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*Brief Report*

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## Vietnamese Refugees with PTSD Symptomatology: Intervention Via a Coping Skills Model

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*The current study of Vietnamese refugee students revealed that the majority had experienced multiple traumatic events and reported moderate to severe PTSD symptomatology. A stress intervention module (SIT), designed to treat rape victims, was introduced to determine its efficacy for the treatment of Vietnamese refugees with PTSD symptoms. Postintervention PTSD symptomatology was significantly reduced contrasted to virtually no change in symptomatology for the control subjects. Serious methodological concerns, e.g., selection bias, sample size, are highlighted in the paper. The current inquiry is essentially a pilot study. The paper is intended for heuristic value. Clinical literature is extant for culturally sensitive intervention approaches for this vulnerable population.*

**KEY WORDS:** trauma; stress inoculation; coping; Vietnamese.

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## INTRODUCTION

After the fall of Saigon on April 26, 1975, more than 1.5 million Indochinese refugees relocated in the United States (Goldfield, Mollica, and Pesavento, 1988). The greatest proportion were from Vietnam.

Of the estimated 2 million who fled Vietnam, more than one half million died trying to escape. Those who fled by boat were frequently victimized by Thai pirates who raped women, kidnapped young females, and forced them into prostitution. Following traumatic exposure during war, escape, re-education camps, refugee camps, and resettlement in the United States, many refugees experienced mental health problems (Flaskerud and Nguyen, 1988). In a recent epidemiological survey (Yamamoto *et al.*, 1989) of 460 Vietnamese living in Orange County, California, 160, or 35%, showed characteristic post-traumatic symptoms ranging from mild to severe in intensity.

Western type therapeutic interventions with severely traumatized refugees have showed equivocal results (Kinzie and Fleck, 1987). A recent report by Mollica and Labelle on "Southeast Asian Refugees" (1988), suggested that traditional Western concepts of illness and diagnosis may not readily apply to the Southeast Asian refugees.

In a report on severely traumatized refugees, Kinzie and Boehmlein (1989) pointed out that many patients may get worse after the initial interview through fear that direct discussion of their experiences would overwhelm them with emotions. Since this potential loss of control is culturally frowned upon, indirect cognitive approaches to therapy have come into favor in recent treatment strategies with Cambodian refugees.

As a follow-up to the epidemiological survey of Vietnamese refugees in Orange County, California (Yamamoto *et al.*, 1989), a psychoeducational module was devised to teach Vietnamese refugees how to cope with PTSD symptoms. This module was based on Stress Inoculation Training (SIT) procedures (Veronen and Kilpatrick, 1983) originally developed for sexual assault victims. The SIT program was modified to make it culturally sensitive. For example, explicit trauma words such as "rape" were omitted to reduce possible offensiveness. Southeast Asians in general are particularly sensitive to disclosure of sexual issues.

## METHOD

### Subjects

In the spring of 1990, eleven Vietnamese refugees enrolled as University of California Irvine undergraduates (mean age 19.3 years) volun-

teered for a course, "Coping with Stressful Experiences." Eight students, four males and four females actually completed the course. Students who enrolled in the course (SIT subjects) were also instructed to obtain Reaction Index ratings from a consenting relative or friend who would serve as a "comparison" (Control) subject. Thus, untreated individuals were assumed to be "yoked" by similar stressful refugee experiences when compared with SIT students on PTSD symptoms. Two students failed to obtain Reaction Indexes from a Control subject; therefore 6 subjects, five females and one male comprised the Control group.

Treatment subjects had lived in the United States from 8-14 years, having left Vietnam when they were 3-10 years old (mean = 6 years). In this study, some refugee students were willing to share their trauma histories only after they had developed a trusting relationship, e.g., one of the students who reported only one traumatic experience (forced eviction from home due to danger) on the standardized interview, later revealed (after the course had progressed) to the instructors that she had been attacked 13 times by Thai pirates in South China Sea and had relocated to 13 different refugee camps before arriving in the United States.

## The Course

The Course was introduced to approximately 50 Vietnamese students on campus. It was presented as a research study to determine the efficacy of using SIT as an intervention module for Vietnamese refugees. The suggested benefit to students for participating in the course was to acquire positive methods for coping with stressful experiences.

The course design consisted of ten 2-hr training sessions (condensed to six 3-hr sessions) held weekly. The course covered the following areas: information gathering (questionnaires); theoretical background; introduction to deep breathing exercises (augmented by pulse meter monitors); thought stopping (deliberately thinking troublesome thoughts for 35-45 sec, then shout "stop!"); deep muscle relaxation; Beck/Ellis A-B-C paradigm (1979, 1961)—introduced by asking the subject to concentrate on a situation in which they become upset then proceed to fill in the paradigm, "A" (the event), "C" (the consequences/how they felt), finally "B" (the beliefs/statements they were telling themselves to cause them to become upset); guided self-dialogue (e.g., preparing for stress); role modeling of stress intervention scenarios (demonstrated initially by instructors, then by students).

