Working with Vietnamese Americans: A Clinical Training Manual for Mental Health Professionals

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Working with Vietnamese Americans: A Clinical Training Manual for Mental Health Professionals

By

Thomas T. Nguyen

A Doctoral Project Presented to the Graduate School of Professional Psychology in Partial Fulfillment of the Requirements for the Degree of Doctor of Psychology

University of St. Thomas

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Doctoral Project Approval Form  

This doctoral project was submitted by Thomas Nguyen under the direction of the chair of the doctoral project committee listed below. It was submitted to the Graduate School of Professional Psychology and approved in partial fulfillment of the requirements for the degree of Doctor of Psychology at the University of St. Thomas.

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9/19/2013  
Date of Final Approval
Abstract

Vietnamese Americans are among the most recent immigrants to the United States (Min, 2006). There is a higher need of mental health services for those who have witnessed traumatic events (i.e., war trauma and forced migration) and those struggling with acculturative stress. Unfortunately, there is a significant deficit of culturally appropriate mental health service providers in working with this specific population (U.S. Department of Health and Human Services, 2010). Despite efforts within the field in recent years to identify barriers to mental health services among Vietnamese Americans, mental health service utilization remains low and rates of early termination remains high. For many Vietnamese, low services utilization does not equate to a lesser need, but it reveals the many barriers (e.g., misunderstanding the Western concept of mental health, language communication, and cultural beliefs and practices) that prevent them from seeking mental health services. Further, a higher early termination rate is likely the result of the clinicians’ lack of cultural awareness and training. Thus, there is a need for a clinical training curriculum for mental health professionals working with this target group. The curriculum will address culturally appropriate interventions (i.e., multicultural awareness, understanding the Vietnamese cultural perception of mental illness, working with language interpreters, and intervention skills) to ensure that clinicians are better equipped with the knowledge and the skills to assist Vietnamese Americans, and also the ever-increasing diverse community.
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Section I: Introduction

Introduction of Topic

Statement of Problem

Meeting the mental health needs of Vietnamese Americans has posed significant challenges for American clinicians since the arrival of the first Vietnamese refugees in 1975. Brown (1987) is among the first clinicians to publically raise awareness of the paucity of effective counseling resources for this immigrant group. Nonetheless, there remains a severe gap between the rates of mental health problems among Asian Americans and effective counseling and interventions (Sue, Cheng, Saad, & Chu, 2012). Compounding this dilemma, current literature on Vietnamese American mental health is limited to nonexistent. Recent waves of refugees and immigrants from Southeast Asia, particularly from Vietnam, need professional attention. Berthold et al. (2007) suggest that this population experiences unusually high mental health burdens resulting from conflicts and exposure to horrific violence resulting from the Vietnam War. The catastrophic and traumatic events surrounding the exodus of refugees from war-torn regions (Rutledge, 1992) are manifested in a range of physical and psychological disorders including: cancer, depression, anxiety, and posttraumatic stress disorder (PTSD) (Hauff & Vaglum, 1993; Kinzie et al., 1990; Mollica et al., 1990).

Once in the United States, immediate post-immigration stressors (i.e., acculturative stresses, limited English proficiency, employment, housing, discrimination) exacerbate lingering mental health problems (Hong & Ham, 1992). As a result, many Vietnamese refugees continue without access to basic physical or psychological treatment (Lin, Matsuda, & Tazuma, 1984). Compounding this challenge, immigrants are generally unaware of both symptomatology and appropriate resources for treatment (Pumariega, Rothe, & Pumariega, 2005).
Following their parents’ example, second-generation individuals (children of refugees/immigrants) exhibit lower rates of mental health utilization than third-generation individuals (Abe-Kim et al, 2007). Mental health disorders remain stigmatized even though these individuals (second-generation) are born and raised in the United States. Abe-Kim and colleagues (2007) suggest that both the family system and cultural factors (i.e., cultural practices and stigmas) may act to constrain service utilization even though English proficiency is rarely a barrier for second-generation Asian Americans.

In engaging this dual contrast, the United States Department of Health and Human Services (U.S. DHHS) in 2001 outlined two fundamental problems regarding mental health delivery models for Asian Americans. The first recognizes a continual absence of culturally appropriate and research-validated resource strategies. The second identifies a scarcity of competent cultural and linguistic providers. In other words, there is a lack of culturally appropriate, evidence-based practice for Asian Americans. Further, there are insufficient language specific, culturally competent clinicians working with Asian Americans, specifically with Vietnamese Americans.

In attempting to answer these fundamental problems, it is important to note that Asian American populations are proportionally the least likely of any racial group to seek professional services addressing mental health needs (Leong & Lau, 2001). Moreover, when clinical resources are identified, the same population group tends to abandon mental health treatment prematurely, often due to lack of culture-specific interventions (U.S. DHHS, 2001). Previous research confirms that Asian American clients exhibit poorer short-term outcomes and greater service dissatisfaction than White Americans (Zane, Takeuchi, and Young, 1994).
Further exacerbating this problem, Hall and Yee (2012) propose that the mental health needs of Asian Americans have been an overall low priority for clinicians. Detrimental to the Asian American community are views that regard this population as relatively: (1) a small racial group, (2) being a model minority, and (3) with little evidence of mental health disparities or neglect. These assumptions may have led to the greater gap between therapeutic services for Asian Americans and for the general population. Furthermore, clinicians and clinicians-in-training do not have sufficient practitioner-focused resources to prepare them for work with this population (Hong & Ham, 2001).

In 2001, the U.S. DHHS reported that mental health disparities do indeed exist in the provision of adequate and effective mental health care for Asian Americans because culturally competent and effective services are often unavailable or inaccessible. In 2010, there were approximately 74 mental health providers of Asian American heritage (psychiatry, psychology, psychiatric nursing, counseling, marriage and family therapy, and social work) available for every 100,000 Asian Americans in the United States; this figure is about one-third of the ratio for Whites (approximately 202 per 100,000) (U.S. DHHS, 2010). On a positive note, this is a slow gain from the 70 Asian American providers per 100,000 Asian Americans in the mid-1990s (Manderscheid & Henderson, 1998).

The Pew Research Hispanic Center projected that the Asian American population will increase from 5% of the total U.S. population in 2005 to about 9% of the total by the year 2050 (Passel & Cohn, 2008). This demographic trend suggests that clinicians of any race are more likely to encounter Asian American clients now and in the near future. Given this situation, it is urgent for mental health clinicians to be culturally aware of Asian American cultures and their mental health needs.
Statement of Purpose

Although a training curriculum that addresses all Asian American needs is ideal, mental health professionals are called to be mindful of the unique differences among Asian groups. Thus, this doctoral project creates an educational opportunity for clinicians in treating Vietnamese Americans. A series of instructional modules will raise the probability of mental health professionals delivering culturally proficient mental health services and develop effective strategies for engaging this population (Hong & Ham, 2001). The training curriculum will address specific domains (i.e., the clinician perspective) that remain significant barriers toward mental health services utilization. The modules will help clinicians gain culturally competent skills (i.e., racial attitudes and biases, working with language interpreters, intervention approaches) in working with this specific group. Further, this doctoral project will provide a comprehensive review of the Vietnamese American migration experience, adjustment challenges in America, and barriers inhibiting this specific group from seeking effective mental health intervention.

Culturally aware mental health professionals are encouraged to acquire additional training in working with culturally diverse clients (Hong & Ham, 2001). In recent years, there has been considerable emphasis on identifying and describing goals, objectives, and competencies for multicultural clinical training (Arrendondo et al., 1996; Pederson, 1998; Sue, Arrendondo, & McDavis, 1992). The present clinical training curriculum will follow Sue et al.’s (1992) conceptual framework of cross-cultural counseling competency, from which most of the cross-cultural skills can either be organized or developed. In this model, Sue et al. suggests that culturally competent counselors possess: an awareness of their own assumptions, values, and biases; an understanding of the culturally different clients; and the ability to develop appropriate
intervention strategies. Each of these characteristics has also three dimensional areas: beliefs and attitudes, knowledge, and skills.

