

# REFUGEES: CULTURAL DISPLACEMENT AND ITS EFFECTS

Laurence Saigo Aylesworth and Peter G. Ossorio

---

## ABSTRACT

Issues in the provision of mental health and other social adjustment services to Indochinese refugees in Colorado have raised issues with regard to our understanding of cultural displacement phenomena and the ability of service providers systematically to provide effective, culturally appropriate services to culturally displaced client populations. A conceptual formulation is presented in connection with an outline for a comprehensive research program. A conceptually derived nontraditional needs assessment is presented that addresses basic human need frustration, negative psychological effects, and psychophysiological effects. This assessment has been applied to Vietnamese, H'Mong, and Cambodian refugees in the Denver-Boulder area. The results of this application are discussed. Findings are integrated with knowledge gained from a nontraditional mental health services program designed on the conceptually derived social participation model. Implications of findings for national refugee resettlement efforts are outlined.

---

**Advances in Descriptive Psychology, Volume 3, pages 45-93**  
**Editors: Keith E. Davis and Raymond M. Bergner**  
**Copyright © 1983 JAI Press Inc.**  
**All rights of reproduction in any form reserved.**  
**ISBN 0-89232-293-4**

## THE PROBLEM

### *Refugees and Mental Health Service*

In 1975 the governments of Vietnam, Laos, and Cambodia fell to the communist forces of the Vietcong, Khmer Rouge, and Pathet Lao, resulting in the displacement of over one million Indochinese refugees from their homelands. Between April 1975 and December 1982, over seven hundred thousand Indochinese refugees were resettled in the United States.

By 1977, the present authors had assisted in the provision of mental health services to approximately sixty Indochinese clients in the state of Washington and throughout the Rocky Mountain region. The consensus on the part of mental health and other service providers to Indochinese was that the members of this group were experiencing significant difficulty in their attempts to adjust to the United States and that these adjustment difficulties were resulting in a disproportionate incidence of serious mental health problems, as compared with the general American population. Frequent presenting problems included depression, anxiety and paranoid reactions, somatization, and reactive psychoses. The further consensus by these providers was that traditional Western mental health assessment and treatment methods were inappropriate and ineffective when applied to Indochinese. Psychiatric and psychological evaluations conducted with Indochinese clients based on accepted Western interview, psychometric, and observational assessment techniques resulted in the frequent misdiagnosis of mental disorders. Western psychotherapeutic interventions which were applied to Indochinese on the basis of these assessment findings were generally found to be inappropriate, and at times were reported to be quite harmful to the refugees' mental well-being.

Indochinese were known to be extremely reluctant to utilize existing American mental health services, as documented by an early national survey conducted by the Pennsylvania State Psychiatric Institute (1979), which found that fewer than four percent of the Indochinese refugees in the United States who had received help for "a serious problem" had received the service from an American mental health center, clinic, or hospital. Indochinese conceptions with regard to mental health and mental illness did not compel the refugee to trust, and thereby seek, help from "an American stranger" except under the most critical or unusual circumstances. It appeared that these beliefs, together with prior experiences with mental hospitals in Indochina, made the widespread utilization of the American mental health system unlikely.

Early programs that addressed the mental health and other social adjustment needs of Indochinese appeared to achieve success by virtue of their acceptability within the various Indochinese ethnic communities. In turn, the reason they were acceptable was that in some way and in some degree they exemplified traditional Indochinese approaches and conceptions with regard to mental health and mental

illness. However, even these efforts were largely ad hoc and were found to have a very limited impact on the refugee population. They tended to be overly responsive to a few highly disruptive and visible cases, including suicide attempts and domestic violence, and tended to assign a disproportionate amount of the limited resources allotted to refugee resettlement to those identified by the system as "most in need." In other cases, services tended to be structured around the needs of those persons most willing to use the service.

Examples of culturally acceptable mental health programs for Indochinese refugees included the crisis center hotline and the community medication clinic. The crisis center hotline, which was initiated in response to a few attempted or successful suicides, evolved into a rap-line in several locations; few genuine mental health cases were treated, and the impact on the overall refugee population appeared negligible.

In Denver, to circumvent the stigma associated with seeking help for mental health problems, a community "medication clinic" was created in 1976. It was based on the observation that many of the Indochinese clients were experiencing psychosomatic complaints associated with their emotional and situational problems. The clinic was utilized by refugees, but the agency's overall mental health program became defined by the general refugee community as a resource for the remediation of somatic complaints among Indochinese from low-income housing projects who by and large had low educational backgrounds.

Existing American service systems that also provided services to refugees (including schools, hospitals, Voluntary Agencies and other social service agencies) tended particularly to identify those adjustment problems for which they were expected to provide solutions. For example, English language programs would discover English language deficiencies, vocational training programs would uncover vocational training deficiencies, and so on.

An early realization was that none of the planning efforts for refugee social adjustment services were based on a comprehensive understanding of the adjustment difficulties experienced by the different Indochinese ethnic groups as such. Prior research related to refugee mental health generally established refugees as groups at high psychological risk. However, most studies were retrospective, and they were based on clinical case materials or psychiatric hospital admissions. Furthermore, they focused on the identification of Western syndromes of psychiatric and medical disorders as exhibited by small subgroups of Europeans or Hispanic refugees or immigrants within the overall culturally displaced groups. Thus, only very limited generalizations to the H'Mong, Cambodian, and Vietnamese refugees in the United States could be made on the basis of either prior research or service efforts with Indochinese.

In this context, the need became evident for a less ethnocentric and more comprehensive approach to the planning of mental health services for Indochinese refugees. It was clear that some sort of needs assessment was desirable, but now questions of method and conceptual framework became prominent, for it

was equally clear that none of the specific needs assessment options which had become traditional in the United States would be responsive to the concerns of our agency and other agencies serving the mental health needs of refugees.

### *Needs Assessments*

The major options for needs assessment include (1) the use of "social indicators," (2) reliance on expert judgments, (3) self-report or community consensus, and (4) the use of symptom counts. Each of these presented serious difficulties:

1. One well-known approach to needs assessment is the use of "social indicators" such as number of alcohol-related arrests, divorces, or violent deaths within a given jurisdiction over a set period of time. However, this approach requires implicit knowledge or assumptions concerning the structure and function of a community. Given an unknown community in a state of flux, neither knowledge nor plausible relevant assumptions were available. Moreover, this approach requires a specific target or criterion variable such as alcoholism, determined by the number of alcohol-related automobile accidents, the social indicator, occurring within a year, the time frame. The criterion variable is generally a problem which is already known or hypothesized to be an identifiable problem and is therefore culturally relative to a high degree. What we needed for our purposes was something closer to a discovery method for determining the range and extent of problems which existed for the different refugee groups.

2. A second approach is the "appeal to expertise" in identifying the needs of a community. The experts are either persons with special training (e.g., economists, sociologists) or persons who are favorably located for observing the phenomenon (e.g., ministers, physicians, politicians, teachers, community leaders). Mental health professionals and social scientists clearly were not in a position to identify the needs of this culturally diverse population by simple observation or interview methods. Conversely, Indochinese ethnic group leaders generally relied on their understanding of mental health problems from Indochina. They tended to identify a narrow range of problems which were disruptive for the community at large. Depression, which is commonly recognized to be the most prevalent mental health problem within the refugee communities, is seldom identified by Indochinese community experts or leaders, with the exception of a few knowledgeable persons. This pattern follows the early prediction of Tung (1975, p. 10), who stated, "Most probably the unhappiness (for Vietnamese refugees) will be suffered in silence and in private: crying alone at night or just staying awake, remembering and regretting and feeling loneliness and emptiness. It could also account for vague symptoms, ascribed to one organ or the other, for then they could be regarded as legitimate reasons to ask for help."

3. A third approach is to use polls or group meetings to establish some degree of community consensus concerning what is needed by a community. In

the present case, the same factors that handicapped the prioritization and identification by community leaders provided an even greater handicap for the refugees in general. Had they been asked what the refugees needed, they would probably mention money or jobs or English training first.

4. A fourth approach is to make a frequency count of identifiable disorders. For example, one might count the number of hospital admissions for schizophrenia or, in the door-to-door survey, inquire as to the frequency of alcohol problems in a given community. This approach requires known problems as criteria and thus is not well suited for discovery. Previous studies have noted the ability of immigrant and ethnic groups social structures to protect, and at times conceal, members who exhibit serious psychiatric symptomatology (Eaton and Weil, 1955; Kitano, 1969), leading Malzberg (1969, p. 395) to suggest: "the comparative incidence of psychoneurosis cannot be measured on the basis of admission to clinics, because ethnic groups differ in the importance they attach to such disorders, and in their willingness to apply for treatment." Self-reports based on door-to-door surveys required a mastery of the concepts governing the phenomenon of interest, but the refugees on the whole were not acquainted with Western mental health theories and constructs.

In the face of these difficulties, recourse to traditional mental health needs assessment approaches was ruled out. If we were going to be able to bring our technical expertise as clinicians and social scientists to bear on the problem, it appeared that we would first have to develop a more cogent conceptualization of the phenomenon of cultural displacement than was available in order to provide guidelines for treatment, assessment, and needs assessment. A conceptual formulation of cultural displacement follows.

## CULTURAL DISPLACEMENT RECONSIDERED

The phenomenon of cultural displacement is conceptualized in the following way: a culturally displaced person is an individual who has an experientially based, internalized culture of origin, a culture which contrasts in more or less important ways with a second, host, culture into which the person has been displaced and is currently living. The problems for culturally displaced persons do not arise simply from the fact that they are inadequately prepared to participate in the social forms of the host society into which they have been displaced. Problems also arise from the fact that they are well prepared and strongly disposed to participate in the social forms of their culture of origin, a culture which has defined for the group what is "right" and "natural" and "real" for them; to participate in the host culture requires that they deviate from what feels right, do what is unnatural, and participate in what seems unreal. Thus, from the point of view of adjustment, the displaced group's view of the host culture is not merely uninformed, but is actively distorted, and the group's behaviors are to a signifi-

cant extent not merely unskilled, but actively maladaptive in the new environment. The culturally displaced group and the host group are prone to mutual and systematic misunderstandings concerning each others' behavior; as a consequence, each group will tend to miscalculate the impact it has on the other.

A prerequisite for the understanding of the phenomenon of cultural displacement (i.e., the functioning of persons in second "host cultures") is an understanding of how people function in "cultures of origin" and how, in general, mental health and psychopathology are related to cultural participation. Such an understanding is provided by the Basic Human Need (BHN) model, which relates mental health and psychopathology to the satisfaction of needs and relates need satisfaction to social participation.

## THE BHN MODEL FOR CULTURAL DISPLACEMENT

The Basic Human Needs (BHN) model provides a comprehensive framework for understanding cultural displacement as a psychological phenomenon. The model provides a formally neutral common basis for making clinical judgments in various cultural contexts. A model of this sort is needed because judgments concerning both ordinary needs and psychopathology have validity only in relation to some particular cultural context. This relativity creates problems of basic understanding and of clinical judgment in dealing with refugees and other displaced persons.

The following is a summary formulation of the Basic Human Needs model. We begin with the following definitions:

*Pathological State.* When a person is in a pathological state there is a significant restriction in (1) his ability to engage in Deliberate Action and, equivalently, (2) his ability to participate in the social practices of his community. This concept of a pathological state is to be distinguished from the familiar notion of psychopathology, as defined by culturally determined sets of diagnostic categories.

*Need.* A need is a condition or requirement which, if not met, results in a pathological state.

*Basic Human Need.* A Basic Human Need (BHN) is a condition or requirement which, if not met *at all*, makes Deliberate Action impossible.

*Behavior Potential.* A person's behavior potential (BP) is his set of behavioral possibilities. Behavior potential is a function of both circumstances (opportunities) and personal capabilities. Restricted behavior potential may result from limited abilities or limited opportunities or both; in the former case a person is in a pathological state.

*Culturally Displaced Person.* A culturally displaced person is one who must

live in a culture which is different (the “host culture”) from the culture in which he has been primarily socialized (the “culture of origin”).

In principle, there is no definitive set of Basic Human Needs. And, in fact, different authors such as Leighton (1959), Coleman (1976) and Maslow (1969) among others, have presented different sets of Basic Human Needs. These sets have little actual overlap, although there are many strong resemblances. Table 1 shows an exemplary set of Basic Human Needs which was developed for use in the needs assessment reported below.

Basic Human Needs are satisfied in specific ways through participation in the social practices of a cultural group. Social practices contrast to Basic Human Needs in that they vary widely from culture to culture; even the “same” social practice will have a different significance in one culture as compared to another culture. Because of this, participation in a given, even highly similar, social practice will not provide the same kind and degree of Basic Human Needs satisfaction in different cultures. For example, the noonday meal has an entirely different significance as it is practiced in Chicano, American, and Vietnamese cultures and can be expected to provide different patterns of Basic Human Needs satisfaction in each. As this example suggests, Basic Human Needs are often satisfied by satisfying ordinary needs for companionship, transportation, employment, and so forth.

Within a given culture, the personal characteristics of the members become adapted to the cultural options for satisfying their Basic Human Needs. Within a given culture, only individuals having a limited and culturally specific set or range of personal characteristics are likely to satisfy their Basic Human Needs in a relatively optimal fashion. To the extent that a person’s Basic Human Needs are unsatisfied, he undergoes psychological distress and probably phenomenological and psychophysiological distress.

