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The Southeast Asian Refugees and Community Mental Health

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This article provides a summary of the descriptive information currently available to community mental health workers about the Southeast Asian refugees. A brief overview of what is known about mental health and migration and refugee status is followed by a consideration of the psychological adjustment of the Southeast Asian refugees and then a description of recent mental health intervention strategies for this population. Suggestions are made for future research and service needs.

After the communists entered Saigon in 1975, many communities across the United States experienced a rapid influx of refugees from the Southeast Asian countries of Vietnam, Laos, and Kampuchea (formerly known as Cambodia). Although the Southeast Asian refugee movement peaked a few years ago, it produced what remains the largest group of refugees to be admitted to the United States. Of the 72,000 proposed refugee admissions to this country for fiscal year 1984, 50,000 are reserved for Southeast Asians (United Nations High Commissioner for Refugees, 1983).

Not all communities across the country have been equally affected by this influx. It is now the policy of the government and voluntary agencies assisting in refugee placement to settle newcomers in areas receptive to the refugees, close to family and friends and other refugees (Office of the U.S. Coordinator for Refugee Affairs, 1981). Since approximately 80% of the 1981 and later refugees are believed to have contacts in the United States and 40% have immediate family members here, communities and states with large refugee groups (e.g., California, Texas, Washington, Pennsylvania, Illinois, Minnesota, Oregon, Virginia, New York, and Louisiana) are likely to see an increase in these groups (Office of the U.S. Coordinator for Refugee Affairs, 1981).

The need for community programs and services tailored to these culturally diverse groups is becoming increasingly apparent. Community psychologists' skills in crisis intervention, in particular, are being called upon, for refugees often exhibit characteristics of a crisis, especially the existence of a precipitating event (Bloom, 1963) and "an imbalance between the difficulty and importance of the problem and the resources immediately available to deal with it" (Caplan, 1964, p. 39). One only needs to recall the media descriptions of the Vietnamese boat people to recognize how well Erich Lindemann's (1944) crisis theory applies to refugees. Two key predictions from crisis theory are that people in crisis are more easily influenced by others (thus more amenable to mental health services) and that unsuccessful resolution of the crisis contributes to an increased incidence of mental illness. This indicates the importance of providing effective mental health services to groups such as refugees.

However, some community psychologists, trained in traditional clinical programs, may wonder if their skills are useful in working with refugees who are so culturally different. Kim (1981) and others suggest that clinical-community psychologists must have a knowledge of their clients' cultural backgrounds in order to provide effective interventions. Cross-cultural psychology provides guidelines for working with the culturally different (e.g., Sue, 1981).

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John Berry (in press), for example, recently extended his work on acculturation to refugees. He suggests that refugees are a unique category of people undergoing acculturation, for they are unlike immigrants who choose to move and unlike native people who have an established territory or ongoing culture for support. Because of these factors, he suggests that refugees may face more challenges to their mental health than any other group undergoing acculturation.

At the present time, few empirical data are available on the adjustment of the Southeast Asian refugees and the effect of their cultural backgrounds and refugee status on their mental health. A formal literature review on their adjustment and adaptation is therefore impossible; however, this paper provides an initial summary of some of the descriptive information that may be helpful to practitioners and researchers interested in the mental health of Southeast Asian refugees. It considers some specific issues in working with the Southeast Asians, following a brief overview of migration and refugee status.

Overview of Migration and Refugee Status

As with other refugee groups in history, there is a tendency to view the Southeast Asian refugee movement as an atypical event. Unfortunately, the suffering of this group is not unique in today's world. Estimates suggest that there are approximately 16 million refugees in the world, with the vast majority in developing countries (Brandel, 1980). An earlier review by David (1970) indicates that the number of international refugees has more than doubled since the beginning of 1968. Viewing refugee flight as an unlikely, atypical event results in poor planning for future (inevitable) exoduses.

This author endorses the approach suggested by others (e.g., David, 1969; Kunz, 1973; Stein, 1981) and views the behavior of the Southeast Asian refugees as part of a more general class of refugee behavior. Thus, literature from earlier immigrant and refugee groups can be used in planning for mental health services for the Southeast Asians. Furthermore, lessons learned from the experiences with the Southeast Asians can be used to improve the services provided to future refugee groups.