This doctoral project proposes clinical guidelines that specifically and effectively bridge the cultural gap between mental health clinicians working with first and second generation Vietnamese Americans. A curriculum of this scope will direct the clinician through the various degrees of cultural complexity when working with Vietnamese American clients.
Section II: Literature Review

Methods

The search for literature was conducted primarily through PsychINFO, although other databases were utilized including Google Scholar, Social Work Abstracts, and PubMed. Index terms were used to determine article relation to the topic area and identify articles to be accessed. If articles were not immediately available, they were requested through St. Thomas interlibrary loan. Accepted sources include peer-reviews, journals, international journals published in English, and books with a basis in research.

Primary keywords for this search include, but are not limited to: Vietnamese Americans, Southeast Asian Americans, Asian Americans, immigrants, cultural competence, mental health, help-seeking behavior, services utilization, and treatment and interventions. Due to the limited resources available, the current literature review encompasses the literature circa 1975 or later in an effort to provide a fuller representation of Vietnamese American mental health that coincides with the first wave of Vietnamese refugees entering the United States. Initially, all articles were accepted. Once the article gathering process concluded, articles were sorted by topic area.

Literature Review

Due to limited literature on the Vietnamese American community, this literature review also includes literature regarding Asian Americans and Southeast Asian Americans to facilitate further understanding. Henceforth, the terms Vietnamese American and Asian American will be used interchangeably.

Overview of population characteristics

The Vietnamese immigrant population ranks as the fourth largest among Asian population subgroups with over 1.55 million Vietnamese living in the United States (U.S.,
Census, 2010). Within the Vietnamese American population, the majority is foreign-born (68%) and most are naturalized United States citizens (Nguyen, 2011). Following a review of general demographic data, this section defines three domains. First, this section reviews mental health related stressors for Vietnamese refugees. A more detailed historical background summary can be found in Appendix B (page 149). Second, this section identifies barriers and perception biases toward mental health services. Finally, this section surveys the current literature on cultural competency skills (i.e., use of language interpreters, building rapport, and intervention approaches) in clinical work with Vietnamese Americans.

**Background**

**Trauma.** Vietnamese American immigrants, in general, have experienced significant stressors after the fall of Saigon in 1975. The trauma inflicted by twenty years of civil war, by Communist-Vietnamese reeducation camps, by the boat-person experience, and by detention in refugee camps continues to linger for years after resettlement (Cargill & Huynh, 2000; Desbarats, 1990; Do, 1999; Do, Phan, & Garcia, 2001; Gold, 1992; Le, 2001; Pumariega et al., 2005; Rutledge, 1992; Sagan & Denney, 1982; Vo, 2006). Exposure to these traumatic events is in itself a major mental health risk (Beiser, 2005). Vietnamese immigrants continually experience significant stressors that negatively influence both physical and emotional health. In addition, the loss of extended family and their kinship network is another contributing factor that may further exacerbate Vietnamese immigrants’ mental health and adaptation challenges to the host country (Pumariega et al., 2005).

Trauma related stressors carry long-term psychological impact after resettlement in the U.S. (Chung & Bemak, 1998). Various studies have identified depression, anxiety disorders (i.e., PTSD), and cultural bound syndromes as correlated with victims of war and migration (Davis,
Fawzy and colleagues (1997a) studied the validity of PTSD among 74 Vietnamese refugees (51 former reeducation camp detainees and 23 political refugees) who had resettled in the metropolitan Boston area. The study found that the number of reported traumatic events was positively correlated with the severity of PTSD-related symptoms. In addition, political refugees experienced greater amounts of trauma accompanied with higher rates of mental disorders (Fawzy et al., 1997b). Although this study offers insights into the mental health needs for Vietnamese immigrants, the small sample size from the study warrant for a larger epidemiological study in order to provide adequate representation for this group.

On average, Vietnamese political refugees experienced over 12 traumatic events compared to the general Vietnamese population in the U.S. (Mollica et al., 1998). Further, over 90% of those surveyed exhibit PTSD symptoms while 49% show some symptoms of depression (i.e., of those who experienced on average 2.6 traumatic events, 79% had PTSD, and 15% had depression) (Mollica et al., 1998).

Tran’s (1993) research demonstrates correlations between pre-migration stresses, nightmares, acculturation stresses, personal efficacy, and depression within a sample population of 147 adult Vietnamese Americans. The results suggest that Vietnamese respondents who experienced more pre-migration stresses also reported increased nightmares and more acculturation problems. Moreover, Vietnamese with more acculturation stresses exhibited lower personal efficacy contributing to lingering depression (Tran, 1993). This is especially true within the older Vietnamese population, as this group has experienced significantly more pre-migration stresses than their younger counterparts (Tran, 1993). Furthermore, men experienced more pre-migration stressors than women, which is likely due to the many adult men who participated in the war as soldiers and exposed to the horrors of warfare.
Current literature about the psychological effects of migration on Vietnamese women is scarce. However, research suggests that Vietnamese women refugees suffered higher rates of physical and sexual violence (e.g., pirate attacks) during migration compared to Vietnamese men (Chung & Bemak, 1998). Vietnamese social mores strongly dictate that virginity and good behavior are normative for women (Chung & Bemak, 1998). As victims of sometimes grotesque sexual violence, Vietnamese women experience powerful shame and guilt. They report that this mistaken belief of “normative behavior” increases harm done to rape victims by adding self-blame for the abuse, thereby negatively affecting help-seeking behaviors (Chung & Bemak, 1998; 2006). An accompanying loss of self-respect and honor leads to a psychological process of repression and fear of family disgrace. Many women hesitate sharing their experience with their husbands for fear this revelation could end their marriage. This situation makes it impossible for many victims to turn to family members for counsel, leaving the woman to suffer in silence (Chung & Bemak, 1998).

Long-term effects of psychological trauma among Vietnamese immigrants appear to be high, and current literature suggests that Vietnamese immigrants in other countries share similar effects. Steel and colleagues (2002) presented a large scale (n=1,161), 10-year study among Vietnamese refugees resettled in Australia. Their study on acculturation and mental health shows that after more than a decade of resettlement, trauma-related mental illness among Vietnamese immigrants reduced steadily over time. Significantly, the prevalence rates of PTSD for the overall Vietnamese Australian respondents were comparable to the national Australian average of 3.5% (Silove, Steel, Bauman, Chey, & McFarlane, 2007). These findings imply that the mental health issues of Vietnamese immigrants do eventually parallel along roughly equal rates
with the general Australian population. However, people with a high degree of trauma exposure continually showed long-term psychiatric morbidity (Steel et al., 2002).

A second longitudinal study in Norway supports a similar conclusion. In this study, the majority of Vietnamese respondents achieved reduction in most mental health symptoms over time (Vaage et al., 2010). Nevertheless, unlike the study in Australia, a substantially higher proportion of the refugee group continued to reach threshold scores even after 23 years of resettlement when compared against the general Norwegian population (Vaage et al., 2010). However, further investigation is recommended due to this study’s low sample size (n=80).

A third PTSD-focused study in Australia confirmed the challenges of untreated PTSD. This study sampled the incidence of PTSD within unemployed Vietnamese migrants. The results showed that 42% of the respondents met DSM-IV diagnostic criteria for PTSD (Goddard & Patton, 1999). This suggests that Vietnamese immigrants with PTSD symptoms continue to experience difficulty in daily functioning, and in this case, obtaining and maintaining employment.

Vietnamese immigrants (i.e., war veterans) also experience other PTSD-related symptoms such as “survivor-guilt” syndrome and the eponymous “Vietnam syndrome” (Do, 1999). Survivor-guilt syndrome manifests as a personal existential crisis as the individual concludes her/his journey out of Vietnam. Individuals with PTSD may describe painful guilt feelings about surviving when others did not, or about things they had to do to survive (American Psychiatric Association, 1994). Often this condition accompanies tremendous amounts of trauma during the journey (e.g., death of loved ones, torture, and starvation). It is difficult to concretize the emotional distress for the survivor given the loss of family and the
concomitant feelings of inadequacy or unworthiness. Survivors continue to think about the myriad reasons why they should have died (Chung & Bemak, 2006).

The second symptom, Vietnam syndrome, manifests as a negative attitude toward social participation among others who are culturally and professionally capable of interaction (Do, 1999). This is especially pertinent to those Vietnamese who were part of military action and were uninformed about the rationale for a military withdrawal during the last months of the war. Other susceptible populations include former high-ranking military officials and those individuals who have spent years in the Communist reeducation camps (Do, 1999). Regrettably, there exists no literature in this area to provide additional insight on how the presented problems psychologically impact daily life.