Table 1  
Exemplary Set of Basic Human Needs

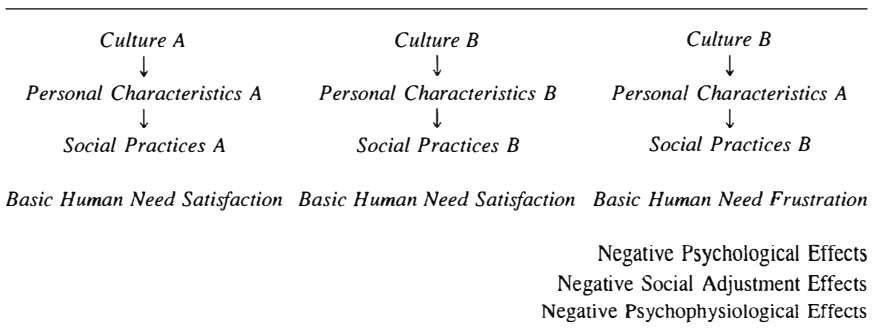
- 
1. Physical Health
  2. Safety and Security
  3. Self-esteem and Worth
  4. Love and Affection
  5. Agency and Autonomy
  6. Adequacy and Competence
  7. Identity
  8. Belonging and Acceptance
  9. Disengagement
  10. Order and Understanding
  11. Personal and Social Legitimacy
  12. Meaning, Hope, and Significance
  13. Extension of Self
-

Because a culturally displaced person is adapted to the satisfaction of his Basic Human Needs in his original culture, he is actively maladapted to the satisfaction of his Basic Human Needs in the host culture. Therefore, initially at least, a culturally displaced person is likely to fail to a significant degree in the satisfaction of his Basic Human Needs in the host culture. The kind and degree of failures are, on the whole, relatively predictable from a comparison of the host culture and the culture of origin. Consequently a displaced person is likely to be in a condition of psychological distress and possibly psychophysiological distress. Either may reach the point of diagnosable symptomatology but need not do so to constitute a degree of human suffering that calls for ameliorative and preventive efforts.

The interrelatedness of the concepts of cultural displacement can be understood schematically through reference to Figure 1 below.

The Basic Human Needs model helps to clarify the nature of the anomalous position in which the displaced person finds himself. If one uses the host culture as the “community” referred to in the definition of a pathological state, then the displaced person is in a pathological or near pathological state to the extent that he is significantly restricted in his ability to participate in the social practices of (what is now) his community. (And he is likely to be treated accordingly by members of the host culture.) On the other hand, if one uses the culture of origin as the “community,” then in general he is not in a pathological state, but is only lacking in opportunity. In either case, his behavior potential is significantly restricted.

To make matters more complicated, the restriction of behavior potential is likely to have an eventual pathogenic influence to a greater or lesser degree. Thus, situational factors which restrict behavior potential are more than merely situational. The net effect is to make clinical judgments with respect to psychopathology, case formulation, and treatment or prevention more complex and more uncertain than usual.



**Figure 1. Culturally displaced persons model.**



## A PARAMETRIC ANALYSIS OF CULTURAL DISPLACEMENT

Given the conceptual understanding provided by the Basic Human Needs model, we can go on to ask about historical or empirical factors which facilitate or restrict the resettlement process. These will be factors that systematically increase or restrict the behavior potential of members of the culturally displaced group. Correspondingly, they will be factors that facilitate or restrict the satisfaction of Basic Human Needs.

The general phenomenon of refugee resettlement can be regarded as consisting, paradigmatically, of a set of (usually large-scale) historical episodes such as the exodus of refugees from Vietnam to the United States since 1975. In each such episode, members of a cultural group, having left their culture of origin, attempt to resettle in a foreign cultural setting. Factors that facilitate or impede successful resettlement can be formulated as parameters of the phenomenon of refugee resettlement and, more generally, of cultural displacement.

The principal factors of this kind, which have been identified to date, are presented below in the form of a parametric analysis of the domain of cultural displacement. (To give a parametric analysis of this domain is to specify how one episode of cultural displacement can resemble or differ from another episode of cultural displacement as such.) The parameters may be classified into those dealing with the process of adaptation and those dealing with the end state.

$\langle CD \rangle = \langle Cd, Su, Vi, Co, Ho, Nu, Di, Lo, Kn, Hp, De \rangle$  where

CD = Cultural Displacement

Cd = Cultural difference

Su = Substitutability

Vi = Visibility

Co = Compatibility

Ho = Hospitability

Nu = Nurturance

Di = Disengagement

Lo = Load

Kn = Knowledgeability

Hp = Hope

De = Deliberateness

These parameters are explicated briefly as follows:

1. *Cultural difference.* Cultural displacement essentially involves a person or group and two cultures. The culture from which a person comes is his culture of origin. The culture in which he must function after being displaced is his host culture. The Cultural Difference parameter involves the kind and degree of difference there is between the two cultures.

2. *Substitutability*. This parameter is the degree to which the displaced person can satisfy basic human needs in the host culture merely by substituting new behaviors for old ones, as against having to develop new attitude/skill/behavior complexes.

3. *Visibility*. What is involved here is the degree to which accommodation to the requirements of the host culture can be accomplished without giving up the concrete, visible forms (e.g., dress, food, behavior patterns) of the culture of origin.

4. *Compatibility*. This parameter is the degree to which the displaced person can accommodate to the requirements of the host culture without serious loss of identity, integrity, or fundamental values.

5. *Hospitability*. A host culture can be more or less genuinely hospitable. What is involved here is the degree to which the displaced person must become indistinguishable from a native in order to be fully accepted in the host culture as opposed to being able to retain some noticeable distinctiveness in a pluralistic societal context. A host society that is maximally hospitable will not be merely permissive, but will actively exploit cultural differences in order to enrich its own culture.

6. *Nurturance*. This parameter concerns the degree to which the displaced person has access to a subgroup within the host culture that can provide a transitional stage by virtue of being more supportive, informative, and compatible with the displaced person's characteristics and inclinations than the host culture as such would be. Ethnic enclaves of immigrants or refugees provide the classic examples of subgroups that provide transitional support for new arrivals.

7. *Disengagement*. This involves the degree to which the displaced person is free to make a new adaptation within the host culture. Having continuing commitments and obligations within the culture of origin carries with it the potential for a high level of stressful culture conflict.

8. *Load*. Resettlement carries with it psychological burdens, which are not evenly distributed over time but rather reach one or more periods of maximum stress. "Load" refers to the maximum stress the displaced person is called upon to cope with, since it is his success in coping with these maxima that determines whether he moves through the resettlement process successfully. Features such as initial status loss or the burden of having to learn a completely unfamiliar language are among those likely to increase the load.

9. *Knowledgeability*. This term refers to the degree to which the displaced person is already knowledgeable concerning the host culture. Within limits, greater knowledgeability may be expected to correspond to greater ease of adjustment to the host culture. For example, the Vietnamese, with over 100 years

of contact with Western culture, could be expected to adapt to the United States more readily than the H'Mong, who had had only marginal contact.

10. *Hope*. In the present context, "hope" refers to the degree to which the displaced person can see a realistic prospect for an eventual satisfactory life in the host culture.

11. *Deliberateness*. This refers to the contrast between the planned and voluntary resettlement in the host culture characteristic of immigrants, and the unplanned and involuntary resettlement characteristic of refugees.

Since cultural displacements do not take place in a historical vacuum, the course and result will be different for each group of refugees or other displaced persons. The parametric analysis above serves as a practical guide to what to expect for a given case of cultural displacement. The simple functional relationships (other things being equal) between parametric values and resettlement success are relatively clear-cut: Adaptation to the host culture varies inversely with Cultural Difference and Load and varies positively with Nurturance, Hospitality, and the remaining parameters.

Within this framework the knowledge already obtained with respect to earlier refugee groups can be used to understand and anticipate the experience of new groups without any gratuitous assumption of uniformities across groups. However, an optimal development along these lines would involve the following components:

1. A parametric analysis of cultural displacement.
2. The development of techniques for assessing values of these parameters in particular cases of cultural displacement.
3. A framework for conceptualizing the kind and degree of hardship suffered by a refugee population and the degree of adaptation achieved at a given time.
4. The development of techniques for assessing the degree of psychological distress and the degree of adaptation.
5. The development of predictive functional models relating parametric values collectively (as against singly) to distress/adaptation indicators.

The results of such a program would provide a conceptual/empirical basis for setting up optimal resettlement programs on short notice, for anticipating trouble spots in the resettlement process, and for monitoring the progress and well-being of the refugees.

In this paper we deal with three of the five components above. The Basic Human Need model provides an implementation of component 3; the parametric

analysis above provides an implementation of component 1; and the instrument used for the needs assessment reported below provides an implementation of component 4.

Although the focus of the present paper is on groups and group differences, both the BHN model and the parametric analysis of cultural displacement are equally applicable to individuals and differences among individuals. Conversely, individual clinical data provide part of the empirical data for the systematic program described above. Thus, for example, clinical case formulations provide special cases of the type of functional model referred to as component 5, above, and they provide part of the basis for the parametric analysis of cultural displacement.

## A NEEDS ASSESSMENT FOR INDOCHINESE REFUGEES

The Basic Human Needs model was used as the conceptual basis for a needs assessment for the Indochinese refugees in the Denver metropolitan area in the spring of 1979. It followed from the model that the primary locus of psychological distress would be in the frustration, or lack of satisfaction, of Basic Human Needs. Further, it could be anticipated that frustration of Basic Human Needs would have both direct correlates, such as negative emotions and attitudes and intellectual interference, and less direct correlates, such as negative somatic effects. It was plausible that there was a corresponding temporal sequence involved; that is, that the failure to satisfy basic human needs would result, if not immediately, then after a time, in negative psychological effects, and that both could eventually result in psychophysiological effects. Finally, it was clear that different patterns of Basic Human Needs frustration should be associated with different psychological and psychophysiological effects and that both group and individual differences could be expected.

If these expectations were met, then the assessment of Basic Human Needs frustration, psychological effects, and psychophysiological effects would provide a deep and revealing picture of the psychosocial status of the refugees. Such a picture could be used for basic understanding, for anticipating later symptomatology and more overt needs, and for planning ameliorative programs at the level of Basic Human Needs. The latter would also qualify as preventive programs with respect to overt symptoms and pathological states. Thus, the study was designed to provide evidence for the expected relationships and to provide a basis for prevention, prediction, and treatment.

### *Methods*

A survey instrument consisting of 202 items was constructed in order to obtain information with regard to:

1. Demographic Background Data
2. Experience and Attitudes
3. Basic Human Need Frustration
4. Life Area Satisfaction
5. Psychological Effects
6. Psychophysiological Effects

The specific areas of Basic Human Need Frustration, Psychological Effects, Psychophysiological Effects, and Composite Scores that were assessed include the following:

A. *Basic Human Needs* (see Table 1).

B. *Psychological Effects*

- (1) Bad Memory
- (2) Fears and Phobias
- (3) Anxiety
- (4) Hypochondriasis
- (5) Compulsive Activity
- (6) Cynicism
- (7) Suicidal Ideation
- (8) Limited Emotionality
- (9) Alcohol Abuse
- (10) Manic States
- (11) Shame
- (12) Guilt
- (13) Shock and Depersonalization
- (14) Inappropriate Affect
- (15) Derealization
- (16) Paranoia
- (17) Preoccupation
- (18) Withdrawal and Isolation
- (19) Anger
- (20) Dependency
- (21) Depression

C. *Psychophysiological Effects*

- (1) Aches and Pains
- (2) Headaches
- (3) Heart or Chest Pains
- (4) Loss of Weight
- (5) Faintness or Dizziness
- (6) Trouble Sleeping

- (7) Numbness or Tingling
- (8) Pain in Lower Back
- (9) Fast Heart Beat
- (10) Diarrhea or Constipation
- (11) Nausea
- (12) Arthritis or Rheumatism
- (13) Stomach Disorder
- (14) Skin Disorder
- (15) Lack of Energy
- (16) Tenseness of Muscles
- (17) Fast Breathing
- (18) Sweatiness or Warmth of Skin

*D. Composite Scores*

- (1) Basic Human Need Frustration
- (2) Negative Psychological Effects
- (3) Negative Psychophysiological Effects

The survey form contained three items for the assessment of level of frustration for each of 12 of the Basic Human Needs and two items for the assessment of physical health. Two or three items each assessed 19 of the 21 negative psychological effects. "Suicidal thoughts" had only one item associated with it, due to the sensitivity of the topic: "fears and phobias" contained seven items, since it represented a broad category of disparate symptoms. Eighteen different physical complaints that are generally diagnosed as psychosomatic or psychophysiological in nature were each assessed by means of a single item.

