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Resilience in Ex-Refugees from Cambodia and Vietnam

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RESILIENCE IN EX-REFUGEES FROM CAMBODIA AND VIETNAM

BY

LYNNE EE LIN YONG

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE
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Abstract

The negative impacts of various forms of trauma on the physical and mental health of victims are well documented, including the experiences of the French Indo-Chinese, who suffered a range of traumatic experiences ranging from displacement to torture. However, a sizable percentage of French Indo-Chinese refugees living in the U.S. do not exhibit psychopathology. Very little is known about the Indo-Chinese refugees who are not seeking services and are doing well in their host country. This study focused on resilient Cambodian and Vietnamese ex-refugees, with the goal of identifying resiliency factors and their underlying processes, in order to inform the development of intervention programs for future refugees to reduce psychopathological outcomes of their trauma.

A sampling of 10 Cambodians and 10 Vietnamese participants, ages 29 to 67, were recruited via the snowball technique. The inclusion criteria for this study were self-identification as an immigrant from Cambodia or Vietnam who 1) left their country of origin at age six or older; 2) originally arrived in the U.S. on refugee status; and 3) reported being relatively satisfied with how their life is going. The men and women participated in a semi-structured interview with open-ended questions, which included items on: 1) demographics; 2) emigration and resettlement; 3) cultural disruption; 4) language acquisition and difficulties; 5) general coping strategies; 6) trauma experience; and 7) coping resources/skills/strategies. The participants were also asked to fill out several self-reports assessing PTSD symptomatology, trauma experience, and well-being indices.

The transactional model of resiliency (Kumpfer, 1999) provided a comprehensive framework in the study of factors and processes of resilience. This study found similar risk and protective factors as those included in the transactional model, which can be categorized as intra-individual traits, cognitive processes, inter-individual traits, coping behaviors, and past learning. However, there were differences in that the participants in this study did not endorse the need for understanding or attaching meaning to their past trauma. In addition, the ability to differentiate and to choose between acceptance or change-oriented skills were more reflective of resilience.

The key processes to positive coping were found in the interaction between individual and environmental factors, as in all human behaviors. When an acute stressor is introduced, it is the transaction between these factors and the positive outcome that determines resiliency in the person. This study found that resilience is a complex transactional system, suggesting that interventions to promote particular factors will have a positive systemic impact. It is not essential to fully delineate the underlying mechanisms of resilience in order to promote positive coping. The results of this study suggest that resiliency can be taught by increasing self-efficacy and enhancing a sense of coherence.

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RESILIENCE IN EX-REFUGEES FROM CAMBODIA AND VIETNAM

Introduction

The concept of extreme emotional reactions to trauma has been in existence for thousands of years. Historians and literary authors have noted profound post-traumatic stress reactions from Homer's Ulysses to Charles Dickens (Friedman & Marcella, 1996). In 1980, the term Post-Traumatic Stress Disorder (PTSD) was first coined to try to capture the myriad symptomatology exhibited by war veterans. Even though the concept of mental dysfunction caused by severe trauma existed in the psychological literature prior to 1980 as "Nostalgia", "Shell Shock", "Combat Neurosis", etc., the inclusion of PTSD into the nomenclature of the Diagnostic and Statistical Manual of Mental Disorders Third Edition (DSM III), further validated the experience of traumatized patients. The conceptualization of PTSD has also been applied to victims of a wide range of traumas, from witnessing a traumatic event to experiencing such events as sexual and physical abuse, natural disasters, political torture, etc.

Justification for This Study

The need for resilience studies on refugee populations that have experienced war trauma is important in this time of global terrorism and strife. The recent conflicts in the Middle East and civil strife in Africa add to the overall number of displaced peoples in the world. To illustrate the severity of this problem, the United Nations High Commission on Refugees (UNHCR) reported that at the start of the new millennium, there were 223 million "people of concern," a phenomenal increase from 21.5 million in 1999. Approximately 51% of that total was refugees.

The tremendous work of the UNHCR in recent years has decreased the number of “people of concern” to 20.6 million at the start of 2003 (<http://www.unhcr.ch/cgi-bin/texis/vtx/basics>), largely due to the efforts of the UNHCR to return refugees to their homelands once it was considered safe. However, the number of people receiving assistance once they had been repatriated jumped from 462,000 in 2001 to 2.4 million in 2002. This shift signifies the complexity and continued severity of the problem. The United States was the foremost country of resettlement for refugees in the late 1990’s. However, with new policy changes, the United States ranks fifth in hosting refugees with approximately 485,000 refugees within its borders.

The need for services to help refugees rebuild their lives is great. As Gorman (2001) indicated, all refugees have undertaken a crossing of interpersonal, socioeconomic, cultural, linguistic, and geographical boundaries. Aside from social services, they often need therapeutic, rehabilitative, and legal services, because of their multiple losses and the trauma of their experiences as refugees.

One of the more widely studied refugee populations is the French Indo-Chinese, who first resettled in the United States between 1975 and 1981. Most of the Indo-Chinese refugees arrived in the United States in two waves. The first wave consisted mostly of South Vietnamese evacuated after the fall of Saigon in 1975 for fear of political reprisals from the incoming communist government. Those refugees who left around 1975 were generally airlifted out of Vietnam; however, those South Vietnamese who left later had to escape via small-overcrowded boats in a perilous journey to the refugee camp. The second wave of

Indo-Chinese refugees included more Cambodians and Laotians who left after 1978 because of unrelenting famine and political repression (e.g., the Khmer Rouge regime in Cambodia and Laos), escaping at great peril to UNHCR sponsored refugee camps at the border of Thailand.

The U.S. Department of Health indicated that from April 1975 to 1990, the United States admitted 817,700 Indo-Chinese refugees into its shores. Most of these refugees had suffered a wide range of traumatic experiences ranging from displacement to torture. The need for psychological services by SEA refugees has been among the highest in American refugee groups. In the refugee mental health needs assessment conducted by the Massachusetts Department of Mental Health (1989), almost 83% of Cambodians and 75% of Vietnamese reported having some form of mental problem, ranging from depression and sleep and eating disorders to Post Traumatic Stress Disorder. In a California mental health study (Gong-Guy, Cravens, & Patterson, 1991), severe mental health needs were four times greater (15%) compared to the general population (3%) for South East Asian refugees.

However, despite these numbers, not all people who experiences trauma are will need psychological services. Studies of resiliency have shown that there are healthy responses to traumatic life events which rely on the interaction among several factors such as age, gender, religion, the availability and timing of social support, and individual characteristics such as self-efficacy, self-confidence, sense of hope and coherence, ability to find meaning and form attachments, ability to seek and accept help, and general internal locus of control (Cicchetti & Garmezy, 1993; Lee, 1988; Lyons, 1991; Masten, Best, & Garmezy, 1990; Rutter, 1987;

Werner & Smith, 1992; Ying & Akutsu, 1997). Therefore, this study hopes to delineate not just the factors but also the specific processes of positive coping in well-functioning Cambodian and Vietnamese ex-refugees in an otherwise highly traumatized refugee population.

The need to study the more positive end of the spectrum of trauma reactions is great. Aside from increasing our knowledge in the field, the importance lies in the potential for informing better treatment approaches for traumatized individuals or groups. Therefore a post-positivist approach, which relies on multiple methods to try to capture as much reality as possible was adopted, with the present qualitative study as the first step in trying to map out the parameters of positive trauma reactions.

PTSD Research

Since its inception as a diagnosis, PTSD has generated a wealth of research. There have been generally four types of PTSD studies. First, epidemiological studies looked at prevalence of PTSD in different settings such as natural disasters (e.g., floods, volcano eruptions, earthquakes, etc.) and man-made violence, which encompassed large-scale violence (e.g., wars and civil unrest) and small-scale violence (e.g., rape, mugging, assault, etc.). Studies have found that the PTSD prevalence rates in the general population in the United States range from 0.5 to 3.5%, but those rates increase to 30.7% for women and 14% for men in populations that have experienced traumatic events (de Girolamo & McFarlane, 1996). Epidemiological studies also looked at different populations such as war veterans, prisoners of war, political prisoners, immigrants, refugees, victims of terrorist

attacks, victims of violence, battered women, incest survivors, victims of sexual assault or rape, victims of natural disasters, first responders, orthopedic patients, cancer patients, burn victims, homeless, and other at risk groups. The prevalence rates for PTSD ranged from 1 to 100% for these groups (de Girolamo & McFarlane, 1996). The basic finding de Girolamo and McFarlane's (1996) review was that the prevalence of PTSD was strongly dependent on the traumatizing events and the individual characteristics of people who experienced it. However, due to methodological differences and differences in how PTSD was diagnosed, no clear conclusion has been reached about the parameters of traumatic events and their impacts on the individual. The World Health Organization (WHO, 1992) tried to delineate the parameters of traumatic event as "an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone." However, epidemiological studies could not account for the fact that not all individuals who experienced traumatic events, as defined by WHO, developed PTSD.

Second, PTSD research tried to address the multidimensionality of the disorder by mapping the psychopathological trauma reactions. Multiple studies were done on "symptoms" that were unique to PTSD such as avoidance, re-experiencing, and arousal (criteria B, C, and D of PTSD in the DSM-TR, 2000). Measures were created to try to capture the construct of PTSD in easily administered and scored diagnostic tools. These measures often resulted in false positive diagnosis of individuals who manifested the trauma symptomatology of avoidance, re-experiencing, and arousal, based on incidents that are generally not

considered to be have prolonged traumatic effects, such as death of a loved one. It also resulted in false negative diagnoses as these measures did not account for the fact that trauma related symptoms range from dysthymia to chronic personality disorder which can easily be mistaken for schizophrenia. Therefore, the conceptualization of pathological trauma response as a particular group of symptoms, as in the medical model of PTSD, does not have enough sensitivity nor specificity to explain the full range of trauma reactions.

Third, considerable effort was invested in PTSD treatment. In order to formulate a treatment for PTSD, theories about how the symptoms came about had to be fleshed out. Shalev, Bonne, and Eth (1996), Foa and Meadows (1998), Frueh, Turner, and Beidel (1995), and Shapiro (1996) provided comprehensive reviews of theory-driven treatments for PTSD. The biological approach to PTSD, which included models of the dysregulation of opioid neuromodulation during stress, memory-imprinting, and kindling, all stressed the neurochemical changes in the brain during periods of extreme stress. Therefore, treatment proposed for PTSD based on the biological approach indubitably includes psychotropic medication. The behavioral approach to PTSD focuses on classical conditioning linking PTSD symptoms to trauma; the negative reaction of the individual (unconditioned response) has been paired to the trauma (unconditioned stimulus), producing a conditioned response (PTSD symptoms), which becomes generalized to stressful conditions (conditioned stimulus). However, unlike classical conditioning, the conditioned response does not extinguish over time, accounting for the pervasive symptomatology of PTSD. The treatment focus informed by this model generally

tried to undo the conditioned stimulus through techniques ranging from gradual desensitization to massive exposure (flooding). The cognitive approach to PTSD theorized that cognitive schemata that the world is being generally benevolent and meaningful are shaken by traumatic experiences, leading to dysfunctional thinking and beliefs, which eventually cause PTSD. Therefore, treatment based on this model of PTSD has tried to address the dysfunctional thinking through exposure and correcting erroneous associations and evaluations. The psychodynamic approach formulated PTSD as a complex and multifaceted construct involving damage to the mental apparatus and unresolved processing of the traumatic event. Naturally, the treatment based on this model of PTSD is psychodynamic therapy to help the individual process through the trauma experience. Finally, a new approach to PTSD, which utilizes Eye Movement Desensitizing and Reprocessing (EMDR), also conceptualizes trauma as unresolved processing of the traumatic event, suggests saccadic eye movements during processing can “reprogram” brain function to finally allow integration of emotional impact of the trauma. There have been other theories, such as learned helplessness/inescapable stress theory, time dependent sensitization theory, fear potentiated startle response theory, and arousal based behavior theory, which all tried to explain a particular symptom of PTSD. All these theories and models underscore the heterogeneity of concepts and treatments in the field, which further obfuscates the goal of trauma research to understand the pathology of PTSD and ultimately prevent it or effectively treat the patient.

Finally, researchers looked at risk factors for PTSD, focusing on the characteristics of the traumatic event such as duration, frequency, level of violence, level of harm, number of perpetrators, etc., plus individual characteristics such as perceived level of threat, reaction to the events, and locus of control with the goal of identifying at risk groups/individuals. The epidemiological studies showed that there is a range of traumatic events and also a range of trauma reactions. For example, the subjective experience of an adult rape victim is different from someone who suffered prolonged childhood sexual abuse. A combat veteran's PTSD symptoms are not identical to those of a victim of political torture. Therefore, the benefit of knowing risk factors might not be as helpful in predicting the development of PTSD or informing treatment. However, there is a general consensus among eminent trauma researchers that on one extreme of the spectrum, exposure to highly negative events that severely jeopardize the physical and mental health of the individuals will traumatize most individuals (Herman, 1992). But again, the underlying message is that not all who are traumatized develop PTSD, and not all who have had traumatic experiences are traumatized.

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV), released in 1994, tried to address this particular issue by including subjective response to the traumatic event. Criterion A2 was added, which specified that the person's response must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior). This criterion was included to address individual differences in reactions to a variety of traumatic events. Thus exposure to traumatic events alone does not

necessitate development of PTSD symptoms. The individual must have a strong negative reaction such as panic, terror, grief, or disgust to the trauma. However, the PTSD criteria still did not capture different manifestations of trauma symptomatology not within the scope of intrusion, avoidance, and arousal.

The above breakdown of trauma research underscores the multidimensionality of PTSD and the amount of work still needed to crystallize the understanding of the range of trauma and its effects on the individual. Despite the many in-roads researchers and clinicians alike have made since the conceptualization of PTSD, the effects of trauma on the individual are still largely unpredictable.

PTSD Construct and Refugee Populations

The construct of PTSD has been widely studied among refugee populations, given the multiple severe traumas they have undergone. Any single traumatic incident many refugees experienced would be sufficient to meet Criterion A of PTSD, let alone the protracted period of multiple traumas typical for refugees. However, there has been considerable debate about the validity of the diagnosis of PTSD for non-Western populations.

Traumatic experiences and reactions of refugees do not fall neatly into the Western-conceptualized PTSD construct, despite the fact that many studies indicated a high prevalence of psychological distress in refugee populations. The correlation between traumatic experiences and PTSD in refugees has been widely studied (e.g., Chung & Kawaga-Singer, 1993; Dyregov, Gupta, Gjested, & Mukanoheli, 2000; Favaro, Maiorani, Colombo, & Santonastaso, 1999; Geltman,

Augustyn, Bernett, Klass, & Groves, 2000; Hauff, & Vaglum, 1993; Kennedy, 2000; Kinzie, 1993; Mollica, & Caspi-Yavin, 1996; Mollica, McInnes, Poole, & Tor, 1998a; Mollica, Poole, Son, Murray, & Tor, 1997; Paardekooper, de Jong, & Hermanns, 1999; Papageorgiou, Frangou-Garunovic, Iordanidou, Yule, Smith, & Vostanis, 2000; Sack, Seeley, & Clarke, 1997; Silove, 1999). The most common diagnoses given to SEA refugees are mood disorders, PTSD, schizophrenia, and organic brain syndrome (Mollica et al., 1997).

Another issue is the relatively wide range of prevalence of PTSD observed across studies of refugee populations. For instance, Kinzie et al. (1990) found PTSD to be prevalent in 75% of the SEA refugee population in his study. However, Kroll et al. (1989) only found about 14% in the SEA refugee population. Currently, PTSD prevalence ranges from 9 to 88% in SEA refugees (Carlson & Hogan, 1991; Hauff & Vaglum, 1993; Kinzie, Sack, Angell, Manson, & Rath, 1986; Kinzie et al., 1990; Kroll et al., 1989; Mollica, Wyshak, & Lavelle, 1987; Moore & Boehnlein, 1991).

However, upon careful reflection, it appears that prevalence rates of PTSD depend on the population sampled. Generally PTSD was diagnosed in 75 to 100% of inpatient subjects. Studies using outpatient but help seeking populations also showed a high prevalence of PTSD, around 45% to 65%. The lowest prevalence of PTSD was found in epidemiological studies, such as the study by Mollica et al. (1993) in Site II of the refugee camp at the border of Thailand. Mollica et al. only found a 15% prevalence rate among the over 2000 participants in the camp. Rates of depressive disorders were higher.

The controversy over the validity of PTSD construct has also generated more research on whether PTSD transcends cultural barriers. Several studies on SEA, Guatemalan, Senegalese, and Malawian refugees found PTSD to be an appropriate diagnosis for the psychological symptomatology of these populations (e.g., Dyregov et al., 2000; Favaro et al., 1999; Gillespie, Peltzer, & MacLachlan, 2000; Hauff & Vaglum, 1993; Kinzie, Fredrickson, Ben, Fleck, & Karls, 1984; Melville & Lykes, 1992; Miller, 1996). Sack et al. (1997) did a factor analytic study on the construct of PTSD with Khmer adolescents and found four factors matching those in the PTSD construct of the DSM-III-R. The four factors were arousal, numbing, avoidance, and re-experiencing. Mollica and his group (1997) also found the PTSD construct to be applicable to SEA refugees. However, the author cautioned that cultural idioms of distress must be included in the assessment to be able to capture the full picture of distress of the SEA refugees. The weakest PTSD factor found was that of avoidance. In a dose-response study of PTSD done by Mollica, McInnes, Poole, and Tor, (1998a), three PTSD factors were found to have a dose-effect relationship. The more traumatic events the refugee experienced, the more severe the arousal (hypervigilance, startle response), re-experiencing (nightmares, flashbacks), and numbing symptoms. However, the factor of avoidance did not show a dose-effect relationship to the number of traumatic experiences. Both Sack et al. (1997) and Kinzie et al. (1984) in Oregon, and Mollica (1998a) in Boston, suggested that the factor of avoidance might have a different meaning for SEA refugees. The authors speculated, from their knowledge

of the SEA culture, that avoidance can best be conceptualized as a coping mechanism instead of a pathologizing mechanism.

On the other hand, since we do not have the base rates of PTSD within the home countries of the refugees, we might not know the effects of the refugee experience versus the war trauma experience. Eisenbruch (1991) indicated that refugee experiences and trauma reactions could best be understood as cultural bereavement, as opposed to PTSD. Lebowitz, Harvey, and Herman (1993) indicated that the current conceptualization of PTSD does not capture the full range of trauma-induced pathology. Furthermore, the authors indicated that psychology and psychiatry have not fully delineated the *normal* reactions to extreme stress in order to be able to differentiate which traumatic reactions are pathological.

Positive Coping to Trauma

The white elephant in trauma research is what to do with the understanding that there is a wide range of individual differences in the reaction to potentially traumatizing events. Unlike statistical models, individual differences in trauma reactions cannot be disregarded as “error.” Sometimes, that “error” is the most interesting finding in terms of understanding trauma reactions. Furthermore, the huge unexplained variance in PTSD studies hinted at the existence of variables that are not considered. Epidemiological studies showed that a sizeable portion of traumatized individuals do not develop PTSD. For example, about 21 to 36 percent of children who were sexually abused are asymptomatic (Finkelhor, 1990). One can assume from the relatively lower percentages that a majority of the children were coping effectively. Therefore, by focusing on the negative reactions to trauma

as in PTSD, trauma research left the field with a fragmented and incomplete understanding of trauma reactions.

On the flip side of trauma studies, examinations positive coping after experiencing traumatic events are somewhat neglected. There are a considerable number of resilience studies, most of which have focused on at-risk children and adolescents. Among the more interesting studies are longitudinal, prospective studies examining resilience against trauma-induced psychopathology. These studies observed a subset of very resilient children who have experienced violent, prolonged, and intrusive abuse by a primary caretaker, without developing psychopathology (Herman, Russell, & Trocki, 1986; Werner & Smith, 1989a). This indicates that the severity of the different parameters of abuse does not fully account for the development of pathological symptoms, as indicated by other trauma research (Wind & Silvern, 1992; Kendall-Tackett, Williams, & Finkelhor, 1993). Therefore, mediating and protective factors such as the child's sense of self, availability of maternal support, positive adult role models, etc., must be included into the equation to fully calculate the impact of abuse on individual children. Furthermore, the few studies on resilience to trauma induced psychopathology mostly looked at risk factors and protective factors as indicated above. These studies were mostly quantitative studies with a priori-defined variables deemed as risk or protective factors. However, at this point in time, we have not exhausted the possible risk or protective factors that could account for the varied trauma responses. In other words, we might not know all the relevant variables that factor

into the wide range of trauma responses. Trauma researchers need to look at positive coping or resiliency to start addressing this oversight.

Southeast Asian Trauma History

Refugee trauma is unique in that it is protracted (sometimes over decades) and encompasses different types of traumatic experiences. The SEA refugee experience is well known from descriptive research studies (e.g., Mollica & Lavelle, 1988), autobiographies such as *First They Killed My Father: A Daughter of Cambodia Remembers* (Ung, 2000), documentaries, and films (e.g., *The Killing Fields*, Joffé, 1984). A brief history of the SEA experience is warranted to illustrate the range and severity of the traumatic experiences most SEA refugees experienced and also to underscore the strength and resilience of these people who managed to thrive in the United States despite their past.

The first experiential stage of the refugees starts within their home countries. To understand the refugee experience, one has to understand the circumstances that push a country's citizens to involuntarily leave their home, family, community, and culture for an unknown future in foreign lands. The SEA refugees fled Indochina because of the dangers of war. A majority of refugees experienced traumatic events such as: witnessing family members or other people being killed or tortured; being tortured themselves; forced labor akin to slave labor; insufficient food and water; constant fears such as being reported by friends or neighbors to the communist authorities and being hauled off to "re-education" camps; constant fear of indiscriminate killings and senseless acts of violence; the list goes on (Mollica, Poole, & Tor, 1998; Kinzie et al., 1984; Rozee & Van

Boemel, 1989). The loss of loved ones or separation from family members is common among SEA refugees.

