

Science of Refugee Mental Health: New Concepts and Methods

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Science of Refugee Mental Health: New Concepts and Methods

**Scientific overviews of the major methods in the field and
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ABOUT THE HARVARD PROGRAM IN REFUGEE TRAUMA

The Harvard Program in Refugee Trauma (HPRT) has been caring for survivors of mass violence and torture for two decades. Its vision has remained the same throughout this time: to bring the advances of modern medical science to those members of our society who in spite of their great suffering have little access to care. In December 1981, HPRT initiated its experiment in medical treatment by opening the Indochinese Psychiatry Clinic (IPC), which provided medical and psychiatric services for Southeast Asian refugees who had newly arrived in the United States. HPRT's initial team consisted of Indochinese paraprofessional staff and American health care professionals. Its methods of inquiry were multi-disciplinary and its treatment strategies unconventional. Little did HPRT's team know that they were defining a new approach to the identification and treatment of torture and mass violence that had not previously existed in the United States. De facto, HPRT was part of an historical trend in human rights that was blossoming in medical centers throughout the world and continues to this day.

In recent years, HPRT has expanded its clinical role by introducing public health science to the emergency phase of refugee and humanitarian relief and to the international reconstruction activities in the more than sixty nations devastated by violence. HPRT along with other scientists have been able to demonstrate for the first time the enormous psychiatric distress and disability associated with mass violence and war. These findings are especially relevant in our age of ethnic violence where 90% of all casualties are civilian. Women, children, and the elderly are especially vulnerable to violent after-effects.

HPRT has sought to build a solid scientific foundation for a new paradigm for the prevention of war and the healing and recovery of survivors of violence. The long-term morbidity associated with the social and psychological consequences of war can no longer be denied or ignored by governments and international agencies. A people-oriented or human-centered approach is necessary to reform current models of recovery that are primarily based upon material support and the repair of physical infrastructure. HPRT and its partners worldwide remain committed to placing human and mental health issues at the center of global approaches to world peace and development.

For more information on the Harvard Program in Refugee Trauma, contact Richard F. Mollica, M.D., M.A.R. at Harvard Program in Refugee Trauma, Third Floor, 8 Story Street, Cambridge, MA 02138, (617) 496-5530 (fax), rmollica@hppt.harvard.edu.

ABOUT THE EVALUATION CENTER@HSRI

Unfortunately the need for widely disseminated materials on refugee mental health is more urgent than ever given the recent refugee crises in Kosovo and East Timor. When we began compiling the proceedings from the 1992 *Science of Refugee Mental Health* meeting over a year ago, we did not anticipate that these crises would erupt and strongly motivate our efforts to quickly disseminate this material to a wider audience. We know that these materials will be helpful to the mental health researchers and providers throughout the world working with survivors of mass violence and torture.

This compilation was produced through a collaborative partnership between the federal Center for Mental Health Services (CMHS), the Harvard Program in Refugee Trauma (HPRT), and the Multicultural Issues in Evaluation program of the Evaluation Center@HSRI. The Evaluation Center@HSRI is a technical assistance center funded by CMHS and operated by the Human Services Research Institute (HSRI), a nonprofit research and planning organization located in Cambridge, Massachusetts. The mission of the Evaluation Center@HSRI is to provide evaluation technical assistance to state and non-profit public and private entities including, but not limited to, researchers, consumers, families, and provider groups. This technical assistance is designed to improve the planning, development, and operation of adult mental health services. The Multicultural Issues in Evaluation program is one of several programs within the Center. This program focuses on mental health evaluation issues related to diverse cultural, racial, and ethnic populations, including refugees.

For more information on the Multicultural Issues in Evaluation Program or the Evaluation Center@HSRI, please contact Rachel Levy, Psy.D. at 2336 Massachusetts Avenue, Cambridge, MA, (617) 876-0426 ext. 305, rlevy@hsri.org.

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FOREWORD

Since the United Nations created the United Nations High Commissioner for Refugees in the 1950s, the numbers of refugees and misplaced persons have continued to increase exponentially. Presently, approximately 10,000 persons become refugees or displaced persons each day. Mental health researchers continue, with limited resources, to try to understand the experience of refugees and displaced persons. New knowledge has been discovered and new methods have been created as a result of these scientific inquiries.

In 1992, the Refugee Mental Health Program of the National Institute of Mental Health (NIMH), the Harvard Program in Refugee Trauma (HPRT) at the Harvard School of Public Health, and the Indochinese Psychiatric Clinic of St. Elizabeth's Hospital of Boston joined together to produce a meeting, *Science of Refugee Mental Health: New Concepts and Methods*, to explore the new scientific knowledge and methods existing in the field of refugee mental health. This meeting grew out of the recognition of the importance of enhancing research in refugee mental health and an acknowledgement of the methodological difficulties in conducting research with these populations. *Science of Refugee Mental Health: New Concepts and Methods* convened leading scholars and researchers in the fields of, both, refugee mental health and scientific methods. Experts in the area of refugee mental health were encouraged to explore how their work could be improved by mainstream scientific methods and research. Similarly, mainstream scientists were challenged to apply their skills to the area of refugee mental health. Attendees contributed and presented papers on these topics at the meeting. This landmark meeting spawned a new generation of high quality, scientifically sound theories and methods, which today are playing an important role in the mental health care of refugees.

The present document is a record of the meeting proceedings. In addition to studying the papers contributed by the meeting participants, WooTaek Jeon, M.D., Ph.D., and Masaya Yoshioka, M.D., HPRT Research Fellows, viewed the participants' videotaped presentations. They have extracted the major themes of each presentation, as well as summarized the presentation's research and clinical implications for scientists and service providers. In addition to the summaries, there is a scientific overview that introduces each major topical section. The entire

document ends with a bibliography that will be useful to the reader wanting more information on various topic in refugee mental health.

Refugee mental health researchers, scholars and clinicians still have barriers to overcome in the attempt to understand and help ameliorate the mental health consequences of the refugee experience. As the field progresses, it is certain that scientific rigor, as emphasized in *Science of Refugee Mental Health: New Concepts and Methods*, will contribute to many new discoveries and practices in refugee public policy and to the overall well-being of refugees worldwide.

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**I. THE MAGNITUDE OF THE REFUGEE MENTAL HEALTH PROBLEM: A
WORLDWIDE SURVEY**



INTRODUCTION

Richard F. Mollica, M.D., M.A.R. and WooTaek Jeon, M.D., Ph.D.

The forced displacement of human beings from their homes remains a major international problem that is not abating. As of December 31, 1997 the total number of refugees and asylum seekers in the world was estimated at almost 14 million persons (U.S. Committee for Refugees, 1997, 1998). Even though it is difficult to assess the exact number of internally displaced persons, they are numbered at approximately 17 million. These individuals live in situations similar to refugees, but do not meet the international definition for being a refugee because they have not crossed over a national border and still reside in their country of origin. It is not surprising that until this major conference, the mental health problems of refugees and internally displaced persons, both subsequently referred to as refugees, had been largely ignored.

Protection and the material assistance of refugees have dominated the policy of international agencies including the United Nations High Commissioner for Refugees (UNHCR, 1997) and non-governmental organizations (NGOs) (UNHCR, 1997). Safely returning refugees to their countries of origin, a practice called non-refoulement, is a bedrock of international assistance. Yet, in spite of this important primary focus on the overwhelming and complex political and humanitarian issues confronting each and every refugee group, refugee mental health is beginning to emerge as an essential element of the refugee relief paradigm.

The condition of being a “refugee” is clearly a category of risk for mental health disorders because embedded within this condition is the often-unspeakable violence associated with the refugee experience. At minimum, refugees have been forced to experience violent expulsion from their houses, villages and country. At worst, refugee populations have been subject to starvation, forced labor, torture and the killing of family members, friends and neighbors. Often the refugee experiences unbelievable acts of human cruelty. For the first time, recent large-scale surveys (Mollica et al., 1993) have demonstrated the trauma and mental health outcomes affecting refugee populations. In fact, the prevalence of psychiatric disorders in refugee communities has been revealed to be up to ten times higher than in non-traumatized populations. A recent survey of Bosnian refugees residing in Croatia, for example, demonstrated that one in

four refugees suffered from major physical disability associated with psychiatric morbidity (Mollica et al., 1999). Scientific investigations are accumulating evidence that the level of psychiatric morbidity in refugee populations can be very high and that psychiatric distress is not benign and is leading to serious social and economic impalement.

If the prevalence of mental health disorders and related disabilities in refugees is high, why has there been neglect of the mental health sequelae of trauma in refugee populations by international policy planners and humanitarian relief organizations? A few speculations come to the foreground. Historically, the psychosocial problems of refugees were not considered medical consequences of mass violence in the same way as landmine or battle injuries. Mental health problems are “invisible” wounds that cannot be readily examined. Emotional distress secondary to the refugee experience is still considered benign because it is a normal human response to bad events (Summerfield, 1996). It is generally believed that a refugee will spontaneously recover from his/her emotional distress once he/she returns home. Unfortunately, little evidence exists that supports this general assumption. Until this conference, research on refugee mental health had not been systematic or scientifically rigorous enough to establish the reliability and validity of diagnoses of mental health disorders in non-English speaking populations (i.e., the majority of refugees). It has only been within the past 20 years that culturally valid measures capable of identifying psychiatric illness in refugee populations have been developed and field-tested. Advances in psychiatric taxonomy including the diagnosis of posttraumatic stress disorder (PTSD) have provided researchers with reliable criteria for measuring traumatic outcomes. Finally, the lack of acute mortality associated with mental disorders in refugees in the emergency phase allowed the medical community to solely focus on infectious diseases, starvation and physical injury. In contrast, as the recent war in Kosovo has illustrated, the broadening of a strict medical model to refugee health care is urgently needed since the major medical effects of violence in Kosovar refugees have primarily been trauma related mental health problems.

The Science of Refugee Mental Health was the first international meeting to advance the importance of using scientific methodologies for studying the major risk factors and outcomes associated with the refugee experience. As can be seen in the summaries that follow, major

methodological barriers in sampling, study design, instruments, and analysis are inherent in the refugee mental health field, and are in need of innovative solutions. New scientific data can result in the proper allocation of resources toward prevention and recovery programs capable of facilitating the rehabilitation of persons and communities devastated by war and mass violence. The magnitude of the refugee problem to date has primarily been a mathematical accounting of the millions of persons each year violently forced from their homes and unable to return. The United Nations estimates that one out of every 200 persons worldwide is a refugee. This is a shocking reminder of the refugee epidemic facing our global society (UNHCR, 1997). While technically valid in a clinical sense, a narrow psychiatric disease model that can screen refugee populations for psychiatric illness may be unrealistic at a macro-level. In the resource poor environments that generally characterize refugee camps, how can so many individuals receive the individual attention of a psychiatrist or counselor? Scientists must help providers clearly identify those risk factors that can be modified or eliminated as well as those resiliency factors that can be supported to enhance the physical and mental well being of the refugee. General approaches aimed at the care of the most emotionally damaged (e.g., rape victims) have demonstrated their cultural usefulness and efficacy (Mollica & Son, 1989). Refugee scientists and public health officials are struggling to develop and use cost efficient and culturally effective mental health interventions. In the late 1990s very few approaches have been field tested and verified. The numbers of refugees are so large and the mental health effects of their violence experiences so ubiquitous, a new public health model of traumatic outcomes may need to be elucidated. The search for this model is proceeding today at a rapid pace and holds the potential of relieving the suffering and disability of millions of refugees worldwide.

REFUGEE CRISES AND MENTAL HEALTH: AN OVERVIEW

Presented by: Susan Forbes Martin, Ph.D., Refugee Policy Group

Summarized by: WooTaek Jeon, M.D., Ph.D.

Refugees are defined in international law as individuals who have been forced to flee their countries because of a well-founded fear of persecution, a particularly virulent form of human rights abuse. The worldwide total of refugees who have been forced from their home countries stands at about 18 million persons today. An equal or probably larger number of people are internally displaced refugees.

Mental health services have generally been considered a luxury that a refugee program is ill able to afford (Arnhoff, 1975). As a result, relatively few programs have been established to address the psychosocial needs of refugees. Refugee movements tend to be defined as emergencies requiring rapid response. Emergency responses tend, in turn, to be defined logistically: how many tents, tons of food, clothing, and medicines can be delivered in the shortest time possible. Failure to respond quickly and efficiently to these emergency needs can result in thousands of deaths. Refugees' nonmaterial needs are much more difficult to qualify. The logistical challenge of helping a small child cope with the loss of his or her parents has not yet been worked out. The after effects of rape and witnessing murder are far more difficult to address than are the after effects of an empty stomach. For many refugees, services to address the effects of trauma are far from being a luxury. The experiences that generate mental health problems include months, if not years, of war and/or repression, the uncertainties and dangers of flight, and prolonged stays in refugee camps. In addition, arrival in a new country and supposed place of safety does not necessarily mean an end to the cause or consequences of these traumas (Beiser & Fleming, 1986; Berry & Kim, 1988).

Complicating the picture is a basic ambivalence about the refugees themselves. On the one hand, refugees are seen as victims, vulnerable groups requiring help. On the other hand, they are known to be the survivors, those who managed to reach safety. This ambivalent view of the refugee tends towards a confused assessment by their caretakers as to their ability to cope with trauma.

The most basic responsibilities of the international refugee system towards refugees fall into two categories. First, refugees must be protected. This requires an improved capacity to respond to the psychological impacts of the refugee situation. Once refugees are in a camp situation, having a trained group of people who listen to, understand and make sense of their stories is absolutely necessary to the continued protection for refugees (Looney & Harding, 1986). Second, durable solutions must be found so that they can cease to be refugees. The psychological well being of refugees is also essential to the search for solutions to the refugee situation. There is growing recognition that the only way in which repatriation will be successful is if it is integrated into plans for the development and reconstruction of the countries to which the refugees are returning.

In examining the risk factors for mental health problems, it is clear that trauma occurs at all stages of the refugee situation. It has its roots in the pre-flight period, with the reasons that people become refugees. Therefore, two strategies are necessary. A first strategy is to figure out what are the interventions that make the most sense at which stages of a refugee movement. It may not be necessary to argue for the same level of intervention, or same types of interventions, at each stage. Instead, during the early emergency phase, interventions may be aimed at the protection of those who remain vulnerable. Initial needs assessments could be conducted to identify those who are at most risk. Early intervention with these groups could play a part in preventing or minimizing later problems. A second point relates to the cumulative effects of stress. A compelling argument can be made that it is not just any given set of occurrences that create mental health problems for refugees, but rather the accumulation of risk factors that determines whether a refugee will be more or less vulnerable to developing psychological problems. In general, in refugee emergencies, there has tended to be much more of a focus on curative, rather than preventive, care within health systems. Primary, preventive care and creative solutions must be found to meet the needs of those refugees with serious mental health problems. Also, effective refugee mental health programming requires greater attention to the needs of refugee women and children who constitute a majority of the refugee population.



Research Implications

A major mission of researchers is to demonstrate the importance and urgency of the mental health problems of refugees and their long-term psychosocial effects. Research data can provide previously unavailable information that relays to policy planners and implementers that attention to the mental health of refugees is not a luxury item. Demonstrating the unique problems of vulnerable refugee groups such as women, children, the elderly, physically ill, disabled, and torture victims is also necessary.



Clinical Implications

Mental health care programs should be included in emergency aid to refugees. These programs should be practical, culturally appropriate and inexpensive. This means that refugee mental health programs should have clear short-term and long-term treatment goals, quick evaluation methods, crisis intervention, and preventive activities. Psychiatrists and mental health workers should be trained to deal with these problems. There is a need to develop a realistic “package” of mental health care for refugees which is ethnic-specific and culture-specific, and which also involves training.

DISCUSSION OF “THE REFUGEE EXPERIENCE: HISTORICAL PERSPECTIVES”

Presented by: Alan M. Kraut, Ph.D., Professor of History, The American University

Summarized by: WooTaek Jeon, M.D., Ph.D.

Lack of experience and imagination are often obstacles too formidable to allow even a compassionate individual to comprehend the trauma to which refugees and displaced persons have been subjected, much less fully appreciate their psychosocial needs. All those who work with refugees or empathize with their plight are well aware of the barriers to such openness, even more so when cross-cultural communication is required, and the great need to develop new plans and strategies to help people on the move. As we gather together to discuss new methodologies for studying refugee mental health, we would do well not to neglect history

A quick scan across American history suggests that many of the concerns about psychosocial adaptation mentioned in Susan Forbes Martin’s paper have troubled public officials, immigrant and refugee advocates of earlier eras. Historians traditionally cite the period from 1840 to 1860 as the first great wave of immigration. Then state government, not the national government, had jurisdiction over immigration (Ernst, 1965). State immigration commissioners in major ports acted to protect America by excluding those judged insane (Kapp, 1969). Those who showed signs of mental illness after admission were institutionalized. Patterns of aberrant behavior—excessive drunkenness, sexual excesses, and emotional displays of grief or anxiety—diagnosed as insanity in the 1840s seemed quite common among newly arrived immigrants. With those insanity criteria, Irish immigrants had the highest rates of insanity.

The debate over what to do with those judged psychologically unfit for America heightened along with the pace of immigration at the end of the last century. Again exclusion at the point of entry remained the first choice. Immigrants and refugees found themselves subjected to psychological as well as physical examination by physicians of the United States Marine Hospital Service. When diagnosed as psychiatric patients, they were admitted to hospital. After an immigrant’s admission, all mental health problems were matters for private charities.

Dr. Fishberg (1903, 1911) found large numbers of newcomers suffering from nostalgia, or homesickness. If the past teaches us anything about refugees' psychosocial needs, especially those who have experienced physical persecution, it is that the approach was too causal and unsystematic. At times, only a crisis such as suicide and administrators' fears of negative publicity stirred action. Clinical understanding of immigrants' and refugees' mental plight is much greater today than it was 1854, 1911, or 1945. However, the formulation of programs that allow sensible repatriation of camp internees and the involvement of refugees themselves in formulating programs and solutions to meet their psychosocial are still embryonic, we must consider the latter so we don't fail our generation's refugees with little more than the best of intentions.



Research Implications

Refugees are individuals with many unique sociocultural and historical considerations. Not only physical and mental health problems and well-being should be considered in research design, but also the historical and political aspects of the refugee experience. Researchers of refugee mental health also are in need of an historical orientation in order to have a more comprehensive view of the refugee experience. Multidisciplinary research projects that link various viewpoints about the refugee's mental health are very important.



Clinical Implications

From 1840 to 1860 Irish immigrants had the highest rates of diagnosed insanity, this fact demonstrates that when the criteria of insanity lack a cultural perspective many errors can occur. Historical experience reveals that a psychiatrist's or mental health worker's ability to evaluate refugees in a culturally sensitive manner is critical, otherwise misdiagnosis and inadequate treatment can occur. Mental health workers must be trained to reliably conduct culturally valid diagnosis and treatment. This skill is very important in a field that requires a comprehensive understanding of the refugees' culture, society, and history.

II. THE RELATIONSHIP BETWEEN THE REFUGEE EXPERIENCE (MIGRATION AND TRAUMA) AND OUTCOMES



INTRODUCTION

Richard F. Mollica, M.D., M.A.R. and Masaya Yoshioka, M.D.

Until the early 1970's, the relationship between the refugee experience and the migrant experience had not been disentangled by scientific investigators and/or clinicians. In fact, since the majority of studies earlier in the century had been based upon the migration and immigrant experience, this paradigm was applied to the new waves of refugees that were resettled in Europe and the United States beginning in the 1970's (Tyhurst, 1951; Malzberg, 1964; Beiser, 1988). A dominant feature of the migration model was related to the basic question- "Did migration place resettled populations at increased risk for serious mental illness as compared to comparable citizens in the country of origin who did not migrate." Considerable attention, therefore, was placed on determining the resiliency of migrants and immigrants to the acculturation stress of resettling in a new culture and society (Berry, Kim, Minde & Mok, 1987; Rogler, Cortes & Malgady, 1991). In the 1970's, rapid translocation of non-Western populations en-mass from Indochina to Europe and the U.S. provided many migration researchers with a new non-Western population to which they could study their migration model (Owen, 1985). Kinzie, Fredrickson, Ben, Fleck and Karls (1984) and Mollica, Wyshak, de Marneffe, Khuon and Lavelle (1987) were the first investigators to reveal the importance of the violence that had occurred to refugees in the pre-migration phase. Many methodological issues had to be initially overcome in these new studies because it was not recognized at the time that refugees could report their many horrific life-threatening traumas. Clinical tradition avoided asking traumatized patients to reveal their trauma history; it was definitely incomprehensible that non-patients in a general survey would reveal accurately their trauma history. (Mollica & Caspi-Yavin, 1991) Fortunately, the development of reliable and culturally validated screening (Kinzie, Manson, Tolan, Anh & Pho, 1982; Mollica et al., 1987; Mollica et al., 1992) advanced the entire scientific process. By the late 1980's, for the first time in the history of this field, simple culturally valid measures had been tested capable of quantifying the trauma events experienced by refugees. Within scientific circles, refugee populations were no longer lumped together with migrants and immigrants because in spite of the universal issues of resettlement affecting all three groups, the pre-migration violence of refugees were an especially potent risk factor for serious mental illness.