In conceptualizing the current problems, although most Vietnamese immigrants are fairly adjusted to their host countries, many continue to silently suffer from mental health related problems (i.e., depression, anxiety, PTSD) (Chung & Bemak, 2008; Fawzy et al., 1997a; Goddard & Patton, 1999; Steel et al., 2002; Tran, 1993; Vaage et al., 2010). For example, almost all ex-political detainees and war veterans experience PTSD related symptoms and about half show symptoms of depression. Yet, many sufferers do not have access to culturally competent mental health services because of unavailability (U.S. DHHS, 2001).

Ultimately, clinician-focused research addressing Vietnamese Americans remains limited to non-existent. Current literature contains small sample sizes with a focus on epidemiology instead of on evidence-based practice approaches. Regrettably, generalizations cannot be made without further investigation. Moreover, there is limited literature on the long-term effect of untreated mental health symptoms and its effect on acculturation. Understanding this effect may help in predicting individual levels of acculturation and identify mental health needs. Lastly,
although there are numerous studies on trauma related issues among American war veterans, research regarding Vietnamese veterans and the cultural syndromes associated with PTSD is scarce. Additional study for further investigation and the development of evidence-based practice is clearly warranted.

Clinical implications of migration.

Adequate understanding of the migration experience is a major clinical factor for effective work with Vietnamese Americans. As previously mentioned, approximately 68% of Vietnamese Americans are foreign born (Nguyen, 2011). Due to this fact, clinicians working with the Vietnamese community require knowledge and tact regarding the psychological impact of migration (Hong & Ham, 2001).

Researchers divide the migration experience into three stages: premigration, migration, and postmigration (Ho, 1987). The premigration stage defines the period before commencing migration to another country. During this stage, individuals establish cultural value systems, practices, and beliefs in what is often the most stable period, and the individuals are likely well-adjusted (Hong & Ham, 2001). However, while this is often true for most migrants, family systems from war-torn countries (e.g., Southeast Asia) are inherently unstable due to trauma related stress (Kirkmayer et al., 2010). These stressors (i.e., civil war, Communist-Vietnamese reeducation camps, boat-person experience, and detention in refugee camps) often carry long-term psychological impact after resettlement in the U.S.

During the migration experience, many immigrants and refugees are separated from their families, support network, and cultural norms. The disruption of family life, in addition to trauma and isolation, contributes to higher levels of stress, which further affects the experience of acculturative stress during the postmigration phase (Ho, 1987; Hong & Ham, 1992; Mollica et
al., 1998). For example, immigrants to the newly adopted country often encounter unpredictable cultural and societal issues brought on by adjustment problems, economic situations, and racial or ethnic prejudice (Berry, 1997; Chung, 1993; Hong & Ham, 2001). In addition, migrants who were forced through the migration experience without a clear goal are more likely to feel distressed than those with established and definable reasons to migrate (Gong, Xu, Fujishiro, & Takeuchi, 2011). The authors suggest that if the individuals actively plan the migration, they are less likely to feel stressed and are more capable of acquiring coping resources in the new environment. For instance, individuals with clear goals for migration tend to have family in the host country and/or are connected to the cultural community to which they are migrating. The added social supports serve as buffers to acculturative stress and isolation (Gong et al., 2011). Furthermore, these individuals are more active in solving problems and transforming stressors into growth opportunities. On the other hand, individuals who are less connected struggle to find resources, which in turn lead to higher stress and depressive symptoms (Gong et al., 2011).

Another model used to describe the migration experience is the Ecological Fit System (Falicov, 1988), which is a modification of Brofenbrenner’s (1977) ecological model. This system considers environmental stresses (i.e., acculturation, economic, lack of familial support, and racial or ethnic prejudice) through interrelated and defined layered contexts: the microsystem, the mesosystem, the exosystem, and the macrosystem. The microsystem consists of family members; the mesosystem consists of interrelationships among the community (e.g., extended family, friends and peers, and religious affiliations); the exosystem consists of institutions or society (e.g., political, educational, governmental); and the macrosystem consists of overarching beliefs and values (Falicov, 1988). For many immigrants, the individual and their family systems experience significant disruption during migration, such as separation from
nuclear family members (microsystem) as well as extended family and community support 
(mesosystem). Given their new American context, immigrants then struggle to adapt to or define 
social, medical, and educational services (exosystem). Finally, these immigrants then learn to 
function and adjust within their new social cultural context and challenges (culture, language, overt/covert racism) (macrosystem) (Hong & Ham, 2001). Within this context, the more 
disruption or dissonance in the new ecological system, the greater the adjustment stress and the 
subsequent likelihood of dysfunction, yet it has been shown that most immigrant families 
achieve stability after resettling and acculturating to the newly adopted culture (Falicov, 1988).

**Adjustment and mental health.** In a study comparing five Asian American groups 
(Asian Indian, Chinese, Japanese, Korean, and Vietnamese), the Vietnamese were found to be the least acculturated to the newly adopted culture when compared to other Asian American respondents (Sodowsky, Lai, & Plake., 1991). The authors hypothesize that the Vietnamese migration status (being not only immigrants but also refugees) influenced their effective acculturation level. Current literature suggests there are tremendous differences in acculturation levels between each ethnic group, with generational differences and immigration status as influencing factors in effective acculturation (Sue & Sue, 2008). Therefore, since Vietnamese immigrants are the most recent group of immigrants, with also a unique reason for migration, it is likely they are the least acculturated compared to the other target groups.

Research on migration stress and the mental well-being of Asian Americans is a developing field of interest. Sue and colleagues’ (2012) review of the literature suggests that some studies indicate a greater severity of mental health disorders within the population while other studies find a lower severity for Asian Americans. The cause for these contradictory findings lies within the data for prevalence rates of mental disorder among Asian Americans,
which is influenced by several factors: sample size, heterogeneity of Asian cultural groups, and
dynamically changing demographic characteristics (Sue, Sue, Sue, & Takeuchi, 1995). Thus, this
calls for an effective review of the mental health literature reporting on prevalence rates of
mental disorders among Asian Americans, specifically reports regarding Southeast Asians and
Vietnamese, which are especially confounded.

**Asian American prevalence rates of mental disorder.** Asian Americans are an extremely
heterogeneous category, with nearly 15.5 million people from various Asian ethnic groups
residing in the U.S. (Hall & Yee, 2012). This broad definition includes Asian Indians,
Cambodians, Chinese, Filipinos, Japanese, Koreans, Vietnamese, Pacific Islander Americans,
and many other groups. Stereotypical beliefs about Asian Americans as models of well-adjusted
ethnic minorities have, in some cases, justified the lack of attention and resources dedicated to
this population (Hall & Yee, 2012; Lee, Lei, & Sue, 2001).

Although Asian Americans are proportionately the fastest growing minority group,
mental health services and delivery for this group is disproportionate. Lee and colleagues’ (2001)
review of the literature reveal that the prevalence rates of depression, somatization, and PTSD
among Asian Americans are at least equal to rates for White Americans, and in many cases,
some Asian groups exhibit even higher rates of psychiatric disorders. For example, Southeast
Asian refugee populations experience higher rates of PTSD, depression, and anxiety as an
aftermath of the Vietnam War and the atrocities committed by the Khmer Rouge (Lee et al.,
2001). The current data clearly suggests that Asian Americans, in general, require as much
access to mental health services as White Americans.

Immigrant men and women experience mental health problems differently. American-
born Asian women were strongly associated with lifetime mental health disorders, while foreign-
born women report lower rates of disorders compared to U.S.-born women (Takeuchi et al., 2007). For Asian men, low levels of English proficiency were associated with mental disorders; immigrant men who spoke English proficiently generally had lower rates of lifetime and 12-month disorders compared to non-proficient speakers (Takeuchi et al., 2007).

