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The Effectiveness of Applying Psychotherapy to a Vietnamese Veteran With Post-Traumatic Stress Disorder

A Research Project Presented to

The Faculty of the College of Social Work

San Jose State University

In Partial Fulfillment

of the Requirements for the Degree of

Master of Social Work

Library San Jose State University

By

Cecilia Nga Nguyen

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The effectiveness of
applying psychotherapy to a
Vietnamese veteran with
Post-Tramatic Stress
Disorder

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Prof. Josie Romero, Faculty Field Liaison

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I. Introduction

Since the end of the Vietnam War in 1975, Post-Traumatic Stress Disorder (PTSD) has been a prevalent mental health problem among the Vietnamese community, especially among the Vietnamese combat veterans who recently immigrated to the United States. In their own land, they were made victims of Communist prisons, the so-called re-education camps. In these camps, they were continually exposed to hostile, life threatening situations, and physical/mental torture. This experience left many permanently damaged and made an indelible mark on their psyche that could never be erased or healed. Their resistance or lack of acceptance to mental health treatment for PTSD was due primarily to cultural tradition and language barriers. Thus, PTSD is often unrecognized and goes untreated among the Vietnamese community here in the United States, particularly among Vietnamese veterans.

This research project utilized a single subject design to measure the effectiveness of applying psychotherapeutic and behavioral frameworks to a Vietnamese male veteran with PTSD. The purpose of this study was to determine if the intervention could reduce the effects of PTSD symptoms (help break down the subject's social isolation) and improve the subject's self-confidence. This study was conducted at John XXIII Multi-Service Center, which is operated by Catholic Charities of Santa Clara County, California.

II. The Context of Services

The John XXIII Multi- Service Center is located at 195 E. San Fernando Street in San Jose, California. This center has been serving the needs of older adults in downtown San Jose and other neighborhoods in Santa Clara County since 1964. This senior center was originally located in Holy Family Hall at River and San Fernando Streets. Shortly after its inception, it received a three-year grant from the California Commission of Aging that enabled the Center to move into a two-story building. The John XXIII Senior Center is operated by Catholic Charities, a private non-profit organization.

Catholic Charities' Mission Statement, as described in its brochure states: "Through services and advocacy, Catholic Charities enhances the quality of life for all members of the community, especially the poor. We promote the dignity of the individual and the family. We partner with others in working toward a community based on justice, freedom, and compassion." Based on the mission of Catholic Charities, the John XXIII Multi-Service Center has been helping older adults in Santa Clara County to be healthy physically as well as mentally so that they can function at their highest level of independence. John XXIII Center provides a place where older adults can spend time to socialize, and feel at home.

At the John XXIII Senior Center, older adults have opportunities to learn English, study for U.S. Citizenship, participate in support groups, and have a hot meal prepared fresh daily in the center's kitchen. They are also provided other

activities such as exercise, dancing, meeting and socializing with friends, and a range of help from case managers and other professionals including mental health workers.

The Nurse Managed Health clinic at John XXIII Center provides services two days a week. San Jose State University staff provides low-cost medical services for adults and children including check-ups, immunization, women's health service, health education, and treatment for common illnesses. Most health services are free. For older adults who are too frail, the Independent Aging program (IAP) provides services such as Respite and Escorted Transportation so that these older adults can remain in their own homes and maintain an independent life style with an appropriate support system. IAP helps the homebound, those who are too frail to be active in the community. For older adults who are experiencing emotional problems and/or mental illness, they are provided case management and mental health services. Catholic Charities has a multi-disciplinary service team that includes an occupational therapist, licensed vocational nurse and social worker who do in-home evaluations. Other services include psychiatric evaluation, medication, individual, group and family therapy.

John XXIII is a "home away from home" for Chinese immigrants, Vietnamese refugees / immigrants, Indo-Americans and Hispanics. For many of these seniors, the Center is an important place where they seek advice and assistance from case managers, meet friends, and avoid isolation by participating and interacting with other people. Nutrition is very important to the seniors' health status. Therefore, the center provides lunch for the seniors with help from staff and volunteers. The Brown

Bag program provides dry or canned foods for seniors to take home. Direct services are carried out by 16 paid staff and about 150-200 volunteers who engage in a mutual support system. Teamwork is the management style used in this center. The clientele of John XXIII is made up of older adults who can come to the center for activities and also those who cannot come due to their limitation of mobility or transportation. The number of clients is estimated at 2,500 per month, and 70% are Asian seniors including Chinese, Vietnamese, Filipino/as, and Indo-Americans. About 20% are Caucasian and Latino/as.

The John XXIII Center is a non-profit organization, and provides an array of services to all older adults of Santa Clara County. Therefore, people from diverse backgrounds cannot be discriminated against due to race, language, or religion. The target population is multi-cultural. All clients are served according to the Cultural Competence Policy, which means the clients are provided with services that recognize and understand their cultural preferences. The services and programs of the Center are modified to keep current with the changing needs within the community.

The Center Administration is concerned about the projected increase in the elderly population of the United States and particularly the elderly in Santa Clara County. Challenges to living are often more frequent and complicated as people grow older. Their needs gradually become more complex and numerous. Emerging needs include in-home support and appropriate transportation. Each year the center experiences an increase in the number of people in need of its services.

The John XXIII Center Director receives supervision from the Catholic Charities Division Director. The John XXIII Center Director provides supervision for the John XXIII Staff in different programs. The staff structure, according to the Director of the Center, is comprised of professional and paraprofessional personnel and is supported by volunteers. The John XXIII Multi-Service Center collaborates with other agencies in providing effective and cost-efficient services. Its funding sources are diversified and include revenue from Catholic Charities, the United Way of Santa Clara County, government, foundations, and individuals. The size of its annual budget is $500,000.

At staff meetings, staff members are brought up to date on what is known about the clients and share any new information that has been obtained from the clients. This sharing of information and collaboration among the various disciplines enables the staff members to coordinate and develop the most appropriate plan of intervention that will meet the elderly client's needs and bring about community involvement.

Evaluation of clients at John XXIII is an on-going process. Clients are evaluated when they start to receive services and again when they have received the services. The center receives anecdotal information from the clients. The professionals who work at the center observe the clients and help to evaluate the Center's performance. Focus groups are also used to add to the information for evaluation purposes.

III. Target Population

The subject of this study is a 65-year-old Vietnamese male veteran who recently resettled in the United States. He is living with his wife in an apartment in San Jose. His son and daughter-in-law live in Milpitas, but they seldom visit his parents because the daughter-in-law does not want to get involved in the complicated problems of caring for her father-in-law. His strongest and almost sole support comes from his wife.

The subject's wife came to the John XXIII Senior Center to attend English classes and to join the mental health education/ support group for Vietnamese Seniors, which was organized by the researcher. In this group, the researcher addressed mental health issues, particularly the Post-Traumatic Stress Disorder symptoms and its consequences, of which members of the Vietnamese community are often unaware. His wife found this support group was useful to her. She wanted her husband, the subject of this study, also to come to this group but he rejected the suggestion. According to the wife, he always felt distress, fear or anxiety in social situations. However, his wife was finally able to persuade him to come to the Center to see the researcher, as a social worker intern, individually.

When the subject came to see the researcher, he complained that he often had head aches, stomach aches, difficulty falling asleep and not sleeping well at night, and dealing with nightmares and loneliness. While listening to his somatic complaints, the researcher recognized that the subject had a psychological problem

but he tried to hide his psychological stress problems because in the Vietnamese and other Asian cultures somatic complaints may be viewed as a defense mechanism as they present the expression of psychological pressures. The subject, after listening to the explanation of the necessity of treatment, was satisfied and voluntarily agreed to participate in the intervention process and in this study. In order to keep his confidentiality, he will be referred to as "Mr. V." in this investigation.

Mr. V. was born and raised in a middle-class family in South Vietnam. After two years in college, he had to join the Army like the rest of the young men in Vietnam during the war. Up to that point, he was a normal, happy man. After the end of the Vietnam War in 1975, Mr. V. was held for 12 years in various re-education camps where he endured life-threatening torture.

During the twelve years in the re-education camps, he was put in very small and dark rooms. Daily, he was given only a small bowl of rice or a few sweet potatoes to eat. He was constantly hungry, thirsty, and cold and in the dark. In those small rooms, he was often tortured with cattle prods and threatened with death many times, but he thought of his wife and his family and prayed every day for God's support. He tried to live, with the hope that one day he would see his loved ones again.

In 1987, after many years in re-education camps, he became so weak and so almost paralyzed, that the Communists thought he would soon die. Therefore they released him to die in his own house so that they would not be responsible for his death. After he was released, his wife and his family took such good care of him,

that as a result, his health gradually improved. He became physically strong, yet he started to experience significant psychological symptoms such as nightmares, anxiety and depression. He also developed a phobia, the fear and avoidance of social situations. He became irrational and out of control. He had difficulty interacting with his family members. Whenever he heard news of the death of one of his former associates in prison, he often asked himself, "Why have I survived when others more worthy than I did not?" His wife was afraid that he would lose his sanity because of his guilt complex. She encouraged him to seek help from doctors in his own town of residence. Unfortunately, in Vietnam there were no psychological treatment systems similar to those found in the United States. So Mr. V. received only medical, and not psychological treatment. As a result, he has been in severe emotional and mental pain for years, and he has never had any opportunity for treatment and recovery from his psychological problems.