Questionnaire items which were used to assess Basic Human Needs and psychological effects made use of a 9-point scale anchored by the following definitions:

- 0 = Does not apply
- 1 = Not at all true
- 3 = Slightly true
- 5 = Somewhat true
- 7 = Moderately true
- 9 = Very true

Judgments for assessing psychophysiological effects made use of the following scale:

- 1 = Never or almost never
- 3 = Seldom
- 5 = Sometimes

7 = Fairly often

9 = Almost all the time

Neither psychological nor medical inventories which had been standardized on American populations were used in the study, since it appeared that these procedures did not have sufficient potential for providing relevant findings. Several items were taken from existing inventories, which included the Cornell Medical Index (C.M.I.) (Wider, 1948), Zung scale of depression (Zung, 1965), and the Symptom Check List Ninety (SCL-90) (Derogatis, 1977). Most psychological and psychosomatic/psychophysiological effect items were derived from the authors' prior research and clinical experience in working with the mental health problems of Indochinese and other refugees. These symptoms are considered to be reasonably representative of the range of difficulties experienced by the group of refugees.

The survey and consent forms were translated into Vietnamese, Laotian, and Cambodian by three bilingual/bicultural Indochinese, all of whom possessed the equivalent of a college education in their native country. To obtain a common understanding with regard to the meaning and significance of each item, several discussion sessions, lasting over ten hours, were held and were attended by all three translators. As a result of these sessions, additional background items were suggested, and items that were potentially offensive from the standpoint of any one of the Indochinese cultures were eliminated.

### *Sample Selection*

The primary source of subjects for the present study was the central file of Colorado's United States Catholic Charities. The file contained folders on over 4,200 Indochinese refugees and was maintained under contract with the Colorado State Department of Social Services. Because the file was organized in terms of date of admission, a skip interval procedure was used to select a subsample. This subsample was randomly sampled within age, sex, and ethnic groups. The result, though not a random sample from the refugee population, was not subject to any known biasing effects.

During April and May of 1979, a sample of 222 Indochinese were interviewed, all of whom were over 18 years of age and lived in the Denver-Boulder metropolitan area. Only one refusal was encountered, and only four interviews had to be dropped due to incomplete data. Thus, the final sample of Indochinese represents 98% of those who were contacted initially and who were asked to participate in the study.

Of the 217 interviews retained for analysis, 119 or 54.8% were Vietnamese, 59 or 27.2% were Laotian or Laotian-H'Mong, and 39 or 18.0% were Cambodian; with regard to sex, 129 or 59.4% were men and 88 or 40.6% were women; and with regard to age, 93 or 42.9% were between 18 and 30 years, 93 or 42.9%

were between 31 and 59 years, and 31 or 14.3% were 51 years of age or older. The ethnic group proportions in this sample were not markedly different from those reported by the Colorado State Department of Social Services.

### *Results*

Statistical analyses which were conducted separately for the age, sex, and ethnic groups revealed ethnic group differences to be most frequent both in the case of the individual items and the derived scores. One-way analyses of variance and Duncan Multiple Range tests were conducted on the 185 interval-scaled questionnaire items, using age, sex, and ethnicity, successively, as the "treatment" variable, and revealed 122 significant ethnic group differences in comparison to 37 sex-group and 28 age-group differences ( $p = .01$ ). Similarly, analyses of the 13 Basic Human Needs, 21 Psychological Effects and 4 Global Scores provided 29 ethnic group differences but only 6 sex-group and 5 age-group differences ( $p = .01$ ).

Further statistical analyses were conducted to determine age and sex differences as a function of ethnic group. A one-way analysis of variance, regressing age as a function of ethnic group, achieved an F ratio of only .09 ( $p < .92$ ) whereas a chi-square of sex by ethnic group obtained a  $\chi^2 = 3.52$  ( $p < .70$ ). Thus, age and sex differences within ethnic group were not significant covariates, and it appears implausible that the ethnic group differences reported below are due to the age and sex differences between the ethnic groups. Since the original intent of the study was to apply the BHN model to the different Indochinese ethnic groups, and since ethnic group differences appear substantial in comparison to age-group and sex-group differences, the focus of the results and discussion in this paper will be on characterizations of the Vietnamese, H'Mong, and Cambodians and on the differences between these groups.

Eleven illustrative demographic sample characteristics are shown in Table 2. Of the total adult sample of the Indochinese included in the study, the typical respondent was 36 years of age; had been in the United States for two and a half years; had moved to escape from the communists between two and three times prior to leaving their country of origin; had completed the ninth year of schooling; and could speak "some" English, that is, at the level of "can say and understand simple things." In terms of marital status, the group was composed of persons who were currently married in three out of five cases, had never married in one out of four cases, and had been divorced, separated, or widowed in one out of seven cases. With regard to religious affiliation, half of the group was Buddhist, one-third was Catholic, and one-ninth was animist. Two-thirds of the group indicated they were able to read and write in at least one language and one-third of the group reported themselves to be totally illiterate in any language.

In the area of current work situation, slightly more than one-third of the group indicated they were employed on a full-time basis, while about the same percent-



age indicated they were students; one in seven was unemployed, one in eleven was a housewife or in an "other situation," and only 3% indicated their situation to be working on a part-time basis. With regard to public assistance, almost half of the sample indicated they did not receive any welfare benefits, slightly more than one-third received full assistance, and about one-sixth received partial assistance.

For descriptive purposes, one-way analyses of variance and Duncans were conducted by ethnic group on six of the items included in Table 2. These items are indicated by an asterisk; the findings reported below achieved significance beyond  $p = .01$  on both the ANOVA and the Duncan multiple range tests.

Ethnic groups show differences both in terms of average time in the United States and in the number of moves to escape the communists prior to coming to the United States. The H'Mong had been in this country a shorter period of time than either the Cambodians or the Vietnamese, but the Cambodians had been in the United States less time than the Vietnamese. The H'Mong also report having made more moves to escape from the communists than either the Vietnamese or the Cambodians.

With regard to education, it was found that the H'mong had fewer years of formal schooling than either the Vietnamese or Cambodians. Consistent with this, the H'Mong report less fluency in English or ability to read or write in any language than either the Vietnamese or the Cambodians. Finally, the H'Mong report greater reliance on public assistance than the Vietnamese.

Thus, the picture which emerges is of the H'Mong as a particularly disadvantaged group within the group of Indochinese. They were the last of the three groups to be resettled in the United States; had more escapes from the communists, less formal schooling, less fluency in English or literacy in any language; and had greater reliance on welfare, at least in comparison to the Vietnamese.

*Basic human needs, psychological effects, psychophysiological effects.* Mean scores and significant differences (Duncan Multiple Range,  $p < .01$ ) are presented in Table 3 for each of the three ethnic groups for Basic Human Needs, Psychological Effects, Psychophysiological Effects, and Global Scores. Ethnic group differences are discussed on the remainder of the results section only if they achieve significance beyond  $p = .01$  on both the Anova and Duncan multiple range tests.

These findings indicate that in the area of Basic Human Need frustration, (BHN) the overall group of Indochinese attained their highest mean scores in the frustration of Order and Understanding ( $\bar{X} = 6.1$ ), Adequacy and Competence ( $\bar{X} = 5.9$ ), and Safety and Security ( $\bar{X} = 5.4$ ). The lowest BHN mean scores for Indochinese were in the areas of Physical Health ( $\bar{X} = 3.0$ ) and Identity ( $\bar{X} = 3.1$ ). The H'Mong were found to have the greatest global need frustration and the Cambodians reported greater global need frustration than did the Vietnamese. The H'Mong reported the greatest frustration on seven of the thirteen needs, and,

Table 2  
Selected Demographic Characteristics of Indochinese Subgroups

<i>Subgroup Characteristic</i>	<i>Viet.</i> ( <i>N</i> = 119)	<i>H' Mong</i> ( <i>N</i> = 59)	<i>Camb.</i> ( <i>N</i> = 39)	<i>Male</i> ( <i>N</i> = 129)	<i>Female</i> ( <i>N</i> = 88)	<i>Young</i> ( <i>N</i> = 93)	<i>Middle</i> ( <i>N</i> = 93)	<i>Elder</i> ( <i>N</i> = 31)	<i>Total</i>
<b>1. Mean Age in Years</b>	35.5	35.4	37.2	34.4	37.9	24.4	39.0	60.2	35.8
<b>2. Marital Status</b>									
a. Married	53.8%	78.0%	43.6%	58.1%	59.1%	40.9%	76.3%	58.1%	58.5%
b. Div., Sep., Widowed	17.6%	5.1%	20.5%	7.9%	25.0%	2.2%	18.3%	41.9%	14.8%
c. Never married	28.6%	16.9%	35.9%	34.1%	15.9%	57.0%	5.4%	0.0%	26.7%
<b>3. Religion</b>									
a. Buddhist	47.1%	35.6%	84.6%	48.1%	54.5%	52.7%	51.6%	41.9%	50.7%
b. Catholic	52.9%	15.3%	7.7%	39.5%	27.3%	32.3%	33.3%	45.1%	34.6%
c. Protestant	0.0%	8.5%	7.7%	4.7%	2.3%	5.4%	2.2%	3.2%	3.7%
d. Animist	0.0%	40.7%	0.0%	7.8%	15.9%	9.7%	12.9%	9.7%	11.1%
<b>4. National Origin</b>									
a. North Vietnam	30.3%	0.0%	0.0%	16.3%	17.0%	8.6%	21.5%	25.8%	16.6%
b. Central Vietnam	31.1%	0.0%	0.0%	17.8%	15.9%	22.6%	12.9%	12.9%	17.1%
c. South Vietnam	38.7%	0.0%	0.0%	24.0%	17.0%	23.7%	21.5%	12.9%	21.2%
d. Laos	0.0%	100.0%	0.0%	22.5%	34.1%	25.8%	28.0%	29.0%	27.2%
e. Cambodia	0.0%	0.0%	100.0%	19.4%	15.9%	19.4%	16.1%	19.4%	18.0%
<b>5. Time in U.S.*</b>									
a. One year or less	15.1%	54.2%	23.1%	24.5%	30.7%	31.2%	25.8%	19.4%	27.2%
b. One to three years	16.0%	44.1%	43.6%	30.2%	26.1%	30.1%	26.9%	29.0%	28.6%
c. More than three years	68.0%	1.7%	33.3%	45.0%	43.2%	38.7%	47.3%	51.6%	44.2%
<i>Mean Time in U.S. (Months)</i>	37.3%	17.4%	26.6%	30.6%	29.0%	27.9%	30.7%	33.8%	30.0%

<b>6. # Moves to Escape Communists*</b>										
a. One or less	44.5%	13.6%	59.0%	41.1%	35.2%	41.9%	35.5%	38.7%	38.7%	
b. Two or three	52.1%	42.4%	41.0%	48.8%	45.5%	43.0%	52.7%	45.2%	47.5%	
c. Four or more	3.4%	44.1%	0.0%	10.1%	19.3%	15.1%	11.8%	16.1%	13.8%	
<b>7. Years of Education*</b>										
a. Zero to eight years	31.4%	76.6%	44.7%	39.1%	52.6%	39.8%	39.5%	70.0%	44.1%	
b. Nine to twelve years	39.8%	10.6%	31.6%	31.3%	31.6%	32.3%	38.3%	10.0%	31.4%	
c. Thirteen or more years	28.8%	12.8%	23.7%	29.7%	15.8%	28.0%	22.2%	20.0%	24.5%	
<i>Mean Years of Education</i>	10.2	6.9	8.9	9.6	8.2	9.9	9.3	5.8*	9.0	
<b>8. Level of English Proficiency*</b>										
a. None = 1	16.8%	61.1%	33.3%	20.9%	47.7%	18.3%	34.4%	64.5%	31.8%	
b. Some = 2	58.0%	25.4%	15.4%	41.1%	42.0%	35.5%	51.6%	29.0%	41.5%	
c. Moderate = 3	20.2%	10.2%	38.5%	28.7%	9.1%	34.4%	11.8%	6.5%	20.7%	
d. Fluent = 4	5.0%	3.4%	12.8%	9.3%	1.1%	11.8%	2.2%	0.0%	6.0%	
<i>Mean Level of English</i>	2.1	1.6	2.3	2.3	1.7	2.4	1.8	1.4	2.0	
<b>9. Read &amp; Write in Any Language*</b>										
a. Yes	71.4%	54.2%	74.4%	81.4%	46.6%	76.4%	59.1%	64.5%	67.3%	
b. No	28.5%	45.8%	25.6%	18.6%	53.4%	23.7%	40.9%	35.5%	32.7%	
<b>10. Present Work Situation</b>										
a. Work full-time	44.5%	22.0%	30.8%	43.0%	26.1%	22.6%	51.6%	29.0%	36.1%	
b. Work part-time	4.2%	1.7%	2.6%	3.9%	2.3%	6.5%	1.1%	0.0%	3.2%	
c. Unemployed	13.4%	8.5%	25.6%	10.9%	19.3%	9.7%	9.7%	41.9%	14.4%	
d. Student	33.6%	47.5%	30.8%	40.6%	31.8%	51.6%	29.9%	22.6%	37.0%	
e. Housewife, other	4.3%	20.3%	10.3%	1.6%	20.5%	9.7%	10.7%	6.4%	9.3%	
<b>11. Public Assistance*</b>										
a. None	56.3%	28.8%	46.2%	53.5%	37.5%	46.2%	55.9%	22.6%	47.0%	
b. Partial	14.3%	15.3%	20.5%	16.3%	14.8%	19.4%	10.8%	19.4%	15.8%	
c. Full	29.4%	55.9%	33.3%	30.2%	47.7%	34.4%	33.3%	58.1%	37.3%	

Note: \*indicates that the cultural group variable was statistically significant in a one-way analysis of variance and that the Duncan multiple range test indicated at least one group to be different from the others,  $p < .01$  or better.