The Takeuchi et al. (2007) study above suffers from several limitations. First, social expressions of psychiatric disorders enjoy distinct perspectives in different cultures (Sue et al., 2012), whereas Takeuchi et al. (2007) focus primarily on Western expressions of psychiatric disorders (i.e., those defined by the Diagnostic and Statistical Manual of Mental Disorders- 4th edition). Therefore, researchers can easily miss the physical expressions of psychiatric disorders, some of which are in fact acceptable within Asian sub-cultures. For example, the individual may experience unexplainable headaches, pains, and other physical complaints as a sign of psychological distress (Bernstein, 2007). Second, the Takeuchi et al. study ignores crucial acculturation factors as potential causes for lower psychiatric disorders among recently arrived immigrants. It is hypothesized that newly arrived immigrants exhibit a tendency to under-report disorders due to fears of stigmatization while more acculturated immigrants and U.S.-born Asians tend to endorse Western cultural belief sets (Sue et al., 2012). Thus, U.S.-born individuals are more likely to recognize and communicate mental health symptoms effectively compared to foreign-born individuals, which may lead to the appearance of a higher trend of mental disorders among U.S.-born Asians. Lastly, the study’s data fails to differentiate between immigration related factors (i.e., refugees vs. immigrants, trauma exposure, and acculturation level), many of which affect individual well-being (Chung & Bemak, 1998; Sue & Sue, 2008).

Contradicting results about Asian American prevalence rates of mental disorders is a possible explanation of mental health disparity among Asian Americans. There are several
large-scale studies that provide epidemiological information on the state of mental health for Asian Americans. For example, the National Latino and Asian American Study (NLAAS), the first national epidemiological survey of Asian Americans in the U.S., indicates that the potential lifetime prevalence rate of any psychiatric disorder for Asian Americans is 17.3%, while a 12-month prevalence for any disorder is 9.19% (Takeuchi et al., 2007). In contrast, the prevalence rates of mental health disorders for Asian Americans are respectively lower than non-Hispanic Whites, African Americans, and Hispanics (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005; Sue et al., 2012). For instance, The National Survey on Drug Use and Health (NSDUH) reveals that Asian Americans have the lowest rates of substance abuse and overall mental health disorders compared to any other racial groups (Sue et al., 2012). However, certain Asian American groups may be at a higher risk than the general Asian American population. Research suggests that Southeast Asian refugees and immigrants continue to suffer a high rate of psychiatric disorder after resettlement (Chung & Bemak, 1998; Steel et al., 2002), which also suggests there is a distinct difference between Asian cultural groups that requires further exploration.

In general, the prevalence rates of Asian American mental health can be understood as follows: Asian cultures are highly heterogeneous (Sue et al., 2012), migration status (refugee vs. immigrant) correlates with one’s mental health status (Buriel & De Ment, 1997; Falicov; 1988; Sodowsky et al., 1991), and Asian Americans as a whole enjoy lower prevalence rates of mental health disorders when compared to other minority racial groups; however, there is a significant difference of prevalence rates between Asian inter-cultural groups (Sue et al. 2012). The following section will take a closer examination of Southeast Asians, specifically Vietnamese Americans, as being the identified at-risk group (Chung & Bemak, 2006).
Southeast Asian prevalence rates of mental disorder. As previously mentioned, not all Asian cultural groups have similar migration experiences; nonetheless, immigration status plays an important role in acculturation and individual psychological well-being (Lui & Rollock, 2012). Current literature suggests that those who leave their country due to political reasons are both more resistant to cultural change and are at a higher risk of psychological distress (Gong et al., 2011; Ho, 1987; Mollica et al., 1998). It is suggested that these individuals lack sufficient resources (i.e., family and community support, limited English proficiency) in the host country which contributes to higher stress and renders them less receptive to change (Gong et al., 2011). In contrast, economic migrants, those who have the means and resources to migrate, tend to be more acculturated and receptive toward the cultural change (Buriel & De Ment, 1997; Shapiro et al., 1999; Ying & Han, 2007).

Many mental health issues originate from the trauma of the migrant experience. Kirmayer and colleagues (2011) suggest that refugees (the majority of forced migrants) who experienced severe exposure to violence often have higher rates of trauma-related disorders such as PTSD, depression, and other somatic complaints. Nicholson (1997) examined the direct and indirect effects of a series of premigration (e.g., experienced trauma) and postmigration factors (e.g., current stressors, perceived health status) on the mental health status among 447 Southeast Asian refugees. The study found that 40% of the participants suffer from depression, 35% from anxiety, and 14% from PTSD. In addition, some immigrants continue to experience a high rate of psychiatric disorders, even decades after their resettlement (Vaage et al., 2010). Stemming from this evidence, Southeast Asian refugees and immigrants are likely to encounter psychological distress and adjustment issues due to traumatic events experienced during migration. Thus, further exploration on the mental health status of this group is warranted. The additional research
will provide further insights into the prevalence rates of mental disorders among the Southeast Asian refugees, which the current literature is lacking.

Marshall, Schell, Elliott, Berthold, and Chun (2005) assessed the prevalence, comorbidity, and correlation of various psychiatric disorders within a Cambodian refugee community after two decades of resettlement in the United States. Their findings suggest that statistically all participants had experienced trauma before immigration (e.g., 99% experienced near-death due to starvation, 98% experienced combat situations, 90% lost family members or friends to murder, and 54% were tortured), and that about 70% of the participants reported exposure to violence following resettlement in the United States. In terms of mental health status, approximately 42% suffer a high comorbid rate of PTSD and depression. Among the respondents, 62% meet DSM-IV diagnostic criteria for PTSD and 51% meet diagnostic criteria for major depression within the past 12 months. From the current evidence, it can be concluded that Southeast Asians, especially those who endured the atrocity of war, have a higher need of mental health related services among the Asian groups (Marshall et al., 2005; Nicholson, 1997; Vaage et al., 2010).

Immigrant children of many Southeast Asian families are negatively affected by their parents’ traumatic experiences and troubled adjustment to the host country. A recent study suggests that such children and adolescents can suffer from similar conditions as their parents, including PTSD, depression, and anxiety (Pumariega et al., 2005). A survey conducted by the Commonwealth Fund found that 30% of Asian American girls in grades 5 through 12 reported depressive symptoms (Ida & Yang, 2003). Longitudinal studies on Cambodian adolescents who had suffered severe trauma suggest that between 25-50% were diagnosed with PTSD years after the trauma (Pumariega et al., 2005). However, many continue to suffer in silence since their
school functioning was not affected and thus, the children went unnoticed by the teachers who cared for them. Although there is limited research on the direct correlation of mental health with Southeast Asian immigrant children, Pumariega and colleagues (2005) suggest that this sub-group is strongly influenced by the responses of external social factors including peer, community, and cultural environments during and after the traumatic experience. In other words, immigrant children may experience difficulty adapting due to chronic stresses created by poverty, discrimination, and lack of social support.

**Vietnamese American prevalence rates of mental disorder.** Migration stress has been well documented (Berry, 1994; Beiser, 1996; Chung & Bemak, 2006; Kinzie, 1996). Studies show that mental health issues strongly correlate with migration stressors (i.e., premigration trauma, and postmigration stress) (Berry, 2006; Davis, 2000; Nicholson, 1997), which in turn lead to adjustment difficulties within a new culture (Berry, 1997; Chung, 1993). This section will identify several clinical issues relating to the Vietnamese migration experience.

First, acts of discrimination and racism have deleterious effects on Vietnamese immigrant communities (Chung & Bemak, 2006). Vietnamese immigrants, as with many other immigrants to the U.S., often experience stress from racial discrimination, such as insults, humiliation, or rude and/or unfair treatment (Banks, Kohn-Wood, & Spencer, 2006; Lee, 2005; Gee, Spencer, Chen, Yip, & Kaplan, 2007). Although there is limited literature on the effect of discrimination on the mental health status of Vietnamese immigrants, other studies on discrimination among Asian Americans report an association between discrimination and an increased risk of depressive and/or anxiety symptoms (Gee et al., 2007). Further, Mereish, Liu, and Helms’ (2012) study on the effects of discrimination on Chinese, Filipino, and Vietnamese Americans’ mental and physical health suggests that all three ethnic groups’ experiences of discrimination are
positively related to psychological distress, which in turn is positively related to somatic symptoms.

Second, Vietnamese immigrants experience economic stressors as they adjust to their new lifestyle (Chung & Bemak, 2006). Like other immigrant and refugee groups in America, educated and skilled people are unable to obtain employment that is appropriate to their previous education and training, mostly because degrees and certifications earned in their native countries are not recognized in the U.S. (Saechao et al., 2011). Similarly, those Vietnamese who formerly held white-collar jobs in their homeland find that their current immigrant context creates difficulties in securing positions that correspond to their professional experience in Vietnam (Do, 1999). Thus, resulting unemployment or underemployment is found to have negative impacts on the immigrants’ mental health, impacts that also extended to their family members (Dean & Wilson, 2009).