In 1995, Mr. V. was allowed to come to the United States as a refugee. At first, he did not want to leave Vietnam because he could not speak English, and he thought himself too old to learn English and make adjustments to the new culture. However, his wife encouraged him to go to the Unites States with the hope that he would be less psychologically stressed because the Communist local police there would no longer be able to harass him.

In the United States, Mr. V. was aware of his mental problems, but he was discouraged by cultural tradition that considered treatment for mental condition to be negative and shameful. Furthermore, his language difficulty, culture differences,

psychological discomfort, and feelings of insecurity are the barriers to his receiving treatment. He has tried to forget his traumas, but they remain with him. The neglect of his psychological needs could lead him into a state of serious depression, unless he has an opportunity for treatment.

Mr. V.'s psychological symptoms fit the diagnostic criteria for 309.81, Post-Traumatic Stress Disorder described in the DSM-IV, 1994. His diagnosis was characterized by flashbacks of traumatic events, recurring nightmares, and phobic behavior lasting longer than one month. His ordeal under the Communist mistreatment is no longer present, but by not being able to overcome the events in the past, the torment continues to burden him.

Mr. V.'s DSM-IV Diagnosis (established on intake):

Axis I (Clinical Syndromes): 309.81 Post -Traumatic Stress Disorder (PTSD)

Axis II (Personality Disorders, mental retardation); V 71.09 (no personality disorder)

Axis III (General Medical Condition): none

Axis IV (Psychosocial and Environment problems): Being in prison for twelve years, tortured, and isolated

Axis V (Global assessment of functioning):

Current GAF = 54-60

Highest GAF in the past 2 years = 60-70

Highest GAF in the past (before the period in prison) = 90

IV. Theoretical Foundations and Literature Review

Before 1980, there was a shortage of extensive research on Post -Traumatic Stress Disorder (PTSD) among traumatized victims of war or other disasters. However, since then, the aspects of PTSD were formally introduced into the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM - III) published in 1980. In the current edition of DSM-IV, published in 1994, PTSD was classified as a new stress-response category (Beall, 1997). As a result, there has been a literal explosion of information on this psychological disorder in both scientific and popular literature, including an increasing number of studies, particularly for Vietnam War Veterans.

It was found in one study of Vietnam veterans, that PTSD rates of about 3.5% was found among non-wounded veterans and 20% among wounded veterans (Helzer et al, 1987). Other studies found PTSD in 40% of wounded Vietnam veterans, and 50% of prisoners of war (Speed et al, 1989). In another study, it was found that 15.2% of all male Vietnam veterans (479,000 out of 3,140,000 men who served in Vietnam) are currently diagnosed with PTSD. Likewise, 8.1% percent of all female Vietnam veterans (610 out of 7,200 women who served in Vietnam) have current cases of diagnosed PTSD. Among the men and women just mentioned, 30.9% of all male Vietnam Veterans had full-blown PTSD at some point in their lives, and 26.9% of all female Vietnam Veterans had full-blown PTSD sometime in their lives (Kulka, 1990).

In the last decade, many books on PTSD have been published. In addition, some movies also have incorporated PTSD into their plots, for example, *Born on the Fourth of July* (1989) and *Heaven and Earth* (1993). These movies presented the Vietnam veterans trying to cope with the trauma of war and exhibiting many of the classic symptoms of PTSD, such as emotional numbing, denial, startle responses, macabre interests in recreating traumatizing events, and substance abuse (Beall, 1997). Literature and the movies have provided information of realistic and vital nature for those who wish to help clients who have been impacted or afflicted by PTSD. The growing numbers of journal articles and books about PTSD testify to an urgent and deeply felt public concern for this disorder (Beall, 1997).

PTSD, according to Niles (1991), is defined as a delayed reaction to a psychologically traumatic event that is generally outside the normal human experience, such as war, terrorism, an accident or natural disaster, and physical or psychological abuse. Baldwin (1997, Internet) defined PTSD as a lingering, deep-seated, and negative emotional response to an event in the past that continues to cause undue levels of stress and anxiety in the present.

The major symptoms associated with PTSD are described in the DSM-IV, 1994, including the first group of symptoms as *intrusive symptoms*, which deal with the unwanted recollection of past painful events. Flashbacks or nightmares and memories are common forms of intrusive experiences of the traumatic events. For example, many Vietnam Veterans report mentally replaying especially problematic combat experiences over and over again. These thoughts are very uncomfortable and

disturbing, yet they are unable to put them to rest. The sound of helicopters, the smell of urine, or the sound of popcorn popping as the sound of small arms gunfire in the distance are the stimuli, which evoked uncomfortable memories for many Vietnam veterans (Baldwin, 1997, Internet). For many veterans, the sound of a helicopter flying overhead is a cue to forget reality for a few seconds and remember Vietnam, re-experiencing feelings they had there. For others, it is just a constant reminder of their time in Vietnam, something they will never forget (Baldwin, 1997, Internet).

The second group of symptoms is *avoidance.* The victims try to avoid thoughts, feelings, or conversations associated with the trauma. They also avoid activities, places, or people that arouse recollections of the trauma. For example, many veterans who witnessed traumatic experiences felt isolated and distant from their peers (Goodwin, 1987, in Post-Traumatic Stress Disorders: A Handbook for Clinician, edited by William). Many of them wanted to extend periods of isolation in the mountains, on the road, or just behind a closed door in the city (Baldwin, 1997, Internet).

The third group of symptoms is *hyperarousal***,** which consists of physiological signs of increased arousal, such as difficulty getting to sleep or staying asleep, irritability or outbursts of anger, difficulty concentrating, and hyper-vigilance, or increased startle response (American Psychiatric Association DSM-IV, 1994). For example, many Vietnam veterans described themselves as being very hypersensitive human beings. Their autonomic responses are tuned to anything out of the ordinary -

- a loud discharge will cause many of them to be startled, or they become very uncomfortable when people walk closely behind them. Some veterans are uncomfortable when standing out in the open, or are uneasy sitting with others behind them. They often prefer to sit against something solid or in the corner of a room where they can see everyone around them. These behaviors are learned survival techniques. If the veteran feels continuously threatened, it is difficult for him to give up such behavior (Baldwin, 1997 Internet).

The symptoms of PTSD are classified into two different phases: *acute* and *chronic*. According to Flannery (1992), if the symptoms of distress continue unabated or return within six months, the victim is in the acute/protest phase of PTSD. These symptoms are characterized primarily by anxiety and fear. The victim's life is fully disorganized by the traumatic event. During the first six-month period, if the traumatic event and its aftermath are not successfully treated or neglected, the victim enters the chronic/numbing phase. The characteristics of the chronic phase include feelings of withdrawal, isolation, numbing, and depression (Flannery, 1992). There seems to be a difference of opinion between Flattery's time-calculation and that of the DSM-IV (1994) as to how long the acute syndrome should last. Flannery calculated six months, but the DSM-IV estimated three months as a necessary test.

According to Figley (1985), people with PTSD problems usually have emotional reactions, such as shock, confusion, helplessness, anxiety, fear, and depression. The obvious example of this is the Vietnam combat veteran population.

The vast majority of Vietnam combat veterans are depressed; many of them have been continually depressed since their experiences in Vietnam (Goodwin, 1987). These veterans have the classic symptoms (DSM-III, 1980) of sleep disturbance, psychomotor retardation, feelings of worthlessness, difficulty in concentrating, and difficulty in establishing emotional relationships. Many veterans become extremely isolated when they are depressed. During depressive periods, substance abuse often occurs, and alcohol is their drug of choice. Many of these veterans possess weapons, and they are no strangers to death (Goodwin, 1987).

There is a considerable amount of research on PTSD problems being focused on mainstream Americans, especially on American Vietnam veterans. However, little research has been reported on the PTSD among minority ethnic and racial groups, particularly the Vietnamese population in the United States. Yet, PTSD is a prevalent problem (50%) among Indochinese refugees (Mollica, et al., 1987). There is no model for diagnostic assessment and treatment recommended for Southeast Asian, particularly for Vietnamese who have the PTSD problem.

As we know, since the end of the Vietnam War in 1975, nearly one million Vietnamese fled to the United States (Krakow's foreword in Once Upon A Dream, edited by Tran, Lam, and Nguyen, 1995). It has been estimated that about 52,000 Vietnamese of all ages are living in Santa Clara County, California (Le, 1997). They came here in different waves. The first wave, (1975-1977) was mainly composed of army officers, professionals, and businessmen. Many of them had been associated with the U.S. mission in Vietnam during the war. This group of people was

generously welcomed by U.S. with jobs and other benefits that enabled them to adapt more easily to their new country and became financially self-sufficient (Karnow in Once Upon A Dream, 1995).