Throughout the 1970s and 1980s, refugee mental health researchers continued to elucidate those risk factors associated with the mental health sequelae of the refugee experience. Susser's model of epidemiology applied to the stressors of life experience and their mental health outcomes provides useful insights into refugee research. Susser (1981) described the importance of epidemiologic triad of *agent-host-environment* in the social sciences. In recent years, scientists have brought to light considerable new knowledge about the nature of the psychosocial and biological effects of violence on refugees. The type of degrading and dehumanizing events experienced by refugees (Mollica et al., 1993) has been described; the mental health sequelae of these events revealed (Mollica et al., 1999); and the dose-effect relationships between cumulative trauma and psychiatric disorders demonstrated (Mollica et al., 1998). In contrast to considerable evidence that trauma is a major risk factor for mental health problems in refugees, still little is known about other risk factors including those that increase resiliency. Using Susser's model, recent scientific investigations have emphasized the *agent* component of the triad. Unfortunately, little is known about those *host* and *environmental* factors that affect traumatic outcomes in refugees. Host factors such as cognitive resiliency to torture have been described by Bosoglu et al. (1994); environmental risk factors such as employment opportunities, family status and language competence in country of resettlement (Rumbaut, 1989) have been demonstrated for resettled refugees. Future research is clearly necessary on environmental and host factors. While sophisticated measures of defining environmental and host characteristics are being developed in other areas of psychosocial research, these measures have been fully elaborated in refugee research.

The measurement of psychiatric disorders in refugees has advanced dramatically over the recent years. The modern concept of posttraumatic stress disorder (PTSD) has improved the ability of investigators to identify reliable criteria for psychiatric illness in refugee populations; a similar comment applies to major depression. In spite of this, the cultural validity of PTSD criteria in refugees is still widely debated. Mollica et al. (1987) and Kinzie et al. (1984) were the first to identify the relevancy of PTSD criteria in a Cambodian refugee group from Southeast Asia. Dose-effect analysis suggests that not all subcategories of PTSD symptoms are culturally universal. (Allden et al., 1996; Mollica et al., 1998) These and many other studies, however, reveal the theoretical value of PTSD criteria (Kinzie et al., 1990). In spite of considerable

criticism of PTSD's Western diagnostic biases, no field studies exist which identify folk-diagnoses or comparable indigenous related responses to PTSD that can replace or modify the PTSD concept. Hopefully, cross-cultural studies will become available allowing for a comprehensive assessment of the relative merits of PTSD and other DSM-IV diagnoses.

Recent studies (Mollica et al., 1999) are also using for the first time measures of disability in refugee populations. This area of investigation suffers from many methodological problems including the limited objectivity of self-reports of disability as well as lack of a baseline for functioning in refugee camp or other asylum situations. What is an expected level of functioning in a refugee camp, for example, is not known since work and other socioeconomic activities are often politically restricted. Similarly, functional and employment status prior to the refugee experience is difficult to determine in retrospect since few health and employment records are available in most situations. The measurement of disability in refugees is a critical, but especially challenging problem.

Finally, enormous advances in the study design of refugee research has occurred, partially promoted by the results of this conference. Almost all of the earliest refugee research emerged from studies of clinical cases (Owen, 1985). While these earliest studies were ground-breaking in their generation of new hypotheses and clinical insights, a newer generation of scientific studies has been forthcoming which use adequate design and sampling including case-controlled studies, cross-sectional surveys and longitudinal follow-ups.

Many examples of case-controlled studies and cross-sectional surveys are now available in the refugee mental health field (Bosoglu, Jaranson, Mollica & Kastrup, 1998). Longitudinal studies are only beginning to be conducted. Yet, in spite of these methodological advances, numerous problems in study design still limit research findings. For example, it is still very difficult to adequately sample refugee populations, especially those in refugee camps or internally displaced persons. Access is almost always difficult because of the danger and violent conditions of refugee environments. Randomization of sampling of refugee participants is limited because of the chaotic nature of housing in refugee encampments. Lack of skilled interviewers becomes a barrier when large numbers of respondents are necessary for the study. The ethical issues

associated with refugee research, especially the relevancy of research into the refugee's traumatic situation, are always in question. Refugees in countries of resettlement continue to dominate refugee research because of their relatively safe accessibility. Resettlement studies, however, often suffer from lack of an appropriate control group. Unfortunately, it is almost impossible to find an adequate control group for resettled refugee populations. In countries of resettlement it is rare to find a comparable comparison group that has all characteristics in common to the refugee index group except their refugee status. It is also very difficult to find a control group that has not been traumatized. One solution has been to compare less traumatized refugees to the most traumatized individuals within the same refugee community. Finally, migration effects are confounded since all resettled refugees are also migrants. For example, how do resettled refugees compare to those with similar characteristics who remained in their country of origin and did not migrate. Because of these methodological barriers, a study that includes migrant and non-migrant refugees from the same background has not been conducted. Now finally scientific investigators have had difficulty describing those "host" characteristics that make resettled refugees uniquely different from comparison groups no matter how closely related group members are to the refugee group. It must be considered that refugees may have unique personality and social characteristics that placed them at increased risk for violence, and thereby, their refugee status. These unique characteristics may influence their mental health outcomes in either positive or negative directions. Selected bias still remains, therefore, a major problem in refugee research.

In summary, in order to develop effective clinical and humanitarian assistance programs for refugees, high quality scientific investigations are necessary. Since World War II, enormous advances in the development of culturally valid mental health instruments, sampling techniques and study design, and the overcoming of selection biases are resulting in the elucidation of the mental health effects of violence. While many risk factors such as trauma have been identified, the clarification of causal mechanisms is still in its infancy.

THE EPIDEMIOLOGY OF MENTAL ILLNESS IN REFUGEES

*Presented by: Kenneth J. Rothman, Dr.P.H., Editor, *Epidemiology**

Summarized by: Masaya Yoshioka, M.D.

Epidemiology is the study of the occurrence of illness. This concept consists of: 1) measure of disease occurrence such as incidence rate, cumulative incidence or prevalence, 2) measure of effect such as rate difference or rate ratio, and 3) study types such as cohort study or case control study.

The epidemiological study of mental illness in refugees is difficult. Diagnostic risk factors, such as the diagnosis of mental illness in refugees as well as selection risk factors such as selection bias, confounding, and information bias will affect the study.

For mental illness, difficulty in defining the illness is profound because the diagnosis is often subjective and relative. It is subjective because it is often based on an impression of observed behavior or symptoms or on a history related by the patient rather than on a clearly defined set of observable criteria. It is relative because mental illness is not defined the same way in all cultures and in all times. By asking the same questions of all patients, a structured interview format that can be applied in many study settings improves the objectivity of the diagnosis of mental illness. However, even with structured interviews, the process of diagnosing of mental illness is highly subjective compared with diagnosing organic illness.

The subjectivity of the diagnosis of mental disease is exacerbated when the patient is a refugee. In that case, the patient's answer or behavior may be more colored than usual by what the patient believes will be the consequences of specific responses (Willis & Gonzalez, 1998).

Most epidemiological studies involve comparisons, with the objective of estimating the effect of some factors on the occurrence of the disease (Basoglu et al., 1994). Finding an appropriate comparison group is a core problem in epidemiological study design. One needs to know what would have been the experience of some groups in the absence of a putative risk factor. Example 1, to study the effect of torture on the subsequent mental health of refugees, investigators would

have to know the degree of depression experienced by refugees prior to their torture experience or if they had not been tortured. This counterfactual information is impossible to know, but researchers might estimate it by trying to find a comparison group whose experiences provide an estimate of the occurrence of depression that tortured refugees would have had if they had not been tortured. Example 2, if comparing refugee groups with other groups, the comparison groups might be non-refugee inhabitants of the host country, non-refugee inhabitants of the refugees' former homeland, or another group of refugees. The difference of refugee groups from other groups such as, the difference between the people who determined to flee to out of their home country and the people who remain in the country, may be conservative or overly optimistic (McKelvey & Webb, 1997). Example 3, if oppression and flight cause mental problems, the final result may be that the prevalence of mental illness among the refugees is no different from that of their original compatriots because it has been raised from a lower level to begin with. It may be lower, equal, or higher than the prevalence among citizens in the refugees' nation of origin, depending on how common mental illness or its diagnosis is in that country. Epidemiologists would expect that selection biases comparing refugees with their new compatriots would be extremely difficult to assess.

Confounding is similar to selection bias, except that it refers to variables that can be measured and controlled more readily than selection factors. For example, the age distribution of a refugee population is typically different from that of the non-refugee population in a given area. The age distribution of a population usually changes slowly, whereas refugees usually migrate in waves over a relatively short time. After migrating, their age distribution changes rapidly with time, because their ranks are not being replenished by a continuing supply of new young members, as happens with the non-refugee population. The factors such as age, gender, socioeconomic level and education are all risk factors for mental illness, and therefore differences in these variables between refugees and non-refugees will lead to confounding. The confounding may be controlled by several different epidemiological methods, but to do so requires that the investigator anticipate the problem and obtain the necessary data to implement the methods for control.

For other diseases, epidemiologists rely on a study design in which the diagnosticians are kept blinded to the exposure information of each subject, and sometimes even the study objectives. It is tough to see how the same methodology could be applied to the diagnosis of mental problems. For example, it is impossible for an investigator to keep an interviewer unaware of a history of torture, if the interviewer is trying to make a diagnosis of mental illness. It may be impossible to conduct an epidemiological study on the mental health of refugees that entirely avoids the problem of information bias.

There is no universal answer to the question whether epidemiological studies of refugees are worth undertaking.



Research Implications

If studies of mental illness in refugees include conducting surveys of non-Western refugees, these studies should use reliable and valid measures of psychiatric distress and psychiatric diagnoses. Considerable attention should be given to choosing an adequate control group. Selection biases should be clearly anticipated and corrected as much as feasibly possible.



Clinical Implications

Clinicians caring for refugees should pay increased attention to the reliability and validity of their psychiatric assessments and diagnoses. The clinician may use available data to *outreach* to those members of a refugee community that have been determined to have a high prevalence of psychiatric illness. The most needy individuals may not be seeking help. Second, the clinician should consider whether their treatment is reducing refugee risk factors such as employment and lack of family resources. Third, clinicians should also consider the unique socio-political, historical and personality characteristics of the refugee communities they serve, as well as what may be differentiated in their patients from non-refugees from the same country.

A THEORETICAL FRAMEWORK FOR STUDYING THE NATURE AND EFFECTS OF RECENT STRESSFUL LIFE EVENTS

Presented by: Bruce P. Dohrenwend, Ph.D., Columbia University

Summarized by: Masaya Yoshioka, M.D.

Life stress processes consist of the following three main structural components (Dohrenwend, 1979). These are:

1. The stimulus component of life events, ranging from extreme situations such as man-made or natural disasters to more usual events such as the deaths of significant others, injuries, marriages, the birth of a child, marital separation and divorce, and job loss.
2. The component of the ongoing social situation that existed before the occurrence of the life event(s) and that is likely to both affect and be affected by the occurrence of the life event(s). The ongoing situation includes such factors as the individual's occupational circumstances, domestic arrangements, and his/her social network.
3. The component of the personal characteristics or dispositions of the individual exposed to the life events. These characteristics involve such factors as the individual's genetic vulnerabilities, past experiences with episodes of physical illnesses, psychiatric disorders, other major life events, and personality characteristics that are likely to be related to his/her ability to cope with the events and changing situations.

Variations in relations within and among these three sets of life stress variables contribute to specific adaptive and maladaptive outcomes.

The most important objective stress-inducing properties of a life event are:

1. The event's negative valence (undesirable rather than desirable; representing loss rather than gain)
2. Its fatefulness, i.e. the extent to which the occurrence of a negative event is outside the control of the individual (the less control over the occurrence, the more stressful) and independent of his/her behavior
3. The extent to which the event is life-threatening
4. The magnitude of change in usual activities that is likely to be brought about for an average person experiencing the event
5. Whether the change is physically exhausting

These elements are central to objectively investigating the nature of coping with events. These properties also are effected both by the objective nature of the events and the ongoing situation, and by the personality characteristics of the respondents.

Intra-categorical variability is the great variability of judgment that depends on particular changes that respondents experienced (such as “death of a close friend”) and effects the aspects of independence from personal predisposition and valence such as “being laid off” that sometimes turned out to be a euphemism for being fired. To assess stressful events by the study of life events and health outcomes intra-categorical variability should be considered. The Structured Event Probe and Narrative Rating Method (SEPRATE) involving obtaining detailed descriptions from respondents of the sequence leading up to the event and the circumstances surrounding its actual occurrence have been developed to deal with this problem of intra-categorical variability in the objective measurement of life events, as a more labor intensive method of measurement (Dohrenwend et al. in 1993).

The outlines of five alternative models portraying different ways in which recent events may be related to each other and to adverse changes in health are set as models of life stress process.

1. **Victimization Model:** This model indicates that accumulations of the stressful life events cause adverse health changes. This model is based on studies of extreme situations such as combat and concentration camps and involves the following events and conditions: exhaustion resulting from life-threatening physical illness or injuries, loss of social support as a result, for example, of geographical relocation, and fateful negative events other than physical illness or injuries over whose occurrence the individual has no control, such as death of a loved one.
2. **Vulnerability Model:** This model describes how preexisting personal dispositions and social conditions modify the causal relation between stressful life events and adverse health changes. The latter hypothesis underlies much of the literature on vulnerability and makes strong use of conceptions such as coping ability and social supports.

3. Additive Burden Model: This model contrasts with the second model in that personal dispositions and social conditions are portrayed as making independent causal contributions to the occurrence of psychopathology, rather than modifying the impact of stressful life events.
4. Chronic Burden Model: This is a further modification of the second model. It denies any role to recent life events, suggesting instead that stable personal dispositions and social conditions alone cause the adverse health changes.
5. Proneness Model: This model indicates that the presence of disorder leads to stressful life events, which in turn exacerbates the disorder.

These models provide a framework for designing research that advances understanding of the relationship between life stress and adaptive or maladaptive responses.

The experiences of refugees occur in several stages:

1. Persecution by other members of the home society.
2. Dislocation in the form of internal and/or external migration in response to persecution.
3. Acculturation to the new setting along any one or several of a variety of paths involving assimilation, separation, integration, or marginality.
4. For some, repatriation in the form of return to the home society. Since the outcomes at each stage affect each subsequent stage, the complexity of the challenge is multiplied.

Comparing these stages with the models of the life stress process, the Victimization Model would be applicable to the persecution stage, especially when threat to life is involved and the stage is long-lasting. This persecution stage may often merge with the dislocation stage, with victimization hypothesis continuing to be applicable. The Vulnerability Model would be applicable to the acculturation stage, but the weight given to personal dispositions in comparison to factors in the ongoing situation would differ according to the relation of this stage to the two stages preceding it and the psychological toll these preceding stages took. Factors that would have to be considered include the process by which the new environment (voluntary-forced choices) was reached and the characteristics of the new environment (similar-dissimilar, hospitable-inhospitable). The stage of repatriation is effected not only by all of the preceding

stages, but also whether major transformations of the home society have occurred that would eliminate the conditions that led to creation of a refugee population in the first place. For people to voluntarily return to the same circumstances in which they were persecuted, one would have to consider the applicability of the Proneness Model. For persons forced to return, political repression would have to be involved and the Victimization Model would again have to be considered.

This is only a brief foray into the complexity of conducting theoretically informed, systematic stress research with refugee populations. The challenge is far from solely scientific. Systematic research is needed that will contribute to the detection and control of harmful environments.



Research Implications

Researchers have to consider not only the refugee's violent experiences but also their personal history, social situation, and personal characteristics. A number of life stress processes may exist at different times in a refugee's life history or occur simultaneously. Attention should be given to the properties of traumatic life experiences as well as the sociocultural and socio-political conditions under which they occur as well as individual coping mechanism. New concepts like "the epidemiology of refugee mental health" that are not stuck in traditional concepts of epidemiology may be considered for this area of studies.



Clinical Implications

The background of the refugee patient including their specific political, cultural and traumatic life situation should be understood in order to have a full appreciation of their life stress. It may be of great help for the rehabilitation of refugees for the clinician to understand the psychological process involved with each stage of the refugee's stressful life events.

III. THE UNIQUE NATURE OF THE REFUGEE EXPERIENCE



INTRODUCTION

Richard F. Mollica, M.D., M.A.R. and WooTaek Jeon, M.D.

Twenty years ago, no one knew what refugee experiences really were. At this time, people did not ask refugees about their traumatic experience for several reasons. First, it was thought by medical and psychiatric practitioners that asking refugees about their traumatic experiences might worsen their mental state. Second, due to the influence of psychoanalysis, clinicians believed that the pre-morbid and pre-event personality of the refugee were more important than the traumatic event in determining the mental health effects of trauma. Third, the conception was widely held that one could not do anything to relieve the psychological damage caused by the mental health effects of torture. So caregivers felt no need to ask refugees about their traumatic life experiences.

Over the past twenty years enormous changes have occurred in the clinical approach to the torture survivor and refugee patient. The “*voice*” of the refugee survivor is no longer “*silent*”, forgotten or neglected. It is now standard practice in research and clinical interviews to ask refugee survivors to give an accounting of their traumatic life experiences. Two interviewing discoveries in the late 1970’s, lead to these dramatic changes in the interview approach to the torture and refugee survivor. First, Chilean psychologists at the height of the Pinochet repression were able to develop an assessment and treatment approach in which political prisoners who had recently been tortured were able to tell their experiences to a mental health team (Cienfuegos & Monelli, 1983). The ex-prisoners were able to do this by talking into a tape recorder while the clinician listened to their story. This innovative technique of using a tape recording machine allowed torture survivors to tell their story of the unbelievable horror and brutality they had experienced. The tape machine could be played over again as survivor and clinician listened to a neutral unemotional third party- i.e. the tape recorder. Dialogue between survivor and clinician could then follow. Similarly, in the early 1980’s, the Harvard group was able to elicit symptoms from Indochinese refugees, many who had been tortured, by the use of a simple screening instrument (Mollica et al., 1987). This instrument, considered a medical test by the patients, allowed the refugees to put words around their emotions as well as describe directly the trauma events that they were not able to express directly in traditional open-ended medical and

psychiatric interviews. Both novel approaches opened up for researchers and therapists clinically safe opportunities for survivors to share with their clinicians their worst experiences. The clinical importance of the use of a simple, neutral third party (i.e., tape machine or screening instrument) in the medical interview was revealed.

Prior to the above discovery, life event researchers had primarily used three methods for obtaining the life history of non-traumatized persons (Mollica & Caspi-Yavin, 1991):

1. Patient/respondent self-report
2. A priori life event rating scales (e.g., Holmes and Rahe Social Adjustment Rating Scale)
3. Contextual model e.g. the life events approach of G. Brown and colleagues

While the life events field had been plagued with proving the reliability and validity of self-reports of life experiences, attempts to improve the accuracy of reporting of psychologically significant life events by approaches such as Holmes and Rahe and Brown also met with considerable criticism. Refugee trauma researchers understanding the nature of this debate, consequently choose to document only those refugee trauma events that were unquestionably of an emotionally disabling and psychologically injurious nature. These types of events included the experience of rape, torture and witnessing the murder of a family member. Amnesty International had already demonstrated their ability to verify the reporting of torture by witnesses based upon historical and political knowledge of a torturing environment and the consistency of multiple reports by witnesses unknown to each other. A number of recent scientific overviews (Willis & Gonzalez, 1998) have supported the reliability and validity of self-reports of torture and mass violence in situations where objective sources such as hospital, prison or military records are not available to serve as corroborators of the refugee reports. While the test-retest reliability of the self-report of refugee trauma events are now being conducted, these results can only suggest and may not prove in highly chaotic refugee situations that certain trauma events have in fact taken place.

Overall, a number of new conclusions have emerged contradictory to prior assumptions related to the refugee experience:

1. Refugees can respond to questions about their traumatic experiences without becoming seriously emotionally distressed.
2. Refugees can express their psychological distress directly in spite of the presence of somatic complaints.
3. Sympathetic listening to the traumatic experience may have a therapeutic effect.
4. Some highly traumatized patients repeatedly tell their trauma story without apparent symptomatic relief. This retelling may not be a “*resistance*” to therapy, but an attempt by them to find meaning in their trauma story so that they can recover from their horrible life experiences.

A number of methodologies now exist for the study of the refugee experience. They include:

1. trauma questionnaires
2. focus groups
3. oral histories
4. in-depth clinical interviews
5. ethnographic studies and field work
6. the arts (e.g., autobiography, plays, poems and the visual arts)

More than one of the above approaches should be combined to most effectively describe the refugee’s life experience. Each approach has its advantages and limitations. For example, while a trauma questionnaire can simply and quickly give an overview of the refugee’s trauma experience, it will not have the developmental context of an oral history, the cultural nuances of an ethnographic study or the personal and intimate insights of a biography. Finally, as in the past, many of the stories told by people who were tortured or traumatized were not usually considered as true and exact by the general public, including medical doctors and scientists. It is sometimes thought that the stories may have been modified for various reasons and not be exact, even though they may not have been purposefully falsified. Using many approaches to obtain information of the refugee’s trauma is, thereby, important to help affirm the validity of their life experience.