It is important to consider the differences between the broad category, immigrants, and the subclass, refugees. Immigrants are often divided into two groups: those whose migration is voluntary and planned versus those who are forced to leave, often under very frightening and threatening circumstances. The United States, in its Refugee Act of 1980, accepted almost verbatim the United Nation's definition of a refugee: "a person who, owing to a well-founded fear of persecution for reasons for race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, unwilling to avail himself of the protection of that country" (Szule, 1980, p. 139); refugees, that is, have no choice about remaining in their native countries.

Kunz (1973) described a kinetic model of refugee flight, suggesting that an immigrant is *pulled* to a new land, but a refugee is *pushed out* of his homeland. Most refugee movements fit into one of two categories: anticipatory or acute. The anticipatory refugee recognizes the danger early and is able to plan an orderly departure from his or her country. Greater options and choices are available to anticipatory refugees than to the acute refugee, whose movement is undertaken in panic with little planning and thought. As Stein (1981) suggests, much more research is needed about the differences in the individuals who fit into these two categories, as well as those who chose to remain in their homeland even in the face of clear danger. Because of the trauma and tragedies

often experienced in acute refugee movements, it is believed that refugee groups are at an even greater risk for emotional problems than are migrants, but the empirical data to support this hypothesis are scarce.

Keller (1975) argues that the refugee experience changes people, making them feel more guilt (perhaps because they survived when loved ones did not) and invulnerability (from the recognition that they survived considerable danger and hardship), which causes them to act more aggressively. Whereas these changes can lead to psychiatric disturbances, they can also be used adaptively. Keller described a group of refugees in Punjab as more innovative and willing to take risks and work hard to build a new life. Refugees also tend to have high expectations about their new life and feel a strong sense that they are owed something by someone (Stein, 1981). Frustration and embitterment often occur when they finally recognize the reality of their situations.

The earliest work on migration and mental illness, fraught with methodological problems, frequently led to the inaccurate conclusion that mental illness was racially determined. This, in turn, led to immigration policy decisions in the United States to restrict certain groups from entry into the country (see Sauna, 1970, for a discussion). Many previous studies on the mental health and adjustment of refugees were concerned with prevalence, incidence, etiology, and symptomatology of mental disorders (David, 1970); relatively few focused on treatment issues and comparisons between the different types of immigrants.

Psychological Adjustment of the Southeast Asian Refugees

Surveys of the general population of Southeast Asian refugees are consistent with the findings from earlier refugee groups of a greater prevalence of psychological disturbances than is seen across cultures in the United States. A two-year study of the health and mental health status of Vietnamese refugees in the Seattle, Washington, area using the Cornell Medical Index found a high and continuing level of physical and mental dysfunction over the study period (Lin, Masuda, Tazuma, 1982; Lin, Tazuma, & Masuda, 1979; Masuda, Tazuma, & Lin, 1980). Lin and his colleagues discovered that some refugees may not fully realize what has happened to them until one to two years after the exodus. The resolution of the crises experienced by the refugees tended to be slow and piecemeal. Anxiety and depression, often of clinical proportions, were the most basic responses to their situations, although reactive psychosis was not uncommon. Because of language and cultural barriers, these temporary psychotic episodes risked being misdiagnosed as schizophrenia (Lin et al., 1982).

The work of Westermeyer and his colleagues with the Hmong population in Minnesota produced similar findings (Westermeyer, Vang, & Lyfong, 1983; Westermeyer, Vang, & Neider, 1983a, 1983b, 1983c). Interviewing 97 of the 103 Hmong living in Minnesota in 1977, Westermeyer, Vang, and Lyfong (1983) found that 61% admitted to experiencing a mental or emotional problem since arriving in the United States, and 29% reported a marital problem. Since conducting this study of the general population of Hmong refugees in Minnesota, Westermeyer has been involved in the treatment of those 17 Hmong who later developed a psychiatric illness. In addition, he has continued to follow and collect data on his sample from the general population. The one-year incidence of psychiatric disturbance in this population of 18% was higher than expected. Sixteen of his 17 patients had depressive symptoms, although many presented with somatic complaints (Westermeyer et al., 1983a).

Westmeyer et al. (1983c) compared the Hmong refugees who sought psychiatric help with those who did not on 60 different factors. One-third of the factors yielded statistically significant differences between patients and nonpatients. Some of these differences suggest ways to identify individuals at greater risk for psychological disturbances and possible interventions. For example, individuals whose vocations or avocations are not suited for life in the United States (e.g., midwives, blacksmiths) are more likely to become patients. Vocational counseling and training could be made available as a preventive measure.