The second major exodus (1977-1982), known as the "boat people," was composed of peasants and fishermen who took unpredictable risks to escape by sea to seek freedom. These people were less skilled, and had experienced serious multi-traumatic events, such as being robbed, raped, incarcerated, tortured, and many suffered the loss of loved ones in the sea during their escape. According to Knoll (1982), between 1977 and 1980 an estimated one-half million "boat people" left Vietnam, and 200,000 of them died at sea. About 80% of the boats were boarded by pirates who robbed, raped, assaulted, and killed the refugees. Many of the survivors had to stay in refugee camps under intolerable conditions for many years before coming to the U.S. In the new country, they had difficulties in adjusting to the new system. However, the Vietnamese tend to have a deep love for learning. They strive to learn the English language and American ways and values in order to succeed (Parker, 1996). They have tried to put behind and forget the traumatic events and deep bitterness experienced in the re-education camps. However, this approach is not an easy way to deal with PTSD problems. As a result, many Vietnamese refugee/ immigrants still have psychological problems.

The most recent group (1990 onward) is composed of South Vietnamese veterans and their families. These veterans were recently released from horrendous Communist re-education camps where they were continually exposed to hostile, life-

threatening situations and torture. Many of them had severe physical and mental injuries. These Vietnamese veterans experienced multiple-trauma associated with PTSD. The types of trauma endured by these Vietnamese veterans include (1) War trauma -- They experienced daily threats of death or injury. In battle, many were wounded and helplessly witnessed the deaths of friends. It has been estimated that about two to three million Vietnamese were killed during the course of the Vietnam War (Parker, 1996). (2) Re-education camp trauma -- After the war ended (1975), the Communists shunted some 300,000 former South Vietnam Officers into prisons (the so-called re-education camps) for years, under extremely harsh conditions. Thousands died of disease and malnutrition or at the hands of brutal guards (Karnow's foreword in Once Upon A Dream, 1995 edited by Tran, Lam, and Nguyen). These veterans have been traumatized by these unspeakable and unforgettable experiences (Foy, 1992). (3) Migration trauma included culture shock and cultural rejection that left many Vietnamese feeling alienated when they arrived in the United States. Lam's expression about this was "When we set foot on the American shore, history is already against us. Vietnam goes on without us. America goes on without acknowledging us. The Vietnamese refugee's first assessment is, inevitably, of his own helplessness" (Karnow in Once Upon A Dream, 1995). However, the Vietnamese's redeeming feature is their resilience -- their ability to look outside their own trauma and think of their children and grandchildren's future.

The unrecognized and untreated trauma experienced by these South Vietnamese veterans has left a chronic and, more or less, permanent condition of

broken human nature. Karnow (in Once Upon A Dream, 1995), expressed this fact: "These people are too broken to start over again". The subject of this study is one of these broken veterans.

The effective treatment approaches that can be applied to PTSD sufferers include counseling, psychoanalysis, cognitive-behavioral therapy, hypnotherapy, and in vivo desensitization or contextual analysis (Lindemann, 1996). There are also many treatment plans and guidelines in published literatures that are very helpful to therapists in planning intervention for clients with PTSD problems. At the same time, these guidelines are not intended to dictate the treatment of specific clients. Therefore, the treatment should be individualized because each individual is a unique system with unique experiences (Lindemann, 1996).

In the subject's case, the specific aspect of PTSD was an anxiety arousal manifested by his phobia, social phobia, which was the targeted problem for intervention. The term "phobia" is derived from the Greek word "phobos" meaning "fear" (Mavissakalian & Barlow, 1989). During the twelve years in re-education camps on a secluded and barren island in the northern part of Vietnam, the subject lived in fear and in isolation. His mind was constantly abused and battered by Communists. The subject's family, relatives, and friends were living far away in the South and were not informed of his actual location. For years, the subject had no visitors or any aid from his family. The only people coming to him were the prison guards or others of their kind, and each time they harshly questioned him for information, using verbal abuse or torture. This situation had significant detrimental

consequences on his psychological state and brought about a social anxiety disorder/ social phobia, which is a constant fear of being criticized or evaluated by other people (Richard, 1997-98, The Anxiety Network, Internet). According to Richard, a psychologist, people with social phobias are nervous, anxious, and afraid of many social situations. When they meet new people, especially those who are authority figures, they freeze up (URL: http:// www. Ranchandcowe. Com/virtual / Anxietynetwork/ptsd.hml).

Psychotherapy is appropriate in helping people with psychological disorders, such as Mr. V., the subject, because it has a greater acceptance as a treatment modality for mental disorders (Garfield & Bergin, 1986). Psychotherapy includes different effective approaches in treatment of phobias, such as education, relaxation training, in vivo exposure, and cognitive therapy (Lindemann, 1989). In psychotherapy, the main issue is what should be changed in behavior and how changes can be affected (Garfield & Bergin, 1986). In the subject's case, he is seeking elimination of the fear in social situations. Therefore, the "systematic desensitization" technique is a means to bring about the changes. Arkava (1974) described systematic desensitization as one of the most popular techniques of behavior modification. To Arkata, this teaching is an effective method of systematically producing change in behavior of individuals, groups, and complex organizations.

According to Rosenhan & Seligman (1989), the systematic desensitization technique for treatment of human phobias was developed by Joseph Wolpe, a South

African Psychiatrist, in the 1950s. This technique is considered as being one of the oldest and most effective psychological treatments in reducing fears and anxiety. It has been proven to be scientific, gradual, and humane (Rosenhan & Seligman, 1989). In this technique, the phobic client is first given exercises in deep muscle relaxation, and then, is progressively exposed to anxiety-evoking situations. "These techniques enable the person to deal with the symptoms, while gaining confidence that the feared consequences of panic attack will not occur," (Lindemann, 1996, p. 293). The following procedures are utilized in the systematic desensitization technique:

1) The phobic client is given exercises in deep muscle relaxation. These exercises help the phobic clients gain a state of relaxation that is expected to neutralize their fears. They also help clients obtain better physical and mental health status during the treatment.

2) The therapist helps the client in building a hierarchy of possibly frightening situations, ranking from the least to the most-feared scenarios. This approach helps the client gain self-control over what would have been an unrestrained sensitive response.

3) The client is exposed to a set of increasingly more fearful situations involving the phobic object while making a response incompatible with fear. At this phase, the client is able to stay in a relaxed state during the treatment while the fear is effectively suppressed through gradual exposition of the anxiety, evoking stimuli from the weakest to the strongest (Paul & Bernstein, 1973).

The significant and practical part of the systematic desensitization technique is that the therapist sincerely guides and directs the course and content of treatment with a small amount of time and effort spent on searching for etiological factors (Paul & Bernstein, 1973). Regarding the effectiveness of the systematical desensitization technique, Rosenhan and Seligman (1989) stated "eighty to ninety percent of specific phobias improve greatly with such treatment." (p. 211)

In conjunction with the systematic desensitization technique, the psycho-education approach was applied to this subject's case. This approach was used because the subject came from a culture that does not have psychological treatment systems. The subject had no knowledge regarding the PTSD symptoms, and he did not understand his phobias. Therefore, the psychoeducation could be an effective approach for the treatment of his phobias. This approach provided the subject with education, including the understanding of what is special about neurotic anxiety, and the causal role of the fear and the normalizing of the subject's reaction associated with PTSD symptoms (Lindemann, 1996). This approach enabled the subject to cope with his PTSD problems, in particular with his social anxiety/ social phobia more confidently and positively, and helped to assure the subject that he was not "crazy". Finally, helping the subject cope with the painful memories of past traumatic experiences was an important part of the ongoing care of the subject with psychological disorders.

V. Design of the Evaluation Study

The purpose of this study was to utilize a single system design to measure the effectiveness of applying psychotherapeutic and behavior frameworks for reduction of the subject's Post Traumatic Stress Disorder (PTSD) symptoms. The intervention in this study focused on treatment of the subject's anxiety (fear) in social situations and his deliberate avoidance of them. This problem was considered the most troublesome ongoing PTSD symptom that the subject has suffered. The consequence of this problem was the subject's social isolation. The aim of the intervention was to change the subject's behavior in common social situations and to reduce his social isolation. It was felt that the subject's ego was strong enough to engage in the therapeutic process of self-analysis and exploration. The subject lived independently and was mentally competent to sign the consent form for this study. Based on a psychotherapy approach, the planned interventions in this study included (1) the individual therapy, and (2) in conjunction with individual therapy, family therapy approach was used to support the subject's treatment.

In individual therapy, there were two preliminaries to the actual treatment including:

(1) The subject was provided the orientation to neurotic anxiety, inappropriate fear. The subject could have some understanding of what is special about neurotic anxiety, and appropriate fear. According to Wolpe (1990), "fear is appropriate under circumstances of real danger, for example walking alone at night in an unsafe

neighborhood. Fear is not appropriate when elicited by situations that contain no real threat -- such as seeing somebody receive an injection or entering a crowded room…Inappropriate fear is called neurotic fear," (p. 90).

(2) The researcher decided on the strategy appropriate for the subject. In the subject's case, the systematic desensitization technique was used as behavioral modification to reduce or break down the subject's anxiety (fear) in social situations. In general, systematic desensitization is indicated for the treatment of fear evoked by situations that one cannot handle (Wolpe, 1990). In the subject's case, the technique was to employ a counteracting emotion step-by-step to overcome an undesirable emotional habit.