An example of a pre-departure trauma will help illuminate the impetus of citizens in becoming refugees. The political instability inadvertently caused by the Vietnam War, communist threat, and an inept Cambodian government at that time, allowed the Khmer Rouge to seize power. Once in power, the Khmer Rouge, under the leadership of Pol Pot, propagated their ideology of a Utopian, agrarian society through very harsh means. They committed the most horrendous crimes, such as genocide on their fellow countrymen, in Cambodia from 1979 to the early 1980's. Urban citizens were rounded up and sent to the rural areas to work as forced laborers. Families were separated. Children were taken from families to be retrained (brainwashed) and eventually sent back to their family as spies or recruited into Angka (all-powerful police). Children as young as eight years old were given the license to kill. Indiscriminate killings were common. Anybody suspected of having an education, namely any professional, was killed because they were suspected to have been corrupted by Western influences. There were no judicial systems.

The "re-education camp" conditions were deplorable and malnutrition was rampant. Citizens were forced to work long hours in the fields with very little food. Diarrheal diseases such as Cholera were rampant and there were no medical services, as all the suspected doctors had been killed. Mass killings were common and most camps had a small hill of skulls to remind others of what would happen to suspected traitors. Torture was also another common occurrence in the camps.

Mollica and Lavelle (1988) reported torture experiences of falanga (hitting the soles of the feet), beating, attempt drowning, and hanging by the feet, were reported by 20% of the SEA refugee populations. More people were forced to witness killings and torture. Given the horrendous situations within their home countries, there is little wonder why people attempted to flee.

The journey to safety was a long road full of hazards. Most Cambodians crossed the hills and jungles on foot, traveling for weeks to reach the Thai border and United Nations sponsored refugee camps. The journey was full of dangers. Not only did they have to escape and avoid detection every step of the journey, most were weak and malnourished. Reports of hunger were common during the journey. Some refugees had to leave loved ones behind who became too weak to continue. Some witnessed others being killed when they were found out. Furthermore, there were reports of witnessing others in their escape group lose life and limb due to the landmines. The flight on foot was very dangerous.

Around the time of the fall of Saigon, there was a mass exodus of South Vietnamese, especially the citizens who had ties with the old government or the American forces, because of fears of reprisal and oppression from the incoming communist government. Most of these people were air-lifted out of Vietnam by the American forces. The South Vietnamese who left Vietnam after the fall of Saigon generally had to escape to Thailand, Malaysia, or the Philippines on small fishing boats. These Vietnamese boat people's experience was the most widely reported flight danger documented in the literature. The UNHCR special report (cited in Mollica & Son, 1989a) on refugees in Malaysia and Thailand noted that more than

75% were attacked by Thai pirates. Women were especially vulnerable as many were kidnapped and raped repeatedly by multiple perpetrators. Again, many witnessed tremendous violence by the pirates: killings and people being thrown overboard. Some boats were sunk and many drowned. The UNHCR reported that only approximately 50% of these boat people made it to their country of destination alive.

If refugees survived all the trauma of war and flight, they entered the transition stage, starting where they arrived at the refugee camps. Camp experiences were reported to be very traumatic, especially for the Cambodians who went to refugee camps on the border of Thailand. There was no safety to be found and food was scarce. The camp conditions were usually bad with poor hygiene and poor control of safety elements. Disease and illness were common with limited medical care. There were also reports of Thai guards beating the refugees and cases of rapes and sexual assaults by the very people who were supposed to guard their safety. The experience of not knowing what will happen next also compounded the helplessness of the refugees.

If the refugees were lucky, their names were called when they were sponsored to a host country, mostly Western countries like America, Europe, and Australia. Comparatively, this post-arrival stage was the safest. However, the refugee populations still faced considerable barriers such as language barriers and learning how to navigate the social and political structures within the host country. Upon first arriving, they were faced with the formidable task of the basic needs of living such as shelter, food, communication, etc. Acculturation eventually became

an issue. Some even had to contend with experiences of racism. It is also at this stage that some studies have shown to be a high-risk period for psychological symptoms to manifest (Chung & Kagawa-Singer, 1993). Their descriptive research study indicated that post-arrival period ranging from 2 to 18 months showed increase in symptomatology for refugee populations.

In view of the SEA refugee experience, it is a wonder that not all of these people need psychological help. Even with the four fold increase in severe mental health needs of SEA refugees (15%) compared to the general population in California (Gong-Guy, Cravens & Patterson, 1991), a majority (85%) of these populations do not seek treatment. However, it is important to note that just because these populations do not seek treatment for their trauma experiences, it does not mean that they do not need treatment. There is evidence to indicate that a majority of these SEA refugees are functioning well in the United States. In a California Southeast Asian mental health needs assessment, Chung and Bemak (1996) found that 25% of the Vietnamese and 12% of the Cambodians never received welfare. Furthermore, 29% and 49% of the Vietnamese and Cambodians, respectively, who were previously on government assistance no longer needed welfare assistance at the time of the survey. The average lengths of time in America for these samples at that time were 6.6 years and 4.7 years for the Vietnamese and Cambodians, respectively. The survey also found that 46% of the Vietnamese and 39% of the Cambodians still required welfare assistance, which signified that a large proportion of these refugees are fully independent. The questions remain - Why are these people not seeking treatment? Do they need

treatment? If not, how are they protected from trauma induced pathology? What are these protective factors and can those factors be replicated with new populations?

Resilience

The current functioning and well being of a majority of the SEA population indicated the presence of some protective factors. The concept of resilience is so important that the American Psychological Association (APA) even had a special practice directorate into the study of this phenomenon in the wake of the September 11, 2001 bombing of the World Trade Center in New York in the hope of providing some form of inoculation for children and adults against stress induced psychopathology. The APA created a task force on “Promoting Resilience in Response to Terrorism” which provided tools and information, assessable via their website to help the public build resilience. The importance of this construct is beyond debate. However, the actual research on resilience as a construct has been fraught with difficulties.

The concept of resilience has been widely studied in many different settings. This phenomenon is generally found in studies of: 1) good outcome in high-risk children, 2) sustained competency in children under stress, and finally, 3) recovery from trauma. To date, the majority of studies that have tried to uncover the mystery of resilience have primarily focused on good outcome in high-risk children (e.g., Rutter 1979; Werner, 1989b) and sustained competency in children under stress (Masten, Best, Garmezy, 1990; Radke-Yarrow & Brown, 1993; Werner, 1992). Resilience in terms of recovery from trauma was relatively less

investigated. Therefore, most of the theories and definitions on resilience are based on the study of high-risk children who thrived in the face of adversity.

The first major problem in resilience research has been the definition of the construct. The difficulty is due to the range of definitions. First, resilience has been thought of as an outcome. The general accepted rule is that resilience can only be demonstrated when an individual experienced some kind of stressor or challenge. Therefore, despite risk factors, an individual exhibiting positive outcome is regarded as resilient. On the flip side, if the individual exhibited negative outcome, the individual is regarded as vulnerable.

The problem with defining resilience as an outcome is the variability in defining “good outcome.” For example, Radke-Yarrow and Brown (1993) defined resilience as having no diagnosis and not being on the borderline of reaching criteria for a diagnosis. In essence, resilience means not having any psychopathology despite risk factors. Therefore, judgment on resilience may vary depending on the outcome measure used. It also confines resilience into a uni-dimensional modality, which does not explain the construct as a whole. For example, if the outcome measure is academic performance and the individual with multiple risk factors does well academically or occupationally but does not have

meaningful relationships socially, by this definition, the individual would still be considered resilient.

Second, resilience has been defined as a process. It is the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstance (Masten, Best, & Garmezy, 1990). In essence, resilience is seen as a moderator towards good outcome.

Therefore, based on this definition, resilience research focused on finding the moderator variables that promotes positive adaptation despite adversity. Numerous studies looked at risk and protective factors. However, as Michael Rutter (1987) pointed out, knowing particular risk and protective factors does not help in promoting resilience if we do not understand the underlying mechanisms of how the factors affect the individuals towards positive outcomes. There has been a shift in resilience research, which increasingly emphasizes the need to understand “how” resilience comes about (more cause and effect studies) versus “what” resilience is (correlation studies).

Third, some researchers have defined resilience as a trait. For example, Tarter and Vanyukov (1999) reported on a definition borrowed from physics and engineering which stated resilience was “the property of a material that enables it to resume its original shape/position after being bent, stretched, or compromised” (p. 86). In human terms, that definition suggests that resilience is the ability/trait of the individual to return to equilibrium or homeostasis after experiencing adversity.

The review of resilience as a trait led to the investigation of factors such as “hardiness,” “stoicism,” etc. Kobasa (1979) defined hardiness as commitment (belief in the importance and value of oneself and one’s own experience and activities) + control (internal locus of control) + challenge (belief that change is normal and represents a positive rather than threatening circumstance). However, upon more consideration of this definition, Tarter and Vanyukov (1999) concluded that resilience has no construct validity or predictive validity because the epigenetic trajectory of a person is constantly being modified. In short, an individual who is seen as being resilient in one aspect at one time may not be considered as resilient in another aspect in another time. So having a particular trait does not predict favorable outcomes in different situations and at different periods in the individual’s life.

Fourth, it has been suggested that resilience is culturally specific. Resilience is closely tied to positive outcome (whether as product or moderator), and what is considered a positive outcome is strongly determined by culture. What is viewed as positive adaptation in one culture might not be viewed as desirable in another culture. For example, individualism and independence, considered to be positive traits in most Western cultures, might not be considered desirable in more collectivistic cultures where self and identity are closely tied to the family or community. Therefore, resilience must be operationalized within the context of the culture being studied.

The range of resilience definitions came about because of the varied ways the construct has been studied. The definition of the construct is relative to the

methodology used. Kumpfer (1999) reviewed and organized resilience studies into five basic methodologies: 1) Retrospective, single sample, or cross sectional studies; 2) Retrospective, cross-sectional, multivariate studies; 3) Short-term, transactional, longitudinal studies; 4) Long-term prospective developmental studies with no control group; and 5) Prospective multiple sample studies. Each method has its strengths and limitations. The first method (retrospective, single sample, or cross sectional studies) primarily explores the parameters of the construct being studied. Such studies use in-depth interviews or life events analysis to develop grounded theory for later hypothesis testing. The second method (retrospective, cross-sectional, multivariate studies) allows for cross validation of the parameters across groups. The third method (short-term, transactional, longitudinal studies) allows for the study of moderator and mediator factors that might influence the construct. Finally, the fourth and fifth methods (long-term prospective developmental without control group studies and prospective multi sample studies, respectively) allow for the validation of the construct over time and also permit the inference of causality. Therefore, each method looks at a section of the construct.

Overall, it would appear that research could be systematically planned and carried out to clarify the construct of resilience. However, Fisher, Kokes, Cole, Perkins, and Wynne (1987) lamented the fact that the terms “invulnerability” and “resilience” are counterproductive, as each implies only one dimension rather than multiple dimensions along which an individual varies. The term implies constancy rather than permitting variations across time, place, developmental stage, or

situational context. They argued that terms like resilience, vulnerability, protective factors, and risk factors do not clarify thought.

Unfortunately, theories and models of resiliency, which are meant to clarify the construct further, have only served to confuse the matter even more. There are more theories and models of resiliency than definitions. For example, Cohler (1987) suggested that resilience is the result of the interaction between temperament and environment, which impacts on later choices of coping strategies. Somewhat similarly, Glantz (1992) proposed a developmental psychopathology model, which suggests that resilience is a dynamic process, which develops as the individual interacts with the environment as he/she matures. This model was based on risk for substance abuse evolving through maturational periods of the child. Egeland, Carlson, and Sroufe (1993) further developed the model into an organizational-developmental framework, which suggested that resilience came from the interaction of genetic, biological, psychological, and sociological factors in the context of environmental support. Both models allowed for the definition of resilience to change as the developmental stages changes. So, the models suggested that resilience is the ability to use internal and external resources successfully to resolve stage-salient developmental issues.

Shaefer and Moos (1992) proposed a transactional and reciprocal feedback model, where by an individual's experience and response, and the subsequent outcome, will affect how they will cope the next time. In essence, life crises and the environmental and personal factors that foreshadow them can shape appraisal and coping responses and affect the likelihood of a positive outcome. Richardson,

Neiger, Jensen, and Kumpfer's (1990) resiliency model elaborated on the above model by incorporating other works from Anthony (1987a,b), Bandura (1989), Flach (1988), Garmezy (1987), and Werner (1989b) to state that resilience is the byproduct of the processes of coping with mild to severe disruptions, which provide opportunities for growth, development and skill building. The product is increased protective skills as well as skills that can facilitate the coping process. Therefore, after repeated mild to severe disruptive experiences, the resilient individual does not become as incapacitated and recovers in a shorter time following disruption. Despite the differences in language and descriptions of these models, the basic tenet is that resilience is learned from successful coping with past problems.

Werner (1986) went beyond describing resilience to a more predictive model, which characterized resilience as a probability ratio of risk factors and stressful life events interacting with protective factors. It almost suggests that resilience can be eventually predicted with mathematical precision. Unfortunately, the model does not account for individual differences as individuals could have the same risks and protective factors but react differently and have disparate outcomes. Jessor (1991) tried to include individual differences by allowing for different levels of coping for different circumstances the individual might face. Their problem behavior theory espouses four systems (social environmental, personality, perceived environmental, and behavioral), each with instigation and control elements against problem behaviors. The balance between instigation and control constitutes the level of risk in this system. However, this theory looks at resilience

within a particular context or set of circumstances, which makes it hard to generalize to the whole person.

Greenbaum and Auerbach (1998) suggested a 3D model of risk which looked at the interaction between 3 factors: 1) external risk vs. protective factors; 2) vulnerability vs. relative invulnerability of the individual; and 3) lack of resilience vs. resilience of the individual. The model was based on the assumption that early experience (of acceptance and risk protection factors) X biological X environmental factors influenced the development of the child. However, the model does not provide any directional prediction in terms of how these interactions influence the development of the child.

Overall, there are considerable obstacles to resilience research; namely, lack of agreement on: 1) operationalization of the resilience concept, 2) gender, age/culturally unbiased definition of successful outcomes, 3) definitions of environmental risk protection, 4) the primary self characteristics of a resilient person, 5) problem separating cause and effect, 6) locating good measures for resiliency variables, and 7) the need for large numbers to determine the most salient/predictive factors of positive outcome despite high risk. However, despite these problems and the differences in definitions, theories and models of resilience, it would appear that there is considerable overlap among the different explanations. It would seem as if resilience research is analogous to the fable about the blind men and the elephant, each looking at one part of the construct with the added problem of using different languages, which prevented any consolidation of thought.

Michael Rutter (1987) hinted at the need for a metatheoretical approach to consolidate the disparate knowledge about resilience in order to further our understanding of this phenomenon. Glantz and Sloboda (1999) suggested the need for a multifaceted approach to evaluate resilience, which was seen as a multifactorial system, in that it views all variables as being influences, mediators, and outcomes, tied in varying degrees to the entire system of variables. To this end, Kumpfer (1999) suggested a non-linear, transactional model (see Figure 1) of person + process + context with four influence domains (acute stressor/challenge, environment, individual characteristics, and outcome) and 2 transactional points (confluence between the environment and the individual and between the individual and the choice of outcomes).

The transactional model of resilience grew from Richardson, Neiger, Jensen, and Kumpfer's (1990) resiliency model, which provided a framework for understanding resiliency as a process within a single point in time. The transactional model of resilience is a metatheoretical approach that tried to address the problems of early models, drawing from the results and conclusions of many resilience studies, by creating 6 major constructs. They are: 1) Acute stressor or challenge--resilience can only be demonstrated when the individual experiences some kind of stressor or challenge; 2) External environmental risk and protective factor--e.g., resilient youth are able to find micro-niches of support with adequate growth opportunities even within high-risk environments; 3) Person-environment interactional processes, including selective perception, cognitive reframing, planning and dreaming, identification and attachment with pro-social people, active

environmental modifications by the youth, and active coping. Some of the protective processes are role modeling, teaching, advice giving, empathic and emotional responsive care-giving, creating opportunities for meaningful involvement, effective supervision and disciplining, reasonable developmental expectations, and other types of pro-social facilitation or support. Internal individual resiliency factors include genetic and biological invulnerability factors such as intelligence, gender, and neurotransmitter imbalances. Internal psychological self-resiliency factors include organization of internal personal traits/self factors such as spiritual, cognitive, social/behavioral, emotional, and physical. Resilience is also regarded as internal capacity or competence; 4) Self resiliency factors, incorporated from various research studies, such as: dreams and goals (Bandura, 1989; Rutter & Quinton, 1984), purpose in life (Neiger, 1992), existential meaning in life (Frankl, 1963), spirituality (Gordon & Song, 1994), belief in uniqueness or oneself (Gordon & Song, 1994), internal locus of control (Werner, 1992), hopefulness and optimism (Seligman, 1975), and determination and perseverance (Bandura, 1989; Werner, 1986). Within the individual context factors include cognitive competencies such as intellectual competence and academic and job skills, moral reasoning, insight and intra-personal reflective skills, self-esteem and ability to restore self-esteem, planning ability, and creativity. The behavioral and social competencies include social skills and street smarts, problem-solving skills, multi-cultural and gender-transcendent competencies, and empathy and interpersonal social skills. The emotional stability and emotional management competencies include the ability for happiness, emotional

management, and humor. The physical competencies include physical self-care; 5) Resiliency processes which still need to be discovered. There is a tremendous need to know how to create these resiliency factors through designing and encouraging resiliency building processes in the transaction between the individual and the environment; and 6) Positive life outcomes which must be culturally relevant to the individual.

The transactional model appears to be one of the most comprehensive models on resiliency, which provides a structure in guiding future research. However, the model is based on research done primarily on at-risk children and adolescents, namely, children at risk for substance abuse, economically impoverished children, children and adolescents whose parents have been diagnosed with psychiatric disorders, children with alcoholic parents, inner city children, Native American children, African American children, abused children, diabetic adolescents, and also a small number of studies on adults with end stage renal disease, institutionalized women, and adult children of alcoholics.

The Present Study

The transactional model has yet to be tested on a non-Western adult population or applied to the issue of resilience against war trauma-induced psychopathology. To this end, this study will investigate SEA resilience, based on the transactional model as the overarching metatheoretical guide partly to investigate the relevance of this model to the SEA refugee population and partly to identify the particular stressors faced by this population. Resilient individuals will be defined within a psychosocial framework based on self-reported well being

within the realms of psychological (lack of psychiatric problems), social (involved and having meaningful relationships), employment (meaningful employment history), and subjective well being (self-defined satisfaction with life in general). Since the outcome measures in these areas, including subjective sense of wellness, will be self-defined, the positive outcome is expected to be culturally specific. As a first step into the study of a population new to resilience research, a retrospective, cross sectional design will be used to explore the parameters of war-trauma related resilience in order to develop hypotheses for later testing.

Despite the descriptive nature of this study, several preliminary hypotheses are proposed:

1. The risk and protective factors will be similar to those found by previous studies on at-risk children included in the transactional model.
2. There will be additional factors that were not proposed in the transactional model, which will be specific to the SEA culture.
3. The underlying mechanism of resiliency will not be a set of distinct factors but rather an interaction of several factors.

Method

Participants

Ten Cambodians (5 men and 5 women, ages 29 to 43) and 11 Vietnamese (3 men and 8 women, ages 32 to 67) participants were recruited via a snowball technique, starting with contacts from the Socio Economic Development Center (SEDC) for Southeast Asians and the Cambodian and Vietnamese Mutual Assistance Associations of Rhode Island and Massachusetts. An appropriate sample for a qualitative study is one that interviews multiple individuals who are homogenous in the particular trait in question (in this case, ethnicity and having certain resilient traits), with the aim of generating as many perspectives as possible until saturation is reached (Strauss & Corbin, 1990). Friends and contacts in the community facilitated the location of the first few participants. Network sampling ensued thereafter, whereby participants already in the study suggested and contacted new potential participants. They were asked only to suggest potential participants whom they knew as doing well economically, emotionally, and socially. The principle investigator then contacted the potential participants via phone or email, depending on the suggestion of the referrer. Some participants individually posted the information of the study into the websites of Vietnamese and Cambodian community agencies, which generated potential participants as well.

Participation in the study was fully voluntary. All participants received verbal and written explanations of the study. Participants were not identified in any way. They were reminded of their rights to refuse to answer any questions or to

quit the study at any time. Participants were informed that there was no compensation for their participation in this study.

To be included in this study, participants had to be self-identified immigrants from Cambodia or Vietnam who 1) left their country of origin at age six or older; 2) originally arrived at the United States on refugee status; and 3) speak English.

Measures

The measures included a semi-structured questionnaire and several self-reports (refer to Appendix C for the semi-structured questionnaire and self-reports). These measures were:

1. Semi-structured questionnaire with open-ended questions which included questions on: 1) demographics; 2) emigration and resettlement; 3) cultural disruption; 4) language acquisition and difficulties; 5) general coping strategies; 6) trauma experience; and 7) coping resources/skills/strategies.

2. Harvard Trauma Questionnaire, Cambodian and Vietnamese versions (HTQ; Mollica, Caspi-Yavin, Bollini, Truong, Tor, & Lavelle, 1992). This is a checklist for measuring trauma, torture events, and trauma-related symptoms in Indochinese patients, which also combines refugee and culture-specific symptoms with DSM-III R PTSD symptom criteria. The inter-rater reliability for trauma events and trauma related symptoms were reported to be 0.93 and 0.98 respectively. One-week test-retest reliabilities for trauma events and trauma-related symptoms were 0.89 and 0.92 respectively, Cronbach's alpha was reported to be 0.90 for trauma events and 0.96 for trauma-related symptoms. Sensitivity was

stated as 78%, while specificity was 65%. The HTQ has an overall predictive efficiency of 75%. Overall, the HTQ is a reliable and valid cross-cultural measure for the Indochinese trauma experience.

3. Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979). The IES is an established measure of the subjective impact of trauma. It has also been used to chart trauma reactions over long periods of time and it is reported to be able to differentiate traumatic stress from usual stressors. However, it is not a diagnostic instrument for PTSD. The psychometric properties of the IES have been tested on traumatized Cambodian youths (Sack, Seeley, Him, & Clarke, 1998) and were found to be an adequate self-report measure of trauma for this population. The internal consistency of this measure on traumatized Cambodian youths were reported with Cronbach's $\alpha = 0.92$. Sack et al. (1998) found a three-factor structure of intrusion, avoidance, and emotional numbing in the Cambodian youths, similar to that found in other traumatized populations, supporting construct validity in this measure.

4. The PTSD Checklist for DSM-IV (PCL-C; Weathers, Litz, Huska, & Keane, 1994). The PCL-C is a new self-report rating scale, developed by the National Center for PTSD for assessing PTSD, which corresponds to the DSM-IV symptoms of PTSD. The PCL-C's reexperiencing symptoms were written generically to apply to any traumatic event. Its test-retest reliability was reported to be 0.96 with an overall Cronbach's α of 0.97. It also has high convergent validity with other PTSD scales. The PCL-C has a kappa of 0.64, sensitivity of

0.82 and specificity of 0.83 making it an established checklist for PTSD symptomatology.

5. Life Attitudes and Feelings Questionnaire is a collection of positive and negative questions to measure attitudes towards the meaning of life and helping behaviors. It is taken from a general survey of lifestyles conducted by the Office of Student Life at the University of Rhode Island (URI).

6. Family Perceptions Scale is also an excerpt taken from the lifestyles survey of URI to measure subjective experiences of family life.

7. Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985). This is a very short self-report scale to measure subjective global life satisfaction. It was reported to have favorable psychometric properties, including high internal consistency and high temporal reliability (two month test-retest correlation coefficient was 0.82 and Cronbach's alpha was 0.87).

8. World Health Organization Quality of Life - Brief (WHOQOL-BREF; Whoqol group, 1995). The WHOQOL-BREF is the short version of the quality of life instrument (WHOQOL-100) developed by the World Health Organization to measure an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It covers four major domains of quality of life: physical, psychological, social relationships, and environment. The domain scores of the WHOQOL-BREF have been shown to correlate 0.90 with the WHOQOL-100 domain scores. The WHOQOL instruments are currently available in 20 different languages. However, since there are no Cambodian or Vietnamese

versions, the American version was used for this study. The use of this instrument was by permission of the WHOQOL group.

Procedure

Four individuals from the SEDC and the Cambodian and Vietnamese mutual assistance associations of Rhode Island and Massachusetts served in two focus groups as cultural experts to assess the cultural relativity of the measures in this study. They also provided the first few contacts, after getting permission from the potential participants. The participants were contacted and an interview scheduled. Place and time of the interview were scheduled at the convenience of the participants.

The majority of participants within Rhode Island and Massachusetts were interviewed in person. For some participants, self-report measures along with a self-addressed stamped envelope were left with the participant to fill out and mail at a later time. Participants from outside the area were emailed the informed consent to review, followed up by a phone call. Once they agreed to participate, a package with the informed consent and self-report measures were mailed to them with detailed instructions on each questionnaire and a return self-addressed stamped envelope. The participants were also informed that the interview was taped and the informed consent form for taping was included in the package. Once the informed consent was received, the interview was done over the phone. Some interviews were divided into two to three parts, depending on the participant's schedule. Each interview took approximately two to three hours.

The goal and nature of the study were explained verbally and in writing to the participant at the very start of the interview process. Their role as participants was explained, including their rights to refuse to answer any questions and to quit the study at any time. They were told that their responses were tape-recorded and could only be identified by their study identification number, which was also explained in their copy of the informed consent form. The participants were also informed that should they decide to refuse to be included in the study data, they could request for their tape back and have their written responses destroyed. Participants were reminded that there was no compensation for their participation. However, they were informed that a donation of US \$20.00 per participant would be donated to either VietAid in Boston, Massachusetts or the Cambodian Mutual Assistance Association in Lowell, Massachusetts, as a token of appreciation for their participation. They were also informed that relevant community associations would be notified of the findings of this study to facilitate their future intervention and prevention programs.

The semi-structured interview contained open-ended questions and the participants' responses were tape-recorded. At the end of the interview process, the participants were given the investigators' contact numbers and a list of services available to them should there be any negative side effects from their participation.

All quantitative data were compiled using SPSS programs. The interview responses were transcribed.

Statistical Procedures and Analyses of Transcripts

General descriptive statistics were run on all relevant quantitative data. For qualitative data, selective thematic coding through phrase by phrase analysis was used. Initially, one transcript was reviewed to extract all possible themes, which were then organized into major conceptual categories. The different categories with their corresponding themes were used as a provisional template for the coding of the other transcripts. After the template was defined, additional excerpts were sought to help refine the major categories. Systematic review of each transcript yielded additional themes and further refined the major analytical categories. Thematic coding was performed based on the existence of resiliency factors and not on the frequency of a particular theme within an interview. In other words, a particular theme can only be coded as either “1” or “0” per participant to indicate the presence of the theme expressed in the interview. Coded excerpts were counted to provide an index of frequency with which a resilient theme arose across the interviews.

Results

Quantitative Data

One Vietnamese participant was not included because of missing data, resulting in a total of 20 participants, 10 Cambodian Americans and 10 Vietnamese Americans. Demographically, there were no significant differences in terms of gender, age, marital status, employment status, level of education, family income, and level of acculturation between the two groups (see Table 1).

Members of the Cambodian cohort were evenly split in terms of gender, but in the Vietnamese cohort there were 7 women and 3 men. The Vietnamese group was slightly older ($M = 43.70$, $SD = 11.16$) than the Cambodians ($M = 35.90$, $SD = 4.93$). However, this difference was due to 2 outliers in the Vietnamese group (ages 67 and 58), which also accounted for the larger standard deviation. The Vietnamese participants were also slightly more educated, with 70% of the group having a Master's level education or higher. This cohort also had a higher income level, with 70% earning more than \$60,000 a year. Finally, 50% of the Cambodian cohort identified themselves primarily as Asian, compared to 80% of the Vietnamese cohort.

Migration data also indicated that there were no significant differences between the two groups (see Table 2). Both groups arrived in the United States around the same age. The Vietnamese cohorts left their country of origin at an older age ($M = 17.90$, $SD = 7.73$) than the Cambodians ($M = 13.10$, $SD = 6.19$), but the difference was not statistically significant. The Vietnamese group came with more family members ($M = 9.60$, $SD = 11.66$) compared to the Cambodian group

($M = 3.90$, $SD = 2.18$). However, one member of the Vietnamese group came with 40 family members, which could have skewed the results and accounted for the larger standard deviation in the Vietnamese group, resulting in no significant differences between the groups. The majority of the participants came from big cities (80%) with the expectations that they would help family members left behind in their country of origin (65%). Both groups left many extended family members behind. Cambodians lost more family members to the war and civil unrest, an average of 5 compared to 2 for the Vietnamese, but the difference was not statistically significant.

Both groups stayed at refugee camps before coming to the United States. However, their refugee camp experiences were very different (see Table 3). The Vietnamese refugees tended to stay at American-operated refugee camps in the Philippines and Guam, and the Cambodians tended to stay at United Nations (UN) sponsored camps at the border of Thailand and Cambodia, which were controlled by Thai soldiers. The Cambodian cohort was significantly more likely to report: not enough to eat, $\chi^2(3, N = 20) = 13.60$, $p = .003$; not enough clean drinking water, $\chi^2(2, N = 20) = 9.33$, $p = .009$; and poor sanitation $\chi^2(3, N = 20) = 11.27$, $p = .01$. The Cambodians also did not feel safe in the camps, $\chi^2(3, N = 20) = 20.00$, $p = .0001$, with reported fear of mugging, rape, and killings from fellow refugees and Thai soldiers. There was almost no overlap in these refugee camp experiences. The Cambodians also stayed significantly longer in the refugee camps ($M = 41.00$ months, $SD = 23.19$) than Vietnamese ($M = 4.40$ months, $SD = 3.02$),

$F(1, 18) = 24.48, p = .0001$. The only similarities in camp experience reported by both groups were the availability of basic shelter and the perception that the camps were too crowded. Overall, the Cambodian cohort had a much more difficult and prolonged refugee camp experience compared to the Vietnamese cohort. However, the HTQ revealed that Cambodians had significantly more trauma events, $F(1, 18) = 37.93, p < .0001$ and personally experienced more trauma events $F(1, 18) = 44.26, p < .0001$ than their Vietnamese counterparts. The mean trauma events experienced by the Cambodian participants were 10.90 ($SD = 2.76$), compared to the Vietnamese participants 3.00 ($SD = 2.54$). It is not surprising that the Cambodians were significantly more impacted by the trauma events than the Vietnamese, $F(1, 18) = 4.84, p = .04$, as measured by the IES.

Despite the significant trauma experiences neither group as a whole met criteria for DSM-III-R PTSD as measured by the HTQ or DSM-IV PTSD as measured by the PCL (see Table 4). Individually, 3 Cambodians met criteria for DSM-IV PTSD as measured by the PCL and 4 Cambodians met criteria for DSM-III-R PTSD as measured by the HTQ. The fact that these individuals still met criteria for PTSD at the present time indicated the pervasive and lingering effects of trauma. However, only two of the Cambodian participants reported experiencing trauma reactions since their time in Cambodia. Another participant misinterpreted the questionnaire and answered retrospectively to the time when she was still in Cambodia. The last participant who met criteria for PTSD reported reacting to gang violence experienced in the United States, and not to the killing fields experience of Cambodia. When PTSD symptomatology was measured using the

HTQ with culturally specific Cambodian and Vietnamese trauma reactions, only 2 participants met criteria for PTSD. Again, one of these two participants was the one who misinterpreted the directions and answered retrospectively. Despite reporting significant distress from their trauma experiences, the participants reported they were functioning well in all major areas of their lives.

Even though the Cambodian participants experienced more trauma events and were more impacted by their trauma experiences than the Vietnamese participants, there were no differences in perceived quality of life across all well-being indices (refer to Table 5). In a subjective measure of life satisfaction (SLS), both groups generally reported being satisfied with their current lives. Both groups reported positive attitudes about life (LAFL) and also about themselves (LAFS). They also reported good/positive family perception (FPS). On the WHOQOL measure, both groups reported good quality of life. Both groups also reported being satisfied with their health. Further delineation of the quality of life measure indicated that both groups are satisfied within the domain of physical health (Vietnamese: $M = 77.70$, $SD = 13.33$; Cambodian: $M = 79.50$, $SD = 14.17$). This domain measures physical attributes such as energy and fatigue, pain and discomfort, sleep and rest, mobility, activities of daily living, dependence on medical aid, and work capacity. Both groups also reported being satisfied with their psychological, spiritual, religious, and personal beliefs (Vietnamese: $M = 73.10$, $SD = 14.85$; Cambodian: $M = 68.90$, $SD = 12.82$). This domain measures satisfaction in areas of bodily appearance and image, negative and positive feelings, self-esteem, thinking, learning, memory and concentration. The participants were

also generally satisfied with their social relationships (Vietnamese: $M = 71.80$, $SD = 12.69$; Cambodian: $M = 68.80$, $SD = 120.90$). This domain measures satisfaction with their personal relationships, social support, and sexual activity. Finally, both groups reported being satisfied with their environment (Vietnamese: $M = 79.00$, $SD = 9.52$; Cambodian: $M = 70.10$, $SD = 8.65$). This domain measures their satisfaction with financial resources, freedom, physical safety and security, accessibility and quality of health and social care, home environment, opportunities for acquiring new information and skills, participation in and opportunities for recreation, physical environment, and transportation.

Qualitative Data

In view of the similarities in terms of functioning and perceived quality of life despite significant differences in trauma experiences, the groups were combined for the qualitative analyses. Several major themes, indirectly and directly related to resilience, emerged from the interviews (see Table 6). The themes can be categorized into five different constructs: intra-individual traits (who they are), inter-individual traits (how they relate to others), cognitive processes (how they think), coping behaviors (what coping behaviors they engaged in), and learning environment (what past experiences they learned from). Although not all themes were endorsed by all participants, there were three themes that every participant endorsed in terms of coping and resilience: 1) being able to correctly differentiate between acceptance versus change-oriented skills; 2) focusing on their goals; and 3) using mature defenses (e.g., suppression, anticipation, sublimation, altruism and humor) when faced with difficulties. A detailed evaluation of the five

constructs will help explain how these individuals were able to develop their resilient traits.

Intra-individual traits. The traits inherent in each participants included: (1) Sense of self (95%): They know who they are and where they come from. As stated by one participant:

... truly what I am and where my family come from is really valuable. It's kind of keep me going. ... I don't forget who I am. C9.

(2) Self acceptance: They have a strong self-image and seem to have accepted their good and bad personal traits. This translates into self-acceptance, which is reflected in this quote:

If I do what I am supposed to do and I am happy with myself, it doesn't really matter what other people say about me. C7.

(3) Sense of cultural heritage: 19 participants specifically stated that they drew strength from their cultural heritage. For example, one participant reported:

I think being culturally Cambodian has helped me cope with a lot of things. C5.

Another simply stated:

Vietnam is my home. ... Because I love my culture, I love my language and I love my family values. So I want them to continue to have it. V4.

In other words, these individuals seem to indicate that their strong sense of self is derived from knowing their familial and cultural history and heritage.

Aside from culturally related traits, the participants also shared several other similarities. For instance, 90% of the participants described themselves as (4) open-minded, (5) pragmatic and (6) compassionate. These traits were mentioned mostly in terms of acculturation factors. A majority of the participants attributed

their perceived lack of acculturation problems to their (7) willingness to learn and their (8) common sense; for example:

I consider myself open to embrace the best of both worlds. V3.

It doesn't matter what nationality you are, you are supposed to learn from everybody. I thought it was pretty good to keep the door open. C7.

These participants were very aware that they needed to acculturate in order to thrive in this country when they first got here. They were also very aware of what they needed to maintain from their own cultures:

... on one hand you want to hang on to what you believe and what you have but on the other hand, you open up to what you can learn everyday. V5.

Their pragmatic nature allowed them to focus on what needed to be done; as one participant put it:

Focus on what needs to be done other than what I want to do. What I need to do is what I need to do rather than like what I want to do. ... A lot of people can't make the distinction between that. ... They get confused over what they need to do and what they want to do. V6.

Survival means being able to take care of oneself and one's own, despite how one feels. As one participant noted, "even lousy job but I work." V2. Participants also revealed a strong sense of compassion. This sense of compassion for others also translated into compassion for the self, allowing them to set realistic and balanced expectations for themselves, as illustrated by one participant:

Although I live, I passed it, but other people in the world right now are going through what I have gone through. You know it is hard. It's that I was not the only one or we, the Cambodians were the only ones, it's still going on. You should feel like, you have to be, you have to appreciate what you have. C7.

Most participants (85%) still (9) set high expectations for themselves in terms of education, having a career, and being able to support their family. They described

a mindset that if they try hard, they will succeed. These participants echoed the concepts of self-efficacy and self-confidence:

I just move myself. Belief in yourself, motivation and inner self-thinking. C8.

You still have to be confident and you will be OK. It's all up to you, how you make it to be. Instead of feeling victimized, I do something about it. I am assertive. I must to survive. V7.

Little at a time, you get through everything. V2.

I think you build in a structure that allows you to believe in yourself. V9.

More than half of the participants exhibited an (10) optimistic or hopeful view of life, with attitudes such as, "It doesn't rain all the time." V7. Or "I think the future looks good for me." V1. Other participants stated:

You have to remain positive. Tomorrow will be a better day. V8.

Maybe one day it will be better. It's all about hope in the camp. C3.

I have high hope that I will be better in the future. V4.

There also appears to be an interaction between hope and hard work. One participant even gave his formula for success:

Basically they have to have the formula for success, which I call the 3 H: Hope, Hard Work, and Help. V8.

Surprisingly, a majority of the participants did not report religiosity as a major coping strategy. However, a few participants did attribute their survival to their faith in a higher power:

Because I know that God gives us life and has had goals and reasons that he gives us a life. C6.

I think religion play a very central role and it's central to a point that it becomes a part of it. In other words, it becomes your second nature. You pray all the time, you begin to learn how to accept it. V9.

Half of the participants also attributed their ability to cope to being young; their youth allows them to adapt to their environment easier, which is helpful when trying to acculturate. Over a third of the participants reported having a sense of humor allowed them to cope with discrimination, while 30% decided to focus on the novelty of the situation as an adventure:

I feel very exciting in one way because I get to live in this country although I didn't know how to say much but there is a lot of things available out there and I know that one day I will be able to do or experience. That's the exciting part. C9.

Cognitive processes. The most important of these processes, endorsed by all the participants, was the ability to know the difference between acceptance-oriented skills and change-oriented skills. The participants understood when to focus on acceptance and when to seek change. It did not take away from their self-efficacy when they were unable to effect any change to their situation, because they have accepted their limitations. For example, they have been completely powerless:

During the war:

The fear was there, you cannot do anything. I think you have to accept it, go on and count your blessings. V9;

in the refugee camps:

It was crowded but it was OK for us. Now, it's not OK but back then it was OK because survival. C1;

to present loss:

If anything, we do the best we can. And if we cannot make it stay, if it is lost, let it be. ... Know that it is the will of God. ... It is beyond our control. C4.

They accepted their own limitations:

If there is something I cannot deal with, something with all my power cannot do, I learn to forget. Not completely forget but I learn to leave it aside. Not dwell on that issue. C8.

Other time we just try to be black and white, right or wrong, but certain situations there are no right or wrong, they are just what they are. ... Therefore, by acceptance, I realize that every moment of life, every second of life has meaning. V9.

And they accepted the past:

I am happy. Again, I think evil will win again if I don't have peace within myself. Then the Khmer Rouge is not over for me. ... You look at it but don't dwell on it. C7.

But acceptance of past situations or losses also charged them with the desire to affect change in areas that they can, and to know the difference between the two situations:

... this does not happen overnight. It's through hard work and through education and building friendships. Networking. The only reason I am doing it, that's the only way that sometimes I can change things. When you learn. Sometimes, you have to learn to accept things. C8.

However, there were instances when the participants could have effected change but chose not to react. Most of these instances had to do with coping with racial discrimination in the United States. For example, one participant consciously chose not to act after weighing the cost and benefit of his actions despite how he felt at that time:

They spit on my head. I was very angry but I kept saying to myself to calm down. ... If I would fight with them, what would I say to the principal? ... But I let it go. ... For me, just come out of the Khmer Rouge, just come out of the refugee camp, surviving the journey and landmines and everything, I could have ripped them apart with the anger in me. ... They don't understand me. ... If I was to do this, how would I explain myself because I don't know the language. C8.

Others chose not to be affected by discrimination by attributing it to the ignorance of others:

Sometime people limited knowledge, do not understand your culture. You can laugh at them or with them, and then you show them. V9.

Still others attributed discriminatory behaviors to the natural order of things:

I feel discrimination is natural. Look at animals, they don't accept some kind of different animal come live with them. V2.

Finally, there were others who had decided to use the system to cope with racial discrimination:

We sue them. We have to use the legal system to protect our jobs and our interest. V8.

Therefore, either through acceptance of negative situations or trying to change them, the resilient participants were able to maintain their sense of themselves without self-doubt or self-criticism (90%). They mainly did not personalize the negative events, instead attributing discrimination to ignorance or lack of values:

By looking at them, they don't have that kind of education. They don't have that kind of values that's instilled in them, so they do the things they do. C8.

Some just chose not to be sensitive to slight discriminations:

Maybe I am just lucky or I don't pick up the slight discriminations. V1.

Others focused on their own value systems and chose to ignore prejudice or discriminatory behaviors against them:

Like Buddhist teachings, forgive them. ... I don't hold a grudge against them. It's a waste of energy. I have other better things to do. C8.

One of the major positive processes these participants described was the ability to focus on positives and gains versus loss. As echoed by one person, "I

think of more positive than negative.” V9. This theme was repeated in all the different stages of migration, from thinking about the war:

I can't blame the Khmer Rouge. What am I going to do? Would I throw away my life too by blaming them and seek revenge? My experience is that people who have helped me through, not anything dealing with ... just moving forward in my life. They are good people. So I rather take on the good things than take on the negative things. ... almost everybody gone through the same experiences that you did. Yet many of them are still good people and positive. Those are the people that I choose to surround myself with. C7;

to escape and refugee camp experiences:

What happened to me only reinforce my faith in the goodness of human nature and also my faith in a bigger power. V8;

and resettlement issues:

Because of the exposure to many cultures that enriched me. Allowed me to see more choices. ... This way, I am more aware and I am a richer person that way. V1.

Upon reflection of what they had gone through, 95% of the participants chose to focus more on what they have gained:

You know, whatever family I have, it's already a plus. C7.

Whatever things that happened are not necessarily bad for me as it changed my life. ... If we stayed back there, I wouldn't be able to enjoy what I have now. ... I guess I am much better off this way than if we were to stay in Vietnam. V1.

Indeed, 95% of the participants were very present and future oriented.

Just think about the future. Take it one step at a time. Think about what's the next step. C2.

Furthermore, their focus on what they want to achieve in life was a guiding force for coping with daily difficulties:

I don't let things pull me down from what I want to do in the future. V4.

... if people revenging, there will be no peace. So if you want to rebuild, keep on going, you have to let the past go. C8.

Another cognitive process was the attitude of “no choice but to survive.”

One participant put it as, “Do or die. Simple.” C4. The lack of choice almost made focusing on what needed to be done easier. The participants were very cognizant of the fact that they would die if they did not do something to help themselves, but the thought of giving up and dying was almost unheard of:

Even though you are weak, if you want to survive, you have to do it. I guess that is the part, you don't know the human strength, how strong you were until you come to that point. I think it is the will to live. Giving up is never an option. My mom is very strong and she said to stay together and to keep on going. C8.

Everything difficult but you are looking to survive. ... I feel that I am the man swimming in the water. I did not know how far I can swim in the water. If I don't swim, I am sinking. So I try my best, I have no choice. I have to do something to survive. V2.

However, the participants also reported that survival instincts become second nature after a while:

...because we were thrown into it and you learn how to swim. You swim so fast that it becomes second nature. V9.