The results of this comparison of refugee patients/nonpatients also suggests that changes in sponsorship policy may help prevent mental dysfunction. There was a large number of patients from one fundamentalist church that sponsored animistic refugees in rural settings (Westermeyer et al., 1983). None of these patients was referred by the pastor sponsor; several were discouraged to seek psychiatric help despite serious depressions or suicide attempts. Apparently the refugees were sponsored in an attempt to convert them to the sponsor's religion. Frequently the refugees were isolated from their cultural peers. A better sponsorship policy might be to encourage church sponsorship only if the refugee is a member of the church and to suggest that rural communities take a group of refugees rather than single individuals or families.

Smither and Rodriguez-Giegling (1979) compared samples of Laotian and Vietnamese refugees with an American group using measures of marginality (defined as being on the edge of two cultures, rather than well-integrated into one), modernity (an interpersonal style that welcomes change, variety, and the challenge of new situations), and anxiety. As these authors predicted, the Southeast Asian groups scored higher in marginality and anxiety and lower in modernity than a sample of Americans. On the other hand, several investigators have commented on the relatively low incidence of alcohol and drug abuse problems among the Southeast Asians (e.g., Kinzie, Tran, Breckenridge, & Bloom, 1980; Mattson & Ky, 1978).

One study (Vignes & Hall, 1979) optimistically concluded that the predicted adjustment difficulties for Vietnamese people adapting to the American culture had not materialized: "Vietnamese children are doing well in school, the refugees have accepted American social norms, and the Vietnamese community has been able to maintain its cultural identity" (p. 44). Unfortunately, their conclusions are seriously limited by their use of the mean score from a social adjustment questionnaire of unknown reliability and validity to place subjects in a high adjustment group (scores at the mean or above) or a low adjustment group (scores below the mean).

There are several reports in the literature primarily concerned with describing the physical health of the Southeast Asian refugee population that mention the high prevalence of psychiatric disturbance, especially depression (e.g., Catanzaro & Moser, 1982; Erickson & Hoang, 1980; Muecke, 1983). In fact, Muecke (1983) suggests that depression may be the greatest threat to the health of the Southeast Asian refugees. These descriptions and the surveys of psychological disturbance described earlier suggest that mental health services are needed for the refugees to increase their coping ability.

Mental Health Intervention Strategies

In any intervention for Southeast Asian refugees, their cultural background must be considered. The first very important issue to recognize is that the Southeast Asian refugees are a very heterogeneous group, coming from different countries, ethnic groups, religions, and social classes. Southeast Asian has been called the most linguistically

diverse area in the world (Gedney, 1979), as well as "an anthropologist's paradise" because of its large number of different cultures (Whitmore, 1979). Some of the ethnic groups from Southeast Asia may even be hostile to one another, sometimes leading to problems if one attempts to establish a single service for all Southeast Asian refugees in a community.

Despite the above caution, there are some generalizations that can be made to help orient the American therapist. The Southeast Asian cultures share many basic structures and belief systems, such as the importance of family, ancestor veneration, respect for the elderly, agricultural traditions, autocratic governments, explicit social hierarchies, Buddhism, animism, some Confucianism, and the importance of tradition (Kermott, 1980). Politeness and saving face are prominent features of many of their cultures, which may lead to misunderstandings with American therapists. A classic example is the use of the word "yes" even when the answer is "no" (*Guide to 3 Cultures Indochinese*, 1980). An affirmative answer is seen as a symbol of politeness, not necessarily of assent.

Southeast Asian patients are likely to have had no experience with mental health services. In most of their countries there were very few, if any, mental health workers. Even in Vietnam, perhaps the most Westernized of the countries, counseling and psychotherapy were virtually unknown (Brower, 1980). Many Southeast Asians attribute the cause of mental illness to evil spirits, and traditional therapies include exorcism and amulets provided for protection (Van Esterik, 1980). At present, there are few reports describing the use of more traditional therapists as service providers, although this may be beneficial. For example, a woman troubled because her mother was not given the appropriate death ritual may be helped by a spiritual ceremony performed in this country. Kinzie (in press) provides a more thorough description of the cultural issues involved in establishing an outpatient mental health service for a population of Southeast Asians in Oregon.