Systematic desensitization technique involved three sets of operations:

(a) Relaxation training was introduced to the subject. The researcher asked the subject to sit down with his eyes closed and to begin a breathing exercise. During inhalation and with his muscles completely relaxed, the subject was asked to say silently in his mind, "I am letting go of my fear when I meet people", or "I am not afraid to talk to people". The subject was asked to do this for about six to twelve minutes. During the actual treatment process, whenever the subject started getting nervous, he was asked to do the same relaxation exercise for about ten to fifteen minutes.

(b) The construction of anxiety hierarchies began; the subject was exposed to a variety of social situations while trying to remain relaxed

as much as possible. The subject started with a minimally stressful situation (taking a walk with the researcher, outside the office, and greeting the people we met on the way with a little smile saying "Hello, how are you?") Then, he met and had conversation with two or three people. The subject then attended recreation with a small group of Vietnamese seniors in the center. Gradually, he attended the mental health education / support group of 20 members, which the researcher was conducting at the center. Then he shared his life-story with the group, and had lunch at the senior center with the group.

(c) The subject designed his own personal hierarchies with the help of the researcher as they applied to whatever stress or anxieties he had, ranking and ordering the situations as he prepared for the actual desensitization process. This was done during the pre-treatment period in the first two sessions. During the pre-treatment period, the researcher used "talk therapy" to normalize the subject's reactions by educating him about the nature of his PTSD. In applying the systematic desensitization, a one-hour session per week was needed. To augment the practice of desensitization of the subject's fear, the researcher assigned the subject to do homework, or daily practice.

When the subject had built the hierarchies for his fear and learned to relax, the actual desensitization process began. This process involved replacing his fear of being in various social situations by decreasing or replacing that fear with relaxation.

Thus, the subject was able to socialize with a larger group of people. These exercises required about fifteen to twenty minutes of observation each week.

In conjunction with individual therapy, a family therapy approach was used to support the subject's treatment and confidence in overcoming his PTSD symptoms. This supportive approach stressed the importance of family education about PTSD and the particular manifestation of his behavior, as well as why he had fear in various social situations and why he avoided them.

Within the Vietnamese culture, people consider the family as the center of the individual's life, the unit of society, and the model or prototype for all social relationships. All the members in the family have an obligation to provide one another with material as well as moral and emotional support. Consequently, the subject's strongest motivational force in his PTSD treatment was his family. The subject's family was able to help him re-establish some sense of control by providing the care, love, and respect he needed. It was important that the therapist help his family, particularly his wife, to understand his PTSD problems and direct them to help him overcome his phobia by accepting him and having a positive attitude toward him. Consequently, family support in his treatment was one of the most important factors of the subject's therapy.

The goals or the desired outcomes of the intervention were (1) to minimize or break down the effects of PTSD in order to reduce the subject's social isolation, his lack of interaction with other individuals, and the separation of himself from the outside world, and (2) to improve his relationships with his family and community,

through his understanding about PTSD and his psychological problems. The effectiveness of the intervention were determined by the standard measures used and the subject's self-report logs.

It is important for both psychotherapist and behavioral therapist to know how anxious the client is at a particular time and in relation to what circumstances (Wolpe, 1990). Therefore, the researcher first utilized the Subjective Anxiety (Sud) Scale to measure the subject's tolerance of fear. In this study, the construction of the Sud Scale was based on the magnitude of the subject's anxiety responses to specific stimuli. That is, in measuring the anxiety aroused by presenting stimuli in a hierarchical way, the subject's initial anxiety state was assessed and recorded at the onset of the study.

Using the Subjective Anxiety (Sud) scale, the subject reported his own tolerance for fear on a scale of 0 to 100. The highest anxiety that the subject could have experienced is 100. The subject's tolerance for fear was measured during the treatment phase or at the actual desensitization period. This scale was introduced to the subject verbally as follows: "Mr. V., think of the worst anxiety you have ever experienced or can imagine and assign to it the number 100. Then think of the state of being absolutely calm, no anxiety at all, and call this Zero (0). At this moment, using increments of 10's, how do you rate yourself? What number would you give to yourself?"

The Sud scale was created by Dr. Joseph Wolpe, and the score can be generally interpreted as follows: 0 is none; 50 is moderate; and 100 is high. There

were 10 intervals, ranking from the least to the most fearful circumstances that the subject could imagine. The time spent for each interval was dependent on what the subject could handle when being exposed to each situation.

Accordingly, the subject's level of tolerance for fear was constructed hierarchically as the following:

0 Calm state

10 The thought of going to meet someone

20 Actually meeting a person

30 Meeting two to three persons

40 Meeting a small group of five persons

50 Meeting a group of ten people

60 Meeting a group of fifteen people

70 Meeting a group of twenty people

80 Giving a speech to ten people

90 Giving a speech to twenty people

100 Giving a speech in front of a large group, fifty or more people

The second measurement technique used was the Social Avoidance and Distress Scale (SAD), which is 28 items designed to measure social fear or to assess anxiety in a social situation. The SAD scale was created by David Watson and Ronald Friend (Fischer & Corcoran, 1994, p. 593). It was appropriate to utilize this instrument because it provides a screening test for social anxiety, and it assessed two aspects of anxiety: one's experience of distress, discomfort, and fear, and the

deliberate avoidance of social situations (Fischer & Corcoran, 1994, p. 593). The SAD scale was chosen because it used simple language and could be administered orally or with paper and pencil. It required no special training for interviewers.

The scoring protocol and guidelines for interpretation are described as follows: According to Fischer & Corcoran (1994), each item is answered either "true" or "false." Items 2, 5, 8, 10, 11, 13, 14, 16, 18, 20, 21, 23, 24, and 26 are keyed for "true" answers, while the other items are keyed "false." (p. 593). The author of the scale noted (as cited in Fischer & Corcoran, 1994, p. 593) that the answers which match the keyed response are given the value of 0. Possible scores range from 0 to 28 with higher scores indicating more anxiety. The scale's reliability was described as follows: The instrument's internal consistency was assessed by correlating each item with the total score on the SAD. The average item to total score correlation was .77 (Fischer & Corcoran, 1994, p. 593). It is stated, "Reliability was also determined by using the Kuder-Richardson Formula 20 and was excellent with a correlation of .94. Test-retest reliability for a one-month period was .68 using a sample of 154 college students enrolled in summer school and .79 for a separate sample" (Fisher & Corcoran, 1994, p. 593). The SAD's validity was assessed by testing to see whether subjects with high scores showed more discomfort in a social situation than did subjects with lower scores (Fischer & Corcoran, 1994, P.593). The SAD scale is shown in Appendix A.

The other measurement was a Socialization Activities Weekly Log which was developed by the researcher. The log was not a precise scientific instrument.

However, from the viewpoint of face validity, it was a useful and simple tool that provided quantitative data about the subject's socialization activities on a weekly basis. The socialization activities included phone conversations or face to face conversations, visiting, and socializing. The subject was required to rate his socialization activities for the week using four possible responses as follows:

1. No activities
2. Having one to two activities
3. Having three to four activities
4. Having five or more activities

The scoring on the Socialization Activities Weekly Log ranged from 0-4, with "no activities" being assigned a score of 0, and "five or more activities" being assigned a score of 4. A higher score indicated an increase in socialization activities. It was believed that the socialization activities and weekly log could indicate any change in social isolation. The weekly log is shown in Appendix B. In addition to the formal scales and weekly log, the researcher also kept notes in which the observations and interactions of the sessions were described. The weekly log and the case notes were employed concurrently to measure progress toward goals.

Due to cultural sensitivity, the SAD scale and the weekly log were translated into written Vietnamese using the translation back-translation method (Brislin, 1970). First, the instruments were translated into the Vietnamese language by the researcher, a Vietnamese-English speaker. Second, a Vietnamese-English speaking graduate student who was not familiar with PTSD or social anxiety problem was asked to

back-translate instruments into English. Then the original instrument was compared to its back-translated version. If there were any particular part with discrepancies, it would be resolved by a team including two Vietnamese-English speaking mental health professionals and a non-Vietnamese speaking social work professional.

The intervention with the subject lasted for 10 weeks. During the first two weeks of this study, the researcher developed a therapeutic relationship with the subject. This is the baseline phase needed for the establishment of rapport and trust between the researcher and the subject. During the baseline period, the researcher reviewed the subject's problem and behavior. Then the goals or desired outcomes were identified. The termination issue was addressed in the baseline period and was brought up as a reminder during the treatment phase.

The training for relaxation and the anxiety hierarchies were introduced to the subject. Also the baseline measures were collected during the first two weeks of the project. The treatment was carried out during the treatment phase, which lasted for seven weeks. In this period, systematic desensitization was applied to the subject once a week by the researcher. There was one psychotherapy session per week and each session lasted for forty to sixty minutes.

Treatment ceased at the end of the ninth week. At the tenth week, the subject completed the post-test which was compared to the pre-test in the second week of the project. The tests were scored using the same Social Avoidance and Distress (SAD) Scale. Due to the subject's limitation of the use of English, the study was conducted in Vietnamese by the researcher, a bilingual Vietnamese-American woman.