Many Vietnamese women chose to enter the workforce after resettling in the U.S. (Rutledge, 1992). Women in intact families quickly realize that a traditional one-income family no longer adequately provides for the household and thus, many then enter the workforce to support their families. For immigrant women, serving as a wage earner fostered independence and autonomy, which also worked to destabilize traditional Vietnamese cultural paradigms that also created significant tensions within the traditional Vietnamese family (Chung & Bemak, 1998; Do, 1999). Some husbands sensed such role changes as threats to their traditional patriarchal view of the family, which led to increases in domestic violence and divorce (Luu, 1989). Contrarily, the current literature does not address acculturation as a correlative factor in the increased reporting of domestic abuse. In other words, working Vietnamese women are likely to report domestic abuse since they are more connected to the community.
Lastly, Vietnamese immigrant families experience significant child-rearing stressors in the host country (Saechao et al., 2011). Intergenerational conflict (e.g., challenging parental authority) between parents and children often occurs after resettlement in the U.S. (Chung & Bemak, 1998; Kibria, 1993). As children and adolescents tend to acculturate faster than their parents, these family members’ new roles do often challenge traditional cultural values, resulting in distress for the parents (Chung & Bemak, 1998). Choi et al. (2008) suggest that Vietnamese and Cambodian youth report higher rates of disagreement and arguments with their parents if they perceive gaps in cultural values. Vietnamese parents maintain that the Western, individualistic culture weakens their ability to effectively parent within their traditional culture and norms (Kibria, 1993). As a result, these identified cultural conflicts weaken parent-child bonding.

Current literature on acculturation and its complex effect on Vietnamese family life is still very limited. Nguyen and Williams (1989) assessed acculturation differences between Vietnamese parents and adolescents based on time spent in the U.S. They conclude that Vietnamese parents endorse more traditional values than Vietnamese adolescents regardless of time spent in America. Rosenthal, Ranieri, and Klimidis (1996) report that Vietnamese girls value Vietnamese traditional values less than boys do, and the authors reason this is so because young Vietnamese girls are more likely to recognize gender dissatisfaction and the disadvantages of female Vietnamese traditional roles. It is clear then that family dynamics are likely disrupted by individuals who wish to adopt the values of the host country (Chung & Bemak, 2006).

A similar study regarding patterns of acculturation differences between first-generation immigrant Vietnamese adolescents, their parents, and the family relationship suggests that a decrease in family cohesion can correlate to the adolescent child’s lower Vietnamese identity and
the parents’ higher Vietnamese identity (Ho, 2010). The reverse is also true: positive family cohesion and satisfaction correlates positively to the adolescents’ high Vietnamese identity (Ho, 2010).

A follow-up study gauging the impact of acculturation on intergenerational conflict and support among Vietnamese American young adults found that those Vietnamese Americans who exhibited a high level of acculturation were more likely to be criticized by their parents and more likely to engage in argumentative dialogue with their parents (Vu & Rook, 2012). Moreover, Vietnamese females were 10 times more likely to report arguments and criticisms from parents compared to their less acculturated counterparts (Vu & Rook, 2012). In contrast, research found no meaningful difference between more acculturated Vietnamese males in comparison to their less acculturated counterparts (Vu & Rook, 2012).

A possible explanation for this discrepancy between the sexes lies in the traditional gender role expectations for Vietnamese men and women (Chung & Bemak, 2006). Each gender is governed by different cultural norms and expectations, with women enduring more restrictions, whereas young Vietnamese men are encouraged to find autonomy with fewer restrictions (Vu & Rook, 2012). Yet, despite ongoing conflicts, Vu and Rook (2012) note that specific gender roles do not affect parental support: Vietnamese parents feel obligated by a strong sense of duty to exhibit unconditional love toward their children regardless of gender.

To summarize, despite the lack of epidemiological data on mental health problems among Southeast Asian immigrants, current research clearly indicates that this immigrant population remains at high risk for a number of psychiatric disorders and adjustment problems. In particular, depression and PTSD have been found to be the most common diagnoses among those seeking treatment, and migration stressors (i.e., discrimination, economic hardship, and
intergenerational conflict) continue to be a source of stress for many immigrants. Further research on the mental health status of Vietnamese Americans and Southeast Asian immigrants, as a whole, is much needed.

**Cultural conceptualization of mental health.**

**Cultural practices.** The Vietnamese philosophical and spiritual practices are good predictors for help-seeking behaviors (Lee, 1997; Nguyen & Anderson, 2005). Buddhism, for example, teaches adherents to be highly tolerant of suffering and to value the enduring of pain through acceptance; in essence, they permit fate to take charge (Hampton, Yeung, & Nguyen, 2007). With this view, it is divine intervention, such as punishment for one’s transgressions in a previous life, which result in psychological disabilities (Chen et al., 2004; Nguyen & Anderson, 2005). Similarly, the Confucian school considers disabilities as a dissonance between the ideal states of harmony, which in turn bring shame to the family of those who need psychological help (Chen et al., 2004). As a result, individuals who believe strongly in these spiritual causes of mental illness have negative attitudes about seeking professional psychological help (Luu, Leung, & Nash, 2009; Morrow, 1987). A further review of Vietnamese spiritual practices and its effects on the conceptualization of mental health can be found in Appendix B.

Asian traditions regard the body and mind as a unit (Kleinman, 1988; Leong & Lau, 2001). In turn, many Asian cultures tend to focus on treatable physical discomforts over emotional symptoms (Lin & Chueng, 1999). A second assumption views mental disturbance as merely the result of bodily imbalance (Kung, 2001). A survey regarding the health status of Vietnamese immigrants found that participants reported only physical symptoms (Lin & Cheung, 1999) but had no difficulties identifying and reporting psychological symptoms when
specifically asked, which suggests they were more aware of their physical discomfort than their psychological functioning.

Asian cultures perceive the symptomology of mental illness as negative reflections on the immediate family as well as family ancestors (Nguyen & Anderson, 2005). Consequently, traditional husbands or fathers resist attending family sessions and resist allowing mental health professionals to influence the family system (Lee, 1997). Many traditional men may even interpret the admission of emotional problems as a sign of weakness and losing face. In the event that their children are in need of therapy, the men typically send their wives to seek help (Lee, 1997) and therefore, without the cooperation and participation of the male figure, it becomes difficult to conduct family sessions. This may then lead to problems for sufferers since they are less likely to receive treatment due to shame, and as a result, are unable to receive appropriate interventions. Thus, by the time these clients are brought to the clinician’s attention, his or her condition is often chronic and severe, and the family is in a state of crisis (Sandhu, 1999).

Vietnamese and Asian Americans alike rely on alternative medical care for various afflictions, including those with psychiatric origins, as a holistic approach in treating various illnesses (Chung & Bemak, 2006). A review of the literature estimates that costs invested in alternative care (e.g., herbal medicine, traditional and folk practices, and spiritual healing) surpasses outpatient medical costs (Lin & Chueng, 1999). Unfortunately, Asian Americans with psychiatric disorders often consult medical doctors and traditional healers before contacting mental health professionals (Lin & Chueng, 1999). Hsiao and colleagues (2006) found that nearly three quarters of Asian Americans used at least one type of complementary alternative medicine (CAM) in the past 12 months, and that Chinese Americans had the highest prevalence of CAM use of any group (86%). Only 50% of Vietnamese participants in one study reported
using CAM when sick and believed that illness results from an imbalance of “âm/dương” (yin/yang) forces (Jenkins et al., 1996, pp. 1054).

Education and acculturation levels are predictive factors for the use of CAM. A study of foreign-born Vietnamese women revealed that those who lived fewer years in the United States, received less education, and were less English proficient had a statistically significant higher use rate of CAM than the general Vietnamese American population (Chung & Lin, 1994; Jenkins, Le, McPhee, Stewart, & Ha, 1996). The effect of this lopsided approach is the reliance on alternative medicine as a form of self-treatment. These clients also find these health care alternatives to be more congruent with their own values, beliefs, and philosophical orientations toward personal health (Astin, 1998). While this may be true, current literature yields no information on Vietnamese Americans’ awareness of mental health services and/or insufficient access to culturally specific providers in the mental health field. Thus, individuals with limited English skills and low acculturation may simply not have access to mainstream service providers and thereby rely on CAM as their only resource (Chung & Bemak, 2006). Furthermore, non-English proficient Vietnamese may use CAM in lieu of mental health care because providers in the former more likely speak their native language, whereas English proficiency is necessary for mental health services.