The participants even used the same cognitive processes to acculturate to a strange new country. They fully understood the necessity to live within the adopted country's cultural mores in order to work towards their life goals. Some (30%) acculturated much easier because they chose to focus more on the similarities between and among the different cultures versus focusing on how people are different:

People are people, that's the first thing. We try to learn what is good about America and keep what is good about us and identify what is similar and mix them up. V8.

So now, I go out, I meet people, I make friend. American and Vietnamese alike. I meet the human being first. I feel good. V2.

Others focused on behaviors rather than cultural expectations:

Vietnamese and non-Vietnamese alike. Or maybe, it's more how you treat the people and how the people treat you back. V9.

Some participants do not even think that they are any different from the

“Americans:”

Maybe because I am flexible. Maybe when I am among them, I don't think like I am different, I look different. ... It's like when I am among them, whatever they do, I could do that as well. C10.

In general, I say it is pretty positive. ... In the neighborhood, you become part of the neighborhood. V9.

One participant described the beauty of nature even when he was exhausted and starved while working in the killing fields of Cambodia:

During the Khmer Rouge time, I think usually, the sky and also the paddy rice fields. I mean the sky, ... it gave me so much. I call it like dragon scales because the puffy clouds are like dragon scales. I can see myself floating. And then the paddy rice fields, especially the harvesting season because it is golden. C5.

Another found solace and peace by being in the moment, as she focused on nature and the dawning sky despite living in very uncertain and difficult times during her refugee camp days. She reported feeling lonely but peaceful at that moment and still thinks back to that time to try to capture the peaceful respite she experienced.

Other participants focused more on kindness from others at times of difficulties:

I remember there were times we don't even know if we are going to have food or if we are going to live the next day. But people risk their lives to share whatever little they have. Those steps are the most precious things that I see about human beings. ... That shows the beauty of human kind. I

witnessed that and that's the picture, human beings can be as evil as they can be kind. C7.

Like when I was in the camp, I always notice generosity from people. ... In terms of my experience, you know you see a lot of dead people and stuff like that. That was scary but at the same time, you see the other side. That people can be real violent but others can be real kind. C3.

These individuals were also content and thankful for what they have, which allowed them to rate their quality and satisfaction of life higher. They chose to compare their present lives to what they have been through which allowed them to be thankful and content of where they are:

It's like going back to the past and compare where you are from and where you were. That gives me a lot of hope, a lot of motivation and encouragement. ... It made me appreciate what I have even more. C5.

... Able to appreciate safety and having enough to eat everyday. Everything. C3.

The relativistic nature of comparing down or up affected how individuals felt about themselves. Individuals who chose to compare down within their own experiences found it bolstered their own sense of self and accomplishment, which also affected their self-efficacy. As one participant put it:

Sometimes when life is easy and you don't have any bad or good experiences, I don't think that makes sense. Like if you don't make any mistakes, how are you going to learn? Now, I am very independent. I am happy with who I am. I have the best opportunities among the people I knew who are in Cambodia right now. C2.

Overall, more than half of the participants reported being content and thankful for what they have, "I think I am on the contented side of life." V3. Their positive cognitive processes and their understanding of the relativistic nature of human experience allowed them to cope with negative experiences and also to feel happy and content with who they are and what they have.

Inter-individual traits. How these individuals think of themselves in relation to other people also revealed several themes that enhanced their sense of self: sense of responsibility, purpose, and duty to family and community. Nearly all (95%) of the participants indicated the importance of responsibility to family in guiding their choices in life:

So I know what I needed to do, like to take care of my younger brothers and sisters. Failing is not an option. ... So maybe for me, the position I was in made it simpler for me to keep my focus. So the only chance she had to relax a little is for me to get a degree and get to work as quickly as I can. ... It wouldn't be appropriate for me to do some work that is not practical. V1.

Responsibility to help my parents raise my younger siblings, financially and being a role model. Nineteen years old, in Vietnam you could kill people too or you could help people not get killed. V8.

Some participants extended their responsibility beyond the family:

You have responsibility with your own family and have responsibility with the community surrounding. V9.

Others expressed a responsibility to stay alive for family:

... I know I have to survive for the rest of my family, my younger sister and my grandmother. C2.

Lastly, some participants felt the responsibility to themselves so as to be able to fulfill their responsibility to others:

You can't fail yourself because when you fail yourself, you fail other people too. V5.

Aside from responsibility, 90% of the interviews also revealed a strong sense of purpose, which gave participants' lives meaning. As one participant puts it:

... therefore our lives have meaning and we need to share our resources, our wealth, and speak out against the unjust and help others. V9.

One participant even gave his understanding of the meaning and purpose of life, which guides his own life:

So that in living, I believe that you don't necessarily live for yourself. You have to be well for yourself and to care for yourself but I strongly believe that you don't live for yourself either. Because that's the major difference. ... But you really live for other people as well. V6.

Together with a sense of purpose, the interviews also revealed that a majority of the participants have a strong sense of duty (70%). Duty and obligation to help the family are not only culturally appropriate for these groups but vital to their sense of who they are. Most participants do not see it as a burden but a privilege:

It was my turn now to do all the things my family needed. ... It was not difficult to carry that responsibility. ... at least I feel that I am valued and needed by my family. I am useful for them and I feel that I am helping them. C10.

The sense of duty is so ingrained into their being that most did not even question it:

No big deal that they depended on me. It's just something that you have to do. V3.

Obligation must help the family. V2.

For some, reflecting on the sacrifices that their parents made to get them to the United States, the sense of duty was inextricably bound to their parent's goals for them:

... thinking back and looking back at her effort for helping us all these years, we are not about to disappoint her in any way. C8.

That sense of duty was also fostered by a sense of trust in others and also in their position within the family. The sense of trust the majority of the younger

participants have in their parents helped tremendously in their ability to cope with whatever difficulties they faced:

Parents know the best because they are parents. ... So I have to trust their instinct. C6.

This was the case no matter the consequences of the parent's decision:

Knowing that escape could cost you your life but my mom made a decision to do that. C7.

Or the state of physical or mental exhaustion they faced:

Mother said you had to do it, so you do. ... For some reason you keep on walking ... C3.

The lessons learned and that sense of trust in others continued to guide some participants in their current lives:

... You don't do things on your own without minimally consulting or share with somebody and hopefully there is a different way of looking at things. Sometimes it is a headache too but at least somebody knows what you are getting into. V6.

Therefore, these people have cultivated a balanced sense of interdependence, brought about by their knowledge, acceptance, and commitment to their role and purpose within their family and their community.

Another inter-individual trait that the participants strongly identified with is to their cultural heritage (95%). There is a strong sense of belonging to a particular culture of which they are extremely proud and which they actively tried to preserve:

... my family was the first Vietnamese family that organize new year celebration in order to mobilize other Vietnamese to come and share together to preserve our culture. V7.

Most participants talked about the importance of keeping their cultural heritage in terms of language, food, and values. In a sea of differences, these people actively held on to their cultural heritage to reinforce their own history and uniqueness, which in turn asserted their own self-identity:

When I first came here, I was fairly young and I consciously tell myself to never never forget Vietnamese. V10.

There was also a sense of familial cohesiveness. Seventy-Five percent reported a sense of belonging to family was paramount in their ability to cope:

We just had to. As long as the family was together. As long as we have each other. V7.

Some participants even attributed their self-efficacy to the knowledge that they have their family to fall back on:

When you raised in a loving family, it will make you a better person. It does not matter what happen. It's not that you have a perfect life, but still when you fall down, you can always get up again. C6.

One participant simply put it as:

You have to have a refuge to go back to. And that's your family or your culture. V8.

One participant even went beyond the immediate family to include the helpfulness of family members several degrees removed, as long as they were somewhat connected and spoke the same language:

Naturally, they were Vietnamese and that was the biggest help. Having family around that speaks the language. V5.

One of the most important advantages of familial cohesiveness was the fact that the participants did not perceive themselves as being isolated, "Everything I

did, I did stuff with my sisters.” V3. The knowledge they were not suffering alone was very helpful in coping with whatever difficulties they faced:

I guess having a family is a big thing and besides I was young. I was only 9 years old and you believe what your sister said and what your parents said. They comfort you. C10.

We had our family which also helped emotionally. V8.

Again, the concept of family extends beyond the immediate family; as long as they felt cared for by someone, they felt able to cope with everyday difficulties. The sense of belonging to a culture or family, which enabled the participants to share both good and bad times, formed a protective shield against feeling isolated in times of difficulties. A sense of belonging offered comfort in the knowledge that life can be full of suffering, but you are not suffering alone.

Coping behaviors. The actual coping behaviors of the participants were also very telling in regard to how they maintained their resilience. Most of the coping behaviors they engaged in reinforced their internal locus of control, thus enhancing their self-efficacy. One of the major coping strategies used by all the participants was the ability to define basic survival needs specific to the situation and time. The situation could be survival during war:

In order to survive, you have to be alone by yourself during the Khmer Rouge. If you need to steal, you steal to survive. If you need to run away, you run away. If you need to hide yourself, you hide yourself. So being with someone is really very very hard. So what gives me my happiness is that I am able to live with someone. C5.

It could be survival during escape:

... At that time, our focus was to get out of Vietnam. Therefore, we did not have time to worry about anything else. V8.

It could be trying to survive in a new country:

Our first winter here, we didn't feel the cold. We focused our energy on rebuilding our lives. V8.

It could be trying to acculturate:

It was very difficult but I know that for survival I have to do that. I have to talk to people and start doing things and start to learn English and try to get along. Eventually, I overcame my shyness. V10.

Or, it could be focusing on long-term goals for success:

... I guess for me, being able to have one goal and be able to keep my eye on my long-term goal and set priorities. Set priorities and persevere and discipline to keep that focus. V1.

All the participants reported being able to set a goal as the situation demands and to block out all other considerations or distractions.

Aside from survival needs and keeping their focus on their long-term goal, 95% of the participants were able to maintain their goals by being solution-focused. Some acknowledged the difficulties they faced but learned to focus on what they needed to do to overcome the particular problem they faced at that time:

When I first came, I was emotional because I miss home a lot. I just coped with it, it's just natural. I focused on what I can do, same as now. V4.

... right away we go to school, we do the right thing, we will get somewhere. ... We might not be rich but we will get somewhere. V10.

I turn my frustrations into work so it don't go to waste. C6.

In general, the participants reported a strong sense of self-efficacy to overcome their problems:

I think that when you are faced with hard problems, you just have to sit down and try to solve it. V1.

It was not easy starting over but it was doable. If you have enough focus on the task at hand, then you can do it. ... Attitude that if you try, you can do it. V8.

Other than focusing on their goals or what they can do, the participants also learned to focus on living moment to moment. A majority (85%) of the participants trusted that things would get better, and that all they could do was to focus on living in the moment:

You just live moment by moment mostly. Another thing is that you don't have much to think. You don't know what will happen next so you cannot think ahead. Generally, the more you think, the more you worry or concerned. V5.

... trying to survive day by day and soon you overcome your problem. You know, you like cured naturally by yourself. ... C1.

I just do one thing at a time, I don't think too far ahead. V10.

It was almost as if the very act of staying alive gave them hope:

Happy to survive till the next day but always afraid. ... Once the sun rise, I was happy. When the sun sets, I was not happy. C2.

Live day by day and there is light at the end of the tunnel. V6.

The participants also focused on breaking down their goals into parts that they can handle. For instance, one participant focused on her sister's verbal instructions as they walked through land-mine infested areas during their escape from Cambodia, to cope with her fears. Basically, the participants were able to set realistic expectations for themselves:

I think that's the mentality that I have. It's just a matter that like I may not be able to do everything but at the same time, I am OK. Just the OK part, I think that's what I value the most. C9.

I believe there is no such thing as perfect in life. V6.

Aside from depending on their own resources, these participants knew when to ask for help. In other words, they have the ability to ask for and accept help,

which reinforced the notion that they do not need to suffer alone. Most (85%) sought out support from family or any family substitute:

First I got a lot of support from the family who sponsored us here. Next I was younger so I adjusted much easier. Mostly, you feel more like home. That you have a place and people cared for you. Especially when you don't have any parents traveling with you. V5.

Most participants (75%) also sought help from whoever they felt was capable of giving it:

... Started writing a lot about how I feel and started to go back a lot, and talked to both professors. Both of them are more like a healer, a therapist, a psychologist. That's how I coped with my PTSD. C5.

But all the participants were appreciative of help they received.

... there are many great human beings that help me along the way and give me different advice and help me with different things. C7.

I know my life is not a total disaster because I met people that helped me. ... But again, I am very fortunate that I have met just enough people like 4 or 5 that were very helpful. I guess they were present in my life at the right moment and that helped me overcome certain things. V10.

Therefore, the ability to accept help is just as important as the availability of help.

The ability to cope with any difficult situation includes the ability to know when to ask for help.

For non-specific issues, 70% of the participants turned to religion or their spirituality for comfort and guidance. As one participant stated it, "I feel that I can talk to God about my sadness." C6; while another participant put faith in karma:

... it's OK. God will help us. ... we do good things and nothing will happen to us. C10.

Religion or spirituality in terms of belief in divine justice also offered some meaning to the suffering of some participants, as illustrated by one participant's

account. Once safely in America, he saw the Khmer Rouge leader who tortured and nearly killed his siblings, living in the same area:

If there is a God, he will suffer the consequences. I don't have to act. ... Sometimes to believe in divine justice is the only way. Because I can't lift my hands to hurt another human being. Sometimes that's the only hope. C8.

Another coping mechanism revealed by the interviews was the use of distractions. Forty percent of the participants reported that they focused on the welfare of their family or other people. The participants found that focusing on their ability to help others in their time of difficulty invariably helped them through distracting themselves from their own troubles and increase their sense of usefulness:

It makes me happy when I can help someone. C6.

Even in the most dire of situations, such as being lost at sea with no food or water left, one participant was able to distract himself from his own fear of drowning by focusing on helping others:

You helping out. You get involved with the people who are seasick. You become active in that environment. V9.

Finally, 40% of the participants found focusing and living for the welfare of their children motivated them and helped them cope with everyday difficulties including homesickness, culture shock, and loss:

...because of my kids. My kid's life, look for the future life. My try to learn. My try to do the best thing. ... Live for the kids. The future of the kids. ... we try to raise them so they have a good life. V11.

Learning. The most powerful lessons the participants learned came from their own experience. The participants (85%) generally expressed an inherent pride

in having survived hard times. These people see themselves as survivors, not victims. The trauma they went through and survived only served to reinforce their sense of self-efficacy:

If you lived through Pol Pot communist, you can live through anything. C4.

All these experiences, ... this is a piece of cake if you have gone through hell already. C7.

I have been through the toughest time of my life and I was able to survive. ... Particularly for myself, it doesn't matter what difficulty I am facing right now, compared to before, I was... I am able to think that it's OK. It's not that bad. C9.

... the refugee experience, it was good because it was a humbling experience. So it makes you proud of who you are. You start empty handed and you work hard and it pays off. ... Like I feel that I am able to appreciate life more and not take things for granted. And I also feel pride, and feel good when I accomplish something. So overall, it makes me feel like no matter whatever hardship I have, I will overcome it. Life is to be experienced whether good or bad and you cope accordingly. V3.

The participants were able to use their past trauma experience as a point of comparison to motivate themselves:

If I went through all that in life, surviving Khmer Rouge, surviving the escape to the Thai Cambodian border, surviving the refugee camp for almost 1.5 years there, I can survive this school. I can survive this culture. ... I said that I am going to make it. I am going to be all right. I am going to do it on my own terms. C8.

The participants also learned valuable life lessons from their experiences.

For instance, they learned to define what is important for their own lives:

It teach me about life. It's about treating people. It teach me about how important it is about having family. It also teach me to be more open-minded and to be more analytical. C5.

Instead of breaking their spirit, the difficulties during the war some of the participants went through only reinforced in them that they couldn't let the

atrocities happen again if they can prevent it. Somehow, the whole experience empowered them to try to make a difference, not just for themselves but for others:

Learned to keep it in and keep in control from the war. Learned to be strong....the lessons that I learned and the things that took place in the past, I will not, if I can help prevent it, will not happen again. C8.

Another participant's purpose was connected to experiences learned from the past where the ultimate purpose was to survive:

I know that the more I learn, the more experience I have, and the better I can survive. C2.

Having survived served again to build their sense of self-efficacy and to reinforce the belief that they control their own destiny:

From experience is the determination. You know, happiness is what you build. V9.

Overall, the trauma and loss experiences of the participants served to underscore the impermanence of life and material possessions. In that sense, one participant echoed the rest in saying, "I think I appreciate life more." V10.

About 60% of the participants were able to name role models who significantly influenced their lives. They were able to learn from these people through observation of their behaviors and also through the values their role models upheld. One participant learned self-efficacy from the training her grandmother gave her:

She taught me how to be self-sufficient, very industrious, and very independent. So later on, I know how to get around. I know how to do things to survive. C2.

Another participant learned to be solution-focused and pragmatic from observing his mother:

She has the inner strength to guide us through. Always looking for a solution and a way out. ... See what needs to be done and go out and do it. I learned a lot from her. C3.

Perseverance and even open-mindedness can be passed on through observation, including the ability to stand up for ones self:

... open minded and perseverance. I got that from my grandmother. ... I learn to fight from my grandmother. I think my father too. V8.

One participant reported that he learned how to be goal-oriented from observing his mother. She would do whatever it took to achieve her goals:

She is the type of person that when she decides she wants something, she would get it done. V1.

Even hard work was reinforced by role models who themselves set an example.

One participant remembers the encouragements he got from his mother, and after all the sacrifice she went through for the children, he could not imagine failing her:

She said to us many times, you are going to make it. ... If you keep on going to school and to study hard and to work hard, you will succeed. C8.

While hard work can be reinforced, so can work ethics and the sense of independence, as another participant learned from her father:

I think we were on welfare for 1 year and a half, and as soon as my father worked, then he stopped. Supported all nine children on welfare and he worked too. ... I look at my parents and grandmother as role models. ... If it was a goal of surviving, then certainly no matter what it takes to rise above, I would. V7.

Role models also imparted values, which were viewed as very important in the formation of a sense of self. Traits such as compassion and even acceptance could be instilled, as illustrated by one participant:

Dad always said that you need to be a boat or ship for someone else. ... I think dad insist on us that when difficult, maybe sometimes we have to learn how to accept that aspect of our own journey in life. V9.

The same participant also learned to focus on living in the moment from observations of his parents:

I think I learned from mom and dad. ... you never see from them the worry for tomorrow. V9.

Furthermore, these resilient traits and values need not come from family. One participant reported learning about values and ways to live from her pastor in America:

He taught us and he mold us. ... it's a good thing that he did what he did. I think it's very beneficial to me. ... C6.

Other Clinical Analysis

Defenses. All the participants used mature defenses such as suppression, anticipation, sublimation, altruism, and humor to cope with emotions and cognitions that were uncomfortable such as fear, anger, helplessness, and hatred (illustrated in the themes above). For instance, many participants were able to suppress their fears while escaping their country of origin by focusing on the task at hand. Others anticipated better times, which motivated them to continue to struggle. Once in the United States, a good majority of the participants poured their energy into their education as a means to a better life. Many also used sublimation to counter feelings of inadequacy when it came to English language abilities and being laughed at in school-- for example, they focused on getting better grades than the native English speakers. Another way that some participants countered language difficulties was by using humor. They were able to laugh at their own mispronunciations, misunderstandings, or lack of comprehension without letting it affect their self-esteem. And finally, a good majority of the participants

reported the necessity of helping others in need. There was a strong sense of paying back the kindness they experienced throughout their journey in life.

Negative coping. There were five participants who also employed neurotic defenses of intellectualization, rationalization, complaining, and displacement. These individuals used these defenses to cope with death of loved ones, having to abandon family or country of origin, difficulty acculturating, and having to support extended family still in their country of origin out of forced obligation. One participant even displaced feelings of frustrations onto the spouse.

Four participants employed immature defenses of devaluation, weepiness, and depression. Again, these defenses were used to cope with forced financial obligation to extended family in country of origin, having to abandon family and country of origin, and acculturation difficulties. However, it must be noted that these defenses were not their primary defenses. These individuals primarily employed mature defenses in coping with everyday difficulties.

The participants who tended to use these defenses and who reported early episodes of depression or anger were also those who were forced to leave their country unwillingly, who left the majority of their immediate family behind, and who did not feel a connection with another person during their escape and resettlement periods. Some of these participants reported feeling very homesick and lost as they resisted acculturating to a strange culture and language. Overall, the participants who initially complained of depression and anger generally had a sense of suffering alone.

Suggestions for the Government

Participants' suggestions for helping new refugees included more social programs such as language programs, housing help, job placement, medical insurance, and transportation to work. One participant even suggested assigning each family a case worker to help with basic acculturation issues, navigate governmental and healthcare system, and provide information on where and how to apply for government services for newly arrived refugees. Another participant wanted the government to overhaul the current welfare system to give people more incentive to work.

Many other participants went beyond help for the refugees and immigrants in the United States. They would like to see the government provide more social services and opportunities to all minority groups, especially in terms of education (i.e., scholarships). One participant wanted the government to help the poor in poor countries or third world countries.

Discussion

The purpose of this study was to identify the factors which promoted resilience against trauma-related psychopathology in Cambodian and Vietnamese ex-refugees. Information from quantitative measures and qualitative interviews were utilized in an effort to uncover the underlying mechanisms of resilience -- not just a listing of factors, but the process by which resilient individuals incorporated these factors.

The traumatic experiences of men, women, and children who escaped from war-torn Southeast Asia in the 1970s is well documented (e.g., Carlson & Hogan, 1991; Gerber, 1996; Hauff & Vaglum, 1993; Kinzie et al., 1990; Mollica & Lavelle, 1988; Rozee & Van Boemel, 1989). The participants in this study had similar stories. Nearly all the Cambodian participants reported having experienced extreme hunger, forced separation from family, forced labor in deplorable conditions, lack of medical care, constant threat to their lives in the work camps, escaping through landmine infested areas, witnessing torture, and witnessing executions or indiscriminate killings. The majority of the Vietnamese participants had experiences of witnessing the devastation and uncertainty of war, fear of being caught when trying to escape, escaping in barely sea-worthy boats with limited rations, constant fear of attacks by pirates, and constant fear of the boat capsizing. Overall, the participants went through a time of uncertainty and constant fear for their lives or future. However, despite their past experiences, these participants have led productive lives in America. All managed to procure employment with a majority of them working within professional fields. Almost all of the participants

(95%) earned a college degree or higher. All the participants reported meaningful social and familial relationships and majority of them are active within their community.