The study utilized a single system AB design that is most often used by social work practitioners and researchers (Nelson, 1988). The "**A**" (dependent variable) is a baseline measurement of the subject's social anxiety prior to treatment. This baseline was established during the first two weeks. For example, the researcher considered the administration of the Social Avoidance and Distress (SAD) Scale, which was initially used to measure the subject's anxiety or fear in social situations. This was a pre-test, and the results of the pre-test were compared to the subject's condition after treatment. The "**B**" part of the design was the data collection during the treatment phase. Data was collected from different sources including subject self-reports, subject-kept logs, subject's family reports, researcher's notes, testing results, and observations. At the conclusion of the intervention phase, the data was analyzed to evaluate the decrease in the subject's level of anxiety or fear of social situations.

The AB design was chosen because of its appropriateness to the researcher engaged in social work practice as well as to the short-term nature of the study. The AB single subject design allowed the researcher to concentrate on one subject to determine whether or not a change had occurred in the subject's behavior.

According to Royse (1995), the advantages of this AB design include: (1) providing practitioners with immediate and practical feedback on the subject's progress, helping the researcher to continue with a particular technique or to modify the interventions; and (2) the design was simple to understand and to use. "Because of its simplicity, the **AB** design is virtually unlimited in its applicability in social work. This is perhaps its greatest strength." (Royse, 1995, P. 61)

The single subject AB design seemed to be appropriate and effective in carrying out the study on the subject. However, it had various disadvantages that Royse (1995) has described: (1) this design could not be used to prove whether or not the changes in the subject's behavior are due to specific interventions used. There may have been other factors that were responsible for change in the subject; (2) there is no control to compare with the subject. Therefore, there is no control for internal validity; and (3) in using a single subject, the researcher cannot generalize the results with the population in general. In order to have greater generalization, the study would need to be replicated with a number of clients.

Data analysis was made of the results on the pre-test measures, of the weekly log, and of post-test measures to determine if the intervention had a measurable impact on the subject's social anxiety and social isolation. The case notes provided qualitative information about the sessions and observations (before and during the intervention period) in order to record change or improvements. The comparisons between the quantitative data (scale and log scores) and the qualitative data (the observations and case notes) were included in the analysis of the intervention. Graphs were utilized to visualize presentation and comparison of the data.

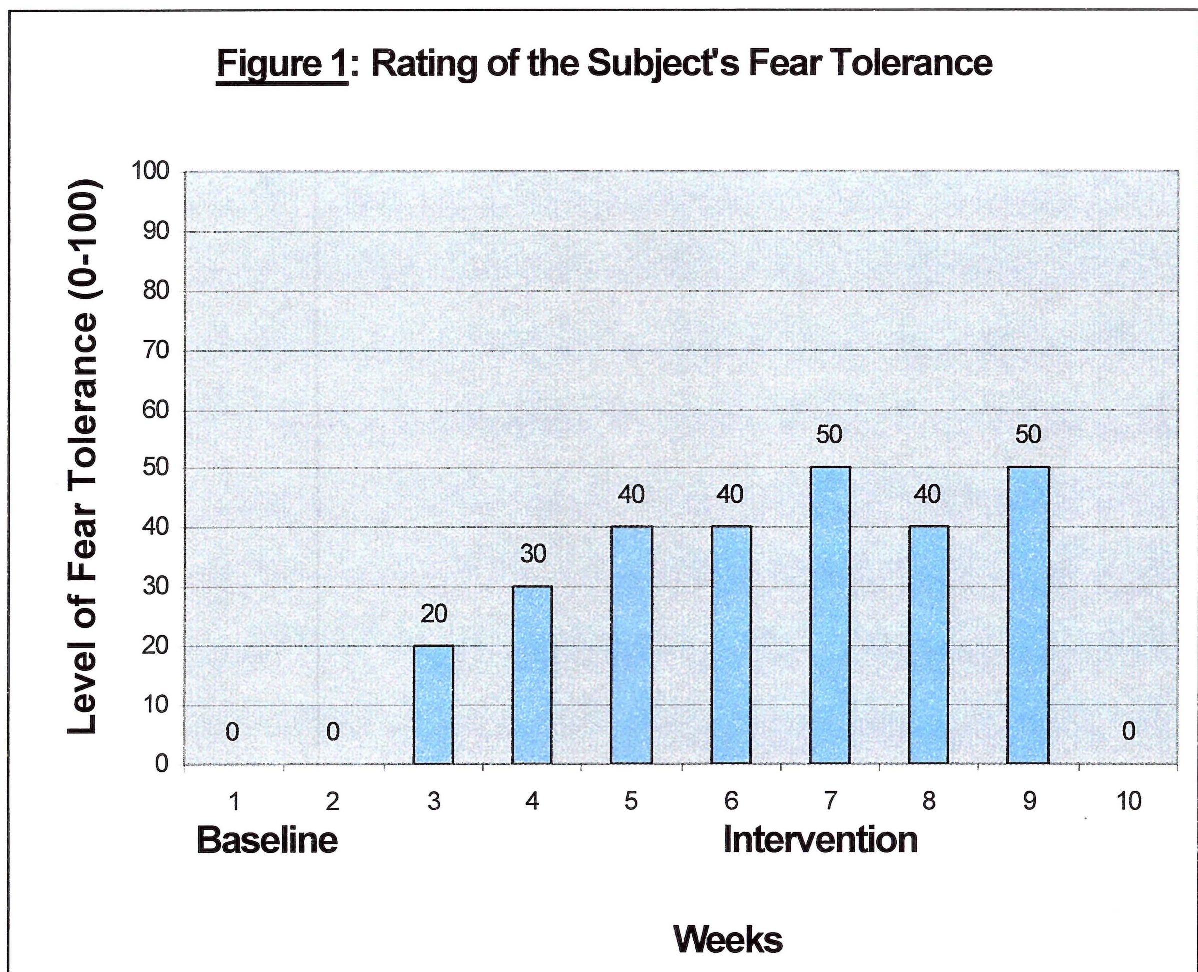
No physical harm to the subject was anticipated. The study involved only minimal mental risk to the human subject, but no greater than one would encounter in daily life. Privacy and confidentiality were protected by using a false name for the subject. Family members' names were changed or not used to preserve anonymity. The Human Subjects Committee at San Jose State University gave approval for this

research study on November 12, 1998. The approval letter from the University is shown in Appendix C. A copy of the Field Agency's Approval of Research Project Prospectus Form is shown in Appendix D. The Consent Form is shown in Appendix E. Diagnostic criteria for 309.81 Post-Traumatic Stress Disorder in DSM-IV, 1994, P.427 is shown in Appendix F.

VI. Results

The purpose of this study was to determine if the intervention could reduce the effects of PTSD symptoms, and help break down the subject's social isolation. The results of this research project were based on quantitative and qualitative data that were collected during the ten weeks of intervention.

A review of the Sud Scale collected during the treatment phase presented the subject's level of fear tolerance when he was exposed to the social situation in each session. The result of the measure is displayed in figure 1.



The Wolpe's Sud Scale was utilized as a measurement for fear tolerance during the treatment phase. The subject reported his own tolerance for fear on the scale of 0 to 100. According to Wolpe (1990), the score can be generally interpreted as follows: 0 is none; 50 is moderate; and 100 is highest level of fear tolerance. As demonstrated in figure 1, the subject had no (0) level of fear tolerance in the first two weeks. The treatment was not conducted in the first two weeks. During the first two weeks of this study, the researcher developed a therapeutic relationship with the subject. This is the baseline phase needed for the establishment of rapport and trust between the researcher and the subject. The relaxation lessons and breathing techniques were given to the subject during the baseline phase.

During the third week, the treatment began. The procedure was started by taking the subject to the outside of the office (where there were many people walking by). The subject took a walk with the researcher and greeted the people on the way with a little smile and said "Hello, how are you?" A plan was made to keep him walking and greeting people for a maximum of twenty minutes, but after fifteen minutes, the subject began to show the signs of physical discomfort such as heavy breathing and trembling hands. The relaxation exercises were given whenever he displayed fear reaction. As demonstrated in figure 1, the subject's level of fear tolerance was 20 on the scale.

The fourth week, the subject had a conversation with one person for fifteen minutes during the treatment session in the center. At first, the subject was nervous while talking. However, after few minutes, he showed some signs of being relaxed

such as smiling and stopping the trembling of his hands. The subject reported that his level of fear tolerance was 30 on the scale.

The fifth and the sixth week, the subject had a conversation with 2-3 people in the senior center for about twenty minutes. He moved one step up on the scale. He was able to talk with more than one person, and seemed more comfortable and more confident in trying to talk with them. In the fifth and sixth sessions, the subject reported that his level of fear tolerance was 40 on the scale.

In the seventh week, the subject attended activities with a small group of Vietnamese seniors at the center. In this session, the subject did show improvement in the level of fear tolerance. The subject was able to play cards and talk with people in the center for about twenty-five minutes. He was able to control his anxiety while he played cards with the group. He reported that the level of fear tolerance was 50 on the scale.