Vietnamese views of mental illness are multifaceted due to various religious and cultural influences. In a qualitative study, Hampton and colleagues (2007) explored the perception of mental illness and rehabilitation services among 40 Chinese and Vietnamese Americans to identify specific cultural understandings of mental illness. Several themes emerged from this study. First, the participants described mental illness as abnormal or not healthy. This is also a shared belief by some mainstream Americans (Link, Phelan, Bresnahan, Stueve, Pescosolido,
Second, perceptions of mental illness are strongly unfavorable. Third, many participants pointed out that Vietnamese and Chinese cultures do not necessarily regard depression as mental illness. Other participants emphasized that mental illness was a “deficiency in the state of mind” (pp. 17). Fourth, participants expressed fear toward people with mental illness. While they were willing to consider distinct types of mental illness, some reported a belief that mental illness caused physical violence. Lastly, a general assumption emerged from the study that the Vietnamese perception of mental illness carries a cultural stigma, which leads to cases being frequently ignored for fear of either physical violence or discrimination.

**Stigma.** Asian Americans suffering from depression are believed to suffer greater stigmas/biases than Whites when facing a mental illness (Fogel & Ford, 2005). The social conventions and philosophies of Asian cultures influence these stigmas. Confucianism, in particular, discourages open displays of emotion in order to maintain social and familial harmony and avoid the exposure of personal weakness (Office of the Surgeon General, 2001).

Overall, Asian cultures operate through the principles of honor and harmony: all individuals of a family are responsible for keeping the family’s honor and dignity (Chung & Bemak, 2006; Nguyen & Anderson, 2005). Shaming serves as a negative reinforcement for individual behaviors, while harmony encourages the individual to follow socially acceptable lifestyles within the community (Gellis, 2003). In this context, mental illness reflects poorly on the individual’s family and jeopardizes future employment, marriage, and family status (Barret, 2006; Hampton et al., 2007). With stakes so high, individuals and their families make great efforts to either deny, suppress, or ignore signs and symptoms of mental illness in order to preserve public appearance and “save face” (Fancher, Ton, Meyer, Ho, & Paterniti, 2010).
**Somatization.** Current literature suggests that somatization of mental health symptoms is ubiquitous in all cultures and more common among non-Western cultures (Kirmayer & Young, 1998). Although its prevalence and specific features vary across cultures, the processes of focusing on, amplifying, and then clinically presenting somatic symptoms are universal and are common expressions of emotional distress worldwide (Kirmayer & Young, 1998). In other words, somatic symptoms are viewed universally as calls for help. Based on their specific cultural context, Southeast Asians are more likely to consider somatic symptoms as legitimate reasons to seek help (Beiser & Fleming, 1986). Thus, due to stigmas, somatization may be a more socially acceptable way for Southeast Asian clients to deal with psychological stresses.

Research suggests that Asian cultures express more somatic symptoms than their White counterparts (U.S. DHHS, 2001). In general, Asian cultures frequently use somatic complaints, exhibited through physical symptoms, in an effort to fit within acceptable “sick” person roles and thereby avoid stigmatization (Gaw, 1993). For example, *hwa-byung* – which literally means “‘anger disease’ or ‘fire disease’” – is a Korean cultural term used to describe emotional symptoms (depression and anxiety) that lead to bodily symptoms (Lin & Chueng, 1999, pp. 776). Both Chinese and Japanese cultures express similar complaints, such as poor appetite, indigestion, and gas, when feeling depressed (Kung, 2001).

These specific culturally bound syndromes are associated with a suppression of emotions that are then often expressed through unexplainable headaches, pains, and other physical complaints (Bernstein, 2007). Kirmayer (2001) also notes that the most common somatic symptoms of depression and anxiety are musculoskeletal pain and fatigue, and that many medical professionals are unable to provide physiological explanations for the cause of these illnesses.
Individuals with medically unexplained symptoms comprise between 15% and 30% of all primary physician consultations (Kirmayer, Groleau, Looper, & Dominicé, 2004). Across cultures, many systems of medicine provide psychosomatic explanations to these symptoms by linking the psychological stressor with the bodily distress. For example, the Vietnamese term *phong tháp* is analogous to the term for rheumatism, which also doubles as a socially acceptable Vietnamese term to describe bodily aches and pains attributed to cold, the depletion of energy, and environmental effects. This culturally bound syndrome is eventually somatized. Also, *uất ức* (writhing) is a perfectly acceptable and suitable term used to describe predicament indignation over a social injustice such as when describing Vietnamese who had served and/or contributed during the war (Kirmayer et al., 2004). Both *phong tháp* and *uất ức* function as acceptable cultural idioms for distress. They also serve to normalize traumatic experiences and to draw attention to particular physiological conditions and/or psychological distress (Kirmayer et al., 2004).

In review, Vietnamese immigrants continue to experience significant barriers toward mental health services, and that cultural conceptualizations of mental illness are among the root causes. For example, many Vietnamese believe that mental illness is the result of supernatural entities, transgressions from a previous life, or a dissonance in the person’s being (Chen, 2004; Hampton et al., 2007; Luu et al., 2009). Due to the stigma associated with mental illness, individuals with a diagnosable mental illness are often prevented from interaction with others outside of the immediate family. Outside help is sought only as symptoms become severe, and thus, Vietnamese often rely on the use of alternative medicine as an integral part of treatment. Lastly, somatization is considered a socially acceptable way of expressing mental distress.
Mental health services utilization

The frequent occurrence of somatic symptoms and other culturally related factors (e.g., cultural, philosophical, and acculturation level) may lead to mental health services underutilization. Current literature indicates that Asian Americans do in fact underutilize mental health services when compared with the general American population (Bui & Takeuchi, 1992; U.S. DHHS, 2001; Zhang, Snowden, & Sue, 1998). According to 2010 NSDUH data, Asian Americans have registered lower rates of mental health utilization each year for the past three decades (Sue et al., 2012). The 2010 rates of utilization of mental health services for American adults 18 and older, broken down by racial groups are: Asian Americans, 5.3%; Hispanics, 7.9%; African Americans, 8.8%; and Non-Hispanic Whites, 16.2% (SAMHSA, 2012). Drawing from current data, Asian Americans have the lowest services utilization while Non-Hispanic Whites are three times more likely to use mental health services.

In a similar study, Abe-Kim et al. (2007) investigated the rates of mental health-related service use among Asian immigrants and American-born Asians, which suggest that only 8.6% of Asian Americans sought help from any mental health services while 17.9% of the general American population sought such help (Abe-Kim et al., 2007). Their findings support that second-generation individuals (i.e., children of immigrants) parallel their parents’ opinions regarding mental health services. Third-generation individuals, in contrast, report a rate of service utilization roughly equal to that of the general American population (Abe-Kim et al., 2007). Further evidence of this conclusion is in the higher rate of service utilization among East Asians (Chinese, Japanese, and Koreans) in comparison to other Asian American groups, as the East Asian group has spent more time in the U.S. (Barreto & Segal, 2005).
**Attitudes toward help-seeking behaviors.**

As a whole, Asian American underutilization of mental health services is well researched, and has revealed that cultural factors (values, beliefs, and stigmas) specifically define Vietnamese American recalcitrance toward mental health providers (Nguyen & Anderson, 2005). However, other factors (e.g., acculturation, confidentiality, and the language barrier) may also influence this group’s attitude toward help-seeking behavior (Luu et al., 2009; Nguyen & Anderson, 2005). Meyer, Zane, Cho, and Takeuchi (2009) posit that American-born Asians utilize mental health services at a rate almost double that of Asian immigrants (40% vs. 23%). The use of mental health services also increases when an individual possesses good or excellent English-language proficiency. In other words, American-born Asians do not have more psychiatric disorders compared to Asian immigrants; rather, these individuals are more receptive toward mental health services and are more likely to seek help. These findings suggest that acculturation levels play an important role in attitudes toward help-seeking behavior. Luu and colleagues (2009) surveyed 210 Vietnamese Americans about their attitudes toward seeking professional psychological help, and the research suggests a positive correlation between healthy acculturation and healthy help-seeking attitudes: the more acculturated participants were, the more they tended to transition away from strong cultural beliefs/practices and migrate toward a comfortable utilization of professional help (Luu et al., 2009). Drawing from the current data, it is recommended that mental health professionals working with Vietnamese clients should consider the clients’ acculturation level as a predictive factor in determining treatment approach.