Studies of trauma victims have suggested that severity of trauma hinders achieving resilience (e.g., Finklehor, 1990; Herman, Russell, & Trocki, 1986; Holtz, 1998; Wind & Silvern, 1992). Thus, quantitative data were collected from these participants to assess the extent of their traumatic experiences and PTSD symptomatology. Notably, the Cambodian cohort suffered significantly more, and more difficult, trauma events than the Vietnamese cohort, with almost no overlap between the two groups on certain trauma events. The Cambodian cohort had an average of 37.7 trauma events and personally experienced an average of 10.9 traumatic events, while the Vietnamese cohorts reported an average of 16.7 trauma events and personally experienced 3 trauma events. All except one of the participants lost family members in the war. The Cambodians lost an average of 5 family members and Vietnamese lost an average of 2 family members. About 90% of the participants had to leave family members behind. All except 2 Vietnamese participants spent time at refugee camps. The Cambodians spent an average of 41 months while Vietnamese spent an average of 4.4 months in the camps. The camp experiences were also vastly different, with Cambodians reporting a lack of food, safe drinking water, sanitation, and safety in the camp. The Vietnamese camp experiences were much better with adequate food and safety. The only camp experience variables the two groups reported that were at all similar were crowded camp conditions and adequate shelter from the elements.

Scores on the PTSD scales, however, indicated that Cambodians were not significantly different from the Vietnamese group in terms of meeting criteria for diagnosis of PTSD. Additionally there were no differences between the groups in all indices of perceived well-being. In fact, in the subjective satisfaction of life scale, with possible scores from 5 to 35 (higher score means more satisfaction), there were no quantitative differences between the groups. This is probably due to the homogeneity of the participants in regards to their perceived well-being as defined by the inclusion criteria. Interestingly, the Cambodians' average satisfaction of life score was 27 compared to the Vietnamese at 26.

Four Cambodian participants did meet criteria for DSM-III-R PTSD diagnosis compared to none from the Vietnamese group. All four participants had experienced very high trauma events as measured by the HTQ. They also reported still experiencing high trauma impact from those events. These four participants experienced loss of immediate family in the war as well. However, upon careful review of their answers, only two of the participants reported still being affected by the killing fields experience. Another participant responded to the self-reports retrospectively to the time when she was still in Cambodia versus the past 7 days or 2 weeks. The last participant was responding to the trauma impact questionnaire in relation to recent trauma in the United States. There was also the possibility that the other participants could have responded retrospectively as well to the PTSD questionnaires. Furthermore, the pattern of losing immediate family and high trauma impact from high trauma events was not specific to these four participants.

Others had very similar trauma profiles who did not report any lingering trauma impact.

Despite meeting PTSD diagnostic criteria, further analysis of the subjective report of well-being revealed that two of the participants reported good quality of life and the other two reported experiencing neither good nor bad quality of life. Three of the participants subjectively stated their satisfaction with life as somewhat satisfied while the other participant reported a very satisfied with their current life. All of them reported having a very positive attitude towards themselves plus moderately to highly positive attitude towards life. In general, even despite meeting diagnostic criteria for PTSD, all four participants reported functioning well all areas including work, meaningful relationship, and physical and emotional self-care. The only difference was that they were still significantly distressed by their traumatic experiences, which did not seem to stop them from enjoying their lives as indicated by their quality of life indices.

This indicates that while severity of trauma may be an important factor in predicting the development of PTSD, it is insufficient in and of itself to account for the disorder. A possible account for these results would indicate that the impact of severity of trauma, after a certain threshold, might not be quantifiable. In other words, after a certain level of protracted trauma experiences, especially when survival is threatened, a natural course of human adaptation is to become desensitized to the new environment and cope accordingly in order to survive. At that point, it is the qualitative nature of the trauma event and how it is perceived by

the individual that would predict the course of trauma impact in terms of vulnerability or resiliency.

Factors Supporting Resiliency

The results indicated that there were several major factors that led to healthy responses to traumatic life events. These major areas of coping can be understood as intra-individual traits, cognitive processes, inter-individual traits, coping behaviors, and past learning.

Intra-individual traits. Resilient individuals were characterized by their strong sense of self and self-acceptance. These individuals knew who they were and seemed to have accepted their strengths and weaknesses. However, in Asian traditional cultures, a person's identity is closely tied to the family or community. Ying and Akutsu (1997) proposed the concept of the sense of coherence, based on their work with Southeast Asian refugee communities. They suggested that having a strong foundation where one feels familiar and safe, where one can foster a sense of belonging, allows for better coping. Consistent with the coherence idea, for most of the participants in this study, their sense of self was also derived from their sense of cultural heritage. The strong cultural foundation that these people valued was not surprising, given their collectivistic cultures of origin, but it was notable for its central place in their self-concepts.

Furthermore, resilient individuals were very pragmatic. They almost exuded common sense and never questioned what they were supposed to do. In fact, a majority of the respondents never thought about "how" they managed to cope with all the difficulties they went through. They just did. It was almost as if

they were still in survival mode and the lack of perceived choices made it relatively easier to focus on what is important. The focus was on what you “must” do instead of what you “wanted” to do. They seemed to understand that distinction quite well. Therefore, these resilient individuals tended not to think of adversity as necessarily negative but as a challenge to be overcome. Adversity provided an opportunity for growth.

The interviewees also had high expectations for themselves and were generally optimistic about their future. This “can-do” attitude bolstered their view of adversity as an opportunity. They were not afraid of change. As a matter of fact, they expected change in certain aspects of their lives. Resilient individuals change with the times and their environment, as supported by the participants’ wide endorsement of traits such as being open-minded and willingness to learn. These people adapted to each new environment or challenge because they understood that they needed to in order to achieve their goals. Those participants who initially resisted their transition reported having a harder time adjusting to the United States and reported having more depressive symptoms. Possibly, it was the fear of losing their cultural heritage within the dominant culture, and thus inadvertently themselves, which led to some resistance to change. However, these traits were countered by their sense of compassion for others, which also eventually translated to compassion for the self. The interviews revealed that throughout it all, a majority of the participants maintained their sense of compassion and empathy, brought about by their own suffering in their journey to America. In the end,

resilient individuals arrived at the conclusion that life is to be experienced and learned from, both the positive and negative aspects of life.

The intra-individual traits described above coincided with some of the internal self-resiliency factors of the transactional model outlined by Kumpfer (1999). They included traits such as Bandura's (1989) dreams and goals, purpose in life proposed by Neiger (1992), and hopefulness and optimism (Seligman, 1975). However, while the belief in oneself proposed by Gordon and Song (1994) was observed, there was a slight variation: members of these two cultural groups believed in themselves relative to their family or community. It was their belief in their role within and connection to their family, community and culture that was found to be more sustaining than an individualistic belief. The participants who perceived a threat to their ability to maintain this belief reported having a harder time emotionally and psychologically. Overall, for the most part, the intra-individual traits of the resilient Vietnamese and Cambodians ex-refugees coincided with the internal self-resiliency factors of the transactional model of resiliency.

Cognitive processes. The above traits gave rise to several positive cognitive processes of resilient individuals. The cognitive processes of these resilient individuals coincided with both the Cognitive Competencies and Person-Environment Interactional processes of the transactional resilience model. The most salient processes were the ability to distinguish between acceptance-oriented skills and change-oriented skills and to discern when to use each. In that sense, the participants were able to employ selective perception and cognitive reframing to cope with any cognitive dissonance they experienced. Understanding the

difference between acceptance and change is a skill largely validated as therapeutically relevant for multiple psychiatric populations, from substance abusers to personality disorders. It is a major concept in Linehan's (1993) Dialectical Behavioral Therapy. It is almost as if these people have internalized the Serenity Prayer (Anonymous): they had the courage to change the things they can, accept the things they cannot change, and the wisdom to know the difference.

Another cognitive characteristic shown by the participants was self-efficacy. These individuals expressed confidence in their intellectual competence in terms of their job or academics. Even during times of extreme stress, the initial fear reaction or tension in their fight for survival decreased as they tried to master that particular situation and/or master their own fears. Successes in facing adversity reinforced their sense of self-efficacy. In fact, it is the unknown and the lack of control over their own destiny that most participants reported as suffering the most from in all the different situations, from war to resettlement.

Attributions of successes and difficulties were also noteworthy. The majority of the participants also attributed most of their successes to their own hard work and perseverance. On the flip side, they were able to use their moral reasoning skills derived from their strong values to not personalize negative events beyond their control, such as racial discrimination. This pattern of attributions coincides with the cognitive competencies of self-esteem and the ability to restore self-esteem within the transactional model. Their self-esteem was maintained by their general attitude of focusing on positives rather than negatives. They were able

to keep their equilibrium even in the most difficult of times by not being completely engulfed in the negativity of their experience.

Furthermore, these resilient individuals were present and future-oriented which relied upon their ability to plan ahead. They lived in the present and lived for the future, which also helped in guiding them towards their goals. They were aware of the relativistic nature of human experience. They exhibited this ability by being able to recognize and appreciate beauty and kindness in times of darkness. It was the ability of the participants to be in the moment that allowed them to recognize beauty and kindness during dark times, which further enhanced their resilient nature. These individuals were able to avoid being overwhelmed by their traumatic experiences by understanding the relativistic nature of human experience or perception. Victor Frankl (1992) came to the same conclusion from his own traumatic experiences of being in Nazi Germany's concentration camp. Just like Frankl, these resilient individuals retained their humanity and also their ability to feel gratitude despite what they were going through at the time.

Inter-individual factors. Resilient individuals showed a pattern of active connection to the family, community and the culture at large. The connection was manifested through the sense of responsibility, purpose, and duty to family and community, and to the preservation of their cultures. A majority of the participants drew meaning for their own lives from that connection. In other words, as members of collectivistic cultures, their sense of responsibility to their own lives was intertwined with their responsibility to family and community; indeed, they reported they felt driven by those responsibilities. In essence, they managed to

foster a sense of balanced inter-dependence within their family and community. Their pride in their cultural heritage and strong familial cohesiveness generally engendered a sense of belonging.

Familial cohesiveness also extends beyond the Western idea of immediate family into extended family and close family friends. These individuals understood and felt that they are a part of something larger than themselves and that they matter. It is this sense of not feeling alone that they were able to draw from in times of darkness. They suffered, but they did not suffer alone. The sense of not suffering alone was found in the majority of the responses. The concept of not suffering alone or universality is widely acknowledged as therapeutic in group therapy with traumatized individuals (Yalom, 1995). The participants reinforced that notion by underscoring the bolstering effect of having family or some form of human connection when they went through their ordeal from war to resettlement. Simich, Beiser and Mawani (2003) found similar role of social support and the significance of shared experience as a determinant of refugee well-being.

It is important to highlight that there is a distinction between being with family members and actually sharing with family members. The participants who reported no close connection to spouse or family in their journey to the United States had a more difficult time adjusting to the new environment and culture. These were the participants who traveled alone, had small children with whom they were not able to share or confide their feelings, or came with a sibling while leaving the majority of their family members behind in their country of origin. These participants reported experiencing some depressive periods. For example,

they reported feeling down, crying a lot, complaining, feeling sorry for themselves, and even displacing their anger or frustration. Therefore, having the sense that they were not suffering alone was very important in allowing these people to cope with everyday difficulties. Again, family members were not the only ones they could connect with. The participants who did not have strong emotional connections with another person on their journey to the United States did feel better when they connected with someone within their own community. Others reached out to their church, sponsor families, or even their teachers.

The inter-individual traits fall within the protective processes realm of the transactional model of resiliency. The availability of empathic and emotionally responsive caregiving and other pro-social facilitation or support can be found within a family group who underwent the same traumatic experiences. Even though the model was originally created for at-risk children, the resiliency factors did apply to the ex-refugee population. However, the factors had to be understood and applied within the cultural mores of this population. For example, the factor of “reasonable developmental expectations” (Rutter, 1987) should be applied to the role of the children within the context of the family, not chronological age as it was originally intended. It was not uncommon for young refugee children to undertake the responsibility of translating for the family. Therefore, what is considered developmental expectation for children differs along cultural lines.

Coping strategies. The actual coping behaviors revealed by these individuals can most likely be generalized to people in most, if not all, situations. The positive coping mechanisms used by these participants included focusing on

their goals, setting realistic expectations, focusing on solutions, living in the moment, asking and accepting help, seeking support, religion, and focusing on the welfare of others. These mechanisms fostered self-efficacy by building successful coping incrementally, but also reinforced the feeling that they are not alone should they require help and support. Simply put, you can overcome difficulties by helping yourself, helping others and getting help when needed. These basic coping behaviors can be subsumed under the model's behavioral or social competencies, mostly under problem-solving skills, social skills and "street smarts." The model also included multi-cultural and gender competencies, which some of these participants mentioned. For example, the participants who found joy in sharing their culture with others and actively sought to learn about other peoples' cultures tended to acculturate faster and more easily. Some of the female participants also took the opportunity to improve themselves by getting a higher education, which would not have been traditionally expected within their culture of origin. In fact, some families took the opportunity to break certain culturally dictated gender inequities once in a new country.

Learning mechanisms. The stories of survival told by the participants underscored the importance of having values that guide how they live their lives. The participants reported that they had learned those values from being a part of a family, a community, and a culture; either they modeled a caretaker directly or they observed their parents' and elders' struggles. The value that was most often mentioned with respect to modeling for this sample was familial coherence. That sense of coherence came from knowing that they matter to their family, their

community, and their culture. The sense of coherence also gave them a sense of purpose, and allowed them to focus on the welfare of others.

Second, these individuals were able to name role models who guided them directly or indirectly. The availability of a positive adult role model or a positive connection with another person promotes resiliency (Masten, Best, & Garmezy, 1990). Rutter (1985) found that adults with psychological and emotional distress who made bad choices in life could turn their lives around when they found someone to connect to positively. These connections were usually in the form of a mentor, spouse or religious figure.

Perhaps most importantly, these resilient individuals felt they had learned from their experiences, whether those experiences had been positive or negative. The trials and hardships they had endured and survived proved to be opportunities to develop self-efficacy.

Finally, evident in these participants was a sense of relativity about their lives. They understood the complexities of life and understood the dialectics of living in an ambiguous world -- as Viktor Frankl (1992) would term it, living life with no extremes and no fundamentalism.

All the factors discussed above are learned, from family, community, culture, role models, and also life experience. Since such traits can be learned, they could also be taught, a point expanded in subsequent sections.

Mechanisms of Resilience

The primary goal of this research was uncovering the underlying mechanisms of how resiliency came about. Unfortunately, the results suggested

that the sources of resiliency are much more elusive, and more complex than a key factor or set of variables acting in linear fashion. Indeed, most of the participants could not clearly recount or express what factors allowed them to cope with difficulties, while others in similar situations perished or become incapacitated. In fact, some participants questioned why they were able to persevere and overcome their problems while some of their peers could not. They mostly stated that they did not know how they were able to stem their fears and focus on what needed to be done. Some implied that when their lives were at stake, survival instincts got activated. However, a deeper analysis of the transcripts suggested some patterns.

First, resilient individuals appear to have been able to learn from their experiences. The most powerful teacher is still experience. Some attributed their resiliency to the very fact that they survived the horrors of war. Their sense of self-efficacy was reinforced just by the very fact that they survived. Their experiences of difficult times also provided a point of comparison for them whenever they needed to bolster their self-esteem, helping them believe that they can overcome any future difficulties. One participant noted that adversity is a very powerful teacher in that it teaches you who you are, what you are capable of, and also what is ultimately important to you. In essence, surviving adversity gave them a sense of perspective about their own lives. It was very encouraging to see traumatic experiences being restated as a survival lesson for most of the participants. They are the personification of the adage: what doesn't kill you makes you stronger. These participants proudly see themselves as survivors, not victims.

A second, and related, mechanism was an overall sense of a positive outcome, which they had learned as well. For the participants, the very fact of surviving their journey through war, escape, and resettlement, is a source of pride for them. These participants were very cognizant of the fact that bad things do happen in life, since they have lived through many of them, but they chose to focus more on the positives. This sense of optimism was helpful in allowing them to cope with difficulties in their lives, because their experience told them it will pass or they can get through it.

The value that the participants felt was most closely linked to resiliency was familial coherence. That sense of coherence came from knowing that they matter to their family, their community, and their culture. Some participants attributed their strong survival instincts to factors such as having family around which buffered their fear in that they were not alone. The sense of coherence also gave them a sense of purpose, allowing them to focus on the welfare of others.

Many of the participants also stated that they had role models who guided them. However, some of the participants were quick to point out that they did not get “formal lessons” in how to cope with difficulties; rather, they were able to name resilient individuals who had influenced their lives. They mentioned observation of their parents’ struggle, the creativity and resourcefulness of their grandparents, and positive lessons from respected elders. The impact of these role models on the lives of the participants shows that resiliency can be taught to some extent. However, it is important to note that resiliency can only be taught if the person is willing to learn. Just as culture is passed on from one generation to the next

through formal lessons or general practice and observation, resiliency can be passed on as well to a willing recipient.

The participants also emphasized the importance of knowing who they are and where they come from. However, the interviews indicated that a strong sense of self and cultural heritage does not mean blind loyalty to their respective traditional cultures. These participants were able to evaluate both their traditional and their adopted cultures by deciding what aspects of each culture to keep and which to discard. They reported being guided by their values, goals, and experience. The ability to have a balanced view of both cultures, they felt, stemmed from a strong sense of self first.

Aside from having a strong sense of self and purpose, the participants also attributed their survival and success to having help from the government and from certain people who came into their lives at the right time. These participants were very appreciative of help, and of the availability of help even when they chose not to accept that help. They felt they were able to ask for and accept help when needed, which did not impact negatively on their own self-perception. However, they made the distinction between handouts and help. Whenever possible, they felt they needed to do things for themselves. This was evident from the short period of time the participants and their families stayed on welfare when they first got to this country. The participants took a lot of pride in not having to be dependent on the government, preferring to support themselves. This attitude also reinforced their sense of self-efficacy.

Specific to trauma and loss, the participants reported that they had had to “let go” a lot of their painful past. They stated that they were able to rebuild their lives by letting go of the past through acceptance of what happened. The participants did not verbalize any need for understanding or meaning to the trauma they suffered. They accepted that it was a meaningless time when horrendous incidents took place, and that there was nothing they could do about it. However, the acceptance these participants talked about was not passive acceptance. Some participants were determined that if they can help it, the suffering they went through will not happen again. Therefore, it is not surprising that a majority of the participants put a lot of emphasis and effort into helping others in need. Aside from the concept of repaying kindness, the participants took back some semblance of meaning and control from the meaningless trauma they suffered, by giving back and focusing on the welfare of others.

Last but not least, the participants reported that having hope helped them survive. That sense of hope and optimism helped some of the participants continue to strive for their goals, despite the challenges they faced.

Suggestions for Needed Services

The participants had several suggestions for the promotion of resilience in newly arrived refugees or immigrants. First and foremost, the participants underscored the importance of providing opportunities for newly arrived refugees and immigrants to help themselves. As one participant puts it, “They need opportunities ...,” as distinguished from charity or handouts, so that people can foster the value of being able to take care of their own family and themselves. That

in turn builds self-efficacy and a sense of purpose or meaning, which ultimately promotes resilience. The participants' suggestions generally mirrored their own values, which emphasized self-efficacy and a sense of coherence.

To that end, the specific suggestions were to: 1) Provide community support. Despite the availability of community agencies funded by the federal and state government, most services were not known to the people. The participants stressed the need for information about available services and programs to be made readily assessable to newly arrived refugees and immigrants. They also suggested recruiting community organizations in disseminating such information, which would also provide additional collaboration on the specific needs of the community; 2) Create a helping network, whereby newly arrived refugees or immigrants are connected to a mentor from their own culture to help with acculturation issues, and then encouraged to mentor others. The progressive nature of mentee-to-mentor relationships can provide an opportunity to build on self-efficacy; 3) Develop job training or other skills based training to emphasize self-efficacy and build self-reliance; 4) Provide a forum to help build community connections and foster cultural exchange; 5) Create an information resource center within medical settings with psychological help subsumed under social services, to be able to better identify and provide help to refugees and immigrants in distress without the stigma of mental illness; and 6) Create opportunities to help the understand or appreciate the complexity and relativity of life in general. Some participants also suggested a pragmatic approach to services such as housing, transportation, health and dental care, help with heating bills, etc. Overall, the

suggestions provided by the participants were complementary to the recommendations by refugee policy makers of the Thailand-Cambodian border refugee camp: to create programs that support work, indigenous practices, and culture-based altruistic behavior among refugees to protect themselves against mental illness despite horrific life experiences (Mollica, Cui, McInnes, & Massagli, 2002).

Aside from the suggestions offered above, a majority of the participants reported that the services available right now are quite adequate compared to when the majority of them got here in the late 1970's and early 1980's. As one stated, "It's a win-win situation in this country." However, despite the generally positive attitude towards the United States government and approval for all the services the government provides, some participants realized that the government could do more in terms of social services for minorities and the poor in general in and beyond their own communities.

Limitations and Future Considerations

The findings of this study should be regarded within the context of its limitations. First, the participants were mostly from the community social service field, which could indicate potential homogeneity in the subject pool and a bias towards self-awareness. Additionally, the small sample size could potentially mean that saturation was not reached to fully delineate the parameters of the resiliency construct. Furthermore, there were surprisingly no participants who endorsed trauma experiences that violated their sense of self or affected their cultural acceptance, such as rape. Therefore, this study could not comment on resiliency

factors in people who suffered trauma that could potentially alienate them from their cultural mores and affect their self-integrity. The qualitative nature of this study allowed a great deal of information, but the participants were still not able to give a full explanation of their actions or intentions. All they could offer were accounts or stories about what they did and why, which are retrospective representations of their experience. The representations might not capture what they really experienced.