In the eighth session, the subject attended the education/support group of 20 members that the researcher conducted at the John XXIII Senior Center. The subject was exposed to a larger group of people. In this session, his anxiety set him back to the sixth week's level, 40 in the scale. He felt very uncomfortable and was able to endure for only ten minutes with the group. It was obvious that Mr. V. was struggling to deal with his fear by the evidence of his physical reaction-- perspiration. He was not able to control his anxiety for more than ten minutes.

In the ninth session, the subject attended the education/ support group again. This time his wife was also present in the group. In this session, the subject showed

a significant improvement in tolerance of fear. He was able to participate with the group for twenty-five minutes. He had been able to control his anxiety for a longer time period. He reported that his level of fear tolerance was 50 on the scale.

In the tenth week, the treatment ceased. Therefore, the level of fear tolerance in the tenth session was not shown in figure 1. In this session, the subject was given a post-test, using the same Social Avoidance and Distress (SAD) scale to score results. As a result, the post-test score was 20 on the scale. Upon comparing the pre-test score with that of the post-test, the researcher found that the subject's level of social avoidance was 5 points lowered after the treatment. The results of pre-test and post-test are exhibited in figure 2, on page 37.

At this point, the researcher recognized that the subject's chronic psychological problems needed a longer timeframe for his treatment. The researcher helped the subject to understand that post- traumatic problems do not go away by themselves, and that he has to work with effort for recovery. He needs to accept the fact that he has been traumatized for a long time. It will take time to be healed. The subject was encouraged to continue having treatment for his mental health problems. The researcher made it clear to him that it is acceptable to seek help. The subject was also encouraged to continue to participate in a support group for Vietnamese older adults who have post-traumatic problems. A group atmosphere would provide him with new coping skills.

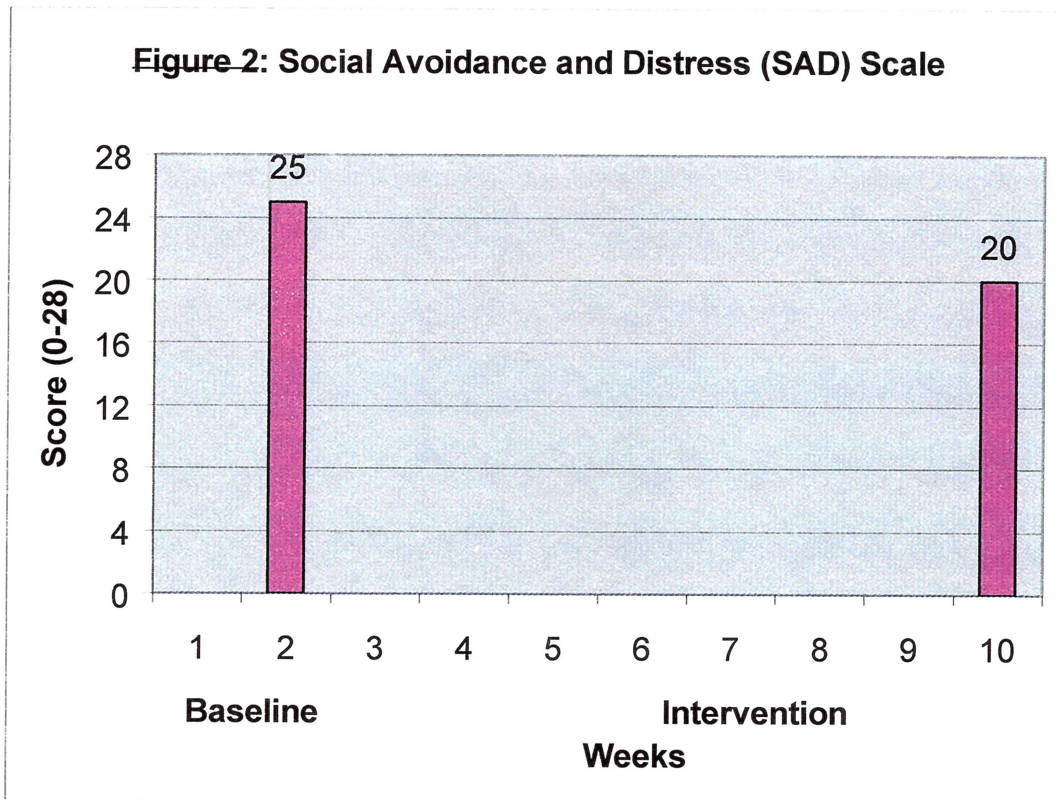
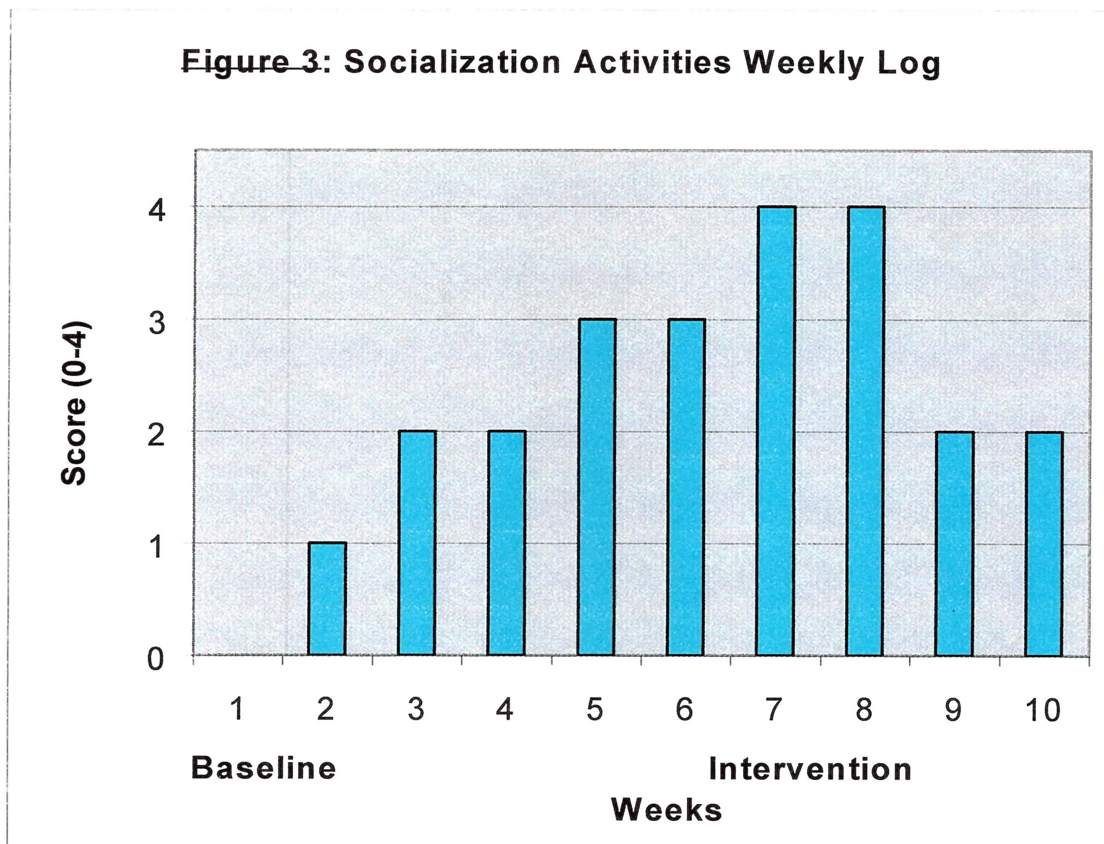


Figure 2 demonstrates the combined results of the baseline measurement taken in the second week of the intervention and the measurement taken in the tenth week when the intervention was completed. As is seen, there was little change or improvement in the subject's score after interventions were administered. His SAD post-test score had exhibited a change from his baseline or pre-test score. His pre-test score was 25, and his post-test score was 20. According to Fisher & Corcoran (1994, p. 593), the score 28 indicates the highest level of social anxiety and social avoidance. Thus, the subject's initial score in the pre-test was an indication of a rather high social anxiety and social avoidance. The post-test showed that the subject had a lower score of social avoidance.

As a measurement tool during the intervention, the subject was required to rate his socialization activities every week by using four possible responses: "No activities," "Having one to two activities," "Having three to four activities," "Having five or more activities." The scoring was ranged from 0-4 with "No activities being assigned a score of 0, " and "five or more activities being assigned a score of 4." A higher social activity score indicated an increase in socialization activities and a reduction in social isolation. Figure 3 shows the subject's scores on the Socialization Activities Weekly Log.



As demonstrated in figure 3, the subject's number of socialization activities gradually increased. During the seventh and eighth week the number of socialization

activities increased significantly. According to the researcher's case notes, the subject described that he was happy in the seventh and eighth week of treatment. He indicated that during these weeks the Vietnamese community celebrated the Vietnamese New Year. His son and daughter-in -law came to visit him and stayed with him for a few days. Also the subject and his wife also visited some Vietnamese friends during those weeks. His wife encouraged him to participate consistently in socialization activities. As a result, the score of socialization activities in these two weeks were highest among the ten weeks of treatment. However, after the New Year celebration the subject's socialization activities decreased significantly. In the case notes, the subject reported that during the ninth and tenth week, he did not feel happy because his son and daughter-in-law returned to their home. He also missed Vietnam, and was concerned about his relatives and friends who are still in Vietnam.