Interventions in Refugee Camps

After fleeing their homes, refugees often find themselves in large camps. Several authors have described their experiences as consultants in refugee camps for the Vietnamese (e.g., Harding & Looney, 1977; Looney, Rahe, Harding, Ward, & Liu, 1979; Mattson & Ky, 1978; Rahe, Looney, Ward, Tung, & Liu, 1978). These consultants report, as with other refugee groups, psychological problems and frustration increase when final resettlement is postponed. Unfortunately, it is not uncommon for some of the later refugee groups to spend several years in camps in Thailand, Hong Kong, Malaysia, Indonesia, Macau, Japan, Singapore, and the Philippines without knowing when (or even if) a third country would accept them. Psychiatric services in camps in Asia are likely to be quite limited. Sughandabhirom (in press), describing camps in Thailand, suggests that psychiatric illness, most often not immediately life threatening, is underestimated by general physicians because of the high prevalence of life-threatening physical illness and the frequent language barrier between physician and patient.

The refugee camp at Camp Pendleton in the United States received psychiatric consultation only after psychological problems began appearing and a few refugees reported suicidal ideation (Rahe et al., 1978). The consultation team identified mental health assets and liabilities of the refugees, suggested ways to handle psychiatric emergencies, and proposed a study of the overall mental health of the refugees.

One area that was particularly problematic for the refugees was the government's resettlement policy of dispersal, rather than settling refugees in a single area of the country for fear of overwhelming communities. This dispersal policy led to agonizing

decisions for families. Unaccompanied children were among the hardest hit by the policy. Since a family had an easier time finding a sponsor if it was small, unofficial foster children (children of relatives or friends left in Southeast Asia) were among the first left behind in the camps. The consultants were unsuccessful in implementing their suggestion that the children be kept with their Southeast Asian foster families, rather than being placed with American families (Harding & Looney, 1977; Looney et al., 1979; Rahe et al., 1978).

The unaccompanied children were placed together in a compound, within the camp, which served to potentiate their feelings of sadness and hopelessness. The children in the facility resembled psychiatric patients with somatic complaints, sleep disturbances, tantrums, antisocial behavior, and withdrawal being typical symptoms (Harding & Looney, 1977). The camp administrators were at first reluctant to staff the facility with the appropriate mental health workers, but eventually did so after one child made a suicide attempt and another had a psychotic episode. However, the administrators continued to downplay the psychiatric nature of the children's problems (Harding & Looney, 1977).

These experiences in the refugee camps lead to some suggestions for improvement in existing and future camps. First, it is obvious that community psychologists and other mental health workers should be involved in planning and caring for any group with a high risk for psychological problems. However, both camp administrators and the public have to be educated about the need for mental health services. It is evident that psychiatric consultation was an embarrassment to the Camp Pendleton administrators. Mental health professionals were not initially involved in any planning, consultation, or service delivery capacity (Harding & Looney, 1977). In fact, the crisis clinic, initially established at the suggestion of the consultants, was shut down for three weeks because of State Department's officials' fear that reporters would equate psychiatric treatments with poor camp administration (Rahe et al., 1978). Clearly, mental health workers have to assist camp administrators in dispelling the notion that recognition of mental health problems in a refugee group is a sign of a poorly run camp, rather than the recognition of the multiple needs of refugees.

It is with the benefit of hindsight that one can conclude that the government's policy of dispersal caused unnecessary trauma and did not accomplish its original goal of reducing the impact of the refugees on communities in the United States. The Southeast Asians' strong family ties led them to make secondary migrations to states such as Texas and California in order to be with relatives and friends. When refugees are separated from others like themselves, they are unable to use their language, feel isolated, and begin to lose their cultural identity. Homesickness and feelings of guilt are increased when others are left behind in the refugee camps. Stein (1980) suggested the deliberate establishment of refugee clusters, taking into account the area's employment needs, the refugees' backgrounds, the communities' housing capabilities, and sending only one ethnic group to an area to reduce the problem caused by having to serve several clusters and languages.

Descriptions of Treatment Efforts

Just as reports of consultants' experiences in refugee camps for the Southeast Asians are beginning to appear in the literature, so are descriptions of encounters of the Southeast Asian refugees with mental health workers in more traditional settings (e.g., Brower, 1980; Burch & Powell, 1980; Carlin, 1979; Kinzie et al., 1980; Santopietro, 1981; Williams & Westermeyer, 1983). Several of the reports (e.g., Brower, 1980; Carlin,

1979; Santopietro, 1981) describe how the cultural background of the refugee should be considered in establishing a relationship and treatment planning.