Table 3  
Ethnic Group Means on Basic Human Need Frustrations (BHN),  
Psychological Effects, Psychophysiological Effects and Global Scores

	<i>Vietnamese</i>	<i>H'Mong</i>	<i>Cambodian</i>	<i>Total</i>
<b>Basic Human Need Frustration (BHN)</b>				
1. Physical Health	2.9	3.1	3.1	3.0
2. Safety & Security	5.1 <sup>a</sup>	6.2 <sup>b</sup>	4.9 <sup>a</sup>	5.4
3. Self-esteem & Worth	3.3 <sup>b</sup>	5.2 <sup>a</sup>	5.8 <sup>a</sup>	4.2
4. Love & Affection	3.7 <sup>c</sup>	5.7 <sup>a</sup>	4.7 <sup>b</sup>	4.2
5. Agency & Autonomy	2.8 <sup>b</sup>	4.8 <sup>a</sup>	4.6 <sup>a</sup>	3.7
6. Adequacy & Competence	5.7 <sup>b</sup>	6.6 <sup>a</sup>	5.6 <sup>b</sup>	5.9
7. Identity	2.4 <sup>b</sup>	4.4 <sup>a</sup>	3.1 <sup>b</sup>	3.1
8. Belonging & Acceptance	3.7 <sup>b</sup>	4.4 <sup>a</sup>	4.2 <sup>a,b</sup>	4.0
9. Disengagement	3.8 <sup>b</sup>	7.3 <sup>a</sup>	4.5 <sup>b</sup>	4.9
10. Order & Understanding	5.3 <sup>c</sup>	7.5 <sup>a</sup>	6.3 <sup>b</sup>	6.1
11. Personal & Social Legitimacy	3.5	3.6	3.7	3.5
12. Meaning, Hope & Significance	3.3 <sup>b</sup>	5.4 <sup>a</sup>	4.0 <sup>b</sup>	4.0
13. Extension of Self	4.2 <sup>a</sup>	3.7 <sup>b</sup>	3.9 <sup>b,a</sup>	4.0
<b>Psychological Effects</b>				
1. Bad Memory	4.5 <sup>b</sup>	3.7 <sup>b</sup>	5.7 <sup>a</sup>	4.5
2. Fears & Phobias	3.3 <sup>b</sup>	3.8 <sup>a</sup>	3.4 <sup>a,b</sup>	3.5
3. Anxiety, Tension	3.1 <sup>a</sup>	1.9 <sup>b</sup>	3.4 <sup>a</sup>	2.8
4. Hypochondriasis	2.6	2.8	2.2	2.6
5. Compulsive Activity	4.5 <sup>b</sup>	7.1 <sup>a</sup>	6.1 <sup>a</sup>	5.5
6. Cynicism	6.1 <sup>b</sup>	6.2 <sup>b</sup>	7.3 <sup>a</sup>	6.4
7. Suicidal Thoughts	1.5	1.8	1.5	1.6
8. Limited Emotionality	2.1 <sup>c</sup>	4.7 <sup>b</sup>	5.7 <sup>a</sup>	3.5
9. Alcohol Abuse	3.5 <sup>a</sup>	2.0 <sup>b</sup>	3.5 <sup>a</sup>	3.1
10. Manic Episodes	4.5 <sup>b</sup>	2.4 <sup>c</sup>	6.2 <sup>a</sup>	4.2
11. Shame	3.2 <sup>b</sup>	3.7 <sup>b</sup>	4.7 <sup>a</sup>	3.6
12. Guilt	5.8 <sup>b</sup>	3.6 <sup>c</sup>	7.4 <sup>a</sup>	5.5
13. Shock, Depersonalization	2.5 <sup>b</sup>	1.6 <sup>c</sup>	3.6 <sup>a</sup>	2.5
14. Inappropriate Affect	2.2	1.8	2.5	2.2
15. Derealization	3.2 <sup>c</sup>	4.2 <sup>b</sup>	6.8 <sup>a</sup>	4.2
16. Paranoia	4.3	4.6	3.8	4.3
17. Preoccupation	4.3	3.6	4.5	4.2
18. Withdrawal, Isolation	3.4 <sup>a</sup>	1.7 <sup>b</sup>	3.3 <sup>a</sup>	2.9
19. Anger	3.5 <sup>a,b</sup>	3.0 <sup>b</sup>	4.3 <sup>a</sup>	3.5
20. Dependency	4.0 <sup>b</sup>	5.0 <sup>a</sup>	5.2 <sup>a</sup>	4.5
21. Depression	3.4	3.3	3.7	3.4
<b>Psychophysiological Effects</b>				
1. Aches & Pain	3.5 <sup>a</sup>	3.6 <sup>a</sup>	1.9 <sup>b</sup>	3.2
2. Headaches	4.1	3.7	3.3	3.8
3. Heart or Chest Pains	1.7 <sup>a</sup>	2.1 <sup>a</sup>	1.2 <sup>b</sup>	1.7
4. Loss of Weight	3.2	2.5	2.7	2.9
5. Faintness or Dizziness	1.8 <sup>b</sup>	2.3 <sup>a,b</sup>	2.9 <sup>a</sup>	2.1

(Continued)

Table 3 (Continued)

	<i>Vietnamese</i>	<i>H' Mong</i>	<i>Cambodian</i>	<i>Total</i>
6. Trouble Sleeping	4.3 <sup>a</sup>	2.8 <sup>c</sup>	3.1 <sup>b</sup>	3.7
7. Numbness or Tingling	1.5	1.8	1.9	1.7
8. Pain in Lower Back	2.6	2.8	2.0	2.6
9. Fast Heart Beat	2.1	2.0	2.1	2.1
10. Diarrhea or Constipation	2.4	1.9	2.6	2.3
11. Nausea	1.9	1.5	2.0	1.8
12. Arthritis or Rheumatism	1.9	1.8	2.0	1.9
13. Stomach Disorder	2.2	2.4	2.9	2.4
14. Skin Disorder	1.8	1.4	2.0	1.7
15. Lack of Energy	2.4	2.9	2.6	2.6
16. Tenseness of Muscles	1.8	1.9	2.3	1.9
17. Fast Breathing	1.9	1.4	1.6	1.7
18. Sweatiness or Warmth of Skin	2.4	2.1	1.8	2.2
<b>Global Scores</b>				
1. Global Life Area Satisfaction	1.4 <sup>a</sup>	1.5 <sup>a</sup>	0.9 <sup>b</sup>	1.4
2. Global Psychophysiological Effects	2.4	2.2	2.3	2.3
3. Global BHN Frustration	3.8 <sup>c</sup>	5.2 <sup>a</sup>	4.4 <sup>b</sup>	4.3
4. Global Psychological Effects	3.6 <sup>b</sup>	3.4 <sup>b</sup>	4.5 <sup>a</sup>	3.7

Note: <sup>a,b,c</sup>Means that differ in superscript are statistically different from each other by the Duncan multiple range test.

conversely, the Vietnamese reported the least frustration on four of the individual need items.

In the area of Psychological Effects, the highest overall group means were in the areas of Cynicism ( $\bar{X} = 6.4$ ), Compulsive Activity ( $\bar{X} = 5.5$ ), and Guilt ( $\bar{X} = 5.5$ ). The lowest group mean scores were on Suicidal Ideation ( $\bar{X} = 1.6$ ) and Inappropriate Affect ( $\bar{X} = 2.2$ ). Between-group comparisons indicate that the Cambodians report the greatest degree of psychological distress in comparison to the other groups, both in terms of the global indicator and the number of Psychological Effect Items on which they have significantly higher scores.

Negative psychophysiological effects were reported by few respondents in any of the three ethnic groups, resulting in uniformly low group means and the absence of any global score inequalities. The highest individual psychophysiological effect mean scores for Indochinese were in the areas of Headaches ( $\bar{X} = 3.8$ ), Trouble Sleeping ( $\bar{X} = 3.7$ ), Aches and Pains ( $\bar{X} = 3.2$ ), and Loss of Weight ( $\bar{X} = 2.9$ ).

Summarizing these results in terms of groups we find the following: As a group, the Indochinese were characterized by high BHN frustration in the areas of Order and Understanding, Adequacy and Competence, and Safety and Security. They were also characterized by a high degree of the negative psychological effects of Cynicism, Compulsive Activity, and Guilt. Major psychophysiological effects were Headaches, Trouble Sleeping, and Aches and Pains.

Each of the ethnic groups showed distinctive patterns of BHN frustration, psychological effects, psychophysiological effects, and correlations between BHN frustration and psychological and psychophysiological effects.

The Vietnamese showed high BHN frustration for Adequacy and Competence, Order and Understanding, and Safety and Security. In this, they matched the characteristics of the overall Indochinese group, but they were the lowest of the three groups on Order and Understanding. The Vietnamese also were lowest on BHN frustration of Self-esteem and Worth, and Love and Affection. With one exception, Extension of Self, the Vietnamese obtained the lowest actual mean score for BHN frustration among the three groups, and they were lowest on overall BHN frustration.

On negative psychological effects the Vietnamese also matched the overall group in scoring high on Cynicism, Guilt, and Compulsive Activity, although in the latter their score (4.5) was much lower than the H'Mong (7.1) and the Cambodians (6.1). They were also the lowest of the three groups on Limited Emotionality, Derealization, and Dependency.

Psychophysiologicaly, the Vietnamese showed the greatest degree of Trouble Sleeping and, along with the H'Mong, were high on Aches and Pains.

The H'Mong scored highest on Global BHN frustration and in seven of the thirteen individual BHN frustrations, including the three which were characteristic of the Indochinese overall, that is, Order and Understanding, Adequacy and Competence, and Safety and Security. The other four most frustrated BHN among the three groups were Disengagement; Love and Affection; Meaning, Hope, and Significance; and Self-esteem and Worth. In addition, the H'Mong were higher than the Vietnamese on BHN for Belonging and Acceptance.

In the area of Psychological Effects, the H'Mong achieved their two highest scores on two of the three negative psychological effects characteristic of the Indochinese overall, that is, Compulsive Activity and Cynicism. In the third of these three effects, that is, Guilt, the H'Mong scored considerably lower (3.6) than the Vietnamese (5.8) and Cambodians (7.4). They also scored the lowest of the three groups on Shock and Depersonalization, Withdrawal and Isolation, Anxiety and Tension, Alcohol Abuse, and Manic Behavior. They were lower than the Cambodians on Anger. They were, however, higher than the Vietnamese on Fears and Phobias and, along with the Cambodians, were higher than the Vietnamese on Dependency.

In the area of psychophysiological effects, where there were few significant group differences, the H'Mong reported more frequent Heart or Chest Pains than did Cambodians.

The Cambodians had high BHN frustration scores on the same three need frustration areas on which the overall Indochinese group scored high, that is, Order and Understanding, Adequacy and Competence, and Safety and Security. They also scored high on BHN frustration for Self-esteem and Worth. They did not score highest or lowest on any of the thirteen BHN frustration measures and emerged as the middle group ( $H > C > V$ ) on overall BHN frustration.

Among the three groups, the Cambodians scored highest on overall Psychological Effects, and they scored highest on eight of the individual negative psychological effects. Considering actual means rather than significant differences, the Cambodians did not score lowest among the three groups on any of the twenty-one psychological effects. They did score highest on Guilt and on Cynicism, and, along with the H'Mong, scored higher than the Vietnamese on Compulsive Activity, so that on the whole, the Cambodians scored highest on the three psychological effects which were highest for the three groups combined. In addition, they scored highest on Derealization, Manic Behavior, Bad Memory, Limited Emotionality, Shame, and Shock and Depersonalization. Cambodians scored higher than the H'Mong on Anger and, along with the Vietnamese, scored higher than the H'Mong on Anxiety and Tension and on Alcohol Abuse. It is noteworthy that the Cambodians scored highest on six psychological effects which were not characteristic of the Indochinese as a whole and that of these six, five were of a dissociative nature. The remaining psychological effects on which the Cambodians scored highest or among the highest, with the exception of Alcohol Abuse, are typically classified as negative emotions (Anger, Shame, Guilt, Cynicism, Anxiety and Tension).

In the area of Psychophysiological Effects, the Cambodians reported more frequent spells of Faintness or Dizziness than the Vietnamese and less Aches and Pains than the H'Mong and Vietnamese.

Pearson correlations between each of the 13 BHN scores and each of the 21 Psychological Effect scores were calculated for the Vietnamese and for the H'Mong and the Cambodians, resulting in 273 correlations for each ethnic group. Table 4 lists the 13 basic human needs and shows the number of significant correlations between a given BHN frustration and the 21 psychological effects. Correlations significant at the .05, .01 and .001 are distinguished. These results are shown for each of the three ethnic groups separately and for the groups combined.

The proportion of significant correlations between BHN frustrations and Psychological Effects was 29% (79/273) for the Vietnamese, 25% (68/273) for the H'Mong and 12% (32/273) for the Cambodians. It was 22% for the total group.