In the case notes, the researcher described that during the intervention period the subject was generally friendly, cooperative, and expressed interest in participating in this research study. The subject was motivated and exhibited initiative to improve or change his quality of life.

VII. Discussion

The scores on the Social Avoidance and Distress (SAD) Scale demonstrated that the subject's level of social avoidance was changed or improved after the intervention. However, the subject's improvement was slight. Two reasons may have affected the level of result. First, the subject of this study already had a chronic level of social anxiety resulting from his experience in the Communist Vietnam re-education camp in 1975. Second, the research considered the subject to have long-lasting and complicated mental health problems presented to the PTSD. Although brief, the intervention demonstrated that the desensitization process could be effective if the client's social involvement and reduction of fear tolerance in a moderately structured environment could be continued.

The subject's socialization activities weekly log demonstrated some swing or variability on the socialization activities. The case notes indicated that the type or nature of the social contacts or activities, such as extended visits from the subject's son and daughter-in-law and friends, had positive impact on the subject's mood and social isolation. Therefore, the family and the community could play an important part in helping the subject decrease his social isolation.

Throughout the intervention period, the researcher educated the subject about the necessity for socialization activities, and community activities, that could reduce the social isolation problems. The subject was provided numerous community events, at several local senior centers. The researcher encouraged the subject to participate in these social activities to expand his support system, and to reduce his

social isolation. The subject recognized his limited social support system, and expressed interest in participating at the senior center and in some community activities.

In this study, the researcher found that the desensitization technique was not the best procedure to meet her expectations, that is, to break down the social phobia in the subject. However, the systematic desensitization is a good way to handle learned anxiety and behavioral problems in the short terms. In the subject's case, the subject's social phobia was gradually reduced during the treatment although the reduction was not as great as anticipated. The technique demonstrated the subject could learn new behaviors, but the experience suggested longer mental health treatment was needed to harness the chronicity of the problem.

The researcher also found that the subject of this study, as happens to many other Vietnamese clients associated with mental health problems, was often ashamed of his symptoms, and did not want to talk about them. Therefore, education played an important role in demystifying the condition. Through education, the subject understood that after the long period of time he was isolated in the re-education camps, his anxiety response to the social situations was normal, and not "crazy". Homework assignments and encouragement were the elements of successful therapy in this intervention. The researcher played the role of a supportive coach working through feared situations while encouraging, pushing gently, and reassuring.

The limitations of this study were first, the single subject AB design could not be used to prove the changes in the subject's behavior, due to the specific

interventions used. There were other factors that were responsible for change in the subject, which probably included the education and his wife's encouragement and support. Secondly, this study was not community-based, but had a single subject focus. As such, the data reported and the results in this study cannot be generalized to all Vietnamese veterans in the United States. More research needs to be done in this population to determine the most appropriate and effective treatment modalities for this population, who suffer from a chronic disorder. The therapist must plan for long-term treatment, and not pressure for a rapid cure, which may provoke further PTSD symptoms.

The strengths of this intervention included involvement of individual and family therapy, and spiritual concerns. In the individual sessions, the researcher was able to build trust and rapport between the subject and the researcher. To help the subject to cope with his anxiety and his fear, the researcher began the session with relaxation by practicing breathing while listening to soft music. Since the subject is a devout Catholic, after practicing breathing, the researcher, who is also of the same faith, discussed spiritual life and they prayed together for a few minutes, then the subject continued sharing his life and his post-traumatic stress problems.

The researcher worked with the subject's family, which was an important part in helping him to reduce his social isolation. In the baseline phase, the researcher met with his wife to collect more information about him, and to orient her in understanding her husband's problems, his needs, and his healing process. By understanding her husband's dilemma, she was able to help him get through the

treatment process. The researcher also talked with the subject's son and daughter-in-law to help them understand the importance of their father's improvement. As a result, they came to visit their father more often to support him emotionally, psychologically, and financially if he needed it. Another strength included the awareness of Vietnamese cultural values and language. The researcher conducted the study in Vietnamese, the subject's native language. The subject was friendly, cooperative, and expressed interest in participating in this study. Even though the subject had a chronic social avoidance problem, he hoped that after treatment, his social phobia would be reduced. It was "hope" that kept him going. His hopefulness was his strength, which gave him a sense that life was still worth living.

It was mentioned in the early part of this paper that the number of Vietnamese veterans and re-education camp survivors who have entered this country is growing. It is necessary to have culturally appropriate mental health services available and future research is needed to evaluate the outcome of such services. Finally, the researcher realized that Vietnamese veterans have problems due not only to loss, displacement, and refugee status, but also due to the effects of excessively horrible, man-made traumas. In order to create effective therapy for this population, the therapist must have a meaningful integration of multiple therapeutic treatments because of the great differences between the Western and Asian cultures.

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Những Sinh Hoạt Xã Giao Hằng Tuần

(Socialization Activities Weekly Log)

Tuần # __________

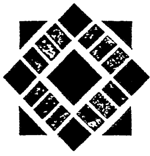
Xin đánh dấu vào câu trả lời nào đúng nhất cho bạn trong tuần qua. Bạn đã có bao nhiêu lần sinh hoạt như nói chuyện qua điện thoại, nói chuyện diện đối diện, và thăm viếng hay họp mặt xã giao trong tuần.

1. Không có sinh hoạt nào __________

2. Có một hay hai lần _____________

3. Có ba đến bốn lần ______________

4. Có năm lần hay nhiều hơn ________



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FROM: Nabil Ibrahim, N. Ibrahim
Acting AVP, Graduate Studies & Research

DATE: November 12, 1998

The Human Subjects-Institutional Review Board has approved your request to use human subjects in the study entitled:

"The Effectiveness of Applying Psychotherapes to a Vietnameses with Post Traumatic Stress Disorder"

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Nabil Ibrahim, Ph.D., immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that all subjects need to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate, or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have any questions, please contact me at (408) 924-2480.

The California State University:
Chancellor's Office
Bakersfield, Chico, Dominguez Hills, Fresno, Fullerton, Hayward, Humboldt, Long Beach, Los Angeles, Maritime Academy, Monterey Bay, Northridge, Pomona, Sacramento, San Bernardino, San Diego, San Francisco, San José, San Luis Obispo, San Marcos, Sonoma, Stanislaus

Appendix D

Field Agency's Approval of Research Project

San José State University
College of Social Work

Field Agency's Approval of Research Project Prospectus

Instructions: This form must be completed by all students participating in university related research projects, including S.W. 298 projects. The form should be completed and submitted to the student's S.W. 298 instructor or faculty sponsor. All students are expected to advise their agencies of the content of their research projects as well as plans related to their proposed methodology, data collection, and data analysis activities. Completion of this form does not remove the obligations of students to complete other college, university, or agency research review and approval procedures/policies.

If significant changes are made in the project a new form must be completed and submitted. All S.W. 298 students must complete and submit this form prior to commencing their actual research work with data collection or clients; and in any event before the end of their first semester of study.

The field instructor's or other agency representative's signature certifies that the student has discussed and shared their plans with the agency, and that the agency is not in opposition to the project. The S.W. 298 instructor and/or other college officials should be contacted if there are any concerns, questions, or objections.

Name of Student Cecilia Nguyen Name of Agency Catholic Charities - John XXIII Center

Field Instructor's Name Katherine Mason F.I.'s Telephone # (408) 944-0469 ext.189

SJSU Instructor's Name Fred Prochaska Semester(s) Fall 1998/ Spring 1999

Proposed Topic: The Effectiveness of Applying Psychotherapy to a Vietnamese Veteran Diagnosed with Post Traumatic Stress Disorder.

Brief Description of Project - Timelines, Sample/Subjects, and Methodology:

This research project is a Single-Subject AB Design to determine whether Psychotherapy/Psychoeducation could reduce the subject's PTSD symptoms, and improve the subject's Self-Confidence and quality of life.

This study will be conducted within the time frame of 10 weeks. It will be implemented in November, 1998, at John XXIII Multi-Services Center.

Signature of Student Cecilia Nguyen Date 10/2/98

Signature of Field Inst./Agency Rep. [signature] Date 10/2/98

Signature of 298 Instructor/College Rep. [signature] Date 10/5/98

Consent Form

Agreement to Participate in a Special Project Study

I have been asked to participate in a special project study that will evaluate the progress of an individual with Post-Traumatic Stress Disorder after Psychotherapy and Psychoeducation approaches are implemented. The purpose of this study is to determine if the treatment of psychotherapy and psychoeducation can reduce the individual's Post Traumatic Stress Disorder (PTSD) symptoms.

No physical or psychological harm is anticipated as a result of participation and there is no compensation for participation. The results of this study will not jeopardize my privacy and anonymity.

No services of any kind, to which I am entitled, will be denied me if I decide to participate in this study.

Participation is voluntary, and that I may withdraw from participation at any time without risk to services presently being received.