Additional research demonstrates that help-seeking preferences and attitudes regarding self-disclosure are significant predictors of perceptions toward mental health services (Nguyen & Anderson, 2005). Within traditional Asian cultures, the system of help-seeking is arranged
primarily through a family hierarchy (Chung & Bemak, 2006; Luu et al., 2009). Personal
dynamics are subsumed in favor of maintaining family honor. Additionally, because Vietnamese
families are concerned about breaches in confidentiality (Luu et al., 2009), traumatic events (e.g.,
torture, rape, domestic violence) are often undisclosed or denied (Kroll et al., 1989). As noted,
solution seeking focuses first within the scope of the immediate or extended family before
seeking external help (Schultz, 1982; Yeh & Wang, 2000). When actually seeking outside help,
the first outreach is toward community resources such as priests, Buddhist monks, or traditional
healers (Schultz, 1982). Due to fears of stigma by both the affected individual and the immediate
family, professional help is sought only as a last resort (Nguyen & Anderson, 2005).

Language barrier. Within the various factors that contribute to underutilization of
mental health services, the language barrier is also an important component regarding help-
seeking behavior. Ease of communication is the most significant factor in facilitating rapport
between clinician and client (Luu et al., 2009). For example, Silove and colleagues (1997) found
that Vietnamese clients with fluency in English, the language of the clinician, were satisfied with
the mental health services they received. In a similar study with a sample of Mexican, White,
Black, Vietnamese, Filipino, and other ethnic groups, Flaskerud (1986) examined the
relationship between culture-compatible approaches to mental health services and the utilization
as measured by client dropout and total number of outpatient visits. The author concludes that
language matches between the therapist and the client are among the best predictors of client
perseverance in therapy.

A second difficulty in attracting and retaining immigrant and refugee clients stems from
the emphasis traditional Western psychotherapy places on open communication, exploration of
emotions, and individuation (Yamashiro & Matsouka, 1997). Such practices are both unfamiliar
and uncomfortable for traditional Asian American clients (Kim, Atkinson, Umemoto, 2001; Leong & Lau, 2001; Sue & Sue, 1990). Yamashiro and Matsouka (1997) suggest that the collective nature of Asian languages may not actually be able to accommodate emotional expressions. Rather, they may be prone to symbolic gestures, or physical and intuitive sensations. Any attempt to describe emotions through words may then be lost in translation and/or simply be inaccurate. Consequently, many Vietnamese clients report continual difficulty communicating with health professionals and subsequently feel hesitant to return (Phan, 2000).

Current literature suggests that language difficulties play a significant role in either underestimating or overestimating a client’s clinical symptoms (Drennan & Swartz, 2002; Kennedy, Jerar-Dunne, Gill, and Webb, 2002; Malgady & Costiantino, 1998). Thus, the use of language interpreters is a necessity for clinicians working with non-English speakers (Kale & Syed, 2010). To date, the use of interpreters in mental health settings often focuses on the medical model and is often underutilized (Kale & Syed, 2010). In this setting, interpretive challenges arise in the accurate assessment and diagnosis of mental illness (Gong-Guy, Cravens, & Patterson, 1991). Some of the problems include: 1) the lack of training mainstream clinicians have with the clinical use of interpreters; 2) the reliance on family members or individuals from the community who have no training in either interpretation or mental health concepts terminology; and 3) the undervaluing of interpreters in many clinical settings, as illustrated by reports of clerical staffs or janitors being asked to interpret during psychiatric evaluation (Gong-Guy et al., 1991). Furthermore, clinicians often have difficulty understanding whether interpreters are struggling to follow what clients are saying or whether clients are merely exhibiting loose association or a flight of ideas (Drennan & Swartz, 2002). Thus, clinicians may
hesitate to use interpreters, which then limit their ability to work with non-English speaking clients.

In summation, Vietnamese cultural factors (i.e., cultural beliefs, practices, and stigmas) have contributed to the Vietnamese American underutilization of mental health services. Many are unable to access services due to the Vietnamese community’s negative perceptions about mental disorder. Thus, these individuals express mental distress (i.e., depression, anxiety) through somatic symptoms, which are acceptable ways of seeking help in their culture. In addition, acculturation levels, the practice of self-disclosure, and communication in a common language are equally important in predicting attitudes regarding help-seeking behavior. As suggested, a high acculturation level positively correlates with an increase in mental health services utilization (Silove et al., 1997). Current literature suggests that individuals with high acculturation also use alternative medicines less and are more receptive to Western-based therapeutic treatment approaches.

From the current literature, two common themes emerged in identifying barriers toward mental health services utilization: acculturation levels and English-language proficiency are good predictors of openness to mental health services utilization. On the contrary, immigrants with high acculturative stress and limited English skills tend to have limited openness and access to mental health services and are thus, more likely to exhibit somatic complaints and a higher use of alternative medicines. Regrettably, acculturation and English-language proficiency are acquired skills that also take time to develop. Yet, clinicians working with immigrants are encouraged to use language interpreters in psychotherapy. On the contrary, current literature yields limited data on the use of language interpreters in psychotherapy, specifically regarding immigrant clients. Despite hesitations that the addition of an interpreter may alter the traditional dyadic therapy
relationship, current literature review is unable to locate any study that advises against the use of language interpreters when working with immigrants.

**Intervention strategies in working with Vietnamese Americans**

Although the client’s factors have been previously discussed, the clinician’s intervention approaches in working with Vietnamese Americans may be contributing factors in effective mental health services delivery. The following section will examine the current literature on best practices when working with Vietnamese Americans.

**Multicultural awareness.** Mental health professionals are susceptible to cultural bias (Sue & Sue, 2008), although not as a blatant form of racism, but rather as a lack of cultural awareness resulting in inadequacies in their provision of mental health services (Morris & Robinson, 2000). Sue and Sue (2008) address this issue when they suggest that mental health professionals are sometimes viewed as: 1) insensitive to the needs of their culturally diverse clients; 2) unaware of their clients feeling abused, intimidated, and harassed by non-minority personnel; 3) discriminatory in their practices of mental health delivery; and 4) professionals who continue to be trained in institutions that ignore multicultural issues. Further, Morris and Robinson (2000) suggest that clinicians tend to assign more severe diagnoses to racial/ethnic minorities than to the general population. In other words, mental health professionals who lack cultural competency are more likely to misdiagnose, use inappropriate treatment options, miscommunicate with clients, make errors in clinical practice, provide poor quality care, and cause premature terminations of treatment (Zane et al., 1994; Chow, 2002).

In recent years, considerable attention has focused on identifying and addressing multicultural competencies in clinical training and practice (Pederson, 1988; Arrendondo et al., 1996; Sue et al., 1992). Most notably, Pedersen (1988) provides a framework of multicultural
competence in clinical practice: *Self-awareness, Knowledge, and Skills*. This framework remains to be the most influential in the field of cross-cultural work (Lynch & Hanson, 1992; Richardson & Molinaro, 1996; Sue et al., 1992). In addition, the American Psychological Association (APA) (2002) has outlined comprehensive multicultural competency guidelines for training and clinical practice. In this document, the APA offers basic guidelines for working with culturally diverse clients, such as being aware of how personal and individual worldviews affect diversity training, how to apply culturally appropriate skills in research and practice, and how to foster organizational change. This recognition is an important progressive step toward meeting the diversity needs in psychological practice, and although the APA multicultural competency guidelines are not an exhaustive list, it provides a framework and direction for clinicians to deliver culturally sensitive services to minorities.