Burch and Powell (1980) described the difficulties in assessing an 18-year-old Vietnamese woman who was referred for problems of promiscuity and runaway behavior. Because she spoke no English, the authors were limited in their use of traditional psychometric testing. Instead, they used art to supplement more traditional procedures and describe how her art work was used for assessment during her hospitalization.

In addition to coming up with innovative assessment and treatment procedures, mental health workers should be aware of the cross-cultural literature on many of the standard psychological tests. For example, the Minnesota Multiphasic Personality Inventory (MMPI) has been translated into several languages including Vietnamese, Chinese, and Thai (Butcher & Bemis, 1983; Butcher & Clark, 1979). It is ironic that the first use of the Thai translation with a patient was in Minneapolis, not in Thailand!

Children and Aolescents: Special Needs and Interventions

A noticeable difference between the Southeast Asians and other refugee groups is the larger number of children among the former. In fact, during the 16-month period between August 1977 and January 1979, about 50% of the refugees admitted to the country were under 18 years old (Office of the U.S. Coordinator for Refugee Affairs, 1981). Thus, mental health professionals in school settings are finding themselves with the difficult task of evaluating and placing refugee children in existing school services. Learning problems have been noted to be significant in a group of adolescent refugees referred to a psychiatric facility (Williams & Westermeyer, 1983). School systems across the United States have responded in many different ways, but an extensive program developed in Wisconsin will be described as an example.

The Institute of Human Design in Winnebago, Wisconsin, and the University of Wisconsin in Oshkosh developed a program for evaluating a refugee's intellectual development and functioning (*Indochinese Assessment and Planning Manual*, 1979; Kotinek, 1980). They published a manual which includes a social history guide and Chinese, Hmong, Laotian and Vietnamese translations of the Raven Coloured Progressive Matrices and the Mazes, Coding, and Block Design subtests of the Wechsler Intelligence Scale for Children-Revised (*Indochinese Assessment and Planning Manual*, 1979). The battery also includes the Peabody Individual Achievement Test and the Peabody Picture Vocabulary Test, to be administered in English, to assess a child's readiness for American classrooms. The complete battery is administered by a trained, indigenous paraprofessional worker. The Institute's staff is currently in the process of collecting normative data on the battery which eventually will be published (Kotinek, 1980).

Unaccompanied children, first identified as being at-risk in refugee camps, appear to have continuing problems even after resettlement in this country. Carlin (1979) described some of the problems facing these children. When placed in American foster homes, these children, whose ability to communicate in English is limited, are often left with unanswered questions about new customs, the whereabouts of their own parents, and frightening stimuli. By the time the child learns enough English to ask questions, he or she may have fantasy explanations and will not ask questions. Older children and adolescents may have some identity conflicts about being Asian in the United States. Carlin (1979) suggests that these conflicts may be manifested in intermittent resistance to American rules and authority. Some children and adolescents may have ambivalent

feelings about Americans who now care for them, but who they may feel deserted them in the war. Furthermore, many of the unaccompanied children were "street children" in Asia, who survived through cunning, fighting, stealing, and cheating. When they begin to apply these old skills to their new life, they get into considerable trouble. Reeducation programs are needed to teach them more appropriate skills for their new life.

Although only four of the 28 psychiatric patients seen by Williams and Westermeyer (1983) were in American foster homes at the time of their initial referral, foster placement was seen as a contributing stressor. Adequate screening was not made of the foster parents and two of their patients experienced inappropriate sexual advances from their foster mothers. Clearly, more effort must be made to screen, train, and monitor these foster families. Studies are needed to determine the best placement for an unaccompanied child. There are not enough data at present to determine the relative efficacy of American versus ethnic foster placements.

As experience with previous refugee groups indicated, children and adolescents tend to acculturate faster than adults. Williams and Westermeyer (1983) described four cases in which family problems were caused by an adolescent engaging in a behavior appropriate to the majority culture, but of concern to the Southeast Asian parent. For example, one 15-year-old Hmong girl had accepted the American values of completing high school and having a career and rebelled when her traditional father accepted a large bride price for her. These problems are best handled with the therapist understanding the good intentions of all concerned and offering explanations for each family member's behavior. Family harmony is usually restored after a few directive sessions. Preventive programs in the schools designed to encourage parent involvement and exposure to the majority culture may be useful, along with programs to increase cultural pride in the young people.