There are also several cautions to this study. In general, resiliency studies are hard to conduct, due in part to the difficulty in operationalizing the construct. This study is based partly on self-definition of resilience and well-being. This construct may vary across time and also within a cross-section of time. In other words, a resilient individual may be coping well at one point in time but not another, and a resilient individual may be coping well with a specific trauma and not another. Therefore, resilience as a general construct is almost impossible to define. Furthermore, resilience must be defined within context of the culture as well. Positive coping and resilience must also incorporate survival skills relative to the country or new culture. However, cultural stereotypes should be avoided when interpreting resiliency factors.

Another problem is the usage of PTSD as a yardstick to measure negative trauma reactions. PTSD is understood as a group of symptoms manifested from trauma reactions. However, the parameters of trauma reactions have not been fully delineated because the traditional research has focused only on negative reactions to trauma. Bonanno (2004) reviewed resilience evidence and came to the

conclusion that resilience is a distinct trajectory of trauma reactions, which indicated that a whole spectrum of positive reaction to trauma has been relatively overlooked. Furthermore, if a person did not meet criteria for PTSD, it does not mean they are not suffering; if a person did meet criteria for PTSD, it does not mean they are incapacitated. And, just because they do not meet criteria now does not mean they did not meet criteria before. In short, the usage of the PTSD diagnosis might further confuse the study of trauma and resilience.

It is important to keep in mind the breadth of trauma reactions, which are dependent on severity, frequency, duration, perceived helplessness, perceived isolation, and time. Even then, the impact of a trauma event is a very individual experience. For instance, one participant was able to cope with his experiences of war and torture, but had a very difficult time coping with the death of his brother from cancer at a later time.

It is also important to note that just because someone is functioning in all aspects of well-being does not mean that they are not impacted by past trauma. For example, one participant reported having nightmares for almost 20 years and was haunted by her traumatic experiences. Then one day, she just woke up without the shadow of past-trauma over her. Throughout those 20 years, she maintained her career, had a fulfilling family life, and had many moments of happiness.

These examples demonstrate the inadequacies of the current conceptualization of PTSD, which measures impairment and symptoms. The full trauma experience of the participant with nightmares, who recovered suddenly and without therapy, would not be fully understood using traditional approaches.

Furthermore, the high comorbidity of PTSD with other disorders within the anxiety and mood disorder spectrum confounds the understanding of trauma reactions. In other words, the current conceptualization of PTSD as a set of diagnostic criteria might not be adequate in capturing the complexity and myriad human reactions to trauma. Resilience varies across time and also within the same time period, depending on how the situation and how the person is coping at that moment.

In order to capture the full spectrum of positive human experience, resilience also needs to include subjective well-being. It is not enough that a person can function on a psychological, social, and occupational level; the person also needs to be able to experience positive emotions. The ability to experience happiness or other positive emotions should be considered a resilience factor as well. As the Dalai Lama indicated in his speech in Central Park in September 2003, the meaning of life is the pursuit of happiness. Even the United States Constitution recognized the unalienable rights in the pursuit of happiness.

Future Research

In general, future research should address the limitations of this study by increasing sample size and strive for heterogeneity of sampling within community groups. It would also be important to include specific populations such as refugee orphans to parcel out individual resiliency factors. This will ensure that better/greater saturation has been reached. It would also be important to include other spectra of trauma relatively common in the refugee experience, such as rape trauma and torture. Once all resiliency factors have been identified, both convergent and divergent studies should be designed to test the contribution of each

factor or group of factors to the resiliency construct. Then and only then can we fully understand the full spectrum of trauma reactions and resilience. The optimal method to study refugee trauma and resilience is to conduct prospective longitudinal studies, mapping the resiliency factors and coping strategies of people from the time they arrive in refugee camps until they achieve acculturation within the host country.

Finally, to minimize the confusion within PTSD and resilience studies, it might be helpful to use a model such as the Ecological Model of Trauma Recovery and Resilience (MTRR: Harvey, Liang, Harney, Koenen, Tummala-Narra, & Lebowitz, 2003) to define and measure trauma and resilience. This model acknowledges that resilience is multiply determined and its expressions are multifaceted and complex. Therefore resilience is defined along multiple dimensions other than the absence of symptoms or some global expression of health and hardiness. Harvey et al. (2003) created an instrument with sound psychometric properties that measures the impact of trauma, resilience and recovery in 8 psychological domains, avoiding the problem of the PTSD construct. The 8 psychological domains of trauma impact, resilience and recovery are: 1) authority over memory; 2) the integration of memory and affect; 3) affect tolerance and regulation; 4) symptom mastery; 5) self-esteem; 6) self-cohesion; 7) safe attachment; and 8) meaning making. The MTRR has been validated in a Chilean sample (Haz, Castillo, & Aracela, 2003), which showed promise for this model with non-Western trauma populations. It would be interesting to investigate the

validity and utility of this measure and model in SEA refugee or other traumatized populations.

Summary and Conclusion

In conclusion, the key processes of positive coping lie in the interaction between individual and environmental factors, as in all human behaviors. The transactional model of resiliency (Kumpfer, 1999) categorized the different resiliency factors and provided an account of the interaction between individual-environmental factors, processes, and outcomes. Individual factors are contained within the five realms of spirituality, cognition, emotion, behavior, and also physical attributes, which are partly genetically predetermined and also strongly influenced by the environment. Environmental factors include the availability of role models, empathic and emotionally responsive caregivers, availability of meaningful opportunities, opportunities for developing human agency, and so on. When an acute stressor is introduced, it is the transaction between the interaction of individual-environmental factors and the positive outcome that determines resiliency in the person.

We have identified several individual factors in these ex-refugee populations that promoted positive coping. These factors were similar to and also augmented past research on protective factors included in the transactional model of resiliency. The intra-individual factors include sense of self, self-acceptance, sense of coherence relative to family, community and culture, pragmatism, optimism, adaptability, hard work, perseverance, and discipline. The cognitive processes factors include understanding change versus acceptance oriented skills,

positive attribution styles, and ability to understand and accept the relativistic nature of life and human experience. The inter-individual factors include having an active connection through the sense of responsibility, purpose, and duty to family, community, and the preservation of culture. The coping behaviors factors included being goal and solution focused, setting realistic expectations, ability to ask and accept help, ability to seek support, living in the moment, and focusing on the welfare of others. These factors were somewhat influenced by past learning from cultural expectations, role models, and most importantly experience. Self-efficacy gained from surviving past adversity coupled with the individual-environmental factors were key to building resilience. We have also identified potential factors that might hinder positive coping, such as a sense of suffering alone, self-centeredness, inability to accept help, and the use of immature and neurotic defenses.

The results of this study also questioned the hypothesis that severity of trauma is a potential factor against resilience as proposed by the dose-response effect of trauma by Mollica et al. (1998a). In general, the Cambodian cohort, who suffered more trauma events and were more impacted by their trauma experiences, were not significantly different from the Vietnamese group in terms of PTSD diagnosis or subjective well-being.

Overall, the transactional model of resilience provided a comprehensive framework in the study of factors and processes of resilience. This study found similar risk and protective factors as those included in the model. However, there were slight differences in that participants in this study did not endorse the need for

understanding or giving meaning to their past trauma. For these participants, the ability to differentiate between acceptance or change-oriented skills, and the ability to utilize the one most appropriate for a given situation, were more reflective of resilience. Due to the systemic nature of resilience processes, this study suggests that the underlying mechanisms of resilience need not be delineated in order to affect positive coping. Rather, resiliency can be taught by increasing self-efficacy and sense of coherence.

The transaction between individual-environmental factors and positive outcome that constitutes the underlying mechanism of resilience is more difficult to uncover. It might not be possible, given the interaction of nature and nurture in human coping behavior, to develop a predictive equation with mathematical precision. However, given the transactional nature of the resilience process, it may not be necessary to fully delineate the actual underlying process. Transactional processes generally assume an interconnected system whereby changing one variable could affect the whole system. This study highlighted several variables that could affect the whole system to positively impact an individual's resilience.

References

- American Psychiatric Committee on Nomenclature and Statistics. (1980).
Diagnostic and statistical manual of mental disorders, third edition.
Washington, DC: American Psychiatric Association.
- American Psychiatric Committee on Nomenclature and Statistics. (1987).
Diagnostic and statistical manual of mental disorders, third edition-revised.
Washington, DC: American Psychiatric Association.
- American Psychiatric Committee on Nomenclature and Statistics. (1994).
Diagnostic and statistical manual of mental disorders, fourth edition.
Washington, DC: American Psychiatric Association.
- American Psychiatric Committee on Nomenclature and Statistics. (2000).
Diagnostic and statistical manual of mental disorders, fourth edition, text-revision. Washington, DC: American Psychiatric Association.
- Bandura, A. (1989). Regulation of cognitive processes through perceived self-efficacy. *Developmental Psychology*, 25(5), 729-735.
- Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist*, 59(1), 20-28.
- Carlson, E. B., & Hogan, R. (1991). Trauma experiences, posttraumatic stress, dissociation, and depression in Cambodian refugees. *American Journal of Psychiatry*, 148, 1548-1551.

- Chung, R. C., & Bemak, F. (1996). Effects of welfare status on psychological distress among Southeast Asian refugees. *Journal of Nervous and Mental Disease, 184*(6), 346-353.
- Chung, R. C., & Kawaga-Singer, M. (1993). Predictors of psychological distress among Southeast Asian refugees. *Social Science and Medicine, 36*(5), 631-639.
- Cicchetti, D., & Garmezy, N. (1993). Prospects and promises in the study of resilience. *Development and Psychopathology, 5*(4), 497-502.
- Cohler, B. J. (1987). Adversity, resilience, and the study of lives. In E. J. Anthony (Ed.), *The invulnerable child: The Guildford psychiatry series* (pp. 363-424). New York, NY: Guildford Press.
- de Girolamo, G., & McFarlane, A. C. (1996). Epidemiology of posttraumatic stress disorder among victims of intentional violence: A review of the literature. In F. L. Mak & C. C. Nadelson (Eds.), *International review of psychiatry* (Vol. 2, pp. 93-119). Oxfordshire, UK: Carfax Publishing.
- Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment, 49*, 71-75.
- Dyregov, A., Gupta, L., Gjestad, R., & Mukanoheli, E. (2000). Trauma exposure and psychological reactions to genocide among Rwandan children. *Journal of Traumatic Stress, 13*(1), 3-21.
- Egeland, B. R., Carlson, E., & Sroufe, L. E. (1993). Resilience as process. *Development & Psychopathology, 5*(4), 517-528.

- Eisenbruch, M. (1991). From posttraumatic stress disorder to cultural bereavement: Diagnosis of Southeast Asian refugees. *Social Science & Medicine*, 33(6), 673-680.
- Favaro, A., Maiorani, M., Colombo, G., & Santonastaso, P. (1999). Traumatic experiences, posttraumatic stress disorder, and dissociative symptoms in a group of refugees from former Yugoslavia. *Journal of Nervous and Mental Disease*, 187(5), 306-308.
- Finkelhor, D. (1990). Early and long-term effects of childhood sexual abuse: An update. *Professional Psychology Research and Practice*, 21(5), 325-330.
- Fisher, L., Kokes, R. F., Cole, R. E., Perkins, M., & Wynne, L. C. (1987). Competent children at risk: A study of well-functioning offsprings of disturbed parents. In E. J. Anthony & B. J. Cohler (Eds.), *The invulnerable child: the Guildford psychiatry series* (pp. 211-228). New York, NY: Guildford Press.
- Foa, E. B., & Meadows, E. A. (1998). Psychosocial treatments for Posttraumatic Stress Disorder. In R. Yehuda (Ed.), *Psychological trauma: Review of psychiatry series* (pp. 179-204). Washington, D.C.: American Psychiatric Press.
- Frankl, V. E. (1963). *Man's search for meaning: An introduction to logotherapy*. New York, NY: Washington Square Press.
- Friedman, M. J., & Marcella, A. J. (1996). Posttraumatic stress disorder: An overview of the concept. In A. J. Marcella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress*

disorder: Issues, research and clinical implications (pp. 11-32).

Washington, DC: American Psychological Association.

Frueh, B. C., Turner, S. M., & Beidel, D. C. (1995). Exposure therapy for combat related PTSD: A critical review. *Clinical Psychology Review, 15*, 799-817.

Geltman, P. L., Augustyn, M., Bernett, E. D., Klass, P. E., & Groves, B. M. (2000).

War trauma experience and behavioral screening of Bosnian refugee children resettled in Massachusetts. *Journal of Developmental and Behavioral Pediatrics, 21*(4), 255-261.

Gillespie, A., Peltzer, K., & MacLachlan, M. (2000). Returning refugees:

Psychosocial problems and mediators of mental health among Malawian returnees. *Journal of Mental Health (UK), 9*(2), 165-178.

Glantz, M. D. (1992). A developmental psychopathology model of drug abuse vulnerability. In M. D. Glantz & R. W. Pickens (Eds.), *Vulnerability to drug abuse* (pp. 389-418). Washington, DC: American Psychological Association.

Glantz, M. D., & Sloboda, Z. (1999). Analysis and reconceptualization of resilience. In M. D. Glantz & J. L. Johnson (Eds.), *Resilience and development: Positive life adaptations. Longitudinal research in the social and behavioral sciences* (pp. 109-126). New York, NY: Plenum Press.

Gong-Guy, E., Cravens, R. B., & Patterson, T. E. (1991). Clinical issues in mental health service delivery to refugees. *American Psychologist, 46*(6), 642-648.

- Gordon, E. W., & Song, L. D. (1994). Variations in the experience of resilience. In E. W. Gordon (Ed.), *Educational resilience in inner-city America: Challenges and prospects* (pp. 27-43). Hillsdale, NJ: Erlbaum Associates.
- Gorman, W. (2001). Refugee survivors of torture: Trauma and treatment. *Professional Psychology: Research and Practice*, 32, 443-451.
- Greenbaum, C. W., & Auerbach, J. G. (1998). The environment of the child with mental retardation: Risk, vulnerability and resilience. In J. A. Burak, R. M. Hodapp, et al. (Eds.), *Handbook of mental retardation and development* (pp.583-605). New York: Cambridge University Press.
- Harvey, M. R., Liang, B., Harney, P. A., Koenen, K., Tummala-Narra, P., & Lebowitz, L. (2003). A multidimensional approach to the assessment of trauma impact, recovery and resilience: Initial psychometric findings. *Journal of Aggression, Maltreatment & Trauma*, 6(2), 87-109.
- Hauff, E., & Vaglum, P. (1993). Vietnamese boat people: The influence of war and flight traumatization on mental health on arrival in the country of resettlement: A community cohort study of Vietnamese refugees in Norway. *Acta Psychiatrica Scandinavica*, 88(3), 162-168.
- Haz, A. M., Castillo, R., & Aracena, M. (2003). Adaptation of the Multidimensional Trauma Recovery and Resilience (MTRR) in a Chilean sample. *Child Abuse and Neglect*, 27(7), 807-820.
- Herman, J. L. (1992). *Trauma and recovery*. New York: Basic Books.
- Herman, J., Russell, D., & Trocki, K. (1986). Long term effects of incestuous abuse in childhood. *American Journal of Psychiatry*, 143(10), 1293-1296.

- Holtz, T. H. (1998). Refugee trauma versus torture trauma: A retrospective controlled cohort study of Tibetan refugees. *Journal of Nervous and Mental Disease, 186*(1), 24-34.
- Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. *Psychosomatic Medicine, 41*(3), 209-218.
- Jessor, R. (1991). Risk behavior in adolescents: A psychosocial framework for understanding and action. *Journal of Adolescent Health, 12*(8), 597-605.
- Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin, 113*(1), 164-180.
- Kennedy, M. G. (2000). Refugee experiences and Southeast Asian women's mental health. *Western Journal of Nursing Research, 22*(2), 162-164.
- Kinzie, J. D. (1993). Posttraumatic effects and their treatment among Southeast Asian refugees. In J. P. Wilson, & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 311-319). New York: Plenum Press.
- Kinzie, J. D., Boehnlein, J. K., Leung, P. K., Moore, L. J., Riley, C., & Smith, D. (1990). The prevalence of posttraumatic stress disorder and its clinical significance among Southeast Asian refugees. *American Journal of Psychiatry, 147*, 913-917.
- Kinzie, J. D., Fredrickson, R. H., Ben, R., Fleck, J., & Karls, W. (1984). Posttraumatic stress disorder among survivors of Cambodian concentration camps. *American Journal of Psychiatry, 141*(5), 645-650.

- Kinzie, J. D., Sack, W. H., Angell, R. H., Manson, S., & Rath, B. (1986). The psychiatric effects of massive trauma on Cambodian children: I. The children. *Journal of the Academy of Child and Adolescent Psychiatry*, 25, 370-376.
- Kobasa, S. C. (1979). Stressful life events, personality, and health: An inquiry into hardiness. *Journal of Personality and Social Psychology*, 37(1), 1-11.
- Kroll, J., Habenicht, M., Mackenzie, T., Yang, M., Chan, S., Vang, T., Nguyen, T., Ly, M., Phommavanh, B., Nguyen, H., Vang, Y., Souvannasoth, L., & Cabugao, R. (1989). Depression and posttraumatic stress disorder in Southeast Asian refugees. *American Journal of Psychiatry*, 146, 1592-1597.
- Kumpfer, K. L. (1999). Factors and processes contributing to resilience: the resilience framework. In M. D. Glantz & J. L. Johnson (Eds.), *Resilience and development: Positive life adaptations. Longitudinal research in the social and behavioral sciences* (pp. 179-224). New York, NY: Plenum Press.
- Lebowitz, L., Harvey, M. R., & Herman, J. L. (1993). A stage by dimension model of recovery from sexual trauma. *Journal of Interpersonal Violence*, 8(3), 378-391.
- Lee, B. S. (1988). Holocaust survivors and internal strength. *Journal of Humanistic Psychology*, 28(1), 67-96.
- Linehan, M. M. (1993). *Cognitive-behavioral treatment of Borderline Personality Disorder*. New York: Guilford Press.

- Lyons, J. A. (1991). Strategies for assessing the potential for positive adjustment following trauma. *Journal of Traumatic Stress, 4*(1), 93-111.
- Massachusetts Department of Mental Health (1989, March). Refugee mental health needs assessment, a key informant study. Retrieved 7/1/04 from the World Wide Web at www.state.ma.us/dph/orih/sas1.htm.
- Masten, A. S., Best, K. M., & Garmezy, N. (1990). Resilience and development: Contributions from the study of children who overcome adversity. *Development and Psychopathology, 2*(4), 425-444.
- Melville, M. B., & Lykes, M. B. (1992). Guatemalan Indian children and the sociocultural effects of government-sponsored terrorism. *Social Science and Medicine, 34*(5), 533-548.
- Miller, K. E. (1996). The effects of state terrorism and exile on indigenous Guatemalan refugee children: A mental health assessment and an analysis of children's narratives. *Child Development, 67*(1), 89-106.
- Mollica, R. F., & Caspi-Yavin, Y. (1996). The assessment of events and their related symptoms in torture and refugee trauma. In T. W. Miller (Ed.), *Theory and assessment of stressful life events* (pp. 273-294). Madison, CT: International Universities Press.
- Mollica, R. F., Caspi-Yavin, Y., Bollini, P., Truong, T., et al. (1992). The Harvard Trauma Questionnaire: Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. *Journal of Nervous and Mental Disease, 180*(2), 111-116.

- Mollica, R. F., Cui, X., McInnes, K., & Massagli, M. P. (2002). Science-based policy for psychosocial interventions in refugee camps: A Cambodian example. *Journal of Nervous & Mental Disease*, 190(3), 158-166.
- Mollica, R. F., Donelan, K., Tor, S., Lavelle, J., Elias, C., Frankel, M., & Blendon, R. (1993). The effects of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps. *Journal of the American Medical Association*, 270(5), 581-586.
- Mollica, R. F., & Lavelle, J. (1988). Southeast Asian Refugees. In L. Comas-Diaz & E. E. H. Griffith (Eds.), *Clinical guidelines in cross-cultural mental health* (pp.262-304). New York: John Wiley & Sons.
- Mollica, R. F., McInnes, K., Poole, C., & Tor, S. (1998a). Dose-effect relationships of trauma to symptoms of depression and post-traumatic stress disorder among Cambodian survivors of mass violence. *British Journal of Psychiatry*, 173, 482-488.
- Mollica, R. F., Poole, C., Son, L., Murray, C., et al. (1997). Effects of war trauma on Cambodian refugee adolescents' functional health and mental health status. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36(8), 1098-1106.
- Mollica, R. F., Poole, C., & Tor, S. (1998b). Symptoms, functioning, and health problems in a massively traumatized population: The legacy of the Cambodian tragedy. In B. P. Dohrenwend (Ed.), *Adversity, stress, and psychopathology* (pp. 34-51). New York: Oxford University Press.

- Mollica, R. F., & Son, L. (1989a). Cultural dimensions in the evaluation and treatment of sexual trauma. *Psychiatric Clinics of North America*, 12(2), 363-379.
- Mollica, R. F., Wyshak, G., & Lavelle, J. (1987). The psychosocial impact of war trauma and torture on Southeast Asian refugees. *American Journal of Psychiatry*, 144(12), 1567-1572.
- Moore, L. J., & Boehnlein, J. K. (1991). Posttraumatic stress disorder, depression, and somatic symptoms in U.S. Mien patients. *Journal of Nervous and Mental Disease*, 179, 728-733.
- Neiger, B. L. (1992). Resilient reintegration: Use of structural equations modeling. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 52(04), 1937.
- Paardekooper, B., de Jong, J. T. V. M., & Hermanns, J. M. A. (1999). The psychological impact of war and the refugee situation on South Sudanese children in refugee camps in Northern Uganda: An exploratory study. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 40(4), 529-536.
- Papageorgiou, V., Frangou-Garunovic, A., Iordanidou, R., Yule, W., Smith, P., & Vostanis, P. (2000). War trauma and psychopathology in Bosnian refugee children. *European Child and Adolescent Psychiatry*, 9(2), 84-90.
- Puttnam, D. P. (Producer), & Joffe, R. (Director). (1985). *The Killing Fields* [motion picture]. United States: Warner Brothers.