The number of significant correlations with psychological effects varied widely from one BHN frustration to another. Combining the three ethnic groups, Personal and Social Legitimacy was the BHN with the greatest number of significant correlations with psychological effects, that is, 30 out of a possible 63 (47%). This was followed by Disengagement, with 23 significant correlations out of a possible 63 (37%). Agency and Autonomy ranked last in this respect with 5 significant correlations (8%) and Identity was next to last with 6 (10%).

For Vietnamese, the BHN frustration showing the greatest number of significant correlations with psychological effects was Disengagement, with 17 (out of a possible 21!), followed by Personal and Social Legitimacy, with 13, and Physical Health, with 11. For the H'Mong the BHN frustrations showing the greatest number of significant correlations were Personal and Social Legitimacy

Table 4  
 Summary of Vietnamese, H'Mong and Cambodian Significant Pearson Correlations Between Psychological Effects  
 and Basic Human Needs

	Vietnamese			H'Mong			Cambodian			Indochinese Total			Total # Signif. Pearson r's	Rank Order
	.05	.01	.001	.05	.01	.001	.05	.01	.001	.05	.01	.001		
<i>Basic Human Need Frustration</i>	.05	.01	.001	.05	.01	.001	.05	.01	.001	.05	.01	.001		
1. Physical Health	3	1	5	4	0	1	1	1	1	8	1	6	15	5
2. Safety & Security	4	3	1	2	0	0	2	1	0	8	4	1	13	6
3. Self-esteem & Worth	3	0	1	3	4	1	0	0	0	6	4	2	12	7.5
4. Love & Affection	5	0	2	4	1	3	3	0	0	12	1	5	18	3.5
5. Agency & Autonomy	1	0	0	1	0	0	3	0	0	5	0	0	5	13
6. Adequacy & Competence	4	6	1	0	0	0	1	0	0	5	6	1	12	7.5
7. Identity	0	0	0	3	0	0	1	1	1	4	1	1	5	12
8. Belonging & Acceptance	1	2	0	2	1	3	0	0	0	3	3	3	9	10
9. Disengagement	8	7	2	3	0	1	2	0	0	13	7	3	23	2
10. Order & Understanding	1	1	1	5	2	2	3	2	1	9	5	4	18	3.5
11. Personal & Social Legitimacy	4	3	6	1	4	6	5	1	0	10	8	12	30	1
12. Meaning, Hope & Significance	0	0	0	3	0	2	2	0	0	5	0	2	7	11
13. Extension of Self	2	1	0	4	1	1	2	0	0	8	2	1	11	9
Total	36	24	19	35	13	20	25	5	2	96	42	41	179	



(11) and Order and Understanding (9); for the Cambodians, it was also Personal and Social Legitimacy (6) and Order and Understanding (6).

For most BHN, the number of significant correlations with psychological effects varied widely from one ethnic group to another. For example, Adequacy and Competence showed 11 significant correlations for the Vietnamese, none for the H'Mong, and one for the Cambodians. Similarly, Order and Understanding showed 3 significant correlations for the Vietnamese, 9 for the H'Mong, and 6 for the Cambodians.

Pearson correlations were also calculated between each of the 13 BHN frustration and the 18 psychophysiological effects, resulting in 234 correlations for each of the ethnic groups and 702 correlations for the groups combined. These results are shown in Table 5, where the significant correlations are classified in terms of significance level (.05, .01 and .001).

The Vietnamese showed 62 out of a possible 234 significant correlations (26%) between BHN frustration and psychophysiological effects. For the H'Mong, 33 correlations (14%) were significant, and for the Cambodians, 19 correlations (8%) were significant. For the overall Indochinese group, 114 out of 702 correlations (16%) were significant.

In contrast to the results in Table 4, the number of significant correlations between BHN and psychophysiological effects did not vary extremely from one BHN to another. Of the 13 BHN, Physical Health had the greatest number of significant correlations with psychophysiological effects, with 34 out of a possible 54 (63%). Disengagement was second, with 17 (32%) significant correlations. These two BHN accounted for 45% of the significant correlations; for the remaining 11 basic human needs the number of significant correlations ranged from 3 to 7.

Also in contrast to the results in Table 4, the number of significant correlations between a given BHN and the psychophysiological effects did not in general vary widely from one ethnic group to another. The one notable exception was Disengagement, which showed 15 significant correlations for the Vietnamese and only one apiece for the H'Mong and the Cambodians.

A survey of the results in Table 4 and Table 5 shows that the proportion of significant correlations between the BHN frustrations on the one hand and either the psychological effects (22%) or the psychophysiological effects (16%) was far greater than would be expected on a chance basis. This is particularly evident when we consider the number of correlations which were significant at the .01 and .001 levels. Table 4 shows considerable variation from one BHN frustration to another in the number of significant correlations and in which ethnic group they are found. Ethnic groups show considerable differences in the number of significant correlations and in the degree of correlation between given BHN and Psychological Effect pairs. For the Vietnamese, Disengagement and Legitimacy were the BHN frustration showing the greatest number of significant correlations with Psychological Effects. In contrast, for the H'Mong and the Cambodians it

Table 5

Summary of Vietnamese, H'Mong and Cambodian Significant Pearson Correlations Between Psychophysiological Effects and Basic Human Need Frustrations

<i>Basic Human Need Frustration</i>	<i>Vietnamese</i>			<i>H'Mong</i>			<i>Cambodian</i>			<i>Indochinese Total</i>			<i>Total # Signif. Pearson r's</i>	<i>Rank Order</i>
	<i>.05</i>	<i>.01</i>	<i>.001</i>	<i>.05</i>	<i>.01</i>	<i>.001</i>	<i>.05</i>	<i>.01</i>	<i>.001</i>	<i>.05</i>	<i>.01</i>	<i>.001</i>		
1. Physical Health	2	1	12	4	0	10	4	0	1	10	1	23	34	1
2. Safety & Security	3	3	0	1	0	0	0	0	0	4	3	0	7	5.5
3. Self-esteem & Worth	1	0	0	3	2	1	0	0	0	4	2	1	7	5.5
4. Love & Affection	2	0	1	0	1	0	0	1	0	2	2	1	5	9.5
5. Agency & Autonomy	1	1	3	0	0	0	2	0	0	3	1	3	7	5.5
6. Adequacy & Competence	1	0	0	2	1	0	1	0	0	4	1	0	5	9.5
7. Identity	2	0	0	0	0	0	0	1	1	2	1	1	4	11.5
8. Belonging & Acceptance	2	0	0	1	0	0	0	0	0	3	0	0	3	13
9. Disengagement	6	3	6	1	0	0	1	0	0	8	3	6	17	2
10. Order & Understanding	2	0	0	0	0	0	1	0	1	2	0	1	4	11.5
11. Personal & Social Legitimacy	0	0	0	4	0	0	2	1	0	6	1	0	7	5.5
12. Meaning, Hope & Significance	4	1	1	0	0	0	1	0	0	5	1	1	7	5.5
13. Extension of Self	0	<u>1</u>	3	2	<u>0</u>	0	1	<u>0</u>	<u>0</u>	3	1	<u>3</u>	7	5.5
Total	26	10	26	18	4	11	13	3	3	62	33	19	114	

was Order and Understanding and Legitimacy that showed the greatest number of significant correlations. In the area of Psychophysiological Effects, all 3 groups had numerous correlations with BHN frustration Physical Health. The Vietnamese, but not the H'Mong or Cambodians, also showed numerous correlations with BHN frustration Disengagement.

Actual correlations between BBNF scores and Psychological Effect scores for each ethnic group are shown in Table 6 and Table 7. Table 6 lists the 13 Basic Human Needs. For each BHN, the Psychological Effects which correlated significantly with the BHN frustration are listed in the order of magnitude of the correlation. These results are given separately for each ethnic group. Table 6 permits the reader to make direct comparisons between ethnic groups in regard to a given Basic Human Need. For example, it can be established at a glance that the BHN frustration of Belonging and Acceptance correlates strongly ( $r = .57$ ) with Dependency for the H'Mong, whereas for the Vietnamese and the Cambodians it does not correlate significantly with Dependency.

Table 7 shows the same correlations organized in terms of Psychological Effects. In this table, the psychological effects are listed, and for each one a list is given of the BHN frustration with which that psychological effect correlates significantly together with the actual correlation; the BHN frustration are listed in the order of magnitude of the correlation. These results are presented separately, but in parallel form, for the three ethnic groups. Table 7 permits the reader to make direct comparisons between ethnic groups in regard to a given psychological effect, that is, what BHN frustration the psychological effect correlates with and how many significant correlations it shows.

Table 8 shows actual correlations between BBNF scores and Psychophysiological Effects scores for each ethnic group. For each BHN the significant correlations with psychophysiological effects are listed in order of magnitude. These results are given separately for each ethnic group. Table 8 permits the reader to make direct comparison between ethnic groups in regard to a given BHN and its correlations with psychophysiological effects. For example, simple inspection shows that BHN frustration Identity is highly correlated with Heart and Chest Pains for the Cambodians ( $r = .549$ ) but is only moderately correlated for the Vietnamese ( $r = .232$ ) and is not significantly correlated with Heart and Chest Pains for the H'Mong.

### *Discussion*

The results of the study indicate that the needs assessment instrument was successful in providing quantitative indices for the concepts of BHN satisfaction frustration, psychological effects, and psychophysiological effects. The correlations analyses show that the assessment of psychological effects does not merely duplicate the assessment of BHN frustration.

The fact that different ethnic groups showed coherent differences with respect

Table 6  
Rank Order of Vietnamese, H'Mong and Cambodian Significant Pearson  $r$ 's Between Psychological Effects  
and Basic Human Need Frustrations

<i>Basic Human Need Frustration</i>	<i>Vietnamese Psychological Effect</i>	<i>Pearson r</i>	<i>H'Mong Psychological Effect</i>	<i>Pearson r</i>	<i>Cambodian Psychological Effect</i>	<i>Pearson r</i>
<b>I. Physical Health</b>	1. Anxiety	.464	1. Hypochondriasis	.635	1. Compulsive Activity	-.360
	2. Hypochondriasis	.414	2. Compulsive Activity	-.315		
	3. Bad Memory	.395	3. Shock & Depersonalization	.311		
	4. Preoccupation	.363	4. Fears & Phobias	.271		
	5. Compulsive Activity	.304	5. Anxiety	.269		
	6. Fears & Phobias	.251				
	7. Depression	.222				
	8. Dependency	.192				
	9. Withdrawal & Isolation	.183				
<b>II. Safety &amp; Security</b>	1. Shock & Depersonalization	.299	1. Shock & Depersonalization	.282	1. Paranoia	.484
	2. Compulsive Activity	.288	2. Suicidal Thoughts	.271	2. Dependency	-.342
	3. Depression	.266			3. Shame	.316
	4. Dependency	.257				
	5. Hypochondriasis	.227				
	6. Preoccupation	.223				
	7. Guilt	.185				
	8. Anxiety	.180				
<b>III. Self-esteem &amp; Worth</b>	1. Cynicism	.363	1. Guilt	.589	1. NONE	
	2. Anger	-.199	2. Depression	.384		
	3. Manic Episodes	-.198	3. Derealization	.384		
	4. Bad Memory	.195	4. Fears & Phobias	.381		
			5. Dependency	.348		
			6. Hypochondriasis	.326		
			7. Shock & Depersonalization	.284		
			8. Limited Emotionality	.257		

<b>IV. Love &amp; Affection</b>	1. Bad Memory	.314	1. Dependency	.588	1. Withdrawal & Isolation	.338
	2. Anxiety	.293	2. Anxiety	-.422	2. Shame	.329
	3. Fears & Phobias	.229	3. Fears & Phobias	.419	3. Guilt	-.318
	4. Cynicism	.223	4. Guilt	.392		
	5. Depression	.222	5. Withdrawal & Isolation	.321		
	6. Preoccupation	.217	6. Manic Episodes	-.306		
	7. Withdrawal & Isolation	.188	7. Depression	.285		
			8. Preoccupation	-.257		
<b>V. Agency &amp; Autonomy</b>	1. Dependency	.223	1. Anger	-.313	1. Withdrawal & Isolation	-.388
					2. Dependency	.374
					3. Compulsive Activity	.363
<b>VI. Adequacy &amp; Competence</b>	1. Anger	.373	1. NONE		1. Withdrawal & Isolation	.364
	2. Alcohol Abuse	.286				
	3. Fears & Phobias	.257				
	4. Withdrawal & Isolation	.247				
	5. Guilt	.239				
	6. Paranoia	.239				
	7. Derealization	.235				
	8. Manic Episodes	.232				
	9. Preoccupation	.212				
	10. Depression	.204				
	11. Shame	.202				
<b>VII. Identity</b>	1. NONE		1. Preoccupation	-.319	1. Cynicism	-.657
			2. Anxiety	-.315	2. Shock & Depersonalization	.422
			3. Dependency	.276	3. Suicidal Thoughts	.357

(Continued)

Table 6 (Continued)

