

Long-term effects of exposure to mass trauma and resettlement amongst vietnamese ...

[Countries](#), [Vietnam](#)



Long-Term Effects of Exposure to Mass Trauma and Resettlement amongst Vietnamese Refugees in Australia

The short-to-medium-term adverse effects of exposure to mass trauma and displacement amongst refugee populations have been studied empirically. Findings from epidemiological studies have revealed that post-traumatic stress disorder (PTSD) and depression are two most prevalent mental disorders in these populations. The prevalence of these two disorders amongst refugee populations is higher than that of non-refugee populations (Fazel, Wheeler, & Danesh, 2005). This indicates that exposure to mass violence and trauma significantly contributes to psychological disability. PTSD plays an appreciable role in the development of depression (Kessler, 2000). The two categories of mental illnesses prevalent amongst refugees, PTSD and depression, are easily identifiable although they show variation across cultures. A dose-response association has been identified from several studies whereby cumulative exposure to trauma is linked with an increased risk for psychiatric morbidity (Steel et al., 2002). Uncertainty though persists about the long-term effects of trauma on the mental well being of resettled refugees (Silove et al., 2007). Studies assessing short and medium term effects are conducted shortly after refugee populations are exposed to trauma and in conditions of numerous abnormal stressors such as refugee camps. This leaves the possibility of early psychological reactions undergoing natural attrition over time (Steel et al., 2002). Knowledge of the long-term impacts of trauma on refugees is crucial since it informs planning for specialized mental health services. These services are necessary to prevent or mitigate trauma-related disability

amongst refugees. Australia hosts refugees from several countries that are or have been embroiled in armed conflicts currently and in the past. A significant number of Vietnamese refugees who fled their country after the communist wars of 1975 were resettled in the country. By 1996, the country was hosting more than 150, 000 Vietnamese refugees (Steel et al., 2002). Studies on the long-term impacts of mass trauma and resettlements amongst Vietnamese refugees in Australia have reported mixed findings. One study by Silove et al., (2007) compared the prevalence of PTSD and depression between a probabilistic sample of Vietnamese refugees and Australian-born citizens. The size of the Vietnamese refugees-derived and Australian samples were $n = 1, 161$ and $n = 7, 961$ respectively. The composite International Diagnostic Interview (CIDI) was used as the diagnostic tool for this survey. The prevalence of PTSD for both study groups was 3. 5%. The condition was present in 19% Australians and 50% of Vietnamese already diagnosed with mental disorders. For this study, trauma was the largest contributor to psychiatric morbidity amongst Vietnamese respondents (odds ratio > 8). Amongst Australian respondents, trauma (odds ratio > 4) and younger age (odds ratio > 3) played a role in the etiology of mental disorders. The disabling effect of PTSD was equal in both study populations although Vietnamese respondents reported physical whilst Australian respondents cited mental disability. The findings of this study seem to suggest that trauma continues to affect the mental well-being of a proportion of Vietnamese refugees more than a decade after being resettled in Australia.

A population-based study by Steel et al. (2002) arrived at conclusions similar

to the Silove et al. (2007) study. The sample for the latter study comprised of 1413 adult Vietnamese refugees who had been resettled in Australia. Of these, only 82% (1161) were interviewed. Questionnaires and a culturally sensitive measure were used to assess the presence of the International Classification of diseases version-10 (ICD-10) mental disorders and psychiatric symptoms respectively in the preceding 12 months. The effect of post-migration stressors was adjusted for by multivariate analysis. The study found that 7 % (75) and 8% (95) of the respondents had mental disorders as defined by the culturally-sensitive measure and ICD-10 respectively.