- Radke-Yarrow, M., & Brown, E. (1993). Resilience and vulnerability in children of multiple-risk families. *Development & Psychopathology*, 5(4), 581-592.
- Richardson, G. E., Neiger, B. L., Jensen, S., & Kumpfer, K. (1990). The resiliency model. *Health Education*, 21(6), 33-39.
- Rozee, P. D., & Van Boemel, G. (1989). The psychological effects of war trauma and abuse on older Cambodian refugee women. *Women and Therapy*, 8(4), 23-49.
- Rutter, M. (1979). Protective factors in children's response to stress and disadvantage. *Annals Academy of Medicine*, 8(3), 324-338.
- Rutter, M. (1985). Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry*, 147, 598-611.
- Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry*, 57, 316-331.
- Rutter, M., & Quinton, D. (1984). Long-term follow-up of women institutionalized in childhood: Factors promoting good functioning in adult life. *British Journal of Developmental Psychology*, 2(3), 191-204.
- Sack, W. H., Seeley, J. R., & Clarke, G. N. (1997). Does PTSD transcend cultural barriers? A study from the Khmer Adolescent refugee project. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36(1), 49-54.
- Sack, W. H., Seeley, J. R., Him, C., & Clarke, G. N. (1998). Psychometric properties of the Impact of Event Scale in traumatized Cambodian refugee youth. *Personality and Individual Differences*, 25(1), 57-67.

- Schaefer, J. A., & Moos, R. H. (1992). Life crises and personal growth. In B. N. Carpenter (Ed.), *Personal coping: Theory, research, and application* (pp. 149-170). New York, NY: Praeger.
- Seligman, M. E. P. (1975). *Helplessness: On depression, development, and death*. New York, NY: Scribner.
- Shalev, A. Y., Bonne, O., & Eth, S. (1996). Treatment of posttraumatic stress disorder: A review. *Psychosomatic Medicine*, 58, 165-182.
- Shapiro, F. (1996). Eye movement desensitization and reprocessing (EMDR): Evaluation of controlled PTSD research. *Journal of Behavioral Therapy and Experimental Psychiatry*, 27, 209-218.
- Silove, D. (1999). The psychological effects of torture, mass human rights violations, and refugee trauma: Towards an integrated conceptual framework. *Journal of Nervous and Mental Disease*, 187(4), 200-207.
- Simich, L., Beiser, M., & Mawani, F. N. (2003). Social support and the significance of shared experience in refugee migration and resettlement. *Western Journal of Nursing Research*, 25(7), 872-891.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage Publications.
- Tarter, R. E., & Vanyukov, M. (1999). Re-visiting the validity of the construct of resilience. In M. D. Glantz & J. L. Johnson (Eds.), *Resilience and development: Positive life adaptations* (pp. 85-100). New York, NY: Plenum Press.

- Ung, L. (2000). *First they killed my father: A daughter of Cambodia remembers*. New York: Harper Collins.
- Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., & Keane, T. M. (1993). The PTSD checklist: Reliability, validity, & diagnostic utility. Paper presented at the *Annual Meeting of International Society for Traumatic Stress Studies*, San Antonio, TX, October.
- Werner, E. E. (1986). Resilient offspring of alcoholics: A longitudinal study from birth to age 18. *Journal of Studies on Alcohol*, 47(1), 34-40.
- Werner, E. E. (1989b). High-risk children in young adulthood: A longitudinal study from birth to 32 years. *American Journal of Orthopsychiatry*, 59(1), 72-81.
- Werner, E. E. (1992). The children of Kauai: Resiliency and recovery in adolescent and adulthood. *Journal of Adolescent Health*, 13(4), 262-268.
- Werner, E. E., & Smith, R. S. (1989a). *Vulnerable but invincible: A longitudinal study of resilient children and youth*. New York: Adams, Bannister, and Cox.
- Werner, E. E., & Smith, R. S. (1992). *Overcoming the odds: High risk children from birth to adulthood*. Ithaca, New York: Cornell University Press.
- WHOQOL group. (1995). The World Health Organization Quality of Life Assessment (WHOQOL): Position paper from the World Health Organization. *Social Science and Medicine*, 41(10), 1403-1409.
- Wind, T. F., & Silvern, L. (1992). Type and extent of child abuse as predictors of adult functioning. *Journal of Family Violence*, 7(4), 261-281.

World Health Organization. (1992). *The ICD-10 classification of mental and behavioral disorders*. Geneva: Switzerland.

Yalom, I. D. (1995). *The theory and practice of group psychotherapy*. New York: Basic Books.

Ying, Y.-W., & Akutsu, P. D. (1997). Psychological adjustment of Southeast Asian refugees: The contribution of sense of coherence. *Journal of Community Psychology*, 25(2), 125-139.

Tables

Table 1

Demographic Information by Ethnicity

	Cambodian		Vietnamese	
	N	%	N	%
Gender:				
Male	5	50	3	30
Female	5	50	7	70
Marital Status:				
Married	5	50	6	60
Divorced	2	20	2	20
Single	2	20	2	20
Divorced & Remarried	1	10	-	-
Employment Status:				
Full Time	10	100	8	80
Retired	-	-	2	20
Income Level:				
15,000 - 24,999	-	-	1	10
25,000 - 39,999	2	20	-	-
40,000 - 59,999	3	30	2	20
60,000 and up	5	50	7	70
Number of Dependents:				
0	4	40	6	60
1	1	10	2	20
2	3	30	2	20
3	1	10	-	-
4	1	10	-	-
Education Level:				
GED	1	10	-	-
Some College	1	10	-	-
Associates Degree	1	10	2	20
Bachelor's Degree	5	50	1	10
Masters Degree	2	20	5	50
Ph.D., M.D., etc.	-	-	2	20
	X	SD	X	SD
Age	35.90	4.93	43.70	11.16

Table 2

Migration Data by Ethnicity

Migration Data	N = 20			
	Cambodian		Vietnamese	
	X	SD	X	SD
Age left country of origin	13.1	6.2	17.9	7.3
Age arrive in the U.S.	16.8	6.5	18.3	8.6
Number of family came with	3.9	2.2	9.6	11.7
Number of family left behind	16.2	11.2	15.1	16.6
Number of family killed	5.2	4.8	2.1	1.3
Residence of origin:				
Big city	N		N	
Town/Small town	8		8	
	2		2	

Table 3

Refugee Camp Experiences by Ethnicity

	Cambodians			Vietnamese		
	Yes	No	Sometimes	Yes	No	Sometimes
Camp Experiences	(N)			(N)		
Stay in Refugee Camp	10	-	-	8	2	-
Enough to Eat *	2	5	3	8	-	-
Clean Drinking Water *	4	6	-	8	-	-
Adequate Sanitation *	3	4	3	8	-	-
Adequate Shelter	10	-	-	8	-	-
Camp too Crowded	8	2	-	5	3	-
No Safety ***	9	-	1	-	8	
* p < .01 *** p < .0001						

Table 4

PTSD and Trauma Indices by Ethnicity

Trauma criteria	Cambodians		Vietnamese	
	(N)		(N)	
	YES	NO	YES	NO
PTSD: DSM-IV (PCL)	3	7	0	10
PTSD: DSM-III-R (HTQ)	4	6	0	10
PTSD-Culturally specific (HTQ)	2	8	0	10
IES:				
Low	4		8	
Medium	1		0	
High	5		2	

Note: PCL is the PTSD Checklist for DSM-IV. HTQ is the Harvard Trauma Questionnaire-Cambodian and Vietnamese versions. IES is the Impact of Event Scale.

Table 5

Well-being Indices by Ethnicity

	Cambodians	Vietnamese
	(N)	(N)
Quality of Life (WHO-QOL):		
Very Good	1	4
Good	7	6
Neither Good/Poor	2	0
Satisfaction of Life Scale:		
High	6	6
Medium	4	3
Low	0	1
Satisfaction with Health (WHO-QOL):		
Very Satisfied	3	2
Satisfied	6	6
Neutral	1	2
Attitudes about Life (Optimism):		
High	7	8
Medium	3	2
Low	0	0
Attitudes about Self (Self-efficacy):		
High	8	8
Medium	2	2
Low	0	0
Family Perception Scale:		
High	5	3
Medium	4	7
Low	1	0

Table 6

Factors Promoting Resiliency

Factor	Components (n, %)
<i>Intra-Individual Traits</i>	<ul style="list-style-type: none"> -Strong sense of self and culture (19, 95%) -Open-mindedness (18, 90%) -Optimism (11, 55%) -Pragmatism (18, 90%) -Compassion (18, 90%) -Empathy (15, 75%) -Adventurousness (6, 30%) -Youth (10, 50%) -Sense of humor (7, 35%) -Self confidence / self-efficacy (17, 85%) -Mindset that hard work leads to success (15, 75%)
<i>Cognitive Processes</i>	
1) Positive Processes	<ul style="list-style-type: none"> -Knowing difference between acceptance-oriented and change-oriented skills (20, 100%) -Attitude of no choice but to survive (12, 60%) -Hope (16, 80%) -Acceptance of things that cannot change, through deeper understanding of past events (14, 70%) -Not personalizing negative events (18, 90%) -Focus on positives/gain vs. negatives/loss (19, 95%) -Focus on similarities vs. differences (6, 30%) -Present- and future-oriented (19, 95%)
2) Relativism	<ul style="list-style-type: none"> -Awareness of beauty and kindness in times of difficulties (19, 95%) -Contentedness, thankfulness for what one has (13, 65%)
<i>Inter-Individual Traits</i>	
1) Knowledge of role and purpose in family, community and culture	<ul style="list-style-type: none"> -Active sense of duty (14, 70%) -Active sense of responsibility (19, 95%) -Purpose (18, 90%) -Sense of trust in others (15, 75%)
2) Sense of belonging	<ul style="list-style-type: none"> -Family cohesiveness (15, 75%) -Not suffering alone (12, 60%) -Strong cultural heritage (19, 95%)
<i>Coping Behavior</i>	<ul style="list-style-type: none"> -Ability to ask for and accept help, appreciation for help (15, 75%) -Ability to seek support from friends and family (17, 85%) -Sharing (8, 40%)

Table 6: *Factors Promoting Resiliency (continued)*

	-Faith in religion or higher power (14, 70%)
	-Focus on children/family/others (8, 40%)
	-Distraction (6, 30%)
	-Lowering expectations when necessary (15, 75%)
	-Realistic expectations. (10, 50%)
	-Focus on goals: learning to define basic survival components, situation specific (20, 100%)
	-Focus on living moment to moment (17, 85%)
	-Focus on what can be done now; problem/solution focus (19, 95%)
<i>Learning / Past Experience</i> (Self-efficacy)	-Strong role models (through values and behaviors) (12, 60%)
	-Pride in having survived hard times: survivor mindset (17, 85%)
	-Learning from experience (17, 85%)

Note. Figures in parentheses are the number of participants mentioning this theme, followed by the percentage of the total.

Figure

Figure 1: Transactional Model of Resilience (Kumpfer, 1999)

Bibliography

- Agger, I., & Jensen, S. B. (1993). The psychosexual trauma of torture. In J. P. Wilson & B. Raphael (Eds.), *International Handbook of Traumatic Stress Syndromes* (pp. 685-702). New York: Plenum Press.
- Allotey, P. (1998). Traveling with "excess baggage": Health problems of refugee women in Western Australia. *Women and Health*, 28(1), 63-81.
- American Psychiatric Committee on Nomenclature and Statistics. (1980). *Diagnostic and statistical manual of mental disorders, third edition*. Washington, DC: American Psychiatric Association.
- American Psychiatric Committee on Nomenclature and Statistics. (1987). *Diagnostic and statistical manual of mental disorders, third edition-revised*. Washington, DC: American Psychiatric Association.
- American Psychiatric Committee on Nomenclature and Statistics. (1994). *Diagnostic and statistical manual of mental disorders, fourth edition*. Washington, DC: American Psychiatric Association.
- American Psychiatric Committee on Nomenclature and Statistics. (2000). *Diagnostic and statistical manual of mental disorders, fourth edition, text-revision*. Washington, DC: American Psychiatric Association.
- Ayalon, O. (1993). Posttraumatic stress recovery of terrorist survivors. In J. P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 855-866). New York: Plenum Press.
- Bandura, A. (1989). Regulation of cognitive processes through perceived self-efficacy. *Developmental Psychology*, 25(5), 729-735.

- Bisson, J. I., Searle, M. M., & Srinivasan, M. (1998). Follow-up study of British military hostages and their families held in Kuwait during the Gulf War. *British Journal of Medical Psychology*, 71(3), 247-252.
- Blackwell, R. D. (1993). Disruption and reconstitution of family, network, and community systems following torture, organized violence, and exile. In J. P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 733-741). New York: Plenum Press.
- Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist*, 59(1), 20-28.
- Bryant, R. A., Moulds, M. L., & Guthrie, R. M. (2000). Acute stress disorder scale: A self-report measure of acute stress disorder. *Psychological Assessment*, 12(1), 61-68.
- Butler, K. (1997, March/April). The anatomy of resilience. *Networker*, 22-31.
- Calhoun, L. G., Cann, A., Tedeschi, R. G., & McMillan, J. (2000). A correlational test of the relationship between posttraumatic growth, religion, and cognitive processing. *Journal of Traumatic Stress*, 13(3), 521-527.
- Carlson, E. B., & Hogan, R. (1991). Trauma experiences, posttraumatic stress, dissociation, and depression in Cambodian refugees. *American Journal of Psychiatry*, 148, 1548-1551.
- Chung, R. C., & Bemak, F. (1996). Effects of welfare status on psychological distress among Southeast Asian refugees. *Journal of Nervous and Mental Disease*, 184(6), 346-353.

- Chung, R. C., & Kawaga-Singer, M. (1993). Predictors of psychological distress among Southeast Asian refugees. *Social Science and Medicine*, 36(5), 631-639.
- Cicchetti, D., & Garmezy, N. (1993). Prospects and promises in the study of resilience. *Development and Psychopathology*, 5(4), 497-502.
- Cohler, B. J. (1987). Adversity, resilience, and the study of lives. In E. J. Anthony (Ed.), *The invulnerable child: The Guildford psychiatry series* (pp. 363-424). New York, NY: Guildford Press.
- Cunningham, M., & Silove, D. (1993). Principles of treatment and service development for torture and trauma survivors. In J. P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 751-762). New York: Plenum Press.
- Davidson, J. R. T., Book, S. W., Colket, J. T., Tupler, L. A., et al. (1997). Assessment of a new self-rating scale for post-traumatic stress disorder. *Psychological Medicine*, 27(1), 153-160.
- Davidson, J. R. T. (2000). Trauma: The impact of post-traumatic stress disorder. *Journal of Psychopharmacology*, 14(2, Suppl 1), S5-S12.
- de Girolamo, G. (1993). International perspectives on the treatment and prevention of posttraumatic stress disorder. In J. P. Wilson, & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 935-946). New York: Plenum Press.
- de Girolamo, G., & McFarlane, A. C. (1996). Epidemiology of posttraumatic stress disorder among victims of intentional violence: A review of the literature.

- In F. L. Mak & C. C. Nadelson (Eds.), *International review of psychiatry* (Vol. 2, pp. 93-119). Oxfordshire, UK: Carfax Publishing.
- Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment*, 49, 71-75.
- Dyregov, A., Gupta, L., Gjestad, R., & Mukanoheli, E. (2000). Trauma exposure and psychological reactions to genocide among Rwandan children. *Journal of Traumatic Stress*, 13(1), 3-21.
- Dyregrov, K., Dyregrov, A., & Raundalen, M. (2000). Refugee families' experience of research participation. *Journal of Traumatic Stress*, 13(3), 413-426.
- Egeland, B. R., Carlson, E., & Sroufe, L. E. (1993). Resilience as process. *Development & Psychopathology*, 5(4), 517-528.
- Eisenbruch, M. (1991). From posttraumatic stress disorder to cultural bereavement: Diagnosis of Southeast Asian refugees. *Social Science & Medicine*, 33(6), 673-680.
- Ekblad, S., Abazari, A., & Eriksson, N-G. (1999). Migration stress related challenges associated with perceived quality of life: A qualitative analysis of Iranian refugees and Swedish patients. *Transcultural Psychiatry*, 36(3), 329-345.
- Favaro, A., Maiorani, M., Colombo, G., & Santonastaso, P. (1999). Traumatic experiences, posttraumatic stress disorder, and dissociative symptoms in a group of refugees from former Yugoslavia. *Journal of Nervous and Mental Disease*, 187(5), 306-308.

- Feinauer, L. L., & Stuart, D. A. (1996). Blame and resilience in women sexually abused as children. *The American Journal of Family Therapy*, 24(1), 31-40.
- Felsman, J. K., Leong, F. T. L., Johnson, M. C., & Felsman, I. C. (1990). Estimates of psychological distress among Vietnamese refugees: Adolescents, unaccompanied minors and young adults. *Social Science Medicine*, 31(11), 1251-1256.
- Finkelhor, D. (1990). Early and long-term effects of childhood sexual abuse: An update. *Professional Psychology Research and Practice*, 21(5), 325-330.
- Fisher, L., Kokes, R. F., Cole, R. E., Perkins, M., & Wynne, L. C. (1987). Competent children at risk: A study of well-functioning offsprings of disturbed parents. In E. J. Anthony & B. J. Cohler (Eds.), *The invulnerable child: the Guildford psychiatry series* (pp. 211-228). New York, NY: Guildford Press.
- Flach, F. (1989). *Resilience: Discovering a new strength at time of stress*. New York, NY: Norton.
- Foa, E. B., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of posttraumatic stress disorder: The Posttraumatic Diagnostic Scale. *Psychological Assessment*, 9(4), 445-451.
- Foa, E. B., & Meadows, E. A. (1998). Psychosocial treatments for Posttraumatic Stress Disorder. In R. Yehuda (Ed.), *Psychological trauma: Review of psychiatry series* (pp. 179-204). Washington, D.C.: American Psychiatric Press.

- Foa, E. B., & Tolin, D. F. (2000). Comparison of the PTSD Symptom Scale-Interview Version and the Clinician-Administered PTSD Scale. *Journal of Traumatic Stress, 13*(2), 181-191.
- Frankl, V. E. (1963). *Man's search for meaning: An introduction to logotherapy*. New York, NY: Washington Square Press.
- Friedman, M. J., & Marcella, A. J. (1996). Posttraumatic stress disorder: An overview of the concept. In A. J. Marcella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research and clinical implications* (pp. 11-32). Washington, DC: American Psychological Association.
- Frueh, B. C., Turner, S. M., & Beidel, D. C. (1995). Exposure therapy for combat related PTSD: A critical review. *Clinical Psychology Review, 15*, 799-817.
- Garnezy, N. (1987). Stress, competence and development: continuities in the study of schizophrenic adults, children vulnerable to psychopathology, and the search for stress resistant children. *American Journal of Orthopsychiatry, 57*(2), 159-174.
- Geltman, P., & Stover, E. (1997). Genocide and the plight of children in Rwanda. *Journal of the American Medical Association, 277*(4), 289-294.
- Geltman, P. L., Augustyn, M., Bernett, E. D., Klass, P. E., & Groves, B. M. (2000). War trauma experience and behavioral screening of Bosnian refugee children resettled in Massachusetts. *Journal of Developmental and Behavioral Pediatrics, 21*(4), 255-261.

- Gerber, L. (1996). We must hear each other's cry: Lessons from Pol Pot survivors. In C. B. Strozier, M. Flynn, et al. (Eds.), *Genocide, war, and human survival* (pp. 297-305). Lanham, MD: Rowman and Littlefield.
- Gillespie, A., Peltzer, K., & MacLachlan, M. (2000). Returning refugees: Psychosocial problems and mediators of mental health among Malawian returnees. *Journal of Mental Health (UK)*, 9(2), 165-178.
- Glantz, M. D. (1992). A developmental psychopathology model of drug abuse vulnerability. In M. D. Glantz & R. W. Pickens (Eds.), *Vulnerability to drug abuse* (pp. 389-418). Washington, DC: American Psychological Association.
- Glantz, M. D., & Sloboda, Z. (1999). Analysis and reconceptualization of resilience. In M. D. Glantz & J. L. Johnson (Eds.), *Resilience and development: Positive life adaptations. Longitudinal research in the social and behavioral sciences* (pp. 109-126). New York, NY: Plenum Press.
- Gong-Guy, E., Cravens, R. B., & Patterson, T. E. (1991). Clinical issues in mental health service delivery to refugees. *American Psychologist*, 46(6), 642-648.
- Gordon, E. W., & Song, L. D. (1994). Variations in the experience of resilience. In E. W. Gordon (Ed.), *Educational resilience in inner-city America: Challenges and prospects* (pp. 27-43). Hillsdale, NJ: Erlbaum Associates.
- Gorman, W. (2001). Refugee survivors of torture: Trauma and treatment. *Professional Psychology: Research and Practice*, 32, 443-451.
- Greenbaum, C. W., & Auerbach, J. G. (1998). The environment of the child with mental retardation: Risk, vulnerability and resilience. In J. A. Burak, R. M.