THE LIFE HISTORY METHOD APPLIED TO THE REFUGEE CONTEXT

Presented by: Donald P. Spence, Ph.D., Robert Wood Johnson Medical School

Summarized by: Masaya Yoshioka, M.D.

A refugee account does three things: 1) it describes a piece of historical truth, 2) it presents an adaptive synthesis of narrative truth, and 3) it gives us a psychological profile of the author, if we assess that accurately. This profile can be immensely helpful in telling us how to listen to the narrative account and what use we can make of it in therapy (Spence, 1982; Kleinman, 1988; Bruner, 1993; Tratt, 1992).

The need for repetition:

1. In the customary formulation, repetition of a traumatic account is a form of working through or, at its most extreme form, a kind of discharge. Used this way, the victim of posttraumatic stress disorder (PTSD) is at the mercy of this mechanism and he/she follows it heedlessly until the poison is out of his/her system.
2. We should see the repetition as not only a piece of pathology but as a creative rhetorical device that enables the narrator to convey a particular kind of horror that words alone cannot tell us.
3. The only way to impress the listener with the nature of the horror of refugee survivors is to recall the happening over and over. Tell it once and we either fail to hear the story or we quickly forget it. The only protection against these two defensive moves is to use repetition.
4. We can treat the repetition as a rhetorical device and interpret the number of repetitions as a kind of scale of horror. We can also hear the nature of the repetition as a mark of understanding.
5. Some of the repeated accounts we hear from survivors speaking in a second language stem directly from the problem of fluency. A careful analysis will show that it is correlated with vocabulary size and ease in speaking a second language. It takes an unusually extended vocabulary to express something in two different ways in a second language; as a result, beginning speakers seem to be saying the same thing over and over.

Professional interpreters have their favorite ways of rendering a specific target sentence, and have to be urged to supply us with interesting variations. If we are speaking to survivors through an interpreter, we need to ask the interpreter whether the story is really the same as before, or he/she is leaving out some of the subtler changes to speed things up. Once the interpreter is clued in to the importance of variation, he or she may become sensitive to minor changes in wording and give us a less stereotyped version. We may have to train interpreters to pay particular attention to word choice and to find ways of rendering those choices in the second language, even at the expense of grammar and fluency, and to make these interpreters sensitive to rhetorical issues and to train them to render repetition and other devices in a way that does justice to the original phrasing.

Narrative as protective coloration: The power of the survivor's story has its impact and also its weakness (Bligh, 1961).

1. Once a refugee speaker learns the impact of the refugee survivor's tale, once he/she learns that the story can silence any listener and make him/her hunger for the speaker's next words, it is hard to give it up and to learn to show him/herself as less of a hero and more of as an ordinary person. The person is tempted to tell the same story because its shock appeal can be literally breathtaking, and it can be a spellbinding experience to watching its effect on the listener. This is one of the reasons why patients suffering from PTSD are apt to tell the same story over and over, not only because of the repetition compulsion, but because it gives them special access to strangers and assures them of something like an immediate audience.
2. Once a refugee has come to see him/herself as an extraordinary survivor who has overcome many obstacles, it may be difficult to allow other pieces of his/her identity to come to the surface, other pieces that may even contradict this picture. From the standpoint of therapeutic technique, holding on to this survivor's identity can be seen as a piece of resistance. Because of our fondness for either/or kinds of thinking, once a particular self-view has taken hold, it tends to drown out all other formulations, especially if they are somewhat contradictory.

3. Once a speaker tries to get spellbound responses, the storyteller's craft will be included. Once the story has been rehearsed enough times with this kind of effect, it is turned into a kind of performance that goes far beyond being one of many possible accounts.
4. The struggle is between the rhetorical voice and the evidential voice. The spellbinding narrative may be a small miracle of dramatic power, but incomplete or seriously biased as an account of what happened. To make the story more complex, even contradictory narrative may run the risk of taking away much of its dramatic appeal and both survivor and therapist may be reluctant to make this move.
5. To revise and re-center the story means to give up a certain identity, not only to give up the power to shock and impress, but the sense that the survivor is no longer the extraordinary exception but one of many. The therapist must be sensitive to the letdown implied by this change, and to be sensitive to his/her reactions to the horror. Unless these are under control, the therapist will always be sending the message that this tale still has the power to shock.

Some kind of supervision and guidance is almost a necessity for this kind of work. Therapists need to find the proper balance between sensitive and skeptical listening and, in the beginning at least, that balance may only come through intensive supervision.

It is useful to mark off an informing assertion from a tellable assertion. The informing assertion refers to its context of presentation and usually includes a justification of why the story is worth telling. The tellable assertion is merely any event-statement, and account of "what happened." The therapeutic problem becomes one of holding on to enough narrative truth to make the story persuasive, while adding enough context to protect the speaker's unique individuality. If he/she makes the story too specific, the story is no longer worth telling and we lose the audience. In making the story too general, we gain the audience but lose the speaker. Therapists need to find a middle ground between the either/or of the two extremes, and the negotiation of this middle ground with the survivor is one way to define the process of the therapy. It is a very special kind of therapy with rhetorical overtones, listening not only to motives and defenses, but in addition, to how something is being phrased, or checking with the translator to learn how he is putting things into English.



Research Implications

To more accurately evaluate the trauma of the refugee's experiences, it is useful to use symptom checklists and/or questionnaires that do not rely on the narrative quality of the refugee's story telling. While these instruments can prevent information bias, they miss out on the texture and narrative richness of the refugee's life history.



Clinical Implications

The therapist should be aware of the quality, substance and nature of the story telling process of refugee survivors. This awareness is very limited if refugee and therapist do not speak the same language or if the refugee patient has little time to tell his/her life history on more than one occasion. If the refugee and the therapist do not speak the same language, the patient should receive treatment through interpreters who are trained in refugee mental health. The interpreters should avoid summarizing the refugee's narrative and should use the original idioms and metaphors of the refugee, so that the therapist can grasp the patient's deep implications. The therapist should be encouraged to study the refugees' language in order to fully understand their culture and experience. Even if the language of a therapist is incomplete, the therapist can understand much more of what the refugee says through an interpreter than the therapist who speaks none of the language. Therapeutic care with language and understanding can favorably help the healing process.

ETHNOGRAPHY, THE LIFE COURSE, AND THE USE OF EVENT CALENDARS

Presented by: Peter W. Van Arsdale, Ph.D., Division of Mental Health, Colorado

Department of Institutions

Summarized by: Masaya Yoshioka, M.D.

“The field” for ethnography in the case of refugees can variously consist of original hometowns or villages, processing camps, internment centers, resettlement agencies and towns of resettlement. In some rare instances, the refugee is systematically observed or interviewed while fleeing or moving across international borders. In other instances, the refugee is systematically observed within a clinical setting, for purposes of understanding the organizational culture of the clinic and/or the patient-psychiatrist dyad. Ethnography is conducted at the “micro level” i.e., in settings specific to the life experiences and activities of the individuals in question. It is empirical and primarily based on qualitative data, but not on experimental findings.

One ethnographic method of importance to the study of refugee mental health is the event calendar. The purpose of this method is the elucidation of significant events in the life courses of individuals, so that personal achievements and failures, gains and losses, and associated stressors can be understood.

This retrospective method relies on the premise that the life course, while in one sense a series of objectively definable and measurable events leading from birth to death, is better understood as subjectively self-interpreted and experientially a rich string of activities punctuated by high and low points. Life is both experienced and remembered in relation to key events such as one’s wedding or the birth of a child.

The event calendar is constructed using three interlocking techniques. First, the researcher determines a set of known datable and externally verifiable events of potential importance to those being studied. Second, the researcher develops a set of open-ended questions based on his or her knowledge of the torture. These are intended to serve as “triggers,” to get the respondents to open up once community entry has been gained and rapport established. Third, the researcher

utilizes reputable key informants to crosscheck and “triangulate” events and experiences described by the respondents.

Through this method subjectively rich, detailed ethnographic information quickly emerges. External anchors also emerge, linking the datable and externally verifiable events to the responders’ approximate ages at those times, if needed. For example, “Were you married yet when the volcano erupted?”, “Had you moved to this village?”, or “ Had the war broken out when your first grandchild was born?”. Information about stressors also emerges.

Among the refugee’s stories, researchers can find qualitative information that enables them to identify a number of events and associated stressors. Researchers can ascertain his/her events during the pre-flight, flight, and post-flight/initial resettlement periods which have served as primary mental health stressors, and ascertain what short-term psychosocial coping mechanisms have been employed during the initial resettlement period. There may be event-specific “trigger” information in his/ her stories.

The terms “emic” and “etic” have come to be used by anthropologists to refer to the viewpoints or worldviews of those being studied and those doing the study, respectively. Etic further suggests that the researcher is employing a “scientific world view” one grounded in Western/Euro-American traditions and paradigms.

These terms remind the social or behavioral scientist that different worldviews exist as the cross-cultural data begins to unfold and illuminate the issue at hand. For example, “sadness” to a Cambodian may be “depression” to a Western-trained scientist. To expand upon this, the Cambodian’s perception of sadness may serve as an all-encompassing cultural category for a type of body-mind disequilibrium, whereas the scientist’s perception of depression may serve as a broad-based category for a type of physical condition triggered by an environmental stressor.

This distinction can be further understood by examining the psychiatrist-patient dyad (Kleinman, 1980). If the psychiatrist and patient are members of the same culture, their general worldviews will likely be similar. However, their perceptions of the mental illness in question may well be

different, for reasons ranging from perception of the self/perception of the other, to the extent of medical knowledge of the patient compared with that of the psychiatrist, to the manner in which the illness is communicated and discussed in the dyad. If the psychiatrist and patient are members of different cultures, as is usually the case with refugees, the emic/etic paradigm becomes still more complex.

An important caveat is that the emic/etic distinction should not be taken to represent a simple dichotomy between competing worldviews, nor as a definitive means of distinguishing between what can be complex, multidimensional perspectives.

One form of ethnographic study is comparative. Two or more ethnically distinct populations subject to similar environmental conditions and/or similar processes of change can be compared along one or more dimensions. Recognizing that control groups are not present and that significant differences exist in terms of culture, prior socioeconomic circumstances and the like, the intent nonetheless is to gain an understanding of the ways in which representatives of each group respond to a common stimulus.

Refugees may need the information about how to cope with a new unfamiliar environment such as strange institutions and a new language. They also may need “a complaint network” so that their broad range of grievances may be voiced. It is possible to develop grassroots refugee self-help organizations in order to cope with those problems (van Arsdale, 1987).

A structured questionnaire is utilized in conjunction with a variant of the focus group method and open-ended key informant interviews. This enables triangulation and crosschecking to occur. A weighted scoring system is developed, based on responses to the questionnaire items, so that a degree of junction/disjunction can be established.

Another type of ethnography is exploratory, aimed at gathering basic information about a topic or issue not well-understood such as the values shaping religious practice, the interplay of political and cultural factors affecting perceptions of medical efficacy, and the economic and political variables associated with ethnic identity.

Epidemiologists emphasize the identification of populations at risk, the factors causing illness, and the search for etiology; anthropologists often emphasize values and perceptions within the context of culture. Both are important, both empirical, and both capable of explaining aspects of the human condition.



Research Implications

Refugees may not describe their story chronologically. An approach called an event calendar can help the refugee recall their life events chronologically as well as identify important experiences and related stressors. Also effective use of comparison groups as well as other qualitative approaches can reveal the social and culture specific character of human responses to extreme environments and life threatening situations.



Clinical Implications

Clinicians must understand that the refugee's perception about disease may be very different than their own (Moore, van Arsdale, Glittenberg & Aldrich 1987; Parsons 1953). If the clinician's culture and the refugee's culture are different, the major mental health differences in world view between the two should be evaluated, discussed and considered in the patient's therapy and individual care.

THE NATURE OF THE UNIQUE EXPERIENCE OF THE DIFFERENT REFUGEE POPULATIONS

Presented by: Cathleen Crain, LTG Associates Inc.

Summarized by: Masaya Yoshioka, M.D.

A narrative retelling of a traumatic event or time by a refugee is variously interpreted as a device that may:

1. Allow the person to divorce him/herself of responsibility/control in the traumatic situation and transfer that to another actor
2. Give responsibility to the gods or the fates - allowing for a sympathetic or malignant cosmos depending upon the interpretation
3. Allow for desensitization of the teller through repetition
4. Achieve affirmation of the refugee speaker through the listener's response and/or
5. Help bring order out of chaos and create "an illusion of mastery and control" where none existed.

Interpretation of the refugee's narrative can inform the strategy for healing of the refugee's trauma, and improving the refugee's functioning. There are as many interpretations as there are refugee survivors. The appropriate coping for each refugee should be noticed and practiced. The interpretation should involve the refugees':

1. turmoil in their countries
2. painful experiences that they had not been previously experienced earlier in life
3. displacement and loss of "home"
4. painful experiences during acculturation
5. experience of growth during transition and strife

A challenge for practitioners is to understand how refugees view their lives (McAdams & Ochberg, 1988). The practitioners must understand how their own culture affects the view of the refugees' culture. Practitioners must have a relevant point of reference to judge health and illness, and to devise treatments which will assist the refugee client in achieving a level of functioning which will allow him/her to integrate into and function within the community. The points of reference must at once satisfy the culture of the refugee community and the mainstream

culture's definitions of harm both to oneself and others. The cultural formulations of different refugee groups will be different reflecting the diversity of responses to life disruption, war, deprivation, disease, genocide, flight, dislocation and resettlement (Eisenbruch, 1991).

Practitioners need to capitalize on their good intentions by first synthesizing the basic ethnographically-based research on the norms and values of each of the refugee communities they serve. Once such a baseline has been laid, then the information can be used for clinical decision-making and to conduct relevant qualitative research.



Research Implications

Cultural constructs affect all aspects of qualitative and quantitative research in the refugee field.



Clinical Implications

Clinicians need to be ethnographically informed in caring for ethnically diverse refugee populations.

IV. DEVELOPING CULTURALLY VALID CONCEPTS AND MEASURES



INTRODUCTION

Richard F. Mollica, M.D., M.A.R., WooTaek Jeon, M.D. and Masaya Yoshioka, M.D.

Many medical diseases have identifiable biological markers; Psychiatric disorders do not. For this reason, modern advances in psychiatric taxonomy have strived to develop diagnostic criteria, which at minimum are reliable, and at maximum are valid as disease constructs. Accordingly, it is not surprising that the reliance upon Western diagnostic criteria such as the DSM-IV in non-western refugee populations remains subject to considerable controversy. (Summerfield, 1996) For example, it has been well demonstrated that the subjective meaning of psychiatric symptoms and the expression of emotional distress is strongly influenced by culture. (Kleinman, 1980; 1988) The cultural contextualization of psychiatric symptoms in refugee mental health is especially important when the cultural background of the refugees and the mental health providers are different from each other.

First, the explanations used to describe the cause of the refugee's mental health problem may fundamentally differ between the refugee and the mental health worker. (Engelhardt, 1976) Second, the evaluation measures used by mental health workers may not be relevant or useful within the refugee context. This "lack of fit" is not just an issue that can be "fixed" by good translations of the measures into the refugees' native language. While successful cross-cultural translation of Western psychiatric criteria, for example, may be adequately achieved item by item, the entire mental health concept of the entire diagnosis when taken as a whole may have limited cultural validity (Westermeyer, 1985).

Acknowledging these issues in refugee research, scientific investigators have elucidated three possible models for explaining the relationship between psychiatric disease considered as a biological reality and the cultural concept of that disease state. The *independent model* regards the core symptoms of a psychiatric disease and the cultural explanation of that disease state as totally independent, e.g. the mental health worker believes the refugee has depression, the refugee feels he has something completely different. In the *rank model* one concept becomes the larger or dominant concept that incorporates all other concepts. For example, the core symptoms of depression may also involve different cultural symptoms in different refugee societies. In this

model the universality of the core symptoms of depression, dominate all other cultural manifestations of depression (Jablensky, Sartorius, Gulbinat & Ernberg, 1981) in the *overlapped model*, the core symptoms of one disease may partially overlap with culture specific symptoms and folk diagnoses (Westermeyer et al., 1989). Again, in considering the concept of depression neither the Western symptom criteria or disease explanation or the culture specific diagnosis and indigenous explanations take precedence over each other. Each exists together. These models suggest that for any postulated psychiatric disease there can exist three domains of symptoms and explanations in the population studied.

Let us take the example of posttraumatic stress disorder (PTSD). Since the early 1970's many investigators do not believe that PTSD exists in non-Western refugee populations (Independent model) (Eisenbruch, 1992). The early pioneering work of Kinzie, Mollica and others, in fact, were able to identify PTSD symptoms in traumatized refugee patients. (Kinzie et al., 1990) Yet, PTSD symptoms as a folk diagnosis were not able to be identified in any refugee culture associated with violence. The Western concept of PTSD, therefore, by default assumed dominance by incorporating more limited cultural explanations of PTSD type-symptoms (Rank Model) into its diagnostic criteria. Eventually, overtime, it was discovered in the Cambodian community that Cambodians had elaborated their own folk diagnosis for mental health problems related to violence and called it "*Tieru-na-km.*" This diagnosis had many features in common with the Western diagnosis of PTSD, but also had its own unique cultural meaning in Cambodia (Overlapped Model) (Mollica et al, 1998). This illustration of the three models for PTSD, not only reveals the complexity of psychiatric measurement, but also the dynamic adaptation of refugee cultures in a relatively short period to foreign concepts of psychiatric illness. One lesson to be learned from PTSD is that an active process of diagnosis creation is spontaneously occurring in highly traumatized refugee populations. Clearly, societies are constantly re-inventing their diagnostic system for emotional suffering as their need arises (Young, 1988).

The above discussion reveals that the translation of psychiatric measurements from one language into another is very complicated (Phillips, 1993; Raybeck & Hermann, 1990). Although, translation of psychiatric symptoms is relatively easy, translation of the cultural concept of

psychiatric disease is more difficult. Development of culturally valid psychiatric measurement is therefore, important. For this reason, three components should be considered:

1. Appropriate evaluation measures for translation must be selected. Researchers should know the characteristics and quality of the original measurements and select one that is appropriate for the purpose of their evaluation. Kirshner and Guyatt (1985) emphasized the importance of differentiating between three types of instruments: discriminative instruments, predictive instruments, and evaluative instruments. Each of them has a different purpose and role. The investigator should choose only these instruments appropriate to the research goal.
2. The translation of any psychiatric instrument must follow the standard procedures of translation, back translation and consensus. The “linguistic equivalence” of any symptom, item, for example, must be achieved. Even though a translated term may be literally correct, the subtle meaning or usage of these terms may be very different in specific cultural contexts. Researchers must consider the cultural meaning of all translated items in a refugees’ society before they start their mental health survey. The measurements, which will be used at the refugee site, must include understanding of the cultural meaning of each and every term. “Feeling blue” may mean something different in Cambodia than in the United States. Furthermore, mental health providers must consider that each refugee survivor has his/her own semantics. For example, individuals can interpret “feels sick” in a variety of ways. Mental health investigators have to grasp the extent and nature of individual variations (Phillips et al., 1991). Focus group discussion may be useful in this work. Although it rarely occurs, researchers should ask refugee respondents to evaluate the clarity of their instruments. It is helpful to ask the refugee respondents what they actually think the instrument is asking of them.
3. Most importantly, the refugee investigator must give full consideration to the construct validity of their measurement tools. Complete linguistic equivalence does not guarantee good construct validity. Flaherty et al. (1988) gives an excellent overview of the different types of validity in cross-cultural research. Their model can be readily applied

to refugee research. While no single study can establish construct validity, the building of study results upon each other over time will dramatically advance the scientific contributions of this field.

ETHNOGRAPHIC RESEARCH: AN OVERVIEW

Presented by: Michael Agar, Ph.D., Department of Anthropology,

University of Maryland at College Park

Summarized by: WooTaek Jeon, M.D., Ph.D.

When a scientist meets a refugee from another nation, it is a meeting of two different people and two different cultures. Studying and understanding refugees involves the study of “different culture.”

Ethnography, the former province of anthropologist and sociologists, is now entering the mainstream of social research. The reasons for the shift are numerous. But it can be said that ethnography is an effective study methodology to answer a simple pair of questions, especially to people of different cultures, “Who are these people and what are they doing?”

The ethnography methodology has the following characteristics. First, “I was there” which means participant observation. Second, “Something happened which I did not understand.” These problems in understanding are called “rich points”. Third, once a rich point occurs, another assumption sets up what an ethnographer does next. That assumption is one of coherence. The rich point is not a refugee’s problems. It’s your problem. The rich point does not mean that they are irrational or disorganized; it means that you are not yet competent to understand it.

The differences between ethnography and the traditionally received view in social science are as follows: First, in ethnography, data collection and analysis are continual and dialectic. Data from participant observation or interview are analyzed, then, based on that analysis, more data is collected, which leads to more analysis, and so on. Second, in ethnography, one tests multiple linked hypotheses continually. At any particular moment during the research, several questions based on previous work are on the front burner, and relevant data are watched for to test them. Third, two considerations guide sampling: 1) Because of the emphasis on rapport relationship, random sampling makes no sense at all. One has to work with people who are willing to spend time with the researcher. 2) Significant dimensions of population variation are learned only after

the research has started. Fourth, in ethnography, the unit and relationships that make up the system are learned rather than being known a priori, and they involve the presence or absence of “qualities” that may not lend themselves to measurement in terms of quantity.