<i>Basic Human Need Frustration</i>	<i>Vietnamese Psychological Effect</i>	<i>Pearson r</i>	<i>H'Mong Psychological Effect</i>	<i>Pearson r</i>	<i>Cambodian Psychological Effect</i>	<i>Pearson r</i>
<b>VIII. Belonging &amp; Acceptance</b>	1. Depression	.284	1. Dependency	.571	1. NONE	
	2. Withdrawal & Isolation	.275	2. Withdrawal & Isolation	.458		
	3. Shock & Depersonalization	.197	3. Fears & Phobias	.447		
			4. Guilt	.384		
			5. Limited Emotionality	.305		
			6. Paranoia	-.269		
<b>IX. Disengagement</b>	1. Anxiety	.304	1. Dependency	.463	1. Guilt	.358
	2. Depression	.295	2. Depression	.321	2. Withdrawal & Isolation	-.318
	3. Fears & Phobias	.280	3. Fears & Phobias	.260		
	4. Hypochondriasis	.274	4. Cynicism	.258		
	5. Limited Emotionality	.274				
	6. Preoccupation	.259				
	7. Alcohol Abuse	.258				
	8. Inappropriate Affect	.250				
	9. Shame	.237				
	10. Dependency	.223				
	11. Derealization	.216				
	12. Withdrawal & Isolation	.212				
	13. Anger	.210				
	14. Compulsive Activity	.209				
	15. Manic Episodes	.204				
	16. Bad Memory	.202				
	17. Guilt	.188				
<b>X. Order &amp; Understanding</b>	1. Cynicism	.431	1. Dependency	.540	1. Inappropriate Affect	-.617
	2. Manic Episodes	-.255	2. Fears & Phobias	.463	2. Cynicism	.455
	3. Bad Memory	.181	3. Manic Episodes	-.347	3. Anger	-.423

			4. Preoccupation	-.342	4. Depression	-.357
			5. Anxiety	-.316	5. Limited Emotionality	.352
			6. Compulsive Activity	.303	6. Dependency	.331
			7. Shame	.282		
			8. Cynicism	.273		
			9. Guilt	.268		
<b>XI. Personal &amp; Social Legitimacy</b>	1. Depression	.435	1. Derealization	.595	1. Shame	.439
	2. Inappropriate Affect	.424	2. Anger	.428	2. Limited Emotionality	-.397
	3. Cynicism	.359	3. Shock & Depersonalization	.425	3. Withdrawal & Isolation	.366
	4. Shock & Depersonalization	.350	4. Guilt	.424	4. Paranoia	.366
	5. Bad Memory	.297	5. Limited Emotionality	.416	5. Anxiety	.333
	6. Anxiety	.291	6. Suicidal Thoughts	.408	6. Fears & Phobias	.316
	7. Derealization	.249	7. Depression	.392		
	8. Withdrawal & Isolation	.243	8. Hypochondriasis	.375		
	9. Shame	.242	9. Fears & Phobias	.358		
	10. Paranoia	.233	10. Inappropriate Affect	.356		
	11. Dependency	.231	11. Withdrawal & Isolation	.259		
	12. Anger	.197				
	13. Limited Emotionality	.183				
<b>XII. Meaning, Hope &amp; Significance</b>	1. NONE		1. Dependency	.618	1. Bad Memory	.368
			2. Manic Episodes	-.480	2. Hypochondriasis	-.324
			3. Fears & Phobias	.312		
			4. Preoccupation	-.287		
			5. Shame	.268		
<b>XIII. Extension of Self</b>	1. Limited Emotionality	.269	1. Preoccupation	.514	1. Limited Emotionality	-.400
	2. Anger	.218	2. Paranoia	.338	2. Dependency	-.367
	3. Withdrawal & Isolation	.195	3. Dependency	-.318		
			4. Anger	.317		
			5. Manic Episodes	.310		
			6. Fears & Phobias	.275		

Table 7

Rank Order of Vietnamese, H'Mong and Cambodian Significant Pearson  $r$ 's Between Basic Human Need Frustrations and Psychological Effects

<i>Psychological Effect</i>	<i>Vietnamese BHN Frustration</i>	<i>Pearson r</i>	<i>H'Mong BHN Frustration</i>	<i>Pearson r</i>	<i>Cambodian BHN Frustration</i>	<i>Pearson r</i>
<b>I. Bad Memory</b>	1. Physical Health	.395	1. Order & Understanding	-.316	1. Meaning, Hope & Significance	.368
	2. Love & Affection	.314	2. Identity	-.315		
	3. Personal & Social Legitimacy	.297	3. Physical Health	.269		
	4. Disengagement	.202				
	5. Self-esteem & Worth	.195				
	6. Order & Understanding	.181				
<b>II. Fears &amp; Phobias</b>	1. Disengagement	.280	1. Order & Understanding	.463	1. Personal & Social Legitimacy	.368
	2. Adequacy & Competence	.257	2. Belonging & Acceptance	.447		
	3. Physical Health	.251	3. Love & Affection	.419		
	4. Love & Affection	.229	4. Self esteem & Worth	.371		
			5. Personal & Social Legitimacy	.358		
			6. Meaning, Hope & Significance	.312		
			7. Extension of Self	-.275		
			8. Physical Health	.271		
			9. Disengagement	.260		
<b>III. Anxiety</b>	1. Physical Health	.464	1. Love & Affection	-.422	1. Personal & Social Legitimacy	.333
	2. Disengagement	.304				
	3. Love & Affection	.293				



	4. Personal & Social Legitimacy	.291				
	5. Safety & Security	.180				
<b>IV. Hypochondriasis</b>	1. Physical Health	.414	1. Physical Health	.635	1. Meaning, Hope & Significance	-.324
	2. Disengagement	.274	2. Personal & Social Legitimacy	.375		
	3. Safety & Security	.227	3. Self esteem & Worth	.326		
<b>V. Compulsive Anxiety</b>	1. Physical Health	.304	1. Physical Health	-.315	1. Agency & Autonomy	.363
	2. Safety & Security	.288	2. Order & Understanding	.303	2. Physical Health	-.360
	3. Disengagement	.209				
<b>VI. Cynicism</b>	1. Order & Understanding	.431	1. Order & Understanding	.273	1. Identity	-.657
	2. Self-esteem & Worth	.363	2. Disengagement	.258	2. Order & Understanding	.455
	3. Personal & Social Legitimacy	.359				
	4. Love & Affection	.223				
<b>VII. Suicidal Thoughts</b>	1. NONE		1. Personal & Social Legitimacy	.408	1. Identity	.357
			2. Safety & Security	.271		
<b>VIII. Limited Emotionality</b>	1. Disengagement	.274	1. Personal & Social Legitimacy	.416	1. Extension of Self	-.400
	2. Extension of Self	.269	2. Belonging & Acceptance	.305	2. Personal & Social Legitimacy	-.397
	3. Personal & Social Legitimacy	.183	3. Self-esteem & Worth	.257	3. Order & Understanding	.352
<b>IX. Alcohol Abuse</b>	1. Adequacy & Competence	.286	1. NONE		1. NONE	
	2. Disengagement	.258				

(Continued)

Table 7 (Continued)

<i>Psychological Effect</i>	<i>Vietnamese BHN Frustration</i>	<i>Pearson r</i>	<i>H'Mong BHN Frustration</i>	<i>Pearson r</i>	<i>Cambodian BHN Frustration</i>	<i>Pearson r</i>
<b>X. Manic Episodes</b>	1. Order & Understanding	-.255	1. Meaning, Hope & Significance	-.480	1. NONE	
	2. Adequacy & Competence	.232	2. Order & Understanding	-.347		
	3. Disengagement	.204	3. Extension of Self	.310		
	4. Self-esteem & Worth	-.198	4. Love & Affection	-.306		
<b>XI. Shame</b>	1. Personal & Social Legitimacy	.242	1. Order & Understanding	.282	1. Personal & Social Legitimacy	.439
	2. Disengagement	.237	2. Meaning, Hope & Significance	.268	2. Love & Affection	.329
					3. Safety & Security	.316
<b>XII. Guilt</b>	1. Adequacy & Competence	.239	1. Self-esteem & Worth	.589	1. Disengagement	.358
	2. Disengagement	.188	2. Personal & Social Legitimacy	.424	2. Love & Affection	-.318
	3. Safety & Security	.185	3. Love & Affection	.392		
			4. Belonging & Acceptance	.384		
			5. Order & Understanding	.268		
<b>XIII. Shock &amp; Depersonalization</b>	1. Personal & Social Legitimacy	.350	1. Personal & Social Legitimacy	.425	1. Identity	.422
	2. Safety & Security	.299	2. Physical Health	.311		
	3. Belonging & Acceptance	.197	3. Self-esteem & Worth	.284		
			4. Safety & Security	.282		
<b>XIV. Inappropriate Affect</b>	1. Personal & Social Legitimacy	.424	1. Personal & Social Legitimacy	.356	1. Order & Understanding	-.617
	2. Disengagement	.250				

<b>XV. Derealization</b>	1. Personal & Social Legitimacy	.249	1. Personal & Social Legitimacy	.595	1. NONE	
	2. Adequacy & Competence	.235	2. Self-esteem & Worth			
	3. Disengagement	.216				
<b>XVI. Paranoia</b>	1. Adequacy & Competence	.239	1. Extension of Self	.335	1. Safety & Security	.484
	2. Personal & Social Legitimacy	.233	2. Belonging & Acceptance	-.269	2. Personal & Social Legitimacy	.366
<b>XVII. Preoccupation</b>	1. Physical Health	.363	1. Extension of Self	.514	1. NONE	
	2. Disengagement	.259	2. Order & Understanding	-.342		
	3. Safety & Security	.223	3. Identity	-.319		
	4. Love & Affection	.212	4. Meaning, Hope & Significance	-.287		
	5. Adequacy & Competence	.212	5. Love & Affection	-.257		
<b>XVIII. Withdrawal &amp; Isolation</b>	1. Belonging & Acceptance	.275	1. Belonging & Acceptance	.458	1. Agency & Autonomy	-.388
	2. Adequacy & Competence	.247	2. Love & Affection	.321	2. Personal & Social Legitimacy	.384
	3. Personal & Social Legitimacy	.243	3. Personal & Social Legitimacy	.259	3. Adequacy & Competence	.364
	4. Disengagement	.212			4. Love & Affection	.338
	5. Extension of Self	.195			5. Disengagement	-.318
	6. Love & Affection	.188				
	7. Physical Health	.185				
<b>XIX. Anger</b>	1. Adequacy & Competence	.373	1. Personal & Social Legitimacy	.428	1. Order & Understanding	-.423
	2. Extension of Self	.219	2. Extension of Self	.317		
	3. Disengagement	.210	3. Agency & Autonomy	-.313		
	4. Self-esteem & Worth	-.199				
	5. Personal & Social Legitimacy	.197				

Table 7 (Continued)

<i>Psychological Effect</i>	<i>Vietnamese BHN Frustration</i>	<i>Pearson r</i>	<i>H' Mong BHN Frustration</i>	<i>Pearson r</i>	<i>Cambodian BHN Frustration</i>	<i>Pearson r</i>
<b>XX. Dependency</b>	1. Safety & Security	.257	1. Meaning, Hope & Significance	.618	1. Agency & Autonomy	.374
	2. Personal & Social Legitimacy	.231	2. Love & Affection	.588	2. Extension of Self	-.367
	3. Disengagement	.223	3. Belonging & Acceptance	.571	3. Safety & Security	-.342
	4. Agency & Autonomy	.223	4. Order & Understanding	.540	4. Order & Understanding	.331
	5. Physical Health	.192	5. Disengagement	.463		
			6. Self-esteem & Worth	-.348		
			7. Extension of Self	.276		
			8. Identity	.276		
<b>XXI. Depression</b>	1. Personal & Social Legitimacy	.435	1. Personal & Social Legitimacy	.392	1. Order & Understanding	-.357
	2. Disengagement	.295	2. Self-esteem & Worth	.384		
	3. Belonging & Acceptance	.284	3. Disengagement	.321		
	4. Safety & Security	.266	4. Love & Affection	.285		
	5. Physical Health	.222				
	6. Love & Affection	.222				
	7. Adequacy & Competence	.204				

Rank Order of Ethnic Group Significant Pearson r's Between Psychophysiological Effects and Basic Human Need Frustration

<i>Basic Human Need Frustration</i>	<i>Vietnamese</i>		<i>H'Mong Psychophysiological</i>		<i>Cambodian</i>	
	<i>Psychophysiological Effect</i>	<i>Pearson r</i>	<i>Psychophysiological Effect</i>	<i>Pearson r</i>	<i>Psychophysiological Effect</i>	<i>Pearson r</i>
<b>I. Physical Health</b>	1. Lack of Energy	.475	1. Lack of Energy	.695	1. Headaches	.470
	2. Stomach Disorder	.442	2. Aches & Pains	.663	2. Loss of Weight	.361
	3. Tension of Muscles	.394	3. Pain in Lower Back	.627	3. Lack of Energy	.346
	4. Trouble Sleeping	.375	4. Faintness or Dizziness	.600	4. Stomach Disorder	.332
	5. Arthritis or Rheumatism	.371	5. Stomach Disorder	.540	5. Diarrhea or Constipation	.322
	6. Faintness or Dizziness	.368	6. Headaches	.517		
	7. Aches and Pain	.364	7. Fast Heart Beat	.468		
	8. Heart or Chest Pains	.317	8. Loss of Weight	.443		
	9. Sweatiness or Warmth of Skin	.309	9. Heart or Chest Pains	.426		
			10. Tenseness of Muscles	.425		
	10. Nausea	.296	11. Arthritis or Rheumatism	.323		
	11. Headaches	.287	12. Fast Breathing	.318		
	12. Pain in Lower Back	.284	13. Sweatiness or Warmth of Skin	.279		
	13. Loss of Weight	.250	14. Numbness or Tingling	.276		
	14. Diarrhea or Constipation	.221				
15. Fast Breathing	.204					
<b>II. Safety &amp; Security</b>	1. Loss of Weight	.258	1. Tenseness of Muscles	.271	1. NONE	
	2. Faintness or Dizziness	.249				
	3. Pain in Lower Back	.235				
	4. Trouble Sleeping	.231				
	5. Sweatiness or Warmth of Skin	.210				
	6. Headaches	.196				
<b>III. Self-esteem &amp; Worth</b>	1. Fast Heart Beat	(-).229	1. Faintness or Dizziness	.383	1. NONE	
			2. Headaches	.353		