Six of the investigators served as instructors for the course. Their ethnic origins were Vietnamese, Korean, Chinese, and Caucasian.

## Instruments

### *General Information Questionnaire*

A 23-item questionnaire was used to obtain sociodemographic data and an inventory of traumatic events experienced in Vietnam and during relocation to the United States.

### *"Self-Appraisal Ratings"*

An avoidance questionnaire was administered; this consisted of seven items pertaining to avoidance of situations, events, interest, emotional distance/numbing. This followed by an Ability to Function Scale (self-rated from 0-100) consisting of three questions (ability to study; ability to relate to others; impairment due to general discomfort/disability).

### *Reaction Index*

This instrument is a self-administered 28-item rating scale for assessing the impact of exposure to traumatic events. Each item is scored on a 0-4 system (0 = none; 4 = most). All SIT subjects were administered these instruments; SIT subjects and Control subjects were administered the Reaction Index at the beginning and ending of the course (Frederick, 1988).

## RESULTS

The SIT subjects' traumatic experience fell into four general categories: (1) Separation/eviction; (2) Deprivation; (3) Witnessing assault, death, demolition; (4) Loss of significant others secondary to combat, disease, or violent death.

The mean number of traumatic events for the SIT subjects was 2.6. The most frequently reported traumata was "forced separation from family."

The pretreatment mean scaled scores are comparable between the SIT subjects and the Control subjects (39.625 versus 39.667, respectively,  $t = 2.80$ ,  $p < .256$ ). A score of 40 classifies the degree of PTSD symptomatology as "severe."

Post-treatment mean scaled scores for the SIT group contrasted with the Control group was 24.00 and 36.83, respectively. A significant ( $t = 3.80$ ,  $p < .027$ ) reduction in PTSD symptoms was shown for SIT subjects in pre-

and post-test scores. There was no significant ( $t = 1.28$ ;  $p < .26$ ) change or reduction in PTSD symptoms for the Control subjects.

Pre- and post-Ability to Function Scale scores for the treatment group showed significant ( $t = -3.03$ ,  $p = .02$ ) improvement in their ability to relate to others. A Pearson correlation of .525 ( $p < .18$ ) was obtained for a comparison of pre- and post-treatment Reaction Index scores ( $t = 2.80$ ) with pre- and post-treatment Ability to Function Scale scores ( $t = -3.03$ );  $df = 7$ .

## DISCUSSION

1. The majority of the treated Vietnamese refugee students had experienced multiple traumatic events.

2. Based on pretreatment assessment of PTSD symptoms, the SIT subjects showed a significant reduction (from scaled score 40 to 24) of these symptoms after completion of the course.

3. SIT subjects who completed the course reported improvement in their ability to relate to others. Since PTSD diagnostic criteria includes emotional numbing/emotional distancing from others, one's ability to relate to others may be germane to assessing the social deficits of this illness.

4. Inspection of items from the Reaction Index questionnaire revealed that change in symptoms (from pre- to postmeasures) represented three categories: easier than before making decisions; able to relax when thinking of events (traumatic); improved sleep.

This investigation is essentially a pilot study with the findings being suggestive for future research. The findings are based on a 3-month coping skills course presented to a small sample ( $N = 8$ ) in one geographical and educational strata with serious self-selection bias (only 11 students out of 50 volunteered for the study).

Methodological concerns punctuate the problems of pairing the SIT subjects with the Controls. Although the Control subjects had nearly identical pretreatment Reaction Index scores, it is difficult to ascertain whether their stressful/traumatic refugee and immigrant adjustment experiences were similar to the SIT group. Therefore, the possible nonequivalence of the two groups could explain the post-test findings.

Another methodological concern addresses a potential response bias among the SIT subjects. It is traditional for Asians to be obedient to their elders and to conform to the expectations of those in authority. Therefore, these subjects may have deflated their Reaction Index post-treatment

scores unwittingly via a cultural bias (to please the wishes of their instructors/elders/authority figures).

The development of culturally sensitive intervention approaches for Vietnamese and other Southeast Asian refugees is in its infancy. Extensive research, including well controlled studies for self-selection bias with a substantially larger prevalence sample, is warranted. Methodological concerns and dependent measures must be carefully studied and accounted for before the dependent measures of treatment approaches (psychoeducational intervention) can be generalized to be efficacious for this population. In future studies, such variables as differences in traumatic experiences, post-traumatic social supports, economic status, and psychological predisposition should be observed for variance in symptomatology.

This paper is intended to have heuristic value in stimulating further investigatory inquiry to develop and test appropriate treatment hypotheses for this vulnerable population.

#### ACKNOWLEDGMENTS

This study was supported in part by the National Research Center on Asian American Mental Health (NIMH R01 MH44331). Thanks to Dr. Edna Foa for sharing the SIT (Stress Inoculation Training) procedures based on her work with sexual assault victims.

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