But the study of culture has had some problems:

1. It has been grounded in closed research space of traditional communities that have been isolated in space and constant through time. This situation can be corrected by looking for analogues in modern society, like the heroin addict or the urban villagers.
2. The modern researcher can also focus on current problems such as economic migration, war and tourism, information and transportation, global identities connected with transnational institutions, i.e., we are all a little of this and a little of that.
3. Conclusion: If the definition of culture describes a closed coherent system of meanings in which an individual always and only participates, then it applies to virtually no one involved in intercultural communication. Of course this is not the case in the current global system of widespread cultural interaction.

So, in the study of culture and refugee, these things should be considered.

Ethnography in the Research of Refugees

People who work in the refugee field such as researchers or clinicians already deal with problems that are central to an ethnographic approach. Refugee programs are, at base, situations of contact between different “languacultures” (Agar, 1993; Friedrich, 1989). Nowhere is this more clear than in Egli’s chapter in “Mental Health Service for Refugees” (1991), where he describes the critical role played by bilingual/bicultural—bilinguacultural—refugees in program design and implementation. Without these unsung heroes, he writes, problems of the sort described in this article could not be resolved. The bilinguacultural refugee workers are, in fact, the “folk-ethnographers” who do the kind of work, in whatever way, described here.

Some examples of refugee research in the conference readings also serve as examples of this ethnographic approach, not surprisingly, since some of the researchers have ethnographic backgrounds. Eisenbruch (1991) and Westermeyer and Zimmerman (1981) both deal with the problematic fit between clinical categories and local cultural categories among refugee

populations. In words of this ethnographic approach, their articles take on “rich points” brought about by contact between Western clinical and refugee languacultures.

The refugee situation is also different in several ways. First, the refugees carry with them the crises of personal trauma and forced relocation that add a dimension of human tragedy not usually found in ethnographic work. Second, the concept of the clinical languaculture stand in a privileged position in terms of the organization of policy, programs, and resources, so the emphasis is more on adapting local languaculture to clinical concepts rather than modifying both to enable intercultural communication. Even with these differences, though, the process of refugee/researcher or refugee/clinician contact lends itself to the general way of thinking about language-based ethnography described in this article.

Ethnography as a method of refugee research has many new strong points. It helps clarify things the refugee field already knows at a tacit level and opens up new possibilities that people in the field will find useful and interesting.



Research Implications

Understanding refugees involves understanding of the refugee’s life-world and includes such things as their current political situation, religion, ethnic history and culture. Cross-sectional data in quantitative studies cannot explain comprehensively and fully the refugee’s life experiences. Partial and incomplete understanding of refugees may results in ineffective assistance policy and aid for refugees. Qualitative study methodologies may provide solution to these problems especially since the problematic fit between the outsider and local categories provide many “rich” points for analysis and understanding. Usually, qualitative study should be the first methodology used to approach new refugee group and it can give a comprehensive and living insight to that refugee group. And these study results can be used in subsequent quantitative studies.



Clinical Implications

In many situations, refugees use language and concepts that are different from that of host country doctors or humanitarian relief workers. So the role of bilingual and bicultural interpreter

is very important. But usually it is difficult for the interpreter to have sufficient knowledge to interpret correctly the refugee's terms with which they describe their suffering, physical and mental symptoms and psychological distress. Usually their terms have subtle meanings that are difficult to interpret into another language. So depending upon the ability of the interpreter, clinical understanding may be insufficient for correct diagnosis and treatment. This paper also suggests that the "rich points" that occur between clinician and refugee patients should not be scorned as "lack of understanding" but should be seen as therapeutic opportunities for the therapist and patient to fully understand each other. This allows for true intercultural communication.

PSYCHIATRIC TAXONOMY IN THE CROSS-CULTURAL CONTEXT

Presented by: Juan Mezzich, M.D., University of Pittsburgh Medical School

Summarized by: WooTaek Jeon, M.D., Ph.D.

Evaluation of the mental problems of refugees requires understanding the cultural background of refugees (Brody, 1990). Without understanding of the cultural background and the cultural uniqueness of refugees, the probability of misdiagnosis will greatly increase.

To solve these problems, we should consider two aspects. First, mental health workers should have a comprehensive perspective of the culture. Second, the classification systems of psychiatric diagnosis, such as ICD-10 and DSM-IV (American Psychiatric Association, 1994), should be made to have a cultural perspective.

In order to have a culturally relevant DSM-IV the following additions were recommended (Lewis-Fernandez & Kleinman, 1995):

1. There should be an introduction of the cultural aspects of diagnosis in the DSM-IV manual.
2. Cultural considerations for the context associated with diagnostic categories (for example, gender, age, society) should be emphasized.
3. A glossary of culture-bound syndromes and issues should be made.
4. Multiaxial schema of diagnosis should have a cultural axis.
5. Cultural relationships need to be considered in diagnosis.

Emphasis on cultural relationships means:

1. It is necessary to describe the patient's cultural identity.
2. We should have cultural consideration of the patient's illness. For example, mental health worker for refugees should pay attention to the personal meaning of complaints. In most situations, because of the language barrier, refugees' complaints will be translated into the worker's language. In this process, there can be some distortion, misinterpretation, or mistranslation of the symptoms that result in misdiagnosis (Rogler, 1993). Usually, refugees have their own explanatory model for their physical and mental symptoms and

disease. Mental health workers should understand and have knowledge of these explanatory models.

3. We should pay attention not only to the personal meaning and cultural context of psychosocial stress and symptoms, but also to the occupational and interpersonal disabilities that are caused by stress and symptoms. Refugees' symptoms always have some relationship with their disabilities, which result in new stress, difficulties, and disability.

Mental health workers for refugees should have the ability to understand the cultural context of a refugee's physical and mental complaints.

In summary, the diagnostic assessment of refugees should include:

1. Psychological symptoms
2. Physical problems
3. Disability
4. Environmental factors - stress and support
5. Refugee experience: reason for migration, torture, and settlement problems

Refugee groups are heterogeneous and vary considerably according to their problems and traumatic experiences. Their reasons for migration, experiences of torture and trauma, and settlement problems are different and various. The refugee worker should be well acquainted with these differences.



Research Implications

In current psychiatric diagnostic systems, including the DSM-IV, considerations of cultural effects on diagnosis are weak and insufficient (Mezzich, Kleinman, Fabrega et al., 1993). In the future, greater cultural sensitivity must be integrated into the DSM-V. Because of this, researchers involved in refugee mental health need to accumulate data and study results that demonstrate the importance of the cultural aspects of psychiatric diagnosis. Medical anthropology and psychiatric anthropology can join in these efforts.

Clinical Implications

Clinicians who treat refugees should be trained in medical anthropology and cross-cultural psychology. Clinicians in this field should not only have medical knowledge, but also knowledge of the social and cultural background of the refugee community they are serving. It is important for young psychiatrists and mental health workers who want to work in this field to have the opportunity to be involved in cross-cultural clinical activity. In order to address these needs, specialized training programs should be created.

ASSESSING TRAUMATIZED CHILDREN

Presented by: John Richters, Ph. D., National Institute of Mental Health

Summarized by: WooTaek Jeon, M.D., Ph.D.

The primary sample included 165 children; age 6 to 10 years, living in a low income, moderately violent neighborhood in Southeast Washington DC. One hundred and eleven children attended the first and second grades, the remaining 54 children attended fifth and sixth grades. The children's parents completed the parent report version of the Checklist of Child Distress Symptoms (CCDS) (Richters & Martinez, 1990), Conflict Tactics Scale (Straus, 1979), Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983) and parent-report version of Survey of Children's Exposure to Community Violence (Martinez & Richters, 1993; Richters & Martinez, 1993). First and second-grade children completed "Things I Have Seen And Heard" (Richters & Martinez, 1990) and were assembled in small groups to participate in a cartoon-based interview of children's distress symptoms (i.e., Levonn) (Richters, Martinez & Valla, 1990). Children in grades 5 and 6 completed the self-report version of the Checklist of Child Distress Symptoms (CCDS), and Child Depression Inventory (CDI). Teachers completed the Teacher Observation of Classroom Adaptation (TOCA-R; Werthamer-Larsson, Kellam, Dolan, Brown & Wheeler, 1990).

The data of this study demonstrate that older and younger children had been exposed to relatively high levels of violence in their home and neighborhood. It was clear that witnessing violence by children also deserves attentions as a public health issue. There were discrepancies between the reports of parent and children. Lack of parental awareness may place parents at a disadvantage in their effort to monitor and effectively supervise their children's activities. The possibility that children may not be reporting more common forms of violence to their parents suggests that it may be beginning to lose its emotional impact for them. Younger children may have failed to discriminate sufficiently between violence that they actually witnessed and violence that they had only heard about.

The data from this study also indicate that violence exposure was associated with distress symptoms in both older and younger children. For children in both groups, victimization by

violence in the community and witnessing violence or violence-related themes in both the community and at home were reliably related to greater levels of distress symptoms. Older children's reports of distress symptoms and depression were significantly associated only with violence involving persons known to them. Younger children with the highest levels of self-reported distress symptoms were significantly more likely than other children to report having seen guns and drugs in their homes. Parents from the most violent homes were significantly less likely to agree with their children about their children's distress symptoms. One interesting finding was the extent to which parents underestimated levels of distress their children were experiencing. Children whose parents are unaware of their distress symptoms may be at heightened risk for developing maladaptive coping responses, and for over generalizing initially adaptive distress reactions to situations and contexts in which those responses are maladaptive. Parents who are unaware of their children's distress may miss important opportunities to console their children and help them cope with the violence they have already experienced as well as develop strategies for avoiding violent situations in the future.

Children as young as age 6 in this study were able and quite willing to discuss their feelings and concerns about violence and distress when given opportunity. In the case of older children, there was evidence that boys who were given high ratings for their anxiety by their parents tended to deny those symptoms and this denial was significantly associated with higher scores on bragging and boasting. This pattern, which was not present in younger boys, may signal in a subset of boys a developmental shift toward bravado and the denial of anxieties and fears that are nonetheless recognized by their parents. Violence exposure was more strongly related to distress symptoms in both younger and older children from households with less educated parents. This suggests that these children may be at particularly high risk for developing maladaptive responses to violence exposure.

Collectively, these data highlight the need for intervention programs in high-risk neighborhoods that can employ methods for helping children talk about their distress and for helping patients to recognize and deal with symptoms of distress in their children. We know very little about either the immediate or long-term implications of their symptoms. To be sure, some symptoms can be seen as normal reactions to abnormal events. Certain types of fear, anxiety, intrusive thoughts,

and even depression can serve adaptive functions in an objectively dangerous environment, particularly when they signal heightened vigilance and healthy emotional reactions to loss and pain.

Given the pattern of disparities between parent and child reports, this should not be interpreted as evidence that distress symptoms are unrelated to children's behavior problems. An important task for future research will be to develop assessment strategies for discriminating more effectively between adaptive and maladaptive reactions to violence, and for detecting maladaptive response patterns before they become pathological.

Beyond distress symptoms per se, much remains to be learned about the impact of chronic violence exposure. Domains that warrant consideration include children's ability to experience and modulate arousal; their images of themselves; their belief in a just and benevolent world; their beliefs about the likelihood of surviving into adulthood; their willingness to form and maintain affective relationships with parents, siblings, and peers who may not survive the violence; the value they place on human life; their sense of morality; and a range of other topics central to normal/adaptive development.



Research Implications

Eighty percent of refugees are women and children. The experiences of trauma, violence, and witnessing of violence of children are some of the most severe of all refugee issues. Research for refugee children must develop evaluation and survey methods that are age appropriate for children. These methods should not only focus on the child's response to his/her traumatic life experiences and distress symptoms, but to the mental health impact of these responses over time. Personal, family and community factors play an important role in the refugee adaptation to mass violence.



Clinical Implications

Clinicians must talk directly to refugee children and learn from them about their life histories and their experiences of emotional distress. For example, this study found that children as young as six years of age were quite willing to discuss their feelings about violence as well as their

emotional upset. In contrast, parents for various reasons including denial and their own emotional distress may underestimate the problems of their children. Clinicians need to evaluate the effect of violence on the parents' mental health status, teach the parents to be more sensitive to their child's emotional condition and provide the parents techniques for coping with upset children. Of course, in refugee camp environments and during resettlement poverty and lack of material and psychological resources may prevent parents from being effective in the family. Therapists should acknowledge the limitations of the refugee's parents and help the family cope as best as it can.

SACRED MEANING

Presented by: Douglas Herrmann, National Center for Health Statistics and

Douglas Raybeck, Hamilton College

Summarized by: WooTaek Jeon, M.D., Ph.D.

Cross-culturally, the criteria for assessing accuracy and appropriateness of communication are not well developed (Hall, 1959; Osgood, Suci & Tannenbaum, 1957). Ample research in anthropology and psychology has demonstrated that linguistic meaning is partially or even totally dependent on the culture in which the language is embedded. Cultural relativity of language can present an insurmountable barrier to full communication. The precise ways that the linguistic sciences might uncover the layers of meaning that underlie the translation of vocabulary, idioms, and syntactic constructions have yet to be well investigated (Raybeck & Hermann, 1990). Correct identification of the plight of refugees through questionnaires and interviews requires an awareness of the methods for determining the nuances of denotative meaning that differ across cultures and subcultures of countries from which refugees flee.

However, there is another aspect of meaning that transcends both denotative and connotative meanings. This is an aspect of meaning that often goes unmentioned in linguistic texts or, when it is mentioned, it is addressed briefly. This is the personal meaning that people acquire when they suffer a horrible experience: for example, being caught in a riot; being a victim of a violent crime; serving in a war; being tortured, being forced to witness the torture, rape, or murder of loved ones or friends.

The memories and the feeling of such experiences are so uniquely personal, that, by the very definition of uniqueness, they cannot ever be fully communicated to others. Refugees and other victims of such brutality can tell us about what happened (the denotation) and convey how most people would evaluate what happened (the connotation) but they also know that their awful experiences cannot be truly communicated. Also, they know that the attempt at retelling these experiences will necessitate reliving the experience again (Osgood, May & Miron; 1975).

All of us have had, hurtful, humiliating experiences and most of us chose not to talk about these experiences. On those rare occasions when we are willing to discuss such sensitive matters, we will only do so with a person we know to be trustworthy. This is our sacred meaning. It simply is not reasonable to hope that a questionnaire, an interview or even a series of clinical interviews will uncover the nature and details of the sacred meaning of refugee experiences. The refugee will go through our social-science procedures because they feel they dare not refuse, if they hope to receive the help and safe haven they need. Further, the validity of answers to questions in such circumstances will be suspect and, if refugees become offended, their answers may turn out to be intentionally misleading.

At best, such disclosure will come honestly only after true friendship and trust have been established. Is it truly necessary to find out the answers to certain questions about dreadful experiences when we already know the answer? For the kind of painful invasion of personal experience that such questions represent, we need a good justification. Otherwise such investigation is more often a macabre version of voyeurism, and a clear ethical violation.

We must address the refugee's personal meaning with the same respect and consideration that we would show to our children, our parent, and our dear friends in order that they are well integrated into our society.



Research Implications

This presentation poses many challenges to the validity and reliability of the reports refugees give as to their traumatic life situations. On the one hand, it is possible that refugee respondents will not share their most intimate experiences, especially if they are humiliating or embarrassing to the social scientist. On the other hand, many human service providers and government officials are skeptical about the accuracy of refugee reports. Some even believe that in certain circumstances refugees will distort or even lie about themselves in order to receive more benefits and support. Clearly the trust and perceived intimacy within each and every scientific study must be assessed. Innovative methods for testing reliability should be used; object measures such as medical records also obtained if possible. Finally, the potential upset generated by researcher's

questions must be ethically evaluated against the relative merits of the study. Ethnographic reports can also help validate the reporting of large-scale quantitative research.



Clinical Implications

The clinician must keep in mind that the refugee's trauma experiences always have personal and sacred meanings that may not be easily understood by mental health clinicians from another culture. The clinician must listen carefully and give the refugee's problems and issues serious consideration. As trust develops between the patient and the therapist deep understanding of the refugee life experience will emerge. Most often, refugees are not looking for the therapist to "solve their problems" but appreciate the opportunity to share some of their most painful, shameful and humiliating life events. The therapist should make clear to the refugee the reality of the therapist's capacity to influence the refugee's real life situation (e.g., immigration/asylum) in order to minimize unrealistic expectations and truth distortions in their refugee patients.

DISCUSSION

***Presented by: Terry Keane Ph.D., Boston Veterans Administration
and Tufts Medical School***

Summarized by: WooTaek Jeon, M.D., Ph.D.

Refugee experiences should be evaluated and considered in the context of continuity and in the life quality of experience. The evaluation of refugees has two dimensions: exposure and response (Keane, Fairbank, Caddell, Zimmering & Bender; 1985). So we should check refugees in these two respects.

Previous studies of experiences involved evaluation of the physiological responses and psychophysiological responses related to biological markers in combat veterans and POWs (Keane & Kaloupek, 1982; Keane et al., 1989). In the study of refugees, this focus is also valuable.

In the evaluation of refugees, we should ask the most fundamental questions: What are we assessing for? What is the purpose of this diagnosis? Is it to assist in intervention? When I look at the previous results of refugee psychopathology, I often think that we are putting the cart before the horse. First and foremost, we should recognize the fundamental purpose of our research.

Evaluation and assessment are to evaluate someone's strengths and weaknesses, someone's assessable behavior. First of all, we should evaluate what they need. Second of all, we should determine what we could do for them. This should be the primary approach for assisting refugees today.

The value of measurement in refugee studies are three-fold: first, for professional communication; second, clarity; third, treatment implications. Each of the latter should be considered when measurements are used in assessing refugees.

Finally, researchers should consider how their research would influence public policy.



Research Implications

Refugees are “human beings of temporal continuity,” i.e. each refugee before the onset of their refugee experience had a prior life, socio-cultural and developmental history. No refugee enters the refugee experience a “tableau rossa.” Unfortunately, to date few refugee studies have sufficiently assessed the pre-morbid history of the refugee and its effect on their current mental health status. Not only do preexisting biological factors such as health status and psychological factors such as cognitive orientation affect the refugee’s resiliency, but also prior life experiences will affect how the refugee perceives and copes with his/her current difficulties. These factors related to “continuity” and “context” should be integrated into current research designs. Finally, “research for research” sake needs to be avoided because of the vulnerability of refugees. Ideally, all refugee research should help improve directly the refugee’s current life situation.



Clinical Implications

Clinicians need to emphasize the unique psychological responses of each and every refugee while simultaneously acknowledging that all traumatized refugees may have many mental health effects in common. For example, the assignment of the diagnosis of PTSD to a refugee patient does not tell the clinician the unique causes of the refugee’s PTSD symptoms nor their ability to cope with their symptoms. A Cambodian widow who is a victim of sexual abuse with PTSD will have a very different clinical “reality” than a Vietnamese general who was a POW who is also diagnosed with PTSD. This author emphasizes the importance of individual evaluations and treatment plans. This includes assessing for all refugee patients their diagnosis, overall quality of life, and social functioning.

V. THE HEALTH AND PSYCHOLOGICAL IMPACT OF TORTURE



INTRODUCTION

Richard F. Mollica, M.D., M.A.R. and Masaya Yoshioka, M.D.

Twenty years ago, mental health practitioners did not believe they could diagnose and treat torture survivors. Since then there has been an enormous proliferation in knowledge as to the physical and psychological sequelae of torture (Goldfeld, Mollica, Pesavento & Faraone, 1988). A number of edited volumes have been recently published on the theory and practice of caring for torture survivors (Jaranson & Popkin, 1998). A recent edited volume by the National Institute of Mental Health (NIMH; Gerrity et. al., 2001) provides an up-to-date review of the scientific studies related to this area. The NIMH document complements the *Science of Refugee Mental Health*, as the former does not focus on research methods, but on the clinical implications of published research. While new scientific investigations have significantly contributed to the recognition and assessment of the medical and psychiatric sequelae associated with torture, a review of the published literature reveals the lack of scientific inquiry into the relative effectiveness of various treatment approaches now commonly used to care for torture survivors. In spite of a plethora of innovative treatment approaches implemented for the care of torture survivors worldwide, the characteristics of culturally effective interventions still needs to be determined (Jaranson & Popkin, 1998).

THE CULTURAL AND POLITICAL CONTEXT OF TORTURE

Presented by: Svang Tor and Yael Yavin, Harvard University and St. Elizabeth's Hospital

Summarized by: Masaya Yoshioka, M.D.

Torture and mass trauma occur within a specific cultural and political context (Benenson, 1961). The background of refugees such as their ethnicity, language and customs should be considered when examining the impact of exposure to torture and mass trauma on their physical and mental health. Furthermore, each refugee's personal detailed history of trauma and his/her circumstances such as personal history, family history, language, customs and religion should be understood many differences in concepts about cultural, national, and ethnic experiences exist, and the effects of the latter on the parent's physical and psychosocial well-being evaluated. Furthermore, between Western countries and non-Western countries, many differences in concepts about cultural, national and ethnic experiences exist. In addition, differences in disease concepts between Western and non-Western countries must be considered.