(Continued)

Table 8 (Continued)

<i>Basic Human Need Frustration</i>	<i>Vietnamese Psychophysiological Effect</i>	<i>Pearson r</i>	<i>H'Mong Psychophysiological Effect</i>	<i>Pearson r</i>	<i>Cambodian Psychophysiological Effect</i>	<i>Pearson r</i>
			3. Sweatiness or Warmth of Skin	.334		
			4. Lack of Energy	.316		
			5. Fast Heart Beat	.310		
			6. Aches & Pains	.268		
<b>IV. Love &amp; Affection</b>	1. Heart or Chest Pains	.344	1. Diarrhea or Constipation	(-).362	1. Loss of Weight	.431
	2. Numbness or Tingling	.194				
	3. Fast Breathing	.185				
<b>V. Agency &amp; Autonomy</b>	1. Arthritis or Rheumatism	.318	1. NONE		1. Loss of Weight	(-).366
	2. Diarrhea or Constipation	.303			2. Fast Heart Beat	.346
	3. Lack of Energy	.280				
	4. Pain in Lower Back	.244				
	5. Loss of Weight	.201				
<b>VI. Adequacy &amp; Competence</b>	1. Pain in Lower Back	(-).217	1. Arthritis or Rheumatism	.320	1. Nausea	(-).362
<b>VII. Identity</b>	1. Heart or Chest Pains	.232	1. Sweatiness or Warmth of Skin	.320	1. Nausea	(-).362
	2. Tenseness of Muscles	.205			2. Sweatiness or Warmth of Skin	.407
<b>VIII. Belonging &amp; Acceptance</b>	1. Diarrhea or Constipation	(-).227	1. Faintness or Dizziness	.317	1. NONE	
	2. Headaches	.184	2. Lack of Energy	.272		
<b>IX. Disengagement</b>	1. Headaches	.372	1. Lack of Energy	.299	1. Loss of Weight	(-).323
	2. Loss of Weight	.335				
	3. Aches & Pains	.323				
	4. Arthritis or Rheumatism	.323				

5. Fast Breathing	.314
6. Trouble Sleeping	.302
7. Sweatiness or Warmth of Skin	.269
8. Heart or Chest Pains	.264
9. Pain in Lower Back	.239
10. Tenseness of Muscles	.222
11. Nausea	.214
12. Skin Disorder	.209
13. Fast Heart Beat	.206
14. Diarrhea or Constipation	.204
15. Faintness or Dizziness	.202

<b>X. Order &amp; Understanding</b>	1. Fast Heart Beat	(-).209	1. NONE	1. Nausea	(-).475	
	2. Numbness or Tingling	(-).197		2. Faintness or Dizziness	(-).402	
<b>XI. Personal &amp; Social Legitimacy</b>	1. NONE		1. Trouble Sleeping	.283	1. Head or Chest Pains	.374
			2. Sweatiness or Warmth of Skin	.274	2. Sweatiness or Warmth of Skin	.372
			3. Pain in Lower Back	.270	3. Pain in Lower Back	(-).318
			4. Faintness or Dizziness	.268		
<b>XII. Meaning, Hope &amp; Significance</b>	1. Arthritis or Rheumatism	.313	1. NONE	1. Aches & Pains	(-).366	
	2. Loss of Weight	.254				
	3. Stomach Disorder	.227				
	4. Pain in Lower Back	.224				
	5. Fast Breathing	.217				
	6. Heart or Chest Pains	.208				
<b>XIII. Extension of Self</b>	1. Faintness or Dizziness	.310	1. Faintness or Dizziness	(-).265	1. Heart or Chest Pains	.344
	2. Heart or Chest Pains	.288	2. Fast Heart Beat	(-).262		
	3. Headaches	.282				
	4. Sweatiness or Warmth of Skin	.247				

to BHN frustration and psychological effects is in accordance with expectations. The fact that the H'Mong, who have the greatest amount of cultural difference (one of the parameters in the parametric analysis of cultural displacement) and the least history of acquaintance with Western culture (the parameter of Knowledgeability) clearly show the greatest cultural displacement effect (BHN frustration) is evidence of the empirical applicability of the conceptualization of cultural displacement presented above.

The correlational analysis conforms to the expectation that there would be many moderate correlations between particular BHN frustrations and particular psychological effects and psychophysiological effects, and that there would be substantial group differences in these respects. The correlations were expected to be only moderate because there is by no means a one-to-one relation between a given BHN frustration and a given emotional, intellectual, or other phenomenological response. For example, anger cannot be expected to be tied to any particular BHN, nor can shame, depression, and so on.

The data also provide some support for the hypothesis that the effects of cultural displacement unfold through time with the most overt and concrete effects, hence, the most easily recognized effects coming last. The data showed that the H'Mong, the most recent arrivals, among the ethnic groups in the present study showed effects at the Basic Human Need level; the Cambodians, who were the next most recent arrivals, showed effects at the psychological level; and the Vietnamese who had been in the country longest and had the greatest prior exposure to Western culture, had a slight predominance of effects at the psychophysiological level. If additional evidence supports the notion that in general the results of cultural displacement appear first in BHN frustration and later in negative psychological effects and still later in psychophysiological effects, this finding would have far-reaching implications for the design, monitoring, and evaluation of effective resettlement efforts.

Additional construct validation may be found in the pattern of results for the Cambodian group. The overall results for psychological effects showed that the Cambodians had significantly greater effects of this sort than the Vietnamese or the H'Mong. However, the differences among groups were not evenly distributed among the 21 psychological effects. Among the latter, 11 can be classified either as negative emotions or dissociative intellectual or behavioral phenomena. It was specifically in these two categories that the Cambodians showed the greater effects—in 10 of 11 cases. These results provide evidence that the psychological effects items were sensitive to the phenomena they were designed to assess and did assess psychological factors that mark important differences among groups.

The correlational results are too rich in detail to summarize effectively. The following analysis of certain results for the Cambodians illustrates how these results can contribute to an understanding of refugees and of group differences.

First, we may note that for the Cambodians, frustration of BHN Safety and



Security is associated with Paranoia (.484) and Shame (.316) and is negatively associated with Dependency (-.342) (In contrast, the Vietnamese show a positive association [.257] with Dependency, and the H'Mong show no significant correlation.) This suggests that the Cambodians are more highly mobilized and vigilant than the other two groups.

Second, we note that for the Cambodians, the two BBNF showing the highest correlations with psychological effects are Order and Understanding and Personal and Social Legitimacy. Not surprising is the correlation for the Cambodians of .439 between Shame and Personal and Social Legitimacy (but for the Vietnamese it was only .242 and for the H'Mong it was not significant). The fact that BBNF Personal and Social Legitimacy also correlates with Withdrawal and Isolation (.384), Paranoia (.365), Anxiety (.333), and Fears and Phobias (.316) suggests a general intro-punitive component for this group.

Third, the correlation of BBNF Order and Understanding with Cynicism (.455), Limited Emotionality (.352), and Dependency (.331) is not surprising. What is more noteworthy is the high negative correlation (-.617) with Inappropriate Affect and negative correlations with Anger (-.324) and Depression (-.357). These results are compatible with other indications that there is a significant sequential aspect to the adjustment process and that, in particular, the Cambodians become more depressed, angry, and subject to episodes of uncontrolled emotionality as they come to terms intellectually with events in Cambodia and changes in their relationships and social standing.

Finally, it is of interest that limited emotionality correlates positively (.352) with BBNF frustration Order and Understanding and negatively (-.397) with BBNF frustration Personal and Social Legitimacy. This result is compatible with the notion that Cambodians have some initial difficulty in explaining what has happened and that eventual understanding involves a massive loss of standing and subsequent emotional reactions of anger, depression, and so on.

As a result of such interpretive analyses, a global picture of each of the ethnic groups emerges. These summary portrayals are given below.

### *Indochinese*

The refugee group as a whole was characterized by high Basic Human Need frustration in the areas of Order and Understanding, Adequacy and Competence, and Safety and Security. The refugees as a whole were also characterized by high Cynicism, Compulsive Activity, and Guilt.

These findings may be regarded as a lowest common denominator portrayal of the status and experience of the refugees. Cultural displacement, except under the most favorable circumstances, could be expected to carry with it a significant degree of disorientation with respect to the society at large and a corresponding lack of confidence in one's degree of security and one's ability to manage the intricacies and requirements of the new social milieu. The finding regarding

Compulsive Activity would seem to indicate a general form of adaptation marked by a relatively high degree of mobilization and activity which might or might not be productive or effective, but in either case, stemming from the felt necessity to "do all you can" or to "do *something*." The Cynicism and Guilt may be more characteristic of the Indochinese refugees than of refugees in general, since it is very easy to understand as the natural consequence of the violence and disruption of political, social, and family ties experienced by the majority of these refugees.

Beyond this general picture, it is the differences between ethnic groups which are salient. An analysis of these differences, which were detailed above, makes possible some further characterizations of each group.

### *Vietnamese*

Given that the Vietnamese consistently show the least BHN frustration and the least negative psychological effects, it would appear that this group is the best adapted to life in the United States. Although the study did not include an American comparison group, it may be assumed that the Vietnamese are nevertheless significantly short of their ultimate level of adjustment, and that their BHN frustration and Psychological Effects and Physiological Effects data reflect this. One salient indicator in this regard is the extremely high number of significant correlations between BHN frustration of Disengagement and both Psychological and Physiological Effects. These findings suggest that an appreciable number of Vietnamese are excessively caught up in instrumental activities and the discharge of responsibilities, and this condition is reflected in a wide variety of psychological and physiological correlates and symptomatology. Since the Vietnamese as a group are not marked by a high degree of BHN Disengagement, it appears that the mobilization and activities of this group are generally realistic and oriented toward improving their lot in the United States. The fact that the Vietnamese score much lower than the H'Mong and the Cambodians on BHN frustration Self-esteem and Worth is consistent with the notion that this is a group that sees itself as being on the road to success and is working hard, perhaps too hard, for comfort at it.

### *H'Mong*

The H'Mong were notable for the very high degree of Basic Human Need frustration overall and with respect to many individual BHN. This massive effect indicates that the H'Mong are still experiencing a major dislocation in their way of living and that the primary effect is one of frustration, immobilization, disorientation, and loss of behavior potential. The numerous correlations, many of them in the .50 and .60 range, between frustration of particular BHN and psychological and physiological effects provide some evidence of the extensiveness and variety of the effects of BHN frustration for this group.

In contrast, the H'Mong show the lowest level of negative psychological

effects overall and generally occupy the middle or low position among the three groups on individual effects. Among these, the markedly lower Anger, Anxiety, and Guilt scores suggest that this group does not have the degree of involvement with present and past events in Indochina that the Vietnamese and Cambodians give evidence of. This conclusion is supported by the relatively low degree of dissociative effects.

On this basis it appears that the H'Mong have a great potential for making direct progress toward an eventual stable and satisfying life in the United States even though they are currently further from that goal than the other two groups.

### *Cambodians*

This group was noteworthy for consistently being neither the highest nor the lowest on individual and overall basic human need frustration and for showing a considerable amount of negative emotionality (Shame, Guilt, Cynicism, Anger), and dissociative symptoms (Bad Memory, Compulsive Activity, Limited Emotionality, Manic Episodes, Derealization, and Shock and Depersonalization).

This combination of results suggests that involvement with past and current events in Indochina, rather than simple cultural dislocation, was the primary factor determining the Cambodians' generally negative state of mind, and that the dissociate phenomena are evidence that efforts to come to terms with these events were significantly short of being successful at the time the data were collected in 1979. The pattern of correlations of BHNF and Psychological Effects, including the presence of a number of negative correlations, suggests that for a significant number of Cambodians coming to a resolution in regard to events in Cambodia was associated with greater anger and other negative emotions.

## CLINICAL OBSERVATION AND AGENCY EXPERIENCE

The authors' experience in working with Indochinese has underscored the extent of the differences among the Vietnamese, H'Mong, and Cambodians. Substantial differences are found in almost all respects, including their histories, their cultures, and their transitional experiences. In fact, the term "Indochinese" is used by none of these ethnic groups to refer to themselves; the term was composed by the French to designate the several countries south of China and north of Indonesia. Each of the three groups has a spoken and written language that is completely unintelligible to members of the other two and little is shared in the way of common history or culture, despite the proximity of the three countries.