- Hodapp, et al. (Eds.), *Handbook of mental retardation and development* (pp.583-605). New York: Cambridge University Press.
- Harvey, M. R., Liang, B., Harney, P. A., Koenen, K., Tummala-Narra, P., & Lebowitz, L. (2003). A multidimensional approach to the assessment of trauma impact, recovery and resilience: Initial psychometric findings. *Journal of Aggression, Maltreatment & Trauma*, 6(2), 87-109.
- Hauff, E., & Vaglum, P. (1993). Vietnamese boat people: The influence of war and flight traumatization on mental health on arrival in the country of resettlement: A community cohort study of Vietnamese refugees in Norway. *Acta Psychiatrica Scandinavica*, 88(3), 162-168.
- Haz, A. M., Castillo, R., & Aracena, M. (2003). Adaptation of the Multidimensional Trauma Recovery and Resilience (MTRR) in a Chilean sample. *Child Abuse and Neglect*, 27(7), 807-820.
- Herman, J. L. (1992). *Trauma and recovery*. New York: Basic Books.
- Herman, J. L., Perry, J. C., & van der Kolk, B. A. (1989). Childhood trauma in borderline personality disorder. *American Journal of Psychiatry*, 146(4), 490-495.
- Herman, J., Russell, D., & Trocki, K. (1986). Long term effects of incestuous abuse in childhood. *American Journal of Psychiatry*, 143(10), 1293-1296.
- Holtz, T. H. (1998). Refugee trauma versus torture trauma: A retrospective controlled cohort study of Tibetan refugees. *Journal of Nervous and Mental Disease*, 186(1), 24-34.

- Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. *Psychosomatic Medicine*, 41(3), 209-218.
- Jessor, R. (1991). Risk behavior in adolescents: A psychosocial framework for understanding and action. *Journal of Adolescent Health*, 12(8), 597-605.
- Jonas, M. R. (1997). Footprints on the soul: Journeys from trauma to resilience. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 57(11-B), 7227.
- Joseph, S. (2000). Psychometric evaluation of Horowitz's Impact of Event Scale: A review. *Journal of Traumatic Stress*, 13(1), 101-113.
- Jung, H. (1984). Indo-Chinese refugee services in metropolitan Boston: An impressionistic assessment. *Asian American Psychological Association Journal*, 16-18.
- Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin*, 113(1), 164-180.
- Kennedy, M. G. (2000). Refugee experiences and Southeast Asian women's mental health. *Western Journal of Nursing Research*, 22(2), 162-164.
- Kim, Y. J., Snyder, B. O., & Lai-Bitker, A. Y. (1996). Culturally responsive psychiatric case management with Southeast Asians. In P. Manoleas (Ed.), *The cross-cultural practice of clinical case management in mental health* (pp. 145-168). New York: Haworth Press.
- Kinzie, J. D. (1993). Posttraumatic effects and their treatment among Southeast Asian refugees. In J. P. Wilson, & B. Raphael (Eds.), *International*

handbook of traumatic stress syndromes (pp. 311-319). New York: Plenum Press.

Kinzie, J. D., Boehnlein, J. K., Leung, P. K., Moore, L. J., Riley, C., & Smith, D.

(1990). The prevalence of posttraumatic stress disorder and its clinical significance among Southeast Asian refugees. *American Journal of Psychiatry*, 147, 913-917.

Kinzie, J. D., Fredrickson, R. H., Ben, R., Fleck, J., & Karls, W. (1984).

Posttraumatic stress disorder among survivors of Cambodian concentration camps. *American Journal of Psychiatry*, 141(5), 645-650.

Kinzie, J. D., Sack, W. H., Angell, R. H., Manson, S., & Rath, B. (1986). The

psychiatric effects of massive trauma on Cambodian children: I. The children. *Journal of the Academy of Child and Adolescent Psychiatry*, 25, 370-376.

Kobasa, S. C. (1979). Stressful life events, personality, and health: An inquiry into hardiness. *Journal of Personality and Social Psychology*, 37(1), 1-11.

Kroll, J., Habenicht, M., Mackenzie, T., Yang, M., Chan, S., Vang, T., Nguyen, T.,

Ly, M., Phommasouvanh, B., Nguyen, H., Vang, Y., Souvannasoth, L., &

Cabugao, R. (1989). Depression and posttraumatic stress disorder in Southeast Asian refugees. *American Journal of Psychiatry*, 146, 1592-1597.

Kulka, R. A., & Schlenger, W. E. (1993). Survey research and field designs for the

study of posttraumatic stress disorder. In J. P. Wilson, & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 145-155). New

York: Plenum Press.

- Kumpfer, K. L. (1999). Factors and processes contributing to resilience: the resilience framework. In M. D. Glantz & J. L. Johnson (Eds.), *Resilience and development: Positive life adaptations. Longitudinal research in the social and behavioral sciences* (pp. 179-224). New York, NY: Plenum Press.
- Kuterovac, G., Dyregrov, A., & Stuvland, R. (1994). Children in war: A silent majority under stress. *British Journal of Medical Psychology*, 67(4), 363-375.
- Larsson, G. (2000). Dimensional analysis of the Impact of Event Scale using structural equation modeling. *Journal of Traumatic Stress*, 13(2), 193-204.
- Lebowitz, L., Harvey, M. R., & Herman, J. L. (1993). A stage by dimension model of recovery from sexual trauma. *Journal of Interpersonal Violence*, 8(3), 378-391.
- Lee, B. S. (1988). Holocaust survivors and internal strength. *Journal of Humanistic Psychology*, 28(1), 67-96.
- Linehan, M. M. (1993). *Cognitive-behavioral treatment of Borderline Personality Disorder*. New York: Guilford Press.
- Lyons, J. A. (1991). Strategies for assessing the potential for positive adjustment following trauma. *Journal of Traumatic Stress*, 4(1), 93-111.
- Magwaza, A. S. (1999). Assumptive world of traumatized South African adults. *Journal of Social Psychology*, 139(5), 622-630.

- Massachusetts Department of Mental Health (1989, March). Refugee mental health needs assessment, a key informant study. Retrieved 7/1/04 from the World Wide Web at www.state.ma.us/dph/orih/sas1.htm.
- Masten, A. S., Best, K. M., & Garmezy, N. (1990). Resilience and development: Contributions from the study of children who overcome adversity. *Development and Psychopathology*, 2(4), 425-444.
- McFarlane, A. C., & Yehuda, R. A. (1996). Resilience, vulnerability, and the course of posttraumatic reactions. In B. A. van der Kolk, & A. C. McFarlane (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 155-181). New York: Guildford Press.
- McKelvey, R. S., & Webb, J. A. (1996). A comparative study of Vietnamese Amerasians, their non-Amerasian siblings, and unrelated, like-aged Vietnamese immigrants. *American Journal of Psychiatry*, 153(4), 561-563.
- Melville, M. B., & Lykes, M. B. (1992). Guatemalan Indian children and the sociocultural effects of government-sponsored terrorism. *Social Science and Medicine*, 34(5), 533-548.
- Mghir, R., & Raskin, A. (1999). The psychological effects of the war in Afghanistan on young Afghan refugees from different ethnic backgrounds. *International Journal of Social Psychiatry*, 45(1), 29-36.
- Miller, K. E. (1996). The effects of state terrorism and exile on indigenous Guatemalan refugee children: A mental health assessment and an analysis of children's narratives. *Child Development*, 67(1), 89-106.

- Mollica, R. F. (1989b). Developing effective mental health policies and services for traumatized refugee patients. In D. R. Koslow & E. P. Salett (Eds.), *Crossing cultures in mental health* (pp. 101-115). Washington DC: SIETAR International.
- Mollica, R. F., & Caspi-Yavin, Y. (1996). The assessment of events and their related symptoms in torture and refugee trauma. In T. W. Miller (Ed.), *Theory and assessment of stressful life events* (pp. 273-294). Madison, CT: International Universities Press.
- Mollica, R. F., Caspi-Yavin, Y., Bollini, P., Truong, T., et al. (1992). The Harvard Trauma Questionnaire: Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. *Journal of Nervous and Mental Disease*, 180(2), 111-116.
- Mollica, R. F., Cui, X., McInnes, K., & Massagli, M. P. (2002). Science-based policy for psychosocial interventions in refugee camps: A Cambodian example. *Journal of Nervous & Mental Disease*, 190(3), 158-166.
- Mollica, R. F., Donelan, K., Tor, S., Lavelle, J., Elias, C., Frankel, M., & Blendon, R. (1993). The effects of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps. *Journal of the American Medical Association*, 270(5), 581-586.
- Mollica, R. F., & Lavelle, J. (1988). Southeast Asian Refugees. In L. Comas-Diaz & E. E. H. Griffith (Eds.), *Clinical guidelines in cross-cultural mental health* (pp. 262-304). New York: John Wiley & Sons.

- Mollica, R. F., McInnes, K., Poole, C., & Tor, S. (1998a). Dose-effect relationships of trauma to symptoms of depression and post-traumatic stress disorder among Cambodian survivors of mass violence. *British Journal of Psychiatry*, 173, 482-488.
- Mollica, R. F., Poole, C., Son, L., Murray, C., et al. (1997). Effects of war trauma on Cambodian refugee adolescents' functional health and mental health status. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36(8), 1098-1106.
- Mollica, R. F., Poole, C., & Tor, S. (1998b). Symptoms, functioning, and health problems in a massively traumatized population: The legacy of the Cambodian tragedy. In B. P. Dohrenwend (Ed.), *Adversity, stress, and psychopathology* (pp. 34-51). New York: Oxford University Press.
- Mollica, R. F., & Son, L. (1989a). Cultural dimensions in the evaluation and treatment of sexual trauma. *Psychiatric Clinics of North America*, 12(2), 363-379.
- Mollica, R. F., Wyshak, G., & Lavelle, J. (1987). The psychosocial impact of war trauma and torture on Southeast Asian refugees. *American Journal of Psychiatry*, 144(12), 1567-1572.
- Mollica, R. F., Wyshak, G., Lavelle, J., Truong, T., Tor, S., & Yang, T. (1990). Assessing symptom change in Southeast Asian refugee survivors of mass violence and torture. *American Journal of Psychiatry*, 147(1), 83-88.

- Moore, L. J., & Boehnlein, J. K. (1991). Posttraumatic stress disorder, depression, and somatic symptoms in U.S. Mien patients. *Journal of Nervous and Mental Disease*, 179, 728-733.
- Neiger, B. L. (1992). Resilient reintegration: Use of structural equations modeling. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 52(04), 1937.
- Nicholson, B. L., & Kay, D. M. (1999). Group treatment of traumatized Cambodian women: A culture specific approach. *Social Work*, 44(5), 470-479.
- Norman, J. (2000). Constructive narrative in arresting the impact of post-traumatic stress disorder. *Clinical Social Work Journal*, 28(3), 303-319.
- Norris, F. H., & Riad, J. K. (1997). Standardized self-report measures of civilian trauma and posttraumatic stress disorder. In J. P. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 7-42). New York: Guilford Press.
- Orenstein, S. W. (1999). Predictors of explanatory style among Holocaust survivors. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 59(10-B), 5583.
- Paardekooper, B., de Jong, J. T. V. M., & Hermanns, J. M. A. (1999). The psychological impact of war and the refugee situation on South Sudanese children in refugee camps in Northern Uganda: An exploratory study. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 40(4), 529-536.

- Paker, M., Paker, O., & Yueksel, S. (1992). Psychological effects of torture: An empirical study of tortured and non-tortured non-political prisoners. In M. Basoglu (Ed.), *Torture and its consequences: Current treatment approaches* (pp. 72-82). Cambridge, England: Cambridge University Press.
- Papageorgiou, V., Frangou-Garunovic, A., Iordanidou, R., Yule, W., Smith, P., & Vostanis, P. (2000). War trauma and psychopathology in Bosnian refugee children. *European Child and Adolescent Psychiatry*, 9(2), 84-90.
- Parslow, R. A., Jorm, A. F., O'Toole, B. I., Marshall, R. P., & Grayson, D. A. (2000). Distress experienced by participants during an epidemiological survey of posttraumatic stress disorder. *Journal of Traumatic Stress*, 13(3), 465-471.
- Pope, K. S., & Garcia-Peltoniemi, R. E. (1991). Responding to victims of torture: Clinical issues, professional responsibilities, and useful resources. *Professional Psychology: Research and Practice*, 22(4), 269-276.
- Puttnam, D. P. (Producer), & Joffe, R. (Director). (1985). *The Killing Fields* [motion picture]. United States: Warner Brothers.
- Racklin, J. M. (1999). The roles of sense of coherence, spirituality, and religion in response to trauma. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 59(9-B), 5106.
- Radke-Yarrow, M., & Brown, E. (1993). Resilience and vulnerability in children of multiple-risk families. *Development & Psychopathology*, 5(4), 581-592.
- Richardson, G. E., Neiger, B. L., Jensen, S., & Kumpfer, K. (1990). The resiliency model. *Health Education*, 21(6), 33-39.

- Robbins, I., & Hunt, N. (1996). Validation of the IES as a measure of the long-term impact of war trauma. *British Journal of Health Psychology*, 1(1), 87-89.
- Rousseau, C., & Drapeau, A. (1998). The impact of culture on the transmission of trauma: Refugees' stories and silence embodied in their children's lives. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 465-486). New York: Plenum Press.
- Rozee, P. D., & Van Boemel, G. (1989). The psychological effects of war trauma and abuse on older Cambodian refugee women. *Women and Therapy*, 8(4), 23-49.
- Rumbaut, R. (1991). The agony of exile: A study of the migration and adaptation of Indochinese refugee adults and children. In F. L. Ahearn & J. L. Athey (Eds.), *Refugee children: Theory, research and services* (pp. 53-91). Baltimore, MD: John Hopkins University Press.
- Rutter, M. (1979). Protective factors in children's response to stress and disadvantage. *Annals Academy of Medicine*, 8(3), 324-338.
- Rutter, M. (1981). Stress, coping and development: Some issues and some questions. *Journal of Child Psychology and Psychiatry*, 22(4), 323-356.
- Rutter, M. (1985). Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry*, 147, 598-611.
- Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry*, 57, 316-331.

- Rutter, M. (1993). Resilience: Some conceptual considerations. *Journal of Adolescent Health, 14*, 626-631.
- Rutter, M., & Quinton, D. (1984). Long-term follow-up of women institutionalized in childhood: Factors promoting good functioning in adult life. *British Journal of Developmental Psychology, 2*(3), 191-204.
- Sack, W. H., Clarke, G. N., Him, C., Dickason, D., et al. (1993). A 6-year follow-up study of Cambodian refugee adolescents traumatized as children. *Journal of the American Academy of Child and Adolescent Psychiatry, 32*(2), 431-437.
- Sack, W. H., Clarke, G. N., Kinney, R., Belestos, G., et al. (1995). The Khmer adolescent project: II. Functional capacities in two generations of Cambodian refugees. *Journal of Nervous and Mental Disease, 183*(3), 177-181.
- Sack, W. H., Clarke, G. N., & Seeley, J. (1996). Multiple forms of stress in Cambodian adolescent refugees. *Child Development, 67*(1), 107-116.
- Sack, W. H., Seeley, J. R., & Clarke, G. N. (1997). Does PTSD transcend cultural barriers? A study from the Khmer Adolescent refugee project. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*(1), 49-54.
- Sack, W. H., Seeley, J. R., Him, C., & Clarke, G. N. (1998). Psychometric properties of the Impact of Event Scale in traumatized Cambodian refugee youth. *Personality and Individual Differences, 25*(1), 57-67.
- Savin, D., Sack, W. H., Clarke, G. N., Meas, N., & Richart, I. (1996). The Khmer adolescent project: III. A study of trauma from Thailand's site II refugee

- camp. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35(3), 384-391.
- Schaefer, J. A., & Moos, R. H. (1992). Life crises and personal growth. In B. N. Carpenter (Ed.), *Personal coping: Theory, research, and application* (pp. 149-170). New York, NY: Praeger.
- Schwartz-Lee, B. (1988). Holocaust survivors and internal strengths. *Journal of Humanistic Psychology*, 28(1), 67-96.
- Seligman, M. E. P. (1975). *Helplessness: On depression, development, and death*. New York, NY: Scribner.
- Shalev, A. Y., Bonne, O., & Eth, S. (1996). Treatment of posttraumatic stress disorder: A review. *Psychosomatic Medicine*, 58, 165-182.
- Shapiro, F. (1996). Eye movement desensitization and reprocessing (EMDR): Evaluation of controlled PTSD research. *Journal of Behavioral Therapy and Experimental Psychiatry*, 27, 209-218.
- Silove, D. (1999). The psychological effects of torture, mass human rights violations, and refugee trauma: Towards an integrated conceptual framework. *Journal of Nervous and Mental Disease*, 187(4), 200-207.
- Simich, L., Beiser, M., & Mawani, F. N. (2003). Social support and the significance of shared experience in refugee migration and resettlement. *Western Journal of Nursing Research*, 25(7), 872-891.
- Simpson, M. A. (1993a). Bitter waters: Effects on children of the stress of unrest and oppression. In J. P. Wilson, & B. Raphael (Eds.), *International*

handbook of traumatic stress syndromes (pp. 601-624). New York: Plenum Press.

Simpson, M. A. (1993b). Traumatic stress and the bruising of the soul: The effects of torture and coercive interrogation. In J. P. Wilson, & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 667-684). New York: Plenum Press.

Smith Fawzi, M. C., Murphy, E., Pham, T., Lin, L., Poole, C., & Mollica, R. F. (1997). The validity of screening for posttraumatic stress disorder and major depression among Vietnamese former political prisoners. *Acta Psychiatrica Scandinavica*, 95(2), 87-93.

Son, L. (1995). Understanding the psychological impact of war trauma and the refugee camp experience on Cambodian refugee children residing in site two. *Dissertation Abstracts International: Section A: Humanities and Social Sciences*, 55(8-A), 2285.

Stein, B., Comer, D., Gardner, W., & Kelleher, K. (1999). Prospective study of displaced children's symptoms in wartime Bosnia. *Social Psychiatry and Psychiatric Epidemiology*, 34(9), 464-469.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage Publications.

Tarter, R. E., & Vanyukov, M. (1999). Re-visiting the validity of the construct of resilience. In M. D. Glantz & J. L. Johnson (Eds.), *Resilience and development: Positive life adaptations* (pp. 85-100). New York, NY: Plenum Press.

- Thompson, M., & McGorry, P. (1995). Psychological sequelae of torture and trauma in Chilean and Salvadorean migrants: A pilot study. *Australian and New Zealand Journal of Psychiatry*, 29(1), 84-95.
- Tobin, J. J., & Friedman, J. (1983). Spirits, shamans, and nightmare death: Survivor stress in a Hmong refugee. *American Journal of Orthopsychiatry*, 53(3), 439-448.
- Tsay, S.-L. (1998). Appraisal, coping, social support, and posttraumatic stress of trauma patients one week following accidental injury. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 58(8-B), 4149.
- Turner, S. W., & Gorst-Unsworth, C. (1993). Psychological sequelae of torture. In J. P. Wilson, & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 703-713). New York: Plenum Press.
- Ung, L. (2000). *First they killed my father: A daughter of Cambodia remembers*. New York: Harper Collins.
- Vaillant, G. E. (1993a). Disadvantage, resilience and mature defenses. In *The wisdom of the ego* (pp. 284-325). Cambridge: MA: Harvard University Press.
- Vaillant, G. E. (1993b). How does the ego mature? In *The wisdom of the ego* (pp. 326-363). Cambridge, MA: Harvard University Press.
- van der Kolk, B. A., & Saporta, J. (1993). Biological response to psychic trauma. In J. P. Wilson, & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 25-33). New York: Plenum Press.

- Vila, G., Porche, L-M., & Mouren-Simeoni, M-C. (1999). An 18-month longitudinal study of posttraumatic disorder in children who were taken hostage in their school. *Psychosomatic Medicine*, 16(6), 746-754.
- Vu, T. Q. (1990). Refugee welfare dependency: The trauma of resettlement. In W. H. Holtzman, & T. H. Bornemann, (Eds.), *Mental health of immigrants and refugees* (pp. 234-244). Austin, TX: Hogg Foundation for Mental Health.
- Walker, E. A., Newman, E., Koss, M., & Bernstein, D. (1997). Does the study of victimization revictimize the victims? *General Hospital Psychiatry*, 19(6), 403-410.
- Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., & Keane, T. M. (1993). The PTSD checklist: Reliability, validity, & diagnostic utility. Paper presented at the *Annual Meeting of International Society for Traumatic Stress Studies*, San Antonio, TX, October.
- Weine, S., Becker, D. F., McGlashan, T. H., Vojvoda, D., et al. (1995). Adolescent survivors of "ethnic cleansing": Observations on the first year in America. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34(9), 1153-1159.
- Weisaeth, L., & Eitinger, L. (1993). Posttraumatic stress phenomenon: Common themes across wars, disasters, and traumatic events. In J. P. Wilson, & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 69-77). New York: Plenum Press.
- Werner, E. E. (1986). Resilient offspring of alcoholics: A longitudinal study from birth to age 18. *Journal of Studies on Alcohol*, 47(1), 34-40.

- Werner, E. E. (1989b). High-risk children in young adulthood: A longitudinal study from birth to 32 years. *American Journal of Orthopsychiatry*, 59(1), 72-81.
- Werner, E. E. (1992). The children of Kauai: Resiliency and recovery in adolescent and adulthood. *Journal of Adolescent Health*, 13(4), 262-268.
- Werner, E. E., & Smith, R. S. (1989a). *Vulnerable but invincible: A longitudinal study of resilient children and youth*. New York: Adams, Bannister, and Cox.
- Werner, E. E., & Smith, R. S. (1992). *Overcoming the odds: High risk children from birth to adulthood*. Ithaca, New York: Cornell University Press.
- WHOQOL group. (1995). The World Health Organization quality of life assessment (WHOQOL): Position paper from the World Health Organization. *Social Science and Medicine*, 41(10), 1403-1409.
- Willis, G. B., & Gonzales, A. (1998). Methodological issues in the use of survey questionnaires to assess health effects of torture. *Journal of Nervous and Mental Disease*, 186(5), 283-289.
- Wind, T. F., & Silvern, L. (1992). Type and extent of child abuse as predictors of adult functioning. *Journal of Family Violence*, 7(4), 261-281.
- World Health Organization. (1992). *The ICD-10 classification of mental and behavioral disorders*. Geneva: Switzerland.
- Yalom, I. D. (1995). *The theory and practice of group psychotherapy*. New York: Basic Books.
- Ying, Y.-W., & Akutsu, P. D. (1997). Psychological adjustment of Southeast Asian refugees: The contribution of sense of coherence. *Journal of*

Community Psychology, 25(2), 125-139.