Methods and the meaning of torture are different in each region, society or country (Berkovskaya, 1996). For example, the methods of sexual torture were very different in Cambodia as compared to South America. The understanding and prevention of torture and the effective clinical care of survivors depends on a systematic generation of new knowledge based on the principles and methods of scientific investigation. In this field, to address meaningful personal issues and socially relevant problems, the understanding of what constitutes universal sequelae to torture should include examination of what is determined by the specific cultural and political circumstances in which the torture occurs.

The primary effects of torture are physical and psychological. A careful documentation of the physical symptoms and physical findings of torture can help the health care provider understand the effects of the experience as well as provide evidence to the courts of human rights abuses. Understanding of the mental health effects of psychological trauma can strongly influence the refugee's process of healing and adaptation to their new societies.

The most common physiologic findings in torture survivors are neuropsychiatric, skin lesions, musculoskeletal deformities and sexual dysfunction. Specific types of torture have different physiological and physical outcomes. For example, beatings to the head result in head injuries with the associated symptoms of chronic headaches, memory disturbances and confusion. Rape and other forms of sexual torture may cause infertility, sexually transmitted diseases (e.g., HIV) and sexual dysfunction.

The emotional suffering associated with torture is acute and chronic. There is little known about the relationship between specific types of torture and their emotional sequelae.

In describing the psychiatric symptoms of torture survivors, early researchers in Denmark and Canada documented cognitive symptoms (e.g., memory disturbances), psychological symptoms (e.g., anxiety, depression, and social withdrawal), and neurovegetative symptoms (e.g., lack of energy, insomnia, and nightmares). Later researchers, including Kinzie et al. (1990), Mollica et al. (1998), Kroll et al. (1989) and others, reported symptoms in Southeast Asian refugee survivors of torture compatible with the DSM-III-R criteria for posttraumatic stress disorder (PTSD) and major depression. However, although symptom criteria associated with PTSD appears to be applicable to refugee populations, the diagnostic validity of PTSD in non-Western societies still needs to be determined. In particular, the relationship between symptoms associated with PTSD and trauma-related symptoms that are culture-specific (i.e., unique to a given culture) must be further explored in order to clarify whether PTSD constitutes a core response to torture or whether culture-specific symptoms are at the core.

The working hypothesis in the treatment and study of Southeast Asian refugees at the Indochinese Psychiatric Clinic (Mollica et al., 1990) is that the mental health response to torture consists of five central elements: depression, recurrent memories of the traumatic event, hyperarousal, impaired memory with poor concentration, and culture-dependent symptoms of emotional distress.

In order to clarify the relevance of the DSM-III-R criteria as a whole and the significance of individual symptoms in describing the psychological distress experienced by Southeast Asian refugee patients, responses of 91 Southeast Asian patients who completed the Harvard Trauma Questionnaire (HTQ) were examined (Mollica et al., 1992). The HTQ is a checklist of 30 symptom items; the first 16 were derived from the DSM-III-R's definition of PTSD and the other fourteen items were compiled by clinicians and bicultural staff to describe additional symptoms manifested by this population.

Based upon the results of the HTQ, 71% of the respondent group had PTSD. All patients experienced every HTQ symptom in varying intensity. However, the PTSD group showed significantly higher rates not only on the 16 DSM-III-R symptoms as would be expected, but also on the additional 14 refugee-specific items. In conclusion, the fact that both PTSD items and refugee specific items distinguished between the two groups indicates some overlap in diagnosis based upon Western and non-Western criteria. However, a unique diagnosis for torture was not found. Similarly, clinical interviews conducted with a random sample of 130 Cambodian refugees residing in Lynn, Massachusetts also did not reveal an indigenous mental health concept for torture in this highly traumatized community.

Cambodia

Before war broke out in 1970, Cambodia was an agricultural country of approximately 8 million people. Cambodians traditionally valued a strong family identity, respect for ancestors and interpersonal conduct that emphasized tolerance and non-confrontation. Although the predominant religion was Buddhism, both Hinduism and Buddhism influenced religious customs. People believed in reincarnation and in Karma.

During the latter half of the 19th century and the middle of 20th century, the period of French involvement in Cambodia, the citizens of Cambodia experienced the exploitation of their labor, slavery and the romanization of the 45-letter Khmer alphabet. During World War II, Cambodia was temporarily under Japanese occupation and strong Japanese nationalism was imposed upon Cambodians. In 1953, Cambodia gained independence. Prince Sihanouk governed for the next 17 years although there was civil war between communist radicals and republicans. General Lon

Nol, who was supported by the United States and the South Vietnamese, abolished the monarchy in 1970. After 5 years of civil war, the victors were the extremist Khmer Rouge who seized power and established a reign of terror under Pol Pot.

During the period between 1975-1979 it is estimated that one-third of Cambodia's population of approximately seven million persons were killed by starvation, disease or execution (Mollica, Poole & Tor, 1998). In particular, Buddhist monks, urban dwellers, government officials, and people with Western education were executed. The Khmer Rouge regulated all aspects of behavior and all aspects of social and political life. Family members were separated; children were placed in children's camps and taught to spy on their parents. Religious practices were outlawed and no form of education was allowed apart from communist propaganda. Contact with the outside world during these years was virtually cutoff. The Khmer Rouge beat, raped, and murdered irrespective of age or gender. Victims were made to witness executions and were allowed no emotional response even when witnessing the execution or torture of a family member. The atrocities perpetrated by the Khmer Rouge on their own people ended when the Vietnamese ousted the Khmer Rouge in January 1979.



Research Implications

Researchers investigating the medical sequelae of torture must be aware of and systematically assess the physical and psychological sequelae of torture (Mollica & Caspi-Yavin, 1991). Torture physically affects all organ systems; some physical effects of torture such as cigarette burns of the skin are pathogenic of torture. Torture also has profound impact on a survivor's emotional status. PTSD may be a valid psychiatric diagnosis for assessing the major psychological symptoms associated with torture. In spite of the latter possibility, many culture dependent symptoms unique to a refugee's society are also highly associated with torture. While ethnographic studies have not revealed a folk-diagnosis for torture, researchers must include phenomenologically PTSD and culture-specific symptoms in their assessments. The latter is especially critical in evaluating the treatment course of refugee survivors over time.

Before beginning research with torture survivors, the cultural background of the survivors such as regional, ethnic, political, linguistic and cultural customs must be considered. Understanding the individual response to torture includes an assessment of the survivor's personal history and his / her family and communities response to torture.

Specific physical, physiological and psychological responses to torture must be independently assessed. Checklists can evaluate trauma-related culture-specific symptoms. Differences in concepts of disease and mental illness between Western and non-Western societies must be factored into the measurement scales. For example, the diagnostic criteria in Western countries should be included with non-Western diagnostic criteria.



Clinical Implications

In order, to provide culturally appropriate and effective care to refugee torture survivors, the clinician needs to:

1. Know the cultural and political history that led to the torture
2. Understand the types of torture experienced in each and every refugee situation since they vary considerably
3. Do a complete physical examination looking specifically for known medical effects caused by specific torture events (e.g., a complete neuropsychiatric evaluation in survivors who experienced head injury)
4. Evaluate the entire range of Western (i.e. DSM-IV) and non-Western (i.e., culture/refugee specific symptoms) psychological phenomena
5. Understand the refugee basic orientation to human suffering
6. Use culturally valid and reliable screening instruments and checklists such as the HTQ to conduct systematic evaluations of the survivor's physical and emotional status
7. Use standardized evaluation techniques to monitor the effects of treatment over time.

Following these steps the clinician can make a culturally effective plan with the survivor for recovery. All activities to help refugees by outsiders must contribute as well to the reconstruction of their families and local communities.

DOCUMENTING TORTURE: A HUMAN RIGHTS APPROACH

Presented by: James Welsh, Ph.D., Amnesty International, London, U.K.

Summarized by: Masaya Yoshioka, M.D.

The Act of Torture

1. The involvement of at least two people: the torturer and the victim
2. The infliction of acute both physical pain and emotional suffering
3. The intention of breaking the victim's will
4. Systematic activity with a rational purpose

What Constitutes Evidence of Torture

1. Physical signs (e.g., scars)
2. The symptoms (e.g., flashbacks)
3. Behavioral changes (e.g., violence)
4. Documents (e.g., medical certifications)
5. Photographs
6. The story by the victims or the witnesses

Torture leaves traces. It is the job of the investigator to find and document those traces (Amnesty International, 1995). The evidence comes in a variety of forms, which carry different levels of weight and pose different problems in evaluation. The evidence can be separated into two kinds: 1) testimonial evidence; the stories given by people who have been tortured or who have seen torture (Willis & Gonzalez, 1998), and 2) objective evidence; material evidence which can be subjected to independent evaluation (Forrest, Knight, Hinshelwood, Anand & Tonge, 1995; Peterson & Rasmussen, 1992).

Torture occurs in different circumstances with different objectives against different targets. There are also unintended victims - unintended only in the sense that they are not deliberately targeted but rather suffer vicariously through the suffering of loved ones who are tortured. The important point to be drawn in each instance is the evidential problems each situation.

The refugee's story is usually the most important source of evidence of torture. The refugee can give whatever information he or she feels is relevant. Moreover, the refugee can answer questions and clarify confusing points. He or she can give evidence about his or her arrest, about the torture itself, their own reaction to the torture including medical information, details about the perpetrators, details about the location of the torture and information about his or her escape. Oral or written evidence is sometimes crucial since objective signs of trauma are no longer visible. This personal testimony can come in the form of written depositions, letters, accounts given via a third party such as a lawyer, or by interview.

Certain forms of torture leave typical physical marks (Goldfeld et al., 1988). In all cases of physical scarring, the possibility of self-infliction has to be taken into account. While some scarring will appear to a layperson to reflect the types of abuse described by the victim, in other cases they will not. In any event, it is very important to have medical evaluation of the available evidence to determine whether or not the physical signs are consistent with the torture alleged.

The trauma of torture, ill treatment, deprivation, escape and alienation all affect the mental state of the victim (Goldfeld et al., 1988). Mental health workers should know that a refugee's disturbed mental state does not point conclusively to the fact that he or she has been tortured.

In some cases torture is documented by official or highly reputable unofficial sources. The most persuasive example of this is a legal document in which the state itself acknowledges that the individual has been tortured. The refugee is unlikely to have such documentation and is more likely to rely on documents such as statements made under oath in the receiving country or medical certificates relating to examinations carried out in the receiving country, and these can be an important source of evidence.

Photographs of scars, deformities, bruising and other trauma-related injuries constitute a form of evidence of torture. The expert evaluation by trauma or forensic specialists may result in strong evidence of torture.

The Problems in Verifying Torture

1. Assessing medical evidence
 - a. Lack of physical signs on victim
 - b. Ambiguity of psychiatric signs and symptoms
2. Dealing with the political dimension of testimony
 - a. Political implications of torture allegations
 - b. Benefits of status of torture victim
3. Assessing the refugee's or witness's story
 - a. Organizations such as trauma institute, trauma center, etc.
 - b. The interviewer

Bruising, abrasions, scarring, fractures and other injuries that can occur as a result of torture, may in fact have a variety of possible causes. Signs, which are not consistent with the victim's story, should be noted and these should be further investigated.

Increasingly, torture is carried out by means that do not inflict long-term physical injuries. These are either physical methods that do not leave scarring, or psychological methods. The physical medical evidence may be slender indeed. In such cases, some effort is required to elucidate a clear description of the torture itself, the effects of the torture and the sequel.

The mental and behavioral sequelae of torture are not uniquely caused by torture alone. Depression, aggressiveness, withdrawal, anxiety, denial and other mental and behavioral changes can be linked to a variety of traumatic experiences (or, indeed, can result from other causes). Careful interviewing and reviewing of the evidence can allow an experienced clinician to draw some conclusions about the relationship between torture allegations and the refugee's mental state.

Torture is one of the most serious allegations that can be made against a government by an individual. For that reason, government opponents may have a vested interest in maximizing the number and severity of torture allegations since this could help demonstrate the moral bankruptcy of that government. It may also lead to further abuse of the victim by that

government. It is important to keep in mind the political framework in which the episode of torture occurred.

Refugee status can confer several benefits on the individual who has fled his or her country. These include primarily security and residence rights, but also provides benefits such as access to health care, housing, jobs and other material benefits. For the individual seeking asylum or refugee status, proof of torture is a solid element in their claim of a justified fear of persecution. Victims of political violence, and particularly refugees, have been through extraordinarily difficult and disorienting experiences and it may happen that, in recalling episodes of his or her experience, the refugee will confuse the location or timing of various events or add details as they come to mind or as they grow more trusting of the interviewer. This may - quite unfairly - give the impression of unreliability, if not dishonesty. In some cases, and there may be the elements of exaggeration which need to be filtered out, there may be held back stories of the refugee's torture for reasons of avoiding painful recall or embarrassment, particularly where sexual torture or humiliation are concerned.

There are many factors posing difficulties in the assessment of torture evidence, which have to do as much with the interviewer as with the interviewee. For example, 1) the gender of the investigator can influence the degree of disclosure of certain, particularly sexual, forms of torture. 2) There is what could be called an "incredibility" factor and accompanying denial. It may be difficult for an interviewer to accept the truth of allegations of extraordinary cruelty or bizarre behavior beyond the limits of normal brutality, and the story or parts of it may be disbelieved solely because the interviewer cannot accept it.

A wish to disbelieve may be compounded if the demeanor of the witness is very controlled or in any other way judged by the interviewer as inappropriate or inconsistent with the story. The problem is perhaps more significant when the person being interviewed claims to have seen atrocities inflicted on others or to have heard of such atrocities from third parties, since it then becomes easier to dismiss such stories as rumor. This underlines the necessity to seek confirming testimony or other documentary evidence.

Torture Verification: A Methodology

Dividing the analysis of the practice of torture into two levels: 1) the macro, or country, level: what is happening within a country or region, and 2) the individual level: what the individual person has experienced.

Macro

1. Monitoring information systematically and over time
2. Maintaining diverse contacts in the field for additional background information
3. Seeing for ourselves: visits to the victim's country
4. Defining a picture of standard ill-treatment
5. Confirming information from different sources, verifying facts

It is important to gather information on individual countries from a wide variety of published and unpublished sources. For example, prisoners, lawyers, families, refugees, domestic and exiled individuals and opposition groups, government sources, the domestic and foreign media, human rights groups, inter- and non-governmental sources. This generates a vitally important database on which to make judgments about reports and allegations of human rights violations and permits an informed assessment work when objective evidence is lacking and when individual allegations cannot be rigorously assessed and verified.

In seeking out information, one should be careful to avoid reliance on particular individuals or indeed reliance on particular political or social groups. Gathering a balance of information is important but also difficult.

Visits to the victim's country are an essential supplement to the systematic monitoring of information sources and interviewing and information gathering.

In many countries, a pattern of ill treatment is regularly and systematically carried out on prisoners. The forms of abuse follow a clear pattern. There also are forms of ill treatment that have seldom been used. This picture of typical ill treatment in that country is useful in assessing new allegations.

Information can travel internationally. It is important to get information about a particular human rights violation from different countries, from individuals and groups. The information comes in different forms and appears at first sight to have originated from different sources. However, careful checking suggests that the information started at one source and then was disseminated to sympathizers beyond the site of the abuse. This does not invalidate the information of course, but it does have implications for the need to confirm its accuracy.

Individual

1. Approach to interview
 - a. Establishing trust
 - b. Not promising more than you can deliver
 - c. Avoiding a hyper-scientific framework
2. Conduct of the interview
 - a. Using a standard but not inflexible interview protocol
 - b. Avoiding leading questions
 - c. Being a “skeptical” but sympathetic interviewer
 - d. Challenging victim in a non-threatening way
3. Attention to:
 - a. The victim’s account of post-torture symptoms
 - b. Procedures used by torturers
 - c. Inconsistencies or odd allegations
 - d. Timing of allegations
 - e. Similarities in allegations
 - f. Drawing on medical evidence

It is likely that a person complaining of torture who is able to give a detailed account of their experience and who knows that there will be no material benefit from their story will essentially be telling the truth though details may be modified, omitted, exaggerated or distorted consciously or unconsciously. In some cases, exaggeration can occur because of the desperate need felt by the refugee for the full significance of the experience to be appreciated by the listener. Some people do make false assertions that they or others were tortured but any evaluation of torture

allegations must start with an open-minded receptivity and a determination to gather as much detail of the story as possible to allow for a considered judgment to be reached later.

Establishing trust is a fundamental step in interviewing victims who must be convinced that the interviewer wants to hear their story, are prepared to spend some time listening and recording the details, and are prepared to respond to their concerns about confidentiality or other worries.

Where the individual's story is unclear, is contradictory or inconsistent with what is already known about human rights in a particular country, it is important to find out why. Finding this out in a spirit of elucidation rather than criticism will help consolidate the relationship between interviewer and victims. In particular, asking about unclear points in different ways and at different points in the interview may allow for clarifying doubtful evidence. The way the refugee describes his/her physical, psychological and emotional state after torture or other ill treatment allows the interviewer to assess the linkage between the event and the symptoms.

The forms of torture reported can be assessed in light of what is known about the kinds of torture inflicted by the army, police, or security forces in the country where the torture took place. Involvement of medical personnel may be an element in this.

It is necessary to be able to determine whether inconsistencies in testimony or bizarre or unlikely practices are the result of torture testimony or to faults in memory exaggerations, or belief in unsubstantiated rumors. On the other hand, inconsistencies or bizarre allegations may reflect cultural differences and misunderstandings between the interviewer and the refugee.

Timing of events is crucial in building a clear picture of events. The refugee may not present information chronologically. It is essential to get the sequence and timing as clearly established as possible.

When individuals with no connection tell similar tales with particular identical details there are grounds for accepting the story. However, the possibility of rumors or received information being recounted as personal experience has to be considered.



Research Implications

The indicators of torture are: 1) admission by governments, characteristic torture-related injuries not attributable to other forms of trauma, 2) legal documents demonstrating that torture had taken place, 3) witnesses' testimony convincingly describing the infliction of torture on a third person, 4) medical evidence, and 5) photographs of torture-related injuries.

The procedure and important points to document an individual torture are: 1) gathering the victim's background information, 2) listening to his/her story, 3) reviewing the documentary evidence, and 4) assessing those.



Clinical Implications

It is necessary to elucidate carefully: 1) the type of torture, 2) where it took place, 3) the effects, 4) the timing, and 5) the perpetrators.

USING THE SURVEY QUESTIONNAIRE TO ASSESS THE HEALTH EFFECTS OF TORTURE: METHODOLOGICAL AND ETHICAL ISSUES

Presented by: Gordon B. Willis, Ph.D., National Center for Health Statistics

Summarized by: Masaya Yoshioka, M.D.

A basic question in the science of refugee health is whether the torture experience, the effects on health status associated with the torture experience, social functioning, and psychological adaptation can be measured through survey designs that rely on standardized screening questionnaire instruments. There are two opposing viewpoints: 1) the view that the torture experience produces private, painful memories that are fundamentally different from other general experiences, but measurable by screening questionnaires and 2) the view that it is neither feasible nor ethical to attempt objective measurements in the same way that we ask general health questions on events.

Logical Issues

The conceptualization of a torture experience includes the following considerations: When, where and what type of torture was practiced? Who were the victims and the perpetrators? How did the torture events happen to occur to the survivors as well as to other victims? Similarly, how did the perpetrators become involved? These factors should be considered in the investigation of affected populations.

To most Western observers and organizations, to be tortured is to be the victim of a very severe type of crime. The application of the label of “crime” to torture is complicated by a multitude of legal and cultural factors, especially because, 1) torture may not have been explicitly illegal in the country where it was carried out, and 2) it may actually have been legal and carried out by the government. It must also be acknowledged that torture victimization is unique, and unlike “common crime” in the sense that it is often as much a process as an event, and can carry with it significant, disabling emotional sequelae.

In survey research, a “sensitive topic” is generally defined as one which involves significant elements of privacy, illegality, social embarrassment, or that which may lead to undesirable consequences if the individual’s answers to questions on that topic are disseminated (Martin,

1986). While it is thought by some researchers that sensitive topics fall outside the bounds of survey measurement and should be only evaluated in clinical research, an associated literature on methodological problems when asking sensitive questions has developed (Locander, Sudman, Brown, 1976). These studies have concluded the feasibility of asking sensitive questions in survey research. By extension, these conclusions apply to the study of torture.

Methodological Issues

In survey research there are three different approaches to the definition and measurement of the torture experience. These include:

1. Self-defined by the respondent:

The survey instrument may ask about the occurrence of torture, and associated details, but the instrument does not define “torture” for the respondent. In some survey research, victims are asked if he/she was a victim of torture in his/her judgment without being actually asked to tell what the torture meant to them. Clearly, the basic meaning of the term, “torture” is markedly different across cultures. “Self-definition” may be vague and ambiguous in this type of research approach.

2. Written definitions:

Some organizations such as the World Medical Assembly, or the United Nations through its Declaration of Human Rights have developed written definitions of torture. Written definitions while useful to policy-makers, may not be useful to survey respondents who have had complex and multidimensional experiences. Many respondents may not have the education or ability to read a UN definition of torture and consider whether or not it applies to their trauma experience.