The Vietnamese in the present study were primarily from the "first wave" of Indochinese resettled in the United States (and thus spent the most number of months in the United States as well as shortest time in the refugee camps); they

were urban, closely associated with the governments of Vietnam or the United States, and had to leave upon short notice due to their close affiliation with one of these governments. They came from a society that had over one hundred years of familiarity with Western culture and frequently could read and write in at least Vietnamese, if not in one of the European languages. After the fall of Saigon, “reeducation camps” and new economic zones were instituted, and the blood bath which was feared did not materialize. While the Vietnamese were frequently separated from their families and friends, they were allowed to write and correspond with them, send money and supplies to their homeland, and plan for an eventual reunion with family members through escape or international negotiations.

Against this background, it is not surprising that the Vietnamese refugees in the United States showed the least cultural displacement effects, approached resettlement with a task-oriented and practical attitude, showed a pattern of cynicism, stress, and mobilization reactions, and somewhat more somatization reaction than the other two groups.

The H’Mong who came to the United States were, historically, a highland, nomad people who lived according to the doctrines of the tribe and the clan, including strict obedience to clan leaders. Animism, the dominant religion of the H’Mong, affirms that spirits inhere in houses, forests, and other objects believed by Westerners to be inanimate. The history and culture of the H’Mong people could be passed on only by word of mouth until a written alphabet for the language was developed in the 1950s. Of the major Indochinese ethnic groups that resettled in the United States, the H’Mong had had the least contact with Western culture and technology and as a group were the least prepared for the pace of life in the United States. Toilets, automobiles, elevators, telephones, and other modern conveniences were generally unknown to the H’Mong. By the time of the study, few H’Mong were still living in Laos and many who were still living were able to come to the United States in intact families.

Given this background, the evidence for massive culture shock provided by the needs assessment is understandable. Likewise, the fact that to a large extent the H’Mong escaped and resettled in relatively intact tribal groups appears to be reflected in the relative absence of shame and guilt among the H’Mong, in contrast to the Cambodians and the Vietnamese.

Cambodians who came to the United States before 1979, like the Vietnamese, were frequently separated from their immediate families and considered to be from the intellectual class. The Cambodians came to the United States later than the Vietnamese, and in contrast to this group, had often directly experienced the horrors of war under the regime of the Khmer Rouge, including the intensity of blood baths, torture, and starvation. In the camps, they were often described as numb, apathetic, and as having “lost the taste for life.” After resettling in the United States, they were not allowed to correspond or send supplies to friends and relatives in Cambodia. They seldom knew even whether such persons were

still living. As a consequence, they were rarely able to bring a sense of resolution to their family situations, remained preoccupied with conditions back in Cambodia, and were unable to directly face the task of making a new life in the United States. The latter result is one of the major summary findings of the needs assessment, which reveals the extent of disorientation, preoccupation and emotional distress suffered by this group.

In general, the background knowledge of the three ethnic groups obtained on the basis of clinical interactions and general contact with Vietnamese, H'Mong and Cambodians (including Indochinese mental health specialists at the agency) fits extremely well with the needs assessment results concerning ethnic group characteristics and differences. The two kinds of information were complementary rather than redundant, since few of the detailed quantitative results or the more complex patterns of results could have been predicted on the basis of other information.

Clinical experience supports the idea that there are significant sequential patterns in the resettlement process. One of the most frequently observed patterns in the initial resettlement experience is marked by a "busy busy" syndrome in which the refugee is highly mobilized, operates on an extremely high level of energy and activity, often juggling multiple jobs, school or English language training, and family responsibilities. This extreme degree of activity and involvement operates to limit the refugee's thinking about past events and coming to terms with them. However, when the refugee has consolidated an initial adjustment and begins to think of events, persons, and relationships in Indochina, significant psychological effects such as depression, guilt, and anger frequently follow. These observations are compatible with the hypothesis that there is a fundamental sequence which starts with limited social participation accompanied by the frustration of basic human needs, followed by psychological effects and symptoms, and by later psychophysiological effects, if any.

Our experience in providing consultation, supervision, and direct services to hundreds of refugees over the years yields compelling evidence that the cultural displacement model has greater applicability with refugees than Western diagnostic categories and treatment strategies. It has been established that other refugees are groups which are psychologically "at risk" but terms denoting culturally specific categories of diseases and illnesses, provide little understanding of the causes of psychological distress and of the social and psychological symptomatology experienced by refugees.

At our agency in Denver, we moved to the development of individual case formulations within the cultural participation framework, and treatment plans were designed explicitly to increase need satisfaction through social participation. The Center uses many traditional Western mental health treatment procedures in working with refugees, but uses these differently with refugee clients. For example, many of the Center's clients have been given diagnoses that imply chronic mental health incapacities, when in fact, they are exhibiting situational

reactions. Consequently, they typically respond rapidly in the Center's day school program.

Clinical experience also supports the assertion that the general characteristics of refugee groups have changed over time. There are two noteworthy differences between recently arrived refugees and the early arrivals. First, the later arrivals appear to be less urban, less educated, and less knowledgeable in regard to Western culture than the earlier groups, which had a high proportion of government officials, military personnel, and persons associated with the government or the military. This holds for all three ethnic groups. We might expect, therefore, that the experience in resettlement of later groups of Vietnamese and Cambodians would more nearly resemble that of the early H'Mong group. Second, the later refugees are more likely to have direct experience of death, pain, injury, and brutality at home, in the process of escaping to refugee centers, and within refugee centers. They are also more likely to have spent one to four years in refugee centers before being resettled. Both kinds of differences between the later arrivals and their predecessors suggest that the current refugees will (other things being equal) experience greater psychosocial adjustment difficulties than did the earlier groups.

## IMPLICATIONS

Both the needs assessment results and treatment experience with refugees strongly support the strategy of approaching refugee problems as expressions of, consequences of, and correlates of cultural participation and Basic Human Needs phenomena, rather than merely as discrete problems of language, vocational, mental health, and so on. The social participation and behavior potential framework provides a basis for understanding refugees and for individual treatment and community prevention efforts. Together with the needs assessment methodology described above, it also provides a basis for establishing and monitoring a rational refugee program at the national level. Such a program, as envisioned, would involve the following elements:

*1. Systematic Research.* A systematic program of research was described above. Five elements were involved: (a) A parametric analysis of culture displacement; (b) the development of techniques for assessing parametric values in particular cases of cultural displacement; (c) a framework for conceptualizing the kind of degree of hardship suffered by a refugee population and the degree of adaptation achieved at any given time; (d) the development of techniques for assessing the degree of psychological distress and the degree of adaptation; and (e) the development of predictive functional models relating parametric values collectively (rather than singly) to distress/adaptation indicators.

The present needs assessment research has provided three of the five elements.

Elements (b) and (e) were not addressed. These elements are needed in order to be able to use distress/adaptation assessments in a normative way to monitor the progress of individual refugees. For immediate application, until a rational functional model is developed, we can use multiple regression techniques to predict distress/adaptation on the basis of parametric values, and we can do limited analyses of variables that are of interest. For example, we can study the differences between refugees who receive public assistance and those who do not. Periodic data gathering is needed in order to validate functional models and to confirm hypotheses concerning the sequential structure of the resettlement experience.

2. *Affirmative and Differential Programs.* Instead of a monolithic or homogeneous program of "services for Indochinese," different program emphases would be developed for Vietnamese, H'Mong, and Cambodians, based on group assessments of distress/adaptation. For example, all the evidence strongly indicates that the differences among the three ethnic groups are so great that no universal program for Indochinese could be expected to be very successful for any of the three groups. However, if differential program emphases were adopted for the different groups, a significant improvement in effectiveness could be accomplished. For example, the program emphasis for the H'Mong could consist of basic social participation learning, with the Vietnamese emphasis on stress management and the Cambodian emphasis on grief work and working through.

The concept of an affirmative program is the concept of planning the resettlement process, monitoring progress and seeing to it that auxiliary resources were available and were brought into play when an individual was not making satisfactory progress. Such a program would contrast with a tradition of making certain services "available."

3. *Individual monitoring.* Normative use of research data would provide the basis for monitoring the progress of individual refugees. Normative criteria would be developed for physical symptoms, linguistic and vocational skills acquisition, and psychological symptoms. In this way, individuals who were progressing substantially more slowly than their assessment data would suggest could be identified as candidates for direct remediation. If specific remediation in the problem area were unsuccessful or unpromising, the person would be referred for social participation and behavior potential evaluation and an individual program for social participation remediation undertaken.

4. *Informed consent.* Given the development of normative criteria based on rational functional models or on multiple regression analysis, refugees would be told in advance what was expected of them in the way of progress in resettlement.

ment. A cooperative model of resettlement would in principle be more effective than the unilateral "provision of services" for a limited period followed by a unilateral cutoff.

5. *Periodic assessment.* Periodic group assessment would provide an evaluation in depth of the effectiveness of the program. It would also provide information concerning change over time in the general characteristics of incoming refugees, and thereby provide a basis for planning and monitoring adaptive changes in program emphases.

Although we have dealt explicitly with Indochinese refugees, a program such as the one described briefly above would also serve as a model for similar programs for other refugee or immigrant groups.

## CONCLUSIONS

In the present chapter we have presented (a) some major cultural features of the Vietnamese, H'Mong, and Cambodian societies, their differences, and, by implication, their differences from American culture; (b) the transitional experiences of these groups in leaving their countries and resettling in the United States; (c) a conceptual framework dealing with cultural participation, Basic Human Needs, and cultural displacement; (d) an empirical assessment of Basic Human Need frustrations and their psychological and psychophysiological effects on the Indochinese refugees; (e) the experience and understanding gained from a successful, nontraditional mental health services program; and (f) an outline for a rational program of refugee resettlement at the national level.

What links these disparate elements is congruence, or complementarity. The conceptualization fits what we know of ourselves and the refugees; by design, it fits the empirical study and the treatment program as well as the hypothetical national program. Likewise, the results of our clinical experience fit the research findings and the cultural and historical facts concerning the three Indochinese groups. The research findings support the conceptualization and the conclusion: based on clinical experience, as well as provide a major portion of the technical requirements for the national program, and they fit the cultural and historical facts concerning the three refugee groups.

The whole is greater than the sum of its parts. We have greater confidence in our understanding and potential effectiveness than we would if, for example, we merely had twenty years of successful clinical experience or if all our experimental findings had been significant at the .001 level in the absence of a conceptual framework or successful practice. The achievement of congruence is not accidental, of course. It is a more or less natural consequence of operating within a multicultural, hence multiperspective, framework rather than more narrowly focused technical, scientific, or professional perspectives.



## ACKNOWLEDGMENTS

The research reported in this chapter was funded by the Indochinese Refugee Assistance Program, Department of Health, Education and Welfare (later reorganized as the Office of Refugee Resettlement, Department of Health and Human Services) under training and research contract #96-M-91700-8-01 with the Park East Community Mental Health Center, Denver, Colorado. The research was performed under subcontract with the Linguistic Research Institute of Longmont, Colorado, with the assistance of Park East personnel. Grateful acknowledgement is made of the assistance provided by Denver Catholic Charities, Indochinese translators and cultural consultants Kham Koly, Do Dung Anh and Kim Leng Ung, and The Vietnamese, H'Mong and Cambodian Mutual Assistance Associations of Colorado. The authors would like to give special thanks to Vo Van Ha of the Region VIII Office of Refugee Resettlement who provided invaluable encouragement and technical assistance throughout the project. Address: Asian-Pacific Development Center, 1840 East 18th Avenue, Denver, Colorado 80218.

## REFERENCE NOTES

1. Office of Refugee Resettlement. *Indochinese refugees*. Office of Refugee Resettlement, Department of Health and Human Services, Washington, D.C., February 1983.
2. Bureau of Research and Training. *National mental health needs assessment of Indochinese refugee populations*. Bureau of Research and Training, Office of Mental Health, Pennsylvania Department of Public Welfare, Harrisburg, Pennsylvania: 1979 (Unpublished report).
3. Tung, Tran Mink. *The Vietnamese refugees and their mental health: A vantage view*. Paper presented at the meeting of the Washington Psychiatric Society, Washington, D.C., October 1975.

## REFERENCES

- Coleman, J. C. *Abnormal psychology and modern life* (5th ed.). Glenview, Ill.: Scott, Foresman, 1976.
- Derogatis, L. *SCL-90: Administration, scoring and procedures manual for the revised version*. Baltimore: Johns Hopkins University Press, 1977.
- Eaton, J., & Weil, R. J. *Culture and mental disorders*. Glencoe, Ill.: The Free Press, 1955.
- Kitano, H. L. Japanese-American mental illness. In S. Polg & R. Edgerton (Eds.), *Changing perspectives in mental illness*. New York: Holt, Rinehart & Winston, 1969.
- Leighton, A. H. *My name is legion*. New York: Basic Books, 1959.
- Malzberg, B. Are immigrants psychologically disturbed? In S. Polg & R. Edgerton (Eds.), *Changing perspectives in mental illness*. New York: Holt, Rinehart & Winston, 1969.
- Maslow, A. Toward a humanistic biology. *American Psychologist*, 1969, 24(8), 734-735.
- Wider, A. *The Cornell medical index*. New York: The Psychological Corporation, 1948.
- Zung, W. W. K. A self rating depression scale. *Archives of General Psychiatry*, 1965, 12, 63.