Exposure to trauma was the most significant predictor of mental illness. The risk for psychiatric illness decreased consistently over time. Participants who had been exposed to 4 or more trauma events (199) had an increased risk for mental illness 12% (30) as compared to those who had no history of trauma exposure 3% (13)(odds ratio 4. 7, $p < 0. 001$). Notably, the mean length of stay in Australia of all the Vietnamese participants was 11. 2 years and the average time since exposure to the most traumatic event was 14. 8 years. The findings of this study are similar to that of the previous study in that they suggest that most of the refugees are free of overt mental illnesses although a small proportion still suffers from trauma-related mental illnesses. The increased risk for psychiatric morbidity for persons exposed to cumulative trauma does not seem to decrease though. An almost identical study by Steel et al. (2005) also arrived at similar findings. The sample for this study was obtained via stratified multistage probability sampling of Vietnamese and Australian households in the state of New South Wales. A sample of 1611 Vietnamese refugees and 7961 Australian-born citizens was

identified. The measures, CIDI and MOS SF-12, were used to assess the 12-month prevalence of depression, anxiety, and drug and alcohol dependence in the two groups of respondents. The prevalence of these conditions was 6.1% and 16.7% amongst the Vietnamese and Australian respondents respectively. Notably, only the Steel et al. (2002) study used a culturally-sensitive measure. The cultural appropriateness of survey questionnaires influences the outcome of studies. This is because concepts of mental health tend to differ across cultures. For instance, the concepts of mental health held by indigenous Australians encompass social aspects in addition to psychological distress and behaviour problems. A study by Steel et al. (2009) sought to bridge this gap in evidence by comparing the prevalence rates of mental illnesses across Vietnamese residing in Vietnam and Vietnamese refugees in Australia. The study also included an Australian-born sample. Participants residing in Vietnam were drawn from a community in the Mekong Delta Region and were 3039 in number. The Australian sample consisting of Vietnamese immigrants and Australian-born participants was drawn from New South Wales and consisted of 1161 and 7961 participants respectively. Western-defined mental illnesses were assessed using CIDI 2.0 and included mood, anxiety, and substance-use disorders as well as neurasthenia as defined by ICD-10. The indigenously based Phan Vietnamese Psychiatric Scale (PVPS) was used to assess for culturally-defined mental illnesses amongst the Vietnamese participants. The prevalence rates of CIDI mental illnesses was 1.8% for Mekong Delta Vietnamese, 6.1% for Australian Vietnamese immigrants, and 16.7% for Australians. The inclusion of PVPS mental conditions increased the prevalence of these disorders to 8.

8% for the sample drawn from Mekong Delta and 11.7% for the Australian Vietnamese sample. Congruency between the PVPS and the CIDI was low for the Mekong Delta Vietnamese (AUC= 0.59) and moderate-to-good for Australian Vietnamese (AUC= 0.77). The findings of this study suggest that cultural variables affect the prevalence rates of mental disorders and non-culturally sensitive measures such as CIDI may underestimate their prevalence. Therefore, the findings of the previous studies cited need to be interpreted with caution because two of these studies did not utilize culturally-sensitive measures. Mixed findings have been reported for psychological disability related to long-term effects of trauma. The Silove et al. (2007) reported that PTSD was equally disabling in the two groups studied. The Vietnamese, however, tended to report physical rather than psychological symptoms. In the Steel et al. (2005) study, Vietnamese participants with mental disorders reported higher disability than their Australian counterparts. Notable differences also exist between the level of utilization of mental health services by Vietnamese refugees and Australian-born study participants. In the Steel et al. (2005) study, the two groups of participants reported comparable levels of mental health consultations. The Silove et al. (2007) study, on the other hand, found that 1 in every 10 Vietnamese immigrants and 1 in every 3 Australians with PTSD sought the help of mental health professionals. In summary, the studies conducted so far on the long-term effects of mass trauma to Vietnamese refugees suggest that majority of Australian Vietnamese refugees are free of mental illnesses. These studies have also reported comparable prevalence rates of PTSD and other mental disorders amongst Vietnamese immigrants and Australians-

born respondents. The prevalence rates for the Vietnamese population may be greatly underestimated. This is because of the studies cited; only two utilized culturally sensitive measures in assessing the prevalence of long-term trauma related adverse effects in this population. Therefore, further epidemiological studies using these measures are required. Long-term follow up of respondents who participated in the original studies on short-term and long-term effects of mass trauma may also provide clearer patterns on the natural attrition rates of these adverse effects. Additional studies are also needed on the health seeking behaviours of Vietnamese immigrants particularly for specialized mental health services. If found health service utilization is found to be low in this population, the factors underlying the low utilization also need to be investigated.

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