3. A wide range of examples of specific events and occurrences:

In order to measure torture, a wide range of event types, which may be classified as torture, are incorporated into the research. This “list” of possibilities allows the respondent to select those examples that they experienced. In this approach, neither the researcher nor the respondent defines “torture”. For example, a questionnaire might ask a refugee to check the events that occurred such as beating, rape, being forced to remain awake, burned and how many times it occurred. This approach is now commonly used in assessment and is increasingly being used in population studies (Mollica & Caspi-YaYin, 1991).

Attribution of cause/effect

In addition to measuring the torture experience, the survey researcher needs to measure the relevant set of core dependent variables that constitute the health effects of torture. A survey instrument must measure those physical and emotional states that are clinically known to be associated with the torture experience. In spite of the valid and reliable measurement of health effects, cause and effect relationships may be especially difficult to attribute solely as effects of torture, due to the multitude of potentially confounding factors. Proper study design and data analysis are critical for establishing causality.

Several specific methodological issues

1. In measuring health outcomes of torture, detailed assessment should not only be made of torture survivors, but also of a comparable control group who has avoided suffering that torture.
2. In order to derive meaningful conclusions, researchers can use imaginative ways to make use of other studies and findings.

Cognitive Issues

The cognitive recognition by an individual of his torture experience varies considerably. The descriptions of two torture survivors experiencing the same event may also be different. Survey researchers therefore must consider whether the torture survivor can mentally process and report on their torture since basic cognitive process may influence the reporting of torture and trauma events. It is necessary to adequately encode the events associated with torture and be able to

retrieve this information. In contrast, if the torture experiences are forgotten, repressed or denied then the assessment of these experiences will be very difficult. A unique investigation of Dutch concentration camp survivors by Wagenaar and Groeneweg (1990) has addressed the process of cognitive encoding and recall of torture-type experiences. Prison officials had originally kept information about the prisoners from 1943 to 1947. Later the survivors were asked about those events as part of a legal trial. The researchers reported that the repetitive everyday events of survivors were remembered well, though the details associated with particular instances were sometimes forgotten. Memory for many other events was extremely accurate. They also reported that recognition memory was generally successful where recall failed. These researchers demonstrated that recognition procedures greatly facilitate retrieval of information by survivors.

The administration procedures of any survey have an important influence on the respondent's decision process. There are some conditions under which respondents are more comfortable reporting behaviors that are sensitive. For example, 1) self-administration of forms seems to be preferred to interviewer-administration in cases in which answers may carry some element of social embarrassment; 2) telephone administration appears to be less well received than other modes when there is some illicit component to the behavior; and 3) when potentially damaging, threatening survey questions are asked, clearly defined confidentiality statements and the provision of anonymity are vital.

For the victims who have are illiterate or have some disability such as speech problems, a computer-based questionnaire administration system might be useful. The respondent needs only to press a few keys to enter responses; the system therefore provides privacy as well as a means of bypassing illiteracy as a practical limitation.

Ethical Issues

It is ethical to research the torture experience, if the following features exist:

1. Strong justification for the study coupled with a meaningful explanation that is provided to each respondent
2. Provision of immediate clinical treatment, if necessary
3. Isolation of research from administrative use of data
4. Appreciation of the cultural values of the respondent
5. Strong support of the research by the surveying organization

Ideally survey research should be part of a larger effort to determine the best clinical treatment of torture survivors. This research would include ongoing evaluation of the effects of any intervention provided. Furthermore, respondents should be provided a simple but well-stated explanation of why survey-takers need to ask about these very private and sensitive issues.

Responses to screening instruments should not be used to make administrative decisions related to the disposition of individual cases.

The general fact that different cultures view the world differently, however, should not necessarily lead to the conclusion that research on members of any culture is inappropriate, or that a particular methodological approach should be rejected outright. The aim of the researcher should be to understand cultural influences on an individual's behavior, and to make allowances for these in designing a program of research. As a further methodological step, questionnaires that are intended for a particular subcultural group should be developed with a staff that includes some members of that group. Additionally, the questionnaires should be pre-tested on members of the target population, using techniques that allow a significant degree of respondent feedback, such as focus groups and cognitive interviewers.

It is necessary that all levels of the research organization believe in and support the research. If it is feared by administrators, for example, that the very act of asking questions on torture will

produce some type of negative psychological consequence to respondents, the study will not be on firm ground and may be undermined by the organization.

Researchers who fear asking about torture implicitly assume that the survivor does not want the issues to be raised. While there are surely reports of torture victims who strive to keep their experience secret (for example, women who have been victims of rape may conceal this indefinitely), there are also victims of similar forms of torture who “want their story told,” and who can only provide meaning to their experience by relating them to others. Having someone in their new environment truly understand what they have been through may be extremely “therapeutic”. Several authors have reported that the testimony of torture experiences is a valuable form of “witnessing” for them; other survivors view their revelations as “normal” admission of fact (Cienfuegos & Monelli, 1983).

Clinical counseling may be a foreign concept for refugees; these individuals may never voluntarily seek such treatment. Or they may receive counseling only when treatment is clearly necessary, after the psychological effects of torture have become disabling to them.

It would be preferable to screen individuals earlier in order to identify those who may be vulnerable and require intervention. An integrated research and treatment environment should be created in which refugees are provided with health care that is linked to a system for scientific investigation. All eligible members of certain refugee populations can be initially screened upon arrival into the United States for the health and mental health effects of torture. Those considered at risk, or who appear to be good candidates for treatments may be presented with early prevention and treatment opportunities.



Research Implications

The survey researcher must place serious emphasis on maximizing the accuracy of reporting of the torture survivor (Tourangeau, 1984). Innovative study designs are needed to reduce those factors that contribute to less than adequate and even false responses by the survivor. Techniques include obtaining objective measures from existing records, assessing through focus groups survivors’ understanding of survey questions, clarifying and reducing through anonymity

potential negative consequences for truthful responses, and cognitive evaluation of the memory capability of each respondent. Culturally accurate checklists with the lists of possible torture events can minimize the need for spontaneous recall, which is often incomplete and inadequate. Ethical research must benefit the survivors' clinical welfare. Treatment must be readily available to all research subjects.



Clinical Implications

The clinician must be aware that individual patients who are survivors, even from the same culture, have varying definitions of torture and can place different meanings to their experiences. The accuracy of reporting of torture events and their effects can also vary considerably because of personality style, gender, type of experience (e.g. rape), relative degree of stigma, associated humiliation and shame, cognitive competence, denial, and the desire of some survivors to manipulate the therapist for financial benefits or increased emotional support. Recognition memory is generally more accurate than spontaneous recall; while some events are remembered in extreme detail, others can be poorly described. Clinicians must be aware of these variations in order to be sensitive and patient with the survivor's memory problems.

THE IMPACT OF TORTURE EXPERIENCE ON PSYCHOLOGICAL ADJUSTMENT: APPROACHES TO RESEARCH

Presented by: Metin Basoglu, M.D., Maudsley Hospital, London, U.K.

Summarized by: Masaya Yoshioka, M.D.

Since the 1980s, numerous investigations have been carried out to study the psychological consequences of torture. These studies have helped increase public awareness of the problem of torture and draw scientific attention to this important human rights issue. There are still important questions which are unanswered after more than a decade's work with torture survivors: 1) whether torture has long-term psychological effects independent of the impact of other traumatic stressors in a politically repressive environment, 2) what are the relative contributions of torture and other traumatic experiences to the stress response syndromes observed in some torture survivors, 3) how uprooted refugee flight into exile are related to the effects of torture, 4) whether post-torture psychological problems constitute a coherent symptom cluster or a syndrome different from existing diagnostic categories such as post-traumatic stress disorder, 5) what factors are related to acute and chronic traumatic stress reactions following torture, and 6) how torture-related psychological factors can be treated most effectively.

Refugee assistance policies have focused on the mental effects of torture and have largely ignored other forms of "organized violence". In reality, most political refugees are faced with a series of traumatic situations including harassment and persecution by the authorities, detention, unfair trials, imprisonment, loss of employment or educational opportunities, bereavement, loss of social ties, having to go into hiding, uprooting from his/her society, forced exile, asylum seeking, and problems in adapting to a new country.

Two detailed reviews of the evidence on the effects of torture by Goldfeld et al. (1988) and Somnier, Vesti, Kastrup and Genefke (1992) found that the most commonly reported problems in torture survivors were 1) psychological symptoms (anxiety, depression, irritability/aggressiveness, emotional vulnerability, self-isolation/social withdrawal), 2) cognitive symptoms (confusion/disorientation, memory and concentration impairment, impaired reading), and 3) neurovegetative symptoms (lack of energy, insomnia, nightmares, sexual dysfunction).

Goldfeld et al. (1988) noted that many studies did not provide sufficient information on: 1) the interview procedures, assessment instruments, diagnostic criteria, and medical diagnoses; 2) medical history and physical findings which would help establish associations between physical symptoms and forms of torture; 3) neurological and neuropsychological findings which might establish a link between head trauma and the symptoms; 4) the length of time between torture and evaluation; 5) the relationship between the symptoms and diagnosis of post-traumatic stress disorder; and 6) the role of individual differences such as gender, age, education, cultural traits, and personality factors in post-torture psychological problems. Somnier et al. (1992) reported that the characteristic features of post-torture psychological states were sleep disturbances, nightmares, affective symptoms (chronic anxiety, depression), cognitive impairment (memory and concentration difficulties), and “changes in identity”. Cerebral atrophy has been reported as a possible consequence of torture (Jensen et al., 1982; Somnier et al., 1982). There is yet no other evidence of progressive cognitive impairment in torture survivors (Somnier & Genfke, 1986).

A serious shortcoming of most studies of torture survivors is the lack of matched controls in their design. This problem precludes definitive conclusions concerning the independent effects of torture among other associated traumas.

Study of the psychological effects of torture requires properly matched controls and validated assessment instruments. The existence of a “torture syndrome” can only be validated by the demonstration of a coherent cluster of symptoms that can be cross-validated in different samples. Multivariate statistical analyses, (e.g. factor analysis, cluster analysis, etc.) based on intensity ratings of individual symptoms could be useful in identifying meaningful symptom clusters. If a meaningful symptoms grouping can be identified, it should then be compared with existing diagnostic categories for similarities and differences. Symptom constructs and clusters also need to be validated across cultures given the wide variability in the meaning of trauma and psychological responses to traumatic stressors from one culture to another.

A study in Turkey (Basoglu et al., 1994) compared tortured political activists with closely matched controls, using standardized assessments based on DSM-III-R. The study included two groups: 1) political activists subjected to systematic torture (n=55); and 2) non-tortured activists

matched with the first group for age, sex, marital and sociocultural status, political orientation, and history of political involvement (n=55). Psychiatric status was examined using the Structured Clinical Interview and Diagnosis (SCID). The torture survivors reported an average of 291 exposures to a mean of 23 forms of torture. The mean length of their imprisonment was 47 months. The survivors of torture had significantly more symptoms of PTSD and anxiety/depression than the non-tortured comparison subjects, although their PTSD symptoms were only moderately severe and their general mood was normal. Despite the severity of their torture experiences, the survivors had only a moderate level of psychopathology.

The results suggest that torture has long-term psychological effects independent of those related to uprooting, refugee status, and other traumatic life events in a politically repressive environment. Prior knowledge of and preparedness for torture, strong commitment to a cause, immunization against traumatic stress as a result of repeated exposure, and strong social supports appear to have protective value against PTSD in survivors of torture.



Research Implications

Studies of the psychological effects of torture require properly matched controls and validated assessment instruments.



Clinical Implications

The mental health effects of torture may be independent of those effects caused by the refugee experience. It is unclear what the reality of this statement might mean to the clinician. Clearly, strong belief systems can contribute significantly to the resiliency of torture survivors. Cognitive therapy may be an effective therapeutic approach for many survivors. Its efficacy still needs to be evaluated.

PRISONER OF WAR RESEARCH: AN OVERVIEW WITH IMPLICATIONS FOR REFUGEE MENTAL HEALTH

***Presented by: Brian E. Engdahl, Ph.D., U.S. Veterans Affairs Medical Center,
Minneapolis, MN***

Summarized by: Masaya Yoshioka, M.D.

Research on former prisoners of war (POWs) is most obviously connected with refugee mental health at the points where research on POWs, concentration camp survivors, and torture survivors intersect. Bibliographic references for findings described in this presentation are available in Engdahl and Eberly (1990) and Engdahl and Page (1991).

From the reports of many Danish survivors in Nazi prison camps, the survivors' recurrent nightmares 20 to 25 years later have been pointed out. Extensive lists of symptoms were reported including memory impairment, libido loss, irritability and emotional instability, and mental dullness and apathy (Thygesen, Hermann & Willanger, 1970).

In randomly selected Australian World War II POW and non-POW combat samples, significantly more depressive symptoms and disorders were found among the POW some 40 years after repatriation. The investigators suggested that over the long follow-up period, anxiety might diminish but depression might increase as a reaction to chronic post-traumatic impairment (Tennant, et. al., 1986).

In the study of POWs and carefully chosen non-POW combat veterans by the US Department of Veterans Affairs (Cohen & Cooper, 1954) a four- to five-fold excess of hospitalizations of psychoneurosis was found among World War II Pacific Theater POWs and European Theater POWs compared with their controls. Significantly, more hospitalizations of POWs were found for a variety of psychiatric illnesses, including schizophrenic disorders, anxiety reactions, alcoholism, "nervousness and physical disability," and other psychoneurotic reactions. Pacific Theater POWs were more physically and psychiatrically disabled than POWs held by the Germans or the Koreans due to the harsher treatment suffered at the hands of the Japanese. In a later study, depressive symptoms were found to be greatly elevated among POWs relative to non-POW combat comparison groups 20 to 40 years after release from captivity. These

symptoms were directly related to captivity maltreatment and inversely related to the amount of social support received upon return from the military and to education and age at the time of capture.

Psychiatric disorders were retrospectively diagnosed among 188 World War II and Korean War POWs. Within one year of their release, 67% met DSM-III criteria for PTSD and more than half of those continued to have symptoms over 40 years later. Generalized anxiety disorders and depressive disorders also were frequent (Kluznik, et. al., 1986). The lifetime prevalence rates for hypertension, diabetes, myocardial infarction, bipolar disorder, schizophrenia, and alcoholism were not elevated relative to the general population groups in a sample of 426 POWs. These POWs, however, had moderately elevated depressive disorder rates and greatly elevated PTSD rates (Eberly & Engdahl, 1991). PTSD was shown to be related to captivity maltreatment and to co-occur frequently with depression. The authors recognized that anxiety disorders could be triggered by life events, that the course is often chronic, and that the course is frequently complicated with depression. These symptoms tend to decrease over time, although persisting anxiety symptoms can lead to a secondary depression or exacerbate an existing depression.

Because PTSD and associated problems are increasingly viewed as having biological, evolutionary, and neuropsychological bases, disruptions in various somatic symptoms should be observed. Careful consideration of the effects of head injuries, malnutrition, and poorly treated diseases can be crucial to understanding survivors of captivity maltreatment.

Stressful life events and a lack of social support were related to psychological distress and reported sleep problems. A central feature of PTSD is the persistent re-experiencing of traumatic events, often through recurrent distressing dreams. A secondary feature is persistent symptoms of increased arousal, often manifested as difficulty falling or staying asleep. A recent review asserted that sleep disturbance is so frequent among individuals with PTSD that it is the hallmark of PTSD (Ross et. al., 1989), although there is disagreement. Little is known about the nature or role of sleep disturbance in PTSD reported behaviors include: 1) snoring and anxiety dreams among the Dutch Resistance fighters, 56% with PTSD; 2) more frequent awakenings due to bad dreams among the survivors of the Nazi Holocaust; 3) repetitive nightmares about escaping,

restless sleep, and difficulties falling asleep among the Czechoslovakian refugees; 4) more anxiety, agitation, and body movements associated with insomnia among the Vietnam combat veterans with PTSD.

A series of somnographic sleep studies of trauma survivors have been reported. Trauma survivors may experience reduced sleep efficiency and total sleep time, which are relatively non-specific correlates of psychiatric disorder per se. Decreased REM, increased REM latency, and increased awakenings may be specific to these groups.

The actigraph also is worn during a standard 3-night sleep study. It is hypothesized that the severity of PTSD will be predictive of increased nighttime restlessness and awakenings, decreased REM, and increased REM latency.

A hyper-scientific attitude should be avoided in interviewing trauma survivors, but unstructured clinical interviewing does not lend itself to quantitative analyses. The Structured Clinical Interview for Diagnosis (SCID) is well written and flexible, and its structure assures the thorough symptom coverage so vital for both assessment and research.

It is not uncommon for refugee research to simply characterize clinical samples. Such reports can be helpful in hypothesis generation, but it is desirable to study more randomly selected non-clinical samples and to include comparison groups. In such studies the comparison samples could consist of people similar to the imprisoned and tortured groups in ethnicity, political beliefs, age, etc. To illustrate, Group 1 would remain the primary group of interest, those imprisoned and tortured. They experienced constraint and maltreatment. Group 2 could be individuals held but not tortured, and Group 3 could be individuals neither imprisoned nor tortured. Comparisons across these three groups would help to separate the effects of captivity and captivity maltreatment.

Despite valid criticisms, multivariate data analytic methods provide the opportunity to examine more complex models of post-traumatic adaptation and make possible informative reports. The field of refugee mental health is in an exploratory stage, where investigations need to examine a

wide range of variables. Multivariate methods can be helpful in data set exploration and reduction, and in modeling the increasingly complex interaction of biological and psychological events confronted in the areas of trauma and refugee mental health.

Farber et. al., (1957) analyzed the influence tactics of captors and identified three components: 1) *debility*, induced through starvation, fatigue, infliction of pain, and failure to adequately treat diseases and injuries; 2) *dread*, the anticipatory anxiety induced through unrelenting uncertainty and threat of death, pain and non-release; and 3) *dependency*, developed because captors totally control resources for alleviating the first two states.

The power relationships developed by captors have components including isolation, deprivation, abuse, and interrogation. Isolation and the denial of access to communication are induced through physical isolation, (solitary confinement) and psychological removal from previous sources of identification. Isolated captives consciously strive to retain their pre-captivity identities. Deprivation includes lack of food and adequate medical care, and inadequacies in other life-sustaining environmental factors.

One of the most important coping mechanisms among concentration camp survivors was the retention of the ability to make at least a few of one's own decisions (Segal, 1986). Those who mobilized active coping mechanisms had fewer psychiatric complications than those who were completely isolated, remained passive, or ascribed survival to mere luck. Antonousky (1979) formulated the idea of "salutogenesis" which emphasizes successful coping strategies among survivors of extreme trauma.



Research Implications

Refugee research to date has primarily been anecdotal descriptions of clinical samples. While such reports have been helpful in describing the clinical phenomenology of refugee patients and in developing testable hypothesis, it is now desirable to study randomly selected non-clinical groups and to include comparison groups. These study designs will help clarify the relative contribution of torture to the mental health status of survivors.

Clinical Implications

Refugee clinicians can learn a great deal from the clinical research findings for other well studied traumatized populations (e.g. Holocaust survivors and POWs). Major resiliency and risk factors have been identified in the latter, which may also apply to torture survivors. The important role of sleep disturbances in trauma survivors is also emphasized. Finally, careful consideration of the physical and psychological effects of PTSD as well as head injuries, malnutrition and poorly treated diseases often found in POW survivors should be stressed in the clinical care of refugees.

VI. RESEARCH ON SERVICES TO REFUGEE POPULATIONS



INTRODUCTION

Richard F. Mollica, M.D., M.A.R., WooTaek Jeon M.D. and Masaya Yoshioka, M.D.

The classical public health model of agent-host-environment can be used to integrate the two major approaches to the refugee mental health field- i.e. the socio-cultural and biological approach (Susser, 1981). The socio-cultural approach places its emphasis on *environment*. It is generally assumed by this approach that environmental risk factors override those of host (refugee) and agent (specific refugee experience). Environmental characteristics such as culture, social structure, family support and socio-economic opportunities are regarded by this school of thought as being of paramount importance. Emphasis is placed on identifying all potential socio-cultural factors that place refugees at risk for mental illness. Casual relationships are analyzed and discussed on the social level. Observation and inductive methods including ethnographic and fieldwork are essential research approaches. One sociocultural model currently in vogue that has a biological framework is evolutionary theory. Unfortunately, the latter has produced little insights as yet into the origins of human aggression and victimization partially due to the difficulty of finding acceptable human models in evolutionary theory.

The biological model in refugee research, although limited, places emphasis on the biological characteristics of the host. Again, it is assumed by this model that the biology of the host overrides the influence of agent and environment. The biological characteristics of the host such as genetic background, biological loading, personality and physical injury are regarded as essential elements of refugee mental outcomes. This model obtains and analyses data on the psychological, genetic and molecular levels. Experimentation and deductive reasoning are its major methods. It is postulated although unproved, that good (strong) hosts cannot overcome such difficulties.