Intervening with a Translator

A crucial element in any mental health services provided to Southeast Asian refugees is the indigenous translator. In the ideal situation, the translator not only interprets the language but serves as a bridge between the patient's and therapist's cultures, explaining each to the other. Unfortunately, very few community psychologists receive training in how to work with a translator, and guidelines in the literature are sparse. One empirical study found that consistent, clinically relevant, translator-related distortions, which could give rise to misconceptions about the patient's mental status, were not uncommon (Marcos, 1979). Three major sources of distortions were identified: deficient linguistic or interpretive skills of the translator, the translator's lack of psychiatric sophistication, and the translator's attitudes towards either the patient or professional.

The optimum solution to these possible distortions is for the community psychologist to train an indigenous translator and develop a working relationship with him or her. Acosta and Cristo (1982) describe a bilingual interpreter program for Spanish-speaking patients using persons from the same community as the patients. However, community psychologists rarely have their own trained translators and have to rely on one provided by other social service agencies or the patient's family members. A meeting of therapist and translator before the therapy session to explain the process to the translator is quite helpful (Gerber, 1980; Marcos, 1979; Santopietro, 1981). The translator should be encouraged to translate the questions and comments of the psychologist without interpretation, provide translations of everything the patient says, even if it seems irrelevant, and be prepared to discuss culturally sensitive topics. The therapist

should also assess the translator's linguistic abilities in this session. Issues of confidentiality are quite important, particularly when the translator is employed by another agency that has an interest in the patient. It is best worked out in advance with the translator's supervisor that the content of the session will not be discussed at the translator's agency unless a release is signed by the patient.

Family members who serve as translators may be motivated either to exaggerate the patient's symptoms or to downplay them (Marcos, 1979). The community psychologist needs to be aware of this and assess the family members' attitudes towards the patient *and* the professional. The therapist should never assume that his or her comments are accurately translated and should occasionally request that the translator tell the therapist what he or she just said to the patient as a check on accuracy.

Finally, the community psychologist needs to be aware that not all individuals are capable of serving as translators in mental health settings. An insensitive translator can undermine the therapeutic relationship, and this needs to be determined as soon as possible. Despite the difficulty in doing so, it is best to get a different translator than to try to make the best of it with an incompetent one.

Conclusions

The information presented in this article leads to the conclusion that community mental health can play an important and needed role in providing services to Southeast Asians and other refugee groups. In considering recent history it is obvious that refugee movements are a part of today's world and require careful, deliberate planning if goals are to reduce suffering and to maximize adjustment for the refugees. Community psychologists are well-suited to help fill the gap in planning for needed services.

One area to be addressed is the training of mental health professionals to enable them to better serve culturally different populations. Students in mental health training programs need both didactic and practicum experiences in working in cross-cultural settings. More attention could be spent on special circumstances, such as using translators in assessment and treatment sessions. The training would benefit not only refugee groups like the Southeast Asians but also more established ethnic minorities such as the Hispanics and perhaps later refugee groups. Community psychologists who have designed programs for special populations are among those most able to teach others.

In addition to training traditional mental health professionals, more attention is needed in the training and use of indigenous paraprofessionals. Research must also be built into such programs in order to determine which types of problems are best handled by an indigenous paraprofessional, how much training is needed, how to select individuals to be mental health workers, etc. A related issue is the use of traditional healers in mental health settings. Can traditional healers be integrated into our mental health system rather than ignored or scorned?

Another important area of focus for community psychologists is the host community, rather than the refugees. Others (e.g., David, 1970; Stein, 1981) have suggested that the community needs to be prepared for the influx. Educational programs about the refugees' culture and ways to foster adjustment, as well as efforts to encourage social interaction among the host community and refugees, are needed. Programs designed to reduce prejudice and racial discrimination would also be very helpful. The general public needs to be educated as to the role of community mental health in the resettlement of refugees so that the presence of a psychologist or psychiatrist is not misinterpreted.

The need for additional research is quite obvious for the evaluation of all these suggestions and others. More information is needed to determine how the refugee experience might change people. We also need to examine cultural barriers to mental health treatment, as well as how mental health problems traditionally are handled within the different Southeast Asian cultures. Our various assessment and treatment techniques need to be explored to determine their cross-cultural generalizability. In an attempt to summarize the descriptive information available to those working with the Southeast Asians, more questions may have been raised than answered. However, it is hoped that such questions may be the beginning of finding the answers.

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