrs. N is a 48-year-old Vietnamese woman who came to the United States in 1982 in a mass exodus from Southeast Asia. Her husband had worked for the U.S. government during the Vietnam War, and after the fall of Saigon in 1975 he was placed in a reeducation camp run by the North Vietnamese. Although Mrs. N does not know the details of her husband's camp experience, she had heard that people placed in such camps were forced to work as laborers under harsh conditions and were regularly tortured. According to an official, her husband died of unknown causes while in the camp.

Upon learning about her husband's death, Mrs. N and her two children (at the time ages 1 and 3) fled Vietnam on a small boat. Because of terrible travel conditions and the lack of adequate hygiene and nutrition, Mrs. N's 1-year-old baby died on the boat. Mrs. N and her 3-year-old daughter finally arrived in Thailand, where they stayed in a refugee camp hoping to gain entry into the United States as refugees. The living conditions in the camp were poor, and Mrs. N and her daughter shared a tent with two other families. After a year and a half of waiting, a church in San Diego, California, became her sponsor, and Mrs. N and her daughter relocated to the United States.

It has been over a decade since Mrs. N and her daughter moved to the United States. Her daughter, now a teenager, appears to be well adjusted with a number of Vietnamese and non-Vietnamese friends. However, Mrs. N continues to have many problems. She still has frequent nightmares about the war atrocities she witnessed and the deaths of her husband and her baby. Mrs. N doesn't share anything about her background or bad dreams with others. Apart from attending special ceremonies and occasional parties, she remains quietly by herself or with two other single Vietnamese women her own age. Having taken many ESL courses, Mrs. N's English skills have improved, and she holds a job as a janitor in a local office building. She often feels sad and has frequent thoughts of ending her life. She explains that the only reason for staying alive is her daughter. Mrs. N came to the clinic on the recommendation of a Vietnamese coworker who was familiar with mental health treatment.

**MLM Level I—Mental Health Education.** Although Mrs. N came to the clinic through a referral of a friend, the psychotherapist (Dr. A) wanted to assess her understanding and expectations about counseling. Dr. A quickly determined that the friend who had referred Mrs. N had provided a good overview about the counseling process. One area that needed clarification was Dr. A's role as a psychotherapist. Mrs. N had assumed that Dr. A would be directive in "telling her what to do to feel better." Dr. A carefully explained the collaborative nature of counseling and how she would assist Mrs. N to gain a better understanding of her experiences.

**MLM Level II—Individual, Group, and/or Family Psychotherapy.** In the assessment of Mrs. N it was clear to Dr. A that she was experiencing a posttraumatic stress disorder (PTSD) and depression. Dr. A decided that initially Mrs. N could benefit from individual short-term therapy to address her PTSD and depressive symptoms. As Dr. A heard Mrs. N describing her loneliness and lack of companionship, Dr. A thought about the Vietnamese culture and Mrs. N's background. Exploring with Mrs. N about her days in Vietnam, Dr. A learned that Mrs. N had many friends and an active social life in Vietnam. Mrs. N commented, "I really enjoyed this time . . . there was always someone to talk with then." Based on an understanding that the Vietnamese culture emphasizes family and community, combined with the fact that Mrs. N was lonely, Dr. A recommended that upon completion of short-term individual psychotherapy, Mrs. N should continue her treatment through group counseling to deal with unresolved issues related to leaving her home country, losing her husband and a child, and adapting to a new culture.

**MLM Level III—Cultural Empowerment.** At the clinic, Dr. A was also conducting an open membership group for refugee women who had lost family members. Dr. A felt that the format, shared experiences with peers, and interpersonal communication provided by this group should be beneficial for Mrs. N. The group therapy sessions were comprised of bereavement and grief counseling sessions. The structure of the group also allowed for an exploration of issues relevant to its members' experience so that in later sessions Mrs. N could explore her forced migration from Vietnam and the problems of adapting to a new culture. The group sessions incorporated MLM Level III—Cultural Empowerment, which focuses on psychoeducational training to enhance acculturation skills. Topics such as difficulties in adjusting to a foreign culture; strategies for adaptation; cognitive, emotional, and behavioral responses to cultural and identity loss; and available resources were presented and discussed during the group sessions. Furthermore, Dr. A had established a relationship with one of the Vietnamese community leaders who works in a resettlement agency, and they periodically meet to discuss the general themes emerging in the group (maintaining confidentiality) related to cultural realities for widowed Vietnamese women.

**MLM Level IV—Indigenous Healing.** Dr. A believed that it was important to learn about the Vietnamese culture because she had been identified by the Vietnamese community as a professional with cultural sensitivity and with an openness to the traditional healing methods important to the Vietnamese community. Although Dr. A was not a Buddhist and did not understand many of the religious practices, she understood from her previous clients and contacts with the community leader that there were practices in the Buddhist religion that may play an important role in the healing process. Despite her Western training as a psychotherapist, she was open to incorporating traditional healing as a curative element to help her Vietnamese clients. Thus Dr. A determined that if Mrs. N believed in traditional practices, MLM Level IV—Indigenous Healing could be introduced at any time during the individual or group therapy. In fact, the Vietnamese community leader had told Dr. A about special ceremonies done by Buddhist monks that gave peace to the deceased. In the counseling sessions, Dr. A explored whether Mrs. N believed in this practice and whether she would be interested in participating in the ceremony with a Buddhist monk. Mrs. N responded, "I am afraid to finally 'let go' but I think it would be best for everyone if I did."

## Conclusion

The support and integration of cultural healing practices in conjunction with Western psychotherapy practices are instrumental in providing culturally sensitive treatment. The case of Mrs. N can be viewed as typical for many Southeast Asian refugees. The implementation of the MLM provides an important framework for working with the Southeast Asian refugees. The model does not require the psychotherapist to work sequentially on each level and does not necessitate additional resources or funding. (For a more in-depth understanding of the MLM regarding such issues as the concurrent usage of multiple levels of the MLM, incorporation of bilingual/bicultural mental health workers in the psychotherapeutic process, gaining crosscultural understanding and awareness, skill development in cross-cultural work, and selection of individual, group and/or family therapy as a method of treatment, see

Bemak, Chung, Pedersen, & Bornemann, in press.) Utilizing the MLM assists in expanding the psychotherapist's role to incorporate culturally sensitive intervention strategies specific to Southeast Asian refugees.

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