A public health model can bridge these two powerful but complementary approaches. The public health approach, as previously suggested, has until recently placed considerable emphasis in refugee mental health on identifying the pathological agent- i.e. trauma, torture and all other forms of physical and psychological violence. The results of this focus of inquiry have been extremely productive locating refugee mental health in a scientific framework in which an agent

can be identified, measured and its effects studied. The implications of this advance for prevention cannot be over-emphasized. The critical role of violence in producing long term, psychiatric morbidity and disability in refugee survivors can no longer be ignored. This approach's emphasis on agent, however, has partially been responsible for researchers ignoring environmental and host risk factors. In subsequent studies a wide range of risk factors must be investigated if any progress is to be made in the prevention and care of mental illness in refugees. For policy planners who work in the refugee field, the biological model may be too narrow and the sociocultural model too generic and abstract, but the public health model can be practical and useful if it can integrate and combine these approaches.

In order to maximize the effectiveness of their humanitarian and therapeutic interventions, refugee workers and clinicians should examine each aspect of the agent-host-environment triad.

First, *agent* aspect. Even though mental health workers cannot do anything about traumatic events that occurred in the past, they can help prevent additional trauma from occurring in refugee camps, resettlement communities and hometowns after repatriation.

Second, *host* aspect. Generally, adequate food, clothing and shelter are regarded as sufficient physical conditions to meet the material needs of refugees. As a consequence of the latter, the host aspect of mental health is easily ignored. But mental health of refugees can be improved by strengthening their physical and mental status. This may include traditional approaches such as meditation, chanting, martial arts, spiritual activity, and even the eating of traditional food. Culturally appropriate physical and cognitive enhancements need to be part of the mental health work of refugees.

Third, *environment* aspect. Of course, a stable and supportive environment is essential to refugee mental health. But supplying necessities is not enough. Good mental health requires:

1. Work - This is more than a money-earning tool. It makes refugees feel they are still being useful, independent and can care for their families.
2. Altruistic activity - Not only receiving help, but also giving help to each other is a very strong factor that enhances the refugees' self-esteem and dignity.
3. Spirituality - Through spiritual activity, refugees can strengthen their hope as well as their inner sense of belonging to their group, which is very important for overcoming difficulties.

Ultimately, the integration of all three can make an even greater contribution to the prevention of mass violence and the rehabilitation of refugee survivors.

THE ROLE OF CULTURE IN THE COUNSELING RELATIONSHIP

Presented by: Nolan Zane, Ph.D., University of California, Santa Barbara

Summarized by: WooTaek Jeon, M.D., Ph.D.

Culture influences the psychotherapeutic relationship between therapist and client and the process of psychotherapy. For example, the dropout rate in psychotherapy of Asians patients is much higher than that of Caucasians. This fact demonstrates the importance of culture-response therapy.

Each ethnic group has its own culture, value system, coping style, and role for the psychotherapist in psychotherapy. In Western culture, psychotherapy is a formal dynamic process between two persons--the psychotherapist and the client. But in Asian culture, there is an informal relationship between two people even before conversation starts between the psychotherapist and patient, which influences their relationship. For example, for an Asian, loss of face or loss of fame is very powerful factor in human relationships. Asian refugees may drop out of psychotherapy very quickly, if they feel that disclosure of his or her trauma in psychotherapy will result in a loss of face. Asian refugees can feel that "too much self-disclosure" involving the sharing of "family secrets" to a stranger such as psychotherapist is a kind of loss of face.



Research Implications

For more effective and successful psychotherapy and counseling for refugees, it is necessary to study each refugee group's unique attitudes toward counseling, authority figures, their expectations and experience with psychotherapy, and the expected role of the psychotherapist or psychiatrist. The effect of trauma on the refugee, counseling experience and the psychotherapeutic process also needs to be explored. Development of standardized culturally validated evaluation methods for the study of treatment methods needs to occur.



Clinical Implications

Each refugee group has its own unique attitudes toward counselors, psychotherapists, and helpers. Mental health workers should become aware of those cultural beliefs that may influence the therapeutic process. For example, dealing with the issue of “loss of face” is critical in psychotherapy with Asian refugees. Before the psychotherapy or counseling process begins refugee patients should be advised of the therapist’s expectations of their participation in therapy; similarly the refugee patient should be encouraged to share their expectations. Any gaps between the two world-views should be addressed. Confidentiality must be emphasized to the patient, role disclosure in psychotherapy reviewed to avoid humiliation or loss of face, and the “strangeness” of the psychotherapist’s approach placed in context.

EVALUATION PERSPECTIVES FOR MENTAL HEALTH CLINIC EFFECTIVENESS

Presented by: Nathaniel Tashima, Ph.D., LTG Associates Inc.

Summarized by: WooTaek Jeon, M.D., Ph.D.

An evaluation of clinic effectiveness generally assesses client satisfaction, staff performance, and administrative operations. However this analysis will focus on five elements that expand the scope of evaluation from the internal evaluation of a clinic's functioning to one that incorporates more far-reaching measures of effectiveness. The five elements or constructs to be examined begin with the client/clinician dyad and then, in what can be visualized as a series of concentric circles, expands outward to include the family social network, the Asian Pacific American community, and the host-community context.

An essential question is: How is effectiveness defined and what entity is to create that definition? On a specific basis, that definition should include the particular client and clinician. So, the providing agency should involve community-based organizations (CBOs) and leadership from the targeted refugees' communities in discussion during the design and development phases of the services.

Clinics must also consider the issue of insider/outsider relationships. There is an insider culture to the clinic, its operational rules and rules of clinician/client interaction. However, even as the client is becoming an insider to the clinic, he or she is maintaining relations with family and friends outside of the clinic. The tension between these contexts (clinic/community) can become a powerful force as the client attempts to understand his/her situation and the options for resolution of concerns.

One way to effect both the effectiveness of the services and the community's perception is through the creation of refugee advisory committees. The committee developed by the clinic through community contacts can involve representatives from a variety of organization and consumers.

On an individual client basis, Western diagnosis of the presenting problem may be clearly indicated that any negotiation of what should be done rapidly becomes one-sided. The clinician takes over the decisions for the patients. In contrast, clinicians should engage the client's family in a discussion of the expected outcomes of treatment and how they might have traditionally dealt with these problems.

At the same time, a clinic's effectiveness may be evaluated based on a target community's general perceptions of the clinic and the community's views of mental health. Community perceptions may be based on direct experience; however, most often these perceptions are based on second- or third-hand knowledge. The perceptions of communities are not always based on facts and objective thinking. If a population does not have an understanding of Western definitions of mental health, there may be resistance to the use of the mental health services. Shame and stigma associated with aberrant behavior in families and social networks may keep most mentally ill refugees out of treatment.

A clinic must be able to appropriately bridge the language barrier between clinic staff and the client and his/her family. It is not enough to have a single individual who is able to speak all the necessary languages on staff. For example, a Cambodian community may reject a Vietnamese staff person who speaks fluent Khmer because of traditional conflicts between the Vietnamese and the Cambodians.

Ideally, the clinic should have at a minimum, a trained paraprofessional who is linguistically and culturally competent as a full-time staff member for each of the targeted refugee communities. If such a full time position cannot be maintained, a part-time staff position with regular hours is a reasonable fallback option. If limited resources are available, another useful strategy is to subcontract with the refugee's Mutual Assistance Association.

A regular list of volunteers from the community should be maintained. In order to be listed, a volunteer should be trained so that the language of mental health in English is clearly defined and a part of the volunteer's working English vocabulary. But it is not enough to train an interpreter or paraprofessional staff in English concepts. There must be a reciprocal effort to

understand traditional definitions of behavior so that family and traditional social networks can discuss the problem and potential solutions with a vocabulary in which they are versed and which has meaning for them. Cultural competency is also a critical issue.

As the clinic evaluates its effectiveness in the client/clinic dyad, the client should also be asked what could be done to improve the services, either in the direct therapeutic relationship or in the way services are provided by the clinic in general. Clients should also be queried about their views and reactions to prescribed medications. It is important to determine how the individual client, as well as cultural norms are structured with respect to Western medication.

In order to evaluate a clinic's services for refugees from a client's perspective, the role of family and extended social networks becomes essential. All of these individuals potentially can have an impact on when a client seeks treatment, how a client adheres to a treatment regimen, and the cultural context in which a client must function during and after treatment.

For many refugees (Southeast Asian), there remains stigma and shame associated with a family who has a member who does not act "normally." There may be significant familial pressure placed on clients; accounting for this potential and working with both the client and their family may significantly increase the likelihood of intervention success.

The initial period of a community's experience with a clinic is generally a testing period. The first client's experience is closely observed by the family and social networks and may be widely reported. As a community begins to accept a clinic's acceptability, appropriateness and accessibility begin to take a stronger position or affirmative connotation, a clinic may see a significant growth in clients for a period time.

Standardized psychometric evaluations, even when they have been standardized cross-culturally, may have limited meaning or no cultural context for many Southeast Asians. Although such tests may provide the clinician with some useful information, unless a culturally appropriate method is devised to give the results meaning in terms familiar to the client's family, the value of these evaluations will be lost on the client and her or his inmate social network.

In the internal evaluation of a clinic's effectiveness, the role that outreach and community education plays in the accessibility of clinic services to a community must be carefully evaluated. A clinic's evaluation of its services to refugees (Southeast Asians) must also examine its relationship to the host community or mainstream service system and policy makers. This partnership can help alleviate anxiety and concern for the family and inmate social network by explaining what is happening within the Western treatment system so that they have clear understanding and can participate appropriately in the treatment and care for their family.



Research Implications

Running a clinic for refugees has various and unexpected problems, however careful observation and evaluation of problems can lead to the development of new techniques to solve these problems. Evaluation of the effectiveness of these new techniques can generate innovative culturally valid treatment approaches. Research and clinical activity should be tightly combined in the refugee field. Clinical activities need culturally sensitive evaluation research; useful research needs active and involved clinicians and patients. So a good “clinic” of refugees is a “laboratory” for good “research”.



Clinical Implications

Running a clinic for refugees can be very meaningful and exciting, but at the same time very difficult and complicated. So “the experience of running a clinic” is the most valuable source of information for other clinics. Recording and sharing their experience should be one of the major jobs of refugee clinics. In this presentation, many valuable ideas and suggestions extracted from experience were given such as the creation of refugee advisory committees, language barrier problems, use of volunteers, the role of family and extended social network. Making a good manual for running clinics for refugees would be valuable for all clinics.

PSYCHOTHERAPY RESEARCH WITH REFUGEE POPULATIONS

Presented by: Kenneth I. Howard, Ph.D., Department of Psychology, Northwestern University, Robert J. Lueger, Michael S. Maling, Zoran Martinovich

Summarized by: WooTaek Jeon, M.D., Ph.D.

Jung may have been the first to describe psychotherapy as occurring in stages. As noted by Groesbeck (1985), Jung delineated the four stages as confession, elucidation, education, and “analysis proper.” According to Horowitz et. al., (1988), symptomatic distress abates dramatically after the first 10 sessions of brief time-limited psychotherapy, but reports of interpersonal problems change more slowly. The phase theory hypothesizes that different facets of a patient’s condition change at different rates over the course of psychotherapy.

In this study, a three-phase model of psychotherapy outcome is proposed that entails progressive improvement of subjective experienced well-being, reduction in symptomatology, and enhancement of life functioning of refugee patients. The model also predicts that movement into a later phase of treatment depends on whether progress has been made in an earlier phase. Thus, clinical improvement in subjective well-being potentiates symptomatic improvement, and clinical reduction in symptomatic distress potentiates life-functioning improvement. A large sample of refugee psychotherapy patients provided self-reports of subjective well being, symptomatic distress, and life functioning before beginning individual psychotherapy and (where possible) after sessions 2, 4, and 17. Change in well-being, symptomatic distress, and life-functioning over this period were consistent with the three-phase model. Measures of patient status on these three variables were converted into dichotomous improvement/non-improvement scores between intake and each of sessions 2, 4, and 17. An analysis of two-by-two cross-classification tables generated from these dichotomous measures suggested that improvement in well-being precedes and is a necessary condition for reduction in symptomatic distress, and that symptomatic improvement precedes and is a necessary condition for improvement in life-functioning.

Improvement in well-being tended to occur early in therapy, showing dramatic changes by session 2, however reductions in symptomatic distress and improvements in life functioning

occurred more gradually and later in treatment. The enhancement of subjective well-being, with its mobilization of hope, will lead to positive changes in personal efficacy (Bandura, 1982). And it may be enough to mobilize the patient's coping resources to such an extent that the patient can handle his or her symptoms (e.g., sleep better, have less difficulty concentrating, ruminate less) and cope more effectively with relevant parameters of the precipitating life situation. At the very least, enhancement of subjective well-being will allow the patient to work more effectively with therapist in dealing with distress and symptoms.

The phase model may be useful in the planning of service provisions in managed mental health care systems. To the extent that these phases are distinct, they may represent different components of psychotherapy in that they each imply specific treatment goals.

From a psychotherapy practice viewpoint, the phase model suggests that different change process (and thus certain classes of interventions) will be appropriate for different phases of therapy and that certain tasks may have to be accomplished before others can be undertaken. It also suggests that different therapeutic processes may characterize each phase. Therapeutic interventions are likely to be most effective when they focus on changing phase-specific problems when those problems are most accessible to change.



Research Implications

Evaluation of the effects of psychotherapy is difficult and abstract. In this presentation, simple and practicable methods for evaluation were demonstrated that could be applied to the research of refugee treatment. However, in order to achieve the latter, the development of culturally valid evaluation tools for refugees is necessary because of their differences in language and culture.



Clinical Implications

Brief treatment can improve the subjective well-being of refugee patients. This finding demonstrates the importance of acute psychotherapeutic intervention for traumatized refugees. In addition, psychotherapy for refugees should not be restricted to symptom reduction but can be extended to include improvement in their human relationships and life functioning. The training

of qualified mental health practitioners for psychotherapy and counseling of refugees is a necessary prerequisite of any refugee mental health program.

MONITORING PUBLIC MENTAL HEALTH SERVICES FOR REFUGEES

Presented by: Joop T.M.V. de Jong, M.D., Ph.D., IPSEER, The Netherlands

Summarized by: WooTaek Jeon, M.D., Ph.D.

One of the main constraints of public health programs reported by most countries, especially when they are technologically less advanced, is inadequate information for the managerial process (WHO, 1987).

A management information system (MIS) is a combination of people, equipment and procedures that collects, analyzes and delivers information to certain persons in the program in a way that enables them to make the best possible decision. The objective of a MIS is to provide information for decision making on planning, initiating, organizing and controlling the operations of the subsystems of the program and provide a synergistic organization in the process.

Because different data can provide the same kind of information, program managers have to decide the kind of information and what measures will provide the most useful information with a view to the core activities. The indicators about program outcomes can only be extrapolated when objectives are clearly stated. Besides, indicators should reflect program characteristics that are critical to the way the program itself is run.

Selecting Data Collection Instrument

Service-oriented collection method

1. Patient records: This is a classic way of collecting data. It also can be used for a case register. Cumulative case registers show the patient's pathway through the network of health, mental health and social services for a community (Horn ten, Giel, Gulbinat and Herderson, 1986).
2. Family register: It can be used in the form of a card with psychosocial data. It can be designed to show at first sight which families are at risk. It can serve as baseline information and later on to assess program coverage.

3. Service support records: It includes data on logistic and administrative matters of the program such as the utilization and maintenance of transport and equipment; personnel assignment and supervision; drug and administrative supply inventories; expenditures and balances of finances.

Community-based data collection

1. Focus groups: This method consists of open group interviews with 5-10 persons to obtain qualitative information on attitude, needs, or emotions.
2. Sondeo method: This is another method to obtain a “sounding” of situation. It differs from focus groups in that a multidisciplinary group consisting of 3-5 members conducts the interview. For example, the group may include a relief worker, an anthropologist, a psychologist or a rural development expert. Questions are asked of a variety of community members within their own context. The multidisciplinary approach widens the perspective, and lack of consensus may yield new hypotheses or problem solving strategies.
3. Key informant interviews: Key informants are chosen for their knowledge or insight about a community. Key informants are selected on the following criteria: they have to represent the various ethnic groups and both sexes, should occupy a position of respect and trust, have lived in the community for a considerable length of time, and they should have functions which bring them into contact with many people within the community or with a particular section of it.
4. Snowball sampling: Snowball sampling involves the selection of samples utilizing “insider” knowledge and referral chains among subjects who possess common traits (Kaplan, Korf & Sterk, 1987). This method is especially useful with regard to “hidden” problems that the program may have to address or should have addressed in a previous phase.
5. Mother test: This method is mainly used to evaluate education outcomes. Usually a set of questions is asked of the mother during a household survey or in a health or educational facility (de Jong & Clarke, 1993).

6. Survey: This methodology needs a culturally validated (i.e., concept, content, semantic, criterion and technical validity) questionnaire using proper sampling techniques.
7. Participant observation and phenomenological narratives.

Four Phases of This Model

The model feeds information back into the program by means of a cybernetic loop that goes through four phases. During the first phase, the exploration, the program and its objectives are described and activities and topics that can be evaluated are identified. During the second phase, norms are formulated to assess these aspects of the program. One has to decide on which level the assessment will take place and which indicators or criteria can be formulated. In the third phase the program is actually assessed with the help of indicators and criteria. During the fourth phase the responsible parties have to decide whether and how they want to adjust the program both in terms of priorities, personnel and service provision. Then the cycle starts again, the fourth phase gradually passing into the first phase and so forth.



Research Implications

Refugees are in an extremely unstable situation socially, physically, and emotionally. Information gathering methodology and processing should, therefore, be carefully considered. Selection of methods can be divided into service-oriented and community-based methods. Several methods can be selected at the same time. Factors such as research purpose, time, cost, practicability, and complementary nature of methods should be considered in the selection.



Clinical Implications

The direct clinical interview with refugee patients may not be enough to understand the patient fully because the social and personal situations of refugees are very complex and multifaceted. So, in order to better understand the refugee patient various information gathering methodologies used in research should be considered and used in clinical practice. This presentation demonstrates that clinical care and research can be carried out at the same time, each benefiting the refugee patient.

VII. CONCLUSION



THE FIELD OF REFUGEE RESEARCH: SUMMARY AND FUTURE DIRECTIONS

Eugene B. Brody, M.D., World Federation for Mental Health,

Editor, Journal of Nervous and Mental Disease

The Intellectual and Emotional Context of Refugee Studies

This conference has considered the gamut of refugee issues from reluctantly leaving one's home in search of a better life, to the experience of forced relocation, to imprisonment and torture. They are tied together by the common theme of pain and loss.

This has special valence for me today, because two weeks ago in Warsaw I was reminded of a similar theme in the poetry of Osip Mandelstam, a Soviet Jew persecuted by Stalin's government as an enemy of the state. The encounter with Mandelstam's work was totally unexpected. It has been adopted by Polish intellectuals, perceiving it as a symbol of the hope for renewal of their civilization suppressed by communist dictatorship and assaulted by the Nazis. His work represented the hope of a new community and solidarity arising from the ashes of past destruction and trauma.

During the noon hour today I looked for some of Mandelstam's writings in a bookstore in Harvard Square and found *The Moscow Notebooks* (1991). He wrote poems to his wife that were smuggled out of the camp. Although he died in the gulag, his work illustrates a theme mentioned here but not given sufficient attention: what is it that allows someone to live and have hope? In March 1931, Mandelstam wrote from the viewpoint of a prisoner of the gulag who was, yet, inspired by hope for a future:

Eyelashes sting with tears as a sob wells up in the chest.
I sense a storm is imminent but I am not afraid.
Someone wonderful hurries me to forget something,
I feel I'm being smothered yet I want to live to the point of dying.
At the first sound I rise from the bunks,
looking round me with wild and sleepy eyes,
thus a prisoner in a rough coat sings a convict song
as the strip of dawn rises over the labor camp.

The wish to continue living, despite past trials; the song rising toward freedom from within the walls of the camp; the strip of dawn succeeding the darkness: all can epitomize the resilience and hopeful spirit of the refugee, a survivor still, and still in transit toward a better future.

The Role of the World Federation for Mental Health

The road to this future has been a constant concern of the World Federation for Mental health, which has been a key link between the Harvard Program in Refugee Trauma and the United Nations. Nearly 50 years have passed since, in 1948, our founding document demanded “that the specialized agencies of the United Nations ... give urgent consideration to the mental health problems of displaced persons, transferred and migrating populations, homeless children, and others constituting the human aftermath of war” (World Federation for Mental Health, 1948).

In 1988, with WFMH co-sponsorship, the first National Conference on Refugee Mental health took place in New Zealand, producing a volume, *Refugee Resettlement and Wellbeing* (Abbott 1989). In that volume Richard Mollica, almost in preparation for this meeting in 1992, wrote: “It is my task to help this conference chart a ... course through the biomedical reductionism and related social injustices of modern medicine toward the development of a useful psychiatric, medical approach which includes diagnosis for classifying torture associated symptoms Can diagnosis be utilized by this new field to define problems and improve the treatment of victims of organized violence?” (p. 90).

There he signaled his interest, first, in moving refugee research away from the sole focus on the acculturation paradigm to one incorporating the experience of massive trauma exemplified by torture; second, in the human rights of refugees; and third, in the understanding and perhaps prevention of organized societal violence which both precedes and follows the movement of refugees.