Questions about the participation in this study may be addressed to Cecilia Nguyen, MSW social worker intern, at (408) 955-9170 Ext. 137. Any complaint about participation in this project may be presented to Dr. Fred Prochaska, Project Chairperson/ Advisor, at (408) 741-2095. Questions about research, subject's rights, or research-related injury may be presented to Serena Stanford, Ph. D., Associate Vice President for Graduate Studies and Research, at (408) 924-2480.

My signature on this document indicates my voluntary agreement to participate in this study.

The signature of the researcher on this document indicates that the participant has been fully informed of his rights.

____________________	____________________	__________
(Participant's Name)	(Signature)	(Date)
____________________	____________________	__________
(Researcher's Name)	(Signature)	(Date)

Social Avoidance and Distress (SAD) Scale

For the following statements, please answer each in terms of whether it is true or false for you. Circle T for true or F for false.

T F 1. I feel relaxed even in unfamiliar social situations.

T F 2. I try to avoid situations, which force me to be very sociable.

T F 3. It is easy for me to relax when I am with strangers.

T F 4. I have no particular desire to avoid people.

T F 5. I often find occasions upsetting.

T F 6. I usually feel calm and comfortable at social occasions.

T F 7. I am usually at ease when talking to someone of the opposite sex.

T F 8. I try to avoid talking to people unless I know them well.

T F 9. If the chance comes to meet new people, I often take it.

T F 10. I often feel nervous or tense in casual get-togethers in which both Sexes are present.

T F 11. I am usually nervous with people unless I know them well.

T F 12. I usually feel relaxed when I am with a group of people.

T F 13. I often want to get away from people.

T F 14. I usually feel uncomfortable when I am in a group of people I don't know.

T F 15. I usually feel relaxed when I meet someone for the first time.

T F 16. Being introduced to people makes me tense and nervous.

T F 17. Even though a room is full of strangers, I may enter it anyway.

T F 18. I would avoid walking up and joining a large group of people.

T F 19. When my superiors want to talk with me, I talk willingly.

T F 20. I often feel on edge when I am with a group of people.

T F 21. I tend to withdraw from people.

T F 22. I don't mind talking to people at parties or social gatherings.

T F 23. I am seldom at ease in a large group of people.

T F 24. I often think up excuses in order to avoid social engagements.

T F 25. I sometimes take the responsibility for introducing people to each other.

T F 26. I try to avoid formal social occasions.

T F 27. I usually go to whatever social engagement I have.

T F 28. I find it easy to relax with other people.

Bản Trắc Nghiệm để Đo Lường sự Xa Lánh Giao Tiếp Với Xã Hội

(SAD Scale)

Để xác nhận những điều sau đây, xin trả lời cho mỗi câu đúng hay sai cho qúy vị.

Nếu đúng xin khoanh tròn chữ T; nếu sai xin khoanh tròn chữ F.

T F 1. Tôi cảm thấy bình tĩnh mặc dù ở trong những môi trường xã hội không quen thuộc.

T F 2. Tôi cố tránh những môi trường mà tôi phải giao tế.

T F 3. Tôi dễ dàng bình thản đối với những người không quen biết.

T F 4. Tôi không có điều gì để muốn chốn tránh thiên hạ.

T F 5. Tôi thường thấy khó chịu trong nhiều hoan canh.

T F 6. Thường thường tôi cảm thấy dễ chịu trong những dịp phải giao tế.

T F 7. Tôi thường cảm thấy dễ dàng khi nói chuyện với một ngườI khác phái.

T F 8. Tôi cố gắng tránh nói chuyện với người ta trừ khi tôi thật quen biết họ.

T F 9. Tôi không bỏ những cơ hội gặp gỡ những người không quen biết.

T F 10. Tôi thường cảm thấy bất bình tĩnh hay căng thẳng trong những buổi họp mặt bất thường mà trong đó có mặt cả hay phái.

T F 11. Tôi thường bị mất bình tĩnh đối với dân chúng trừ khi tôi thật quen biết họ.

T F 12. Tôi thường cảm thấy bình tĩnh khi tôi ở trong nhóm đông người.

T F 13. Tôi thường muốn chốn tránh dân chúng.

T F 14. Tôi thường cảm thấy khó chịu khi tôi ở trong một nhóm người mà tôi không biết họ.

T F 15. Tôi cảm thấy mình bình tĩnh khi gặp người ta lần đầu tiên.

T F 16. Khi tôi được giới thiệu với người khác, tôi thấy mất bình tĩnh và căng thẳng.

T F 17. Mặc dù trong một phòng đầy những người lạ, tôi vẫn thản nhiên bước vào không sao.

T F 18. Tôi sẽ tránh né đi với, hay tham dự vào với nhóm đông người.

T F 19. Khi người trên quyền muốn nói chuyện với tôi, tôi sẵn sàng nói chuyện với họ.

T F 20. Tôi thường cảm thấy bị bất tình tĩnh khi ở trong một đám đông người.

T F 21. Tôi có khuynh hướng tránh né người khác.

T F 22. Tôi không ngại nói chuyện với người ta ở trong những buổi tiệc hay những buổi tụ tập xã giao.

T F 23. Ít khi tôi hòa đồng trong nhóm đông người.

T F 24. Tôi thường lấy nhiều cớ để từ chối những buổi xã giao.

T F 25. Tôi thỉnh thoảng chịu trách nhiệm việc giới thiệu người ta với nhau.

T F 26. Tôi trốn tránh những việc xã giao nghiêm trang.

T F 27. Tôi thường đến bất cứ những buổi xã giao nào mà tôi có.

T F 28. Tôi thấy dễ dàng bình tĩnh đối với những người khác.

Socialization Activities Weekly Log

Week # __________

Please mark the answer that best describes how you rate your socialization activities (such as a phone conversation, face to face conversation, and visiting or socializing with others) for the week.

1. No activities ____________________

2. One or two activities ____________

3. Three to four activities __________

4. Five or more activities __________

Bản Ưng Thuận

Sự Đồng Ý Tham Gia váo một việc Nghiên Cứu học hỏi Đặc Biệt

(Agreement to Participate in a Special Project Study)

Tôi đã được mời tham gia vào một dự định nghiên cứu học hỏi đặc biệt về một người bị khủng hoảng tinh thần sau khi trải qua những biến cố kinh hoàng trong đời sống. Việc nghiên cứu này là để định lượng sự tiến triển của một người sau khi đã được chữa trị bằng phương pháp tâm lý và giáo dục. Mục đích của việc học hỏi này là để xem phương pháp trị liệu bằng tâm lý và giáo dục có làm thuyên giảm sự khủng hoảng tinh thần của người này không.

Kết qủa của việc tham gia vào việc học hỏi này sẽ không bị tai hại về thể lý hay tâm lý. Người tham gia sẽ không được trả công bằng tiền bạc. Tên tuổi và đời tư của tôi sẽ không bị nguy hại.

Tất cả những dịch vụ mà tôi đang được quyền hưởng sẽ không bị từ chối khi tham gia vào việc học hỏi này.

Việc tham gia này hoàn toàn do sự tự nguyện và tôi có thể rút lui không tham gia bất cứ lúc nào mà không ảnh hưởng đến những quyền lợi mà tôi đang được hưởng.

Những thắc mắc về việc tham gia vào việc học hỏi này sẽ được đặt ra với Cecilia Nguyễn, Nhân viên Xã Hội đang thực tập để lấy bằng Cao Học về Công Tác Xã Hội, tại số điện thoại: (408) 955-9170, ext. 137. Bất cứ điều gì muốn phàn nàn về việc tham gia này sẽ được trình bày với Dr. Fred Prochaska, vị chủ tịch/ cố vấn, tại số (408) 741-2095.

Những thắc mắc về sự tham khảo, quyền lợi của người tham gia, và những tổn thương liên quan đến việc tham khảo học hỏi này sẽ được trình bày vớI Serena Stanford, Ph. D., Trợ Tá Phó Chủ Tịch của trường Cao Học liên quan đến việc nghiên cứu học hỏi, tại số (408) 924-2480.

Chữ ký của tôi trên bản lưu này nói lên sự đồng ý tự nguyện của tôi về việc tham gia vào cuộc tham khảo học hỏi này.

Chữ ký của người nghiên cứu học hỏi trên tờ lưu này nói lên rằng người tham gia đã được trình bày cho biết tất cả những quyền lợi của họ.

______________________	______________________	___________
Tên Người Tham Gia	Chữ Ký	Ngày
______________________	______________________	___________
Tên Người Làm Nghiên Cứu	Chữ Ký	Ngày

Appendix F

Diagnostic Criteria for 309.81. Post-Traumatic Tress Disorder in DSM-IV

Diagnostic criteria for 309.81 Post-Traumatic Stress Disorder

A. The person has been exposed to a traumatic even in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

(2) the person's response involved intense fear, hopelessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive pay any occur in which themes or aspects of the trauma are expressed.

(2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).

Note: In young children, trauma-specific reenactment may occur.

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g., unable to have loving feelings)

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

(American Psychiatric Association (1994) DSM-IV, P. 427- 429).