In March 1990, at the WFMH-Hogg Foundation for Mental Health migration conference in Houston, he reminded us that “losing control of the world” is an essential feature of what he now called the trauma/torture experience; he brought to it the therapeutic question framed by Douglas Bennett in regard to non-refugee patients, “How do you repopulate this depleted human

landscape with social relationships and meaningful activities such as work?"; and, again, foreshadowing our meeting here, he called for the development of a "*science of human rights*."

Refugee Mental Health as a Field of Scientific Research and Practice

The assigned task of this final session is to discuss the identity or unity of refugee mental health as a field of scientific research, its possible distinctiveness, and the future directions that it might take in search of relevant facts, or at least propositions.

I resonate positively to the attempt to achieve more precise terms of reference, consensus about concepts and methods, and a more adequate knowledge base for practical applications. We have, indeed, heard a great deal about methodologies that might be used to assess and measure various aspects of the refugee experience. Gordon Willis' talk, however controversial, exemplified this. Joop de Jong provided another kind of example.

We also seem to have agreement on three general issues. First, it is important to achieve careful measurement of the dimensions of phenomena before trying to integrate them into particular unitary concepts or definitions. Second, there is a place both for clinical and statistical checklist approaches to the problem. Third, refugee mental health practice, research and documentation do not, together or separately, constitute a science. They come together as a form of praxis informed not only by the biological and psychosocial sciences, but also by the humanities, ethics, art, literature, human relations, administration and clinical knowledge and skill. And much of what needs to be done is political. I define political with Lyndon B. Johnson's definition: the art of the feasible.

So let us look at what else we have heard in these past two days. An important message, as I have already indicated, is that there is a many-faceted area with many useful approaches. Refugee studies, in general, may be regarded as an instance of research on adaptive behavior in high-risk situations. The research subfields represented here are familiar areas with semi-permeable boundaries between them.

One boundary is between subjective and objective studies, or those of private versus publicly observable phenomena. Thus some research focuses on the experience of individual refugees, their subjective lives; this involves participant-observation with interpretive explanations by the investigator (Brody, 1981a). The other side of this coin is research about refugees in relation to social context, studied en masse in terms of numbers, as objects or observation by others. Historical, socioeconomic summaries are an example. On the borderline between subjective and objective are observations about publicly observable behaviors, usually supplemented with interview data.

Epidemiological studies are farther to the objective right. But even those dealing with direct observations are only as good as the interaction between interviewer-observer and the subject whom provides the original data. These data are, ultimately, generated in dialogue, even though it may, in many instances, be largely nonverbal. So, here, too, we have the permeable boundary between public and private, subjective and objective. An aspect of this is the problem of recognizing how “outer” knowledge of the social context in which the refugee participates is related to the presumably “objective” investigator’s “inner knowledge” of the respondent’s subjective life (Brody, 1990, p. 185). Isaiah Berlin (1976) describing the ideas of Giambattista Vico wrote: “whatever the splendors of the exact sciences, there was a sense in which we could know more about our own and other men’s experiences — in which we acted as participants, indeed as authors, and not as mere observers — than we could ever know about non-human nature which we could only observe from the outside ... The distinction he draws is between ‘outer’ and ‘inner’ knowledge...”

Other data consist of countable acts without the complications added by dialogue. But they reflect the social institutions (and their human components and socio-political influences upon them) which compile them: for example, rates of hospital or clinic admission for psychiatric disorder, substance abuse, and family violence in refugee populations; of unemployment, divorce, criminal arrest or imprisonment. In terms of data analysis in this complex field, Dr. Rothman came down hard against use of multivariate techniques in favor of simple tabulations of frequencies and distributions as a basis for inferring what is happening. Most of us who have attempted to simplify and codify complex observations, especially those reflecting observer-

subject interaction, have been forced to realize that by the time one has arrived at clean numbers they are a long way, indeed, from dirty data, i.e. the “real” behaviors of our subjects’ life courses. Secondary data analysis is often necessary because “pure” comparisons are rarely, if ever, possible.

What research defines the refugee mental health field as we know it today? First let’s divide the answer into individual and social components.

Refugees as Social Problems and the Need for Social Research

While studies of individual experience are most appealing to clinicians and ethnographers, the social aspects of the field (to which we have paid insufficient attention during this conference) give it its contemporary urgency and most visible public definition. The major social challenges posed by the refugee floods are to solve problems beginning with the community violence that initiates so many refugee movements, and, then, their consequences. In 1951 Oscar Handlin wrote of waves of nominally voluntary migrants, largely of European origin, who made American what it was (Handlin, 1951). In recent years, the mass movements from Latin America, Asia, Africa, and elsewhere have transformed North American and European cities into multicultural urban concentrations with conflict not only between the newcomers and the dominant power holders, but also between the recent arrivals and older, established minorities competing for limited opportunity. In the United States this has been especially prominent in conflicts between native-born African Americans and “Hispanics”, mainly from Cuba, in Florida and between African Americans and Koreans in New York City, and most recently in the West Los Angeles riots of 1992.

In the European Economic Community in particular, refugees and other migrants, including “guest workers” from less developed regions, often former colonies, and hence, language-sharers, of European powers, are increasingly attracted by the presumed security and economic opportunity of these industrial democracies. Many host countries are seeing a reactive resurgence of militant nationalism. Their citizens complain of loss of jobs and taxes, and overwhelmed community services, by immigrants who are changing their neighborhoods in ways perceived as unpleasant.

We need to be able to understand and plan for the impact of these developments on the future economic development and cultural integrity and coherence of cities and nations as a whole. In the United States we are for the first time seeing an emphasis on ethnic identity reminiscent of that of minority groups — often known as nationalities — elsewhere in the world. This is particularly true for the varied migrant groups sharing the Spanish language and some cultural traditions that have coalesced as “Hispanics” (Bryant & Riche, 1992). The new watchwords are not assimilation, but pluralism and mosaic.

One research focus, not recognized here, could be on the social structure and strengths of various refugee communities. Others are conflict resolution and prevention, promoting social integration, and immigration policy. An important related research area is that of family dynamics as it is influenced by the stresses of forced relocation and resettlement. Perhaps some of John Richter’s methods for studying the influence of adverse environmental exposure on intrafamilial violence might be applied here.

We hear less, and we know less, about the migratory masses in Africa and Asia moving from the world’s poorest nations to others of the world’s poorest nations.

The Mental Health of Individual Refugees

Now let us return to the mental health of individual refugees that has occupied most of our time. If there is a core research area here it must be the experience of forced removal from home and community. If we focus on those actually forced to leave by war, persecution, and other fearful events I suspect that one can identify and describe an experiential core that differentiates them from other migrants and will lead to different behavioral consequences. While this must involve the trauma story, including torture, it must also involve the experience of boundary crossings and the myriad aspects of the acculturative struggle that remain even for those suffering the most severe psychological mutilation. The problems of managing the encounter with new places, new faces and new norms do not go away (Brody, 1969).

Every step of the migratory journey has its special features and mental health consequences which require study and documentation: the decision to leave in the face of fear, persecution, organized violence or economic collapse and lack of opportunity; the transit, by whatever means over varying time periods; communities of asylum which may be confined camps holding people for years; communities of final resettlement including ethnic enclaves which may be staging areas for moves out into the larger community (Brody, 1969) or deteriorating housing including squatter settlements on the periphery of metropolitan areas (Brody 1973, 1981b); and communities of repatriation to which everyone does not want to return, so repatriation itself — the hypothetical final goal — may be forced. It seems evident that, even in the absence of torture, refugees are all, in some measure, traumatized. They are “the uprooted” (Handlin, 1951), who having suffered losses of every description — of autonomy, occupation, social identity, former attachments and support networks — are struggling to find their way in a new, often hostile setting, with a new language and new customs. In Bruce Dohrenwend’s felicitous term they are dealing with adversity. As Primo Levi reminded us: “the man who loses everything loses himself.”

Studies of stress shade into studies of trauma. In the subfield of trauma studies the extreme is torture. Dr. Basoglu this morning regarded torture as only one of many forms of organized violence suffered by refugees. But I sense that his conclusions remain open to debate, at least for a proportion of torture victims. Here I think Ron Levy’s description of being victorious or vanquished by torture has a message for us in regard to individual coping. The implicit question is whether the torture experience is so devastating that it blots out individual, including cultural differences, so that for these refugees it should be the primary, or, perhaps, the only focus of research?

Most of the individual issues, discussed in these 2½ days: stress, trauma, loss, psychological assessment and life history analysis are not unique to refugees, but are basic to all studies of human psychology, ordered and disordered. From this perspective, the field (aside from the core I have just mentioned) consists of many familiar pieces given new meaning by the experience of forced removal and resettled, and the sheer enormity of the numbers involved. Or it can be regarded as another example of the study of life in extreme fateful situations — that is outside of

individual behavior control with physical exhaustion, threats to life, and loss of supportive networks. Whether it the King Lear of life is uncertain.

From the measurement point of view we still face the usual questions of how much rating scales, check lists, or more complex instruments utilizing either fallible memories or direct observation by the interviewer distort and narrow the richness of individual life as it has actually been lived.

Cross-cultural Diagnosing

And we still have the familiar arguments on how to arrive at cross-culturally acceptable definitions of ill health, disease, or disorder. We have known for a long time that disorders viewed locally as extensions of cultural concern with particular ways of behaving do not necessarily fit Western diagnostic guidelines. Not, as Eisenbruch (1992) pointed out, do we always understand the logic by which refugees from other cultures characterize the world. We do not even have a consensus about the universal validity of the diagnosis or concept of PTSD. Some observers have suggested that the diagnosis is based on Western ethnocentric assumptions about how refugees should express their distress and the distress should be ameliorated. It is even possible that, as Eisenbruch suggests, a person's culturally shaped perceptions of how his body and mind function, after a traumatic loss of social and identity supports, may reflect an attempt to maintain the relationship between past and present rather than an illness. Under these circumstances active intervention by Western physicians requiring an illness diagnosis, rather than work with a traditional healer, may compound the distress. Even for Western refugees, or highly stressed people in our own society it is important to remember that intrusive thoughts and suspicious wariness may be adaptive rather than symptomatic (Brody, 1974).

Cultural issues and the need to deal with ethnic diversity are familiar in research with long settled or native minority groups with limited access to the social power of the dominant culture (Brody, 1968) and we have paid little attention to this. This issue was only touched upon by Richter, in his discussion of violent behavior.

At the individual level there are other obvious research problems that have been studied in non-refugee populations. What, for example, is the impact on child development of exposure to chronic community violence? Several speakers expressed interest in those people who seem to be thriving despite their losses and the social tensions that they encounter. What are the sources of their apparent resiliency? How can this knowledge be used for preventive and therapeutic purposes?

This conference also paid little attention to the problem of dependency in refugee populations. Life in the lower socioeconomic strata of open society, as well as in refugee camps, fosters dependency; life without opportunity can wither initiative. Over twenty-five years ago, Lloyd Rogler trained Puerto Rican immigrants to participate in the political process (Brody, 1969). The idea that political self-determination and economic opportunity improve mental health seems self-evident, but requires more systematic study. Refugees and other migrants appear to be increasingly finding their own voices, and embracing the ideals of justice, autonomy, and self-determination as keys to their future welfare.

The Study of Refugee Narratives

Finally, we have discussed the study of refugee life histories or narratives, sometimes what Mollica has referred to as “the trauma story.” These retrospective accounts or recitals — becoming part of a group’s oral history — constitute significant data regarding the refugee experience. One aspect of this research is epistemological, trying to get at the truth criteria of the individual refugee story. As in any clinical narrative, especially the psychoanalytic one, there is a question about how much is a social construction created in the dialogue between the observer and observed, shaped in part by the therapist’s intrusions into the patient’s field and the status and power differences between them, and how much is historical fact distorted by its highly personal meaning for the teller (Brody, 1990). The epistemology of the clinic has much in common with the epistemology of ethnographic fieldwork (Brody, 1981a). All narratives obtained through clinical or ethnographic interaction are provisional and change with repeated contact. This means that the data should include an account of the perceived relationship between investigator and investigated as the context in which information is obtained and recorded.

The difference in status, power and means between interviewer and refugee is even more marked than that between the investigating-treating clinician and a patient from the same community and culture. The interviewer is a source of material as well as psychological assistance for the refugee. This can highlight the struggle noted by Jacques Lacan over being created by and for the other (Brody, 1990, pp. 37-38). The subject implicitly asks the interviewer: what do you want me to be?

The subject's story might be a gift to the interviewer, or even resistance. Anthropologist-psychoanalyst George Devereux, for example, understood that his American Indian patients' accounts of their customs often helped them, and the analyst, avoid psychologically important issues, and that the analyst's interest in them could sometimes be understood as countertransference. In this sense the anthropologist's focus on cultural phenomena could help maintain an artificial position of "neutrality" by defending against the encounter with feelings generated within the interviewing relationship.

The function and meaning of the refugee survivor's account requires understanding within the framework of the dialogue as well as the respondent's life history. It is typically multidetermined and multifunctional: mastering past traumas; desensitization by symbolically repeating disturbing experiences in a protected setting; witnessing for those who fell along the way as an effort at mastery; or establishing one's privileged position after an escape across a political or geographic boundary, which, itself, may have symbolic value.

The personal narrative also helps the refugee construct a new private identity. As Frederic Dilthey wrote in the early 1900s, "I possess the singular unity of my life only by recollecting its course" (quoted in Habermas, 1968, p. 152). Some of the new private identity formation, as in psychoanalytic recollection and reconstruction, is accomplished by remembering (or creating) linkages between life phases previously felt as disconnected (Brody, 1990). A new autobiography is produced in which earlier discontinuities are healed. As it is repeated and reified it aids the tendency emphasized by Erik Erikson to maintain a "subjective conviction of sameness over time."

The teller's narrative form can be determined by previous habits of personal recounting with significant others. Culture, gender, and socioeconomic structure determine stylistic usages and frames of intelligibility. As Reissman (1992) put it, "stories are a kind of cultural envelope into which we pour our experiences and signify its importance to others" (p.232); the culture speaks through the individual story. Narratives, as Mary Gergen wrote (1992, p. 130), can also be understood as ideology, and a life story as a way of validating the status quo. Cultural boundary crossers soon learn that what they regarded as legitimate and appropriate rights, privileges and standards for reciprocal respect in their homes cultures are not necessarily so regarded in the new one. The refugee's expectation of continuing social coercion may lead to incorporating defensive and ambiguous elements in the personal narratives.

Finally, I suggest that narrative may be useful in arriving at a working conception of human rights for individual refugees and groups. Within the context of a reflective dialogue with individual refugees it should be possible to arrive at some understanding of the beliefs which support their ideas of right and wrong, the practices which can be considered ethical, and how they have changed in consequence of the refugee experience.

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APPENDIX A: MEETING AGENDA
SCIENCE OF REFUGEE MENTAL HEALTH
NEW CONCEPTS AND METHODS

September 28 - October 1, 1992
Harvard University Faculty Club
Cambridge, MA

Tuesday, September 29, 1992
4:00 - 6:00 p.m.

INTRODUCTION

4:00 - 4:30 p.m.

Welcome to the conference

Opening remarks

Presenters

William H. Anderson, M.D., M.P.H., Department of Psychiatry, St. Elizabeth's Hospital and Harvard University

Thomas Bornemann, Ed.D., Refugee Mental Health Program, National Institute of Mental Health

Dina Birman, Ph.D., Refugee Mental Health Program, National Institute of Mental Health

Richard F. Mollica, M.D., M.A.R., Harvard Program in Refugee Trauma, Indochinese Psychiatry Clinic, St. Elizabeth's Hospital

SESSION I

THE MAGNITUDE OF THE REFUGEE PROBLEM: A WORLDWIDE SURVEY

4:30 - 6:00

Session Moderator: Thomas Bornemann, Ed.D.

A. Refugee Crises and Mental Health: An Overview

Presenter

Susan Forbes Martin, Ph.D., Refugee Policy Group

B. Discussion

Discussants

Alan Kraut, Ph.D., Department of History, American University

Rosemarie Rogers, Ph.D., The Fletcher School of Law and Diplomacy, Tufts University

C. Open discussion

Reading by Marjorie Agosin, Chilean poet, Wellesley College

Reception

6:00 - 7:00 p.m.

Harvard University Faculty Club

Wednesday, September 30, 1992
8:30 a.m. - 5:30 p.m.

SESSION II
THE RELATIONSHIP BETWEEN THE REFUGEE EXPERIENCE (MIGRATION AND TRAUMA) AND OUTCOMES

8:30 - 11:15 a.m.

Session Moderator: Angela Gonzales Willis, Ph.D., Refugee Mental Health Program, National Institute of Mental Health

A. The Epidemiology of Mental Illness in Refugees

Presenter

Kenneth Rothman, Dr.P.H., Editor, *Epidemiology*

B. A Theoretical Framework for Studying the Nature and Effects of Recent Stressful Life Events

Presenter

Bruce Dohrenwend, Ph.D., Columbia University

C. Discussion

Discussant

Richard F. Mollica, M.D., M.A.R.

Break: 10:50 - 11:15 a.m.

SESSION III
THE UNIQUE NATURE OF THE REFUGEE EXPERIENCE

11:15 a.m. - 1:00 p.m.

Session Moderator: Richard F. Mollica, M.D., M.A.R.

A. The Life History Method Applied to the Refugee Context

Presenter

Donald Spence, Ph.D., Robert Wood Johnson Medical School

B. Discussion

Discussants

Franco Paparo, M.D., University of Rome

Cathleen Crain, LTG Associates Inc.

Peter Van Arsdale, Ph.D., Division of Mental Health, Colorado Department of Institutions

C. Open discussion

Lunch: 1:00 - 2:15 p.m.

SESSION IV
DEVELOPING CULTURALLY VALID CONCEPTS AND MEASURES
2:15 - 5:30 p.m.

Session Moderator: Karen Donelan, Ed.M., Harvard School of Public Health

A. Ethnographic Research: An Overview

Presenter

Michael Agar, Ph.D., Department of Anthropology, University of Maryland

B. Psychiatric Taxonomy in the Cross-Cultural Context

Presenter

Juan Mezzich, M.D., University of Pittsburgh Medical School

Break: 3:35 - 4:00 p.m.

C. Assessing traumatized children

Presenter

John Richters, Ph.D., National Institute of Mental Health

D. Discussion

Discussant

Terry Keane, Ph.D., Boston V.A. and Tufts Medical School

E. Open discussion

Break: 5:30 - 6:30 p.m.

Reception and dinner
6:30 - 9:00 p.m.
Harvard University Faculty Club

Thursday, October 1, 1992
8:30 a.m. - 5:30 p.m.

SESSION V
THE HEALTH AND PSYCHOLOGICAL IMPACT OF TORTURE
8:30 - 11:45 a.m.

Session Moderator: James Lavelle, LICSW, Harvard Program in Refugee Trauma and Indochinese Psychiatry Clinic

A. Defining the Meaning of Torture: Implications for Research

1. The Cultural and Political Context of Torture

Presenters

Svang Tor and Yael Yavin, Harvard University and St. Elizabeth's Hospital

2. Documenting Torture: A Human Rights Approach

Presenter

James Welsch, Ph.D., Amnesty International, London, U.K.

**3. Using the Survey Questionnaire to Assess the Health Effects of Torture:
Methodological and Ethical Issues**

Presenter

Gordon Willis, Ph.D., National Center for Health Statistics

Break: 10:30 - 10:55 a.m.

**B. The Impact of Torture Experience on Psychological Adjustment: Approaches to
Research**

Presenter

Metin Bosoglu, M.D., Mandsley Hospital, London, U.K.

C. Prisoner of War Research: An Overview With Implications for Refugee Mental Health

Discussant

Brian Engdahl, Ph.D., U.S. Veterans Affairs Medical Center, Minneapolis

D. Open discussion

SESSION VI
RESEARCH ON SERVICES TO REFUGEE POPULATIONS
11:45 a.m. - 12:40 p.m.

Session Moderator: Dina Birman, Ph.D.

A. The Role of Culture in the Counseling Relationship

Presenter

Nolan Zane, Ph.D., University of California, Santa Barbara

B. Open discussion

Lunch: 12:35 - 1:45 p.m.

SESSION VI (continued)
RESEARCH ON SERVICES TO REFUGEE POPULATIONS
1:45 - 3:45 p.m.

Session Moderator: Dina Birman, Ph.D.

C. Evaluation Perspectives for Mental Health Clinic Effectiveness

Presenter

Nathaniel Tashima, Ph.D., LTG Associates Inc.

D. Psychotherapy Research with Refugee Populations

Presenter

Kenneth Howard, Ph.D., Department of Psychology, Northwestern University

E. Discussion

Discussant

Joop T.V.M. de Jong, M.D., Ph.D., IPSER, The Netherlands

F. Open discussion

Break: 3:45 - 4:10 p.m.

SESSION VII
WRAP UP

4:10 - 5:20 p.m.

Session Moderator: William H. Anderson, M.D., M.P.H.

Presenters

Eugene Brody, M.D., World Federation for Mental Health, and *Journal of Nervous and Mental Disease*

Margaret Locke, Ph.D., McGill University

CLOSING REMARKS

5:10 - 5:20 p.m.

William H. Anderson, M.D., M.P.H.