Culturally competent clinicians must first demonstrate awareness of their own cultural identity development (Sue & Sue, 2008). Several approaches have been developed within the last two decades dedicated to helping mental health professionals address this need. The Helms White Racial Identity Model and the Rowe, Bennet, and Atkinson’s model of White Racial Consciousness Types and Their Characteristics are among the most discussed (Sue & Sue, 2008), of which the Helms (1990, 1992) model is the most widely cited and applied (Sue & Sue, 2008). This model’s particular strengths lie in the delineation and identification of awareness stages in cultural identity development, especially for White clinicians. This model was originally proposed as a framework for preparing mental health professionals for their work with culturally diverse clientele. The awareness stages are assumed to develop sequentially as follows: contact, disintegration, reintegration, pseudoindependence, immersion/emersion, and autonomy (Helms, 1992; 1995).
Nonetheless, Helms’ model also has its critics. Rowe, Bennett, and Atkinson (1994) claim the model is erroneously based on a racial/ethnic minority identity development model which may not apply to White identity. In addition, too much emphasis is placed on White attitudes toward minorities and not enough is placed on their own identity. Lastly, it appears that Helms organized the model into developmental stages and that the progression from less healthy to more healthy is based merely on personal standards (Rowe et al., 1994). However, Helms (1995) responded to criticism by saying that she is not a stage theorist and therefore prefers the term developmental status instead of developmental stages.

Engaging clients in psychotherapy. The therapeutic relationship is considered the single most important determinant of positive therapeutic outcomes (Weinberger, 1993). Regardless of the clinician’s theoretical orientation, therapeutic practice remains ineffective in the absence of a therapeutic alliance with the client. Historically, the practice of talk therapy is Western-based and therefore remains a concept that many Asian American clients find unfamiliar and uncomfortable (Hong & Ham, 2001; Lee, 1997; Sue & Sue, 2008), which results in their seeking mental health professionals only as a last resort (Lee, 1997; Nguyen, 2005). For Asian cultures, the acceptance of professional help (i.e., medical doctor) requires the attending physician to provide a physical, tangible benefit (e.g., medication) (Hong & Ham, 2001). In other words, Asian clients expect quick and direct relief from their symptomology. Regarding mental health interventions, Asian Americans demonstrate a lower tolerance for ambiguity, and a higher preference for more structured interventions and immediate resolutions to problems when compared to Whites (Leung, 1986). In consequence, therapeutic alliances are likely to result in early termination should the clients not perceive immediate resolutions to their problems (Berg & Java, 1993; Kim, Li, & Liang, 2002).
Though the development of relational trust and confidence is a priority for clinicians interacting with any clientele (Berg & Java, 1993), there are several critical relational directives that must be observed by clinicians when interacting with Vietnamese clientele specifically. First, the clinician must refrain from overzealous or perceived indiscretions when inquiring about personal information, especially when the information is a source of shame (Lee, 1997). McKelvey (1994) writes that the “loss of face” resulting in premature termination of therapy is most likely to occur when therapists push too hard and too early for sensitive information. This is especially important during the initial stage of treatment as clients begin to develop a trustful rapport with the clinician (Hong & Ham, 2001). Second, Lee (1997) suggests that the clinician continually empathize with the clients and encourage them to verbalize feelings of shame as it relates to the therapeutic process. It is also important to reassure the client about the confidentiality and anonymity of the therapeutic relationship (Lee, 1997). Finally, the clinician should exercise extreme sensitivity around intimate issues that the client may present, in particular sexual and family issues. Furthermore, acknowledging the client’s discomfort is helpful (Lee, 1997). The clinician may begin to inquire about the issue by saying, “I know it may be difficult for you to talk about this, but it is really important for me to know…” to convey to the client that the clinician is aware of the cultural sensitivity around the issue (Hong & Ham, 2001, pp. 122). However, these probing questions should be reserved only after the clinician has developed a strong therapeutic bond with the client.

The current literature recommends a solution-focused, goal oriented, directive, and symptom-relieving approach during the initial stage of treatment (Berg & Java, 1993; Kim et al., 2002; Lee, 1997; Sue & Sue, 2008). However, an insight-oriented approach should not be totally disregarded (Akutsu, 1997; Tung, 1991). Once the client is engaged in the therapeutic
relationship and gains a sense of success, the clinician can introduce more insight-oriented goals to help the client identify their illness and recognize its sources (Lee, 1997). Note that the clinician’s decision to use either a directive or insight-oriented approach depends on the client’s acculturation level as it may influence therapeutic effectiveness (Akutsu, 1997). Interestingly, the literature suggests that mental health clinicians are likely to use an assertive, directive, and structured approach with traditional Asian clients while they tend to use more assertive, confrontational, and interpretive methods with acculturated Asian clients (Akutsu, 1997). However, much research in this area is still needed since current literature is based primarily on clinical experience rather than controlled studies.

Effective relationship development for Asian American clients is often facilitated through directive approaches, such as clinicians temporarily assuming the roles of case manager, teacher, and advocate for clients and their families during the initial stage of therapy (Chung & Bemak, 2006; Kung, 2001; Lee, 1997). In the introductory stage of the relationship, a clinician’s role intersects with duties often defined with case managers or other social workers. Eng and Balancio (1997) suggest that clinical case management acknowledges the dynamic interplay of multiple factors (i.e., psychological, biological, psychosocial rehabilitation variables, and environmental supports) that contribute to the client’s stress. Further, for Southeast Asian clients who may maintain a guarded attitude towards strangers, clinical case management is a good vehicle to develop trust and build better rapport with the clients and their families (Eng & Balancio, 1997).

In order to positively engage such reserved clients, the clinician should behave and serve as the undisputed and unambiguous expert or teacher with concomitant problem-solving knowledge (Lee, 1997; Uba, 1994). Statements such as “we will find out together how to deal
with this problem” or “you are the only one who can solve your problem” and “I cannot tell you what to do” (Hong & Ham, 2001, pp. 114) can actually be misinterpreted by the client as clinician incompetence. Instead, the clinician should become actively involved with the client’s present problems. Lee (1997), for example, highlights that the clinician needs to take the present concern seriously and respond immediately with concrete, actionable solutions in order to continue to build rapport. Hong and Ham (2001) suggest that the clinician demonstrate expertise in the field through an authoritative, albeit courteous and respectful attitude throughout sessions. Furthermore, the clinician should be directive but also ensure full collaboration from the client in developing goals and intervention strategies (Sue & Sue, 2008), thereby creating opportunities for clients to try to intervene on their own, which promotes the client cultural value of self-sufficiency.

While treatment planning is a standard form of practice, some adjustments must be made accordingly for clients of Asian cultures to fit their needs and remain culturally sensitive (Lee, 1997). Simply, the clinician is reminded to focus and respond to the immediate needs that brought the client to the agency. Hong and Ham (2001) suggest that it is helpful to create and identify achievable goals within 8 to 12 sessions. With this timeframe, the client can establish realistic objectives and can expect immediate change within a definable session period. Telling clients that they will be in therapy for a long period is extraordinarily discouraging for Asian clients and greatly increases the risk of early termination (Hong & Ham, 2001). On the other hand, a clearly laid out, short-term, achievable treatment plan will help the client feel more comfortable and increases therapy attendance (Iwamasa, Hsia, & Hinton, 2006).

During sessions, an effective clinician can take advantage of the holistic health model by integrating parallel elements from both Western medical and psychological practices (Lee,
1997). As an example, the clinician may educate the client on Western biological and psychological perspectives on mental illness. The clinician could also survey the client’s cultural approaches to treatment (e.g., herbal medicine, acupuncture, and qi gong) (Lee, 1997). With this approach, the clinician enhances the relationship by developing trust with the client and by being culturally sensitive to the client’s cultural values.

An often overlooked dynamic of clinician-client interaction is the unspoken social etiquette code, and having a proper understanding of such facilitates good rapport (Hong & Ham, 2001). Although Asian Americans generally sanction less physical contact between genders (Hong & Ham, 2001), most Vietnamese clients are familiar with handshakes as a greeting. They are also accustomed to a simple bow or nod (McLeod & Nguyen, 2001). Other common gestures like patting a person on the shoulder (especially if the person is older) or patting a child’s head should be avoided since it is regarded as disrespectful or considered to bring bad luck (Hong & Ham, 2001). These cultural missteps may negatively impact the relationship building process (Lee, 1997).

In addition to social mores, oral communication styles are also a critical skill that the clinician should exercise when working with Vietnamese clients. Asian cultural groups tend to exhibit lower levels of verbal and emotional expressiveness than Whites (Leung, 1986), which may lead clinicians who are unaware of this cultural practice to erroneously conclude that the person is repressed, inhibited, or shy (Leung, 1986). Unlike the direct communication style of mainstream Americans, Asian Americans prefer indirect statements and nonverbal expressions (Uba, 1994). For example, a client may state, “Some people say I should try…” as a polite way to disagree with the clinician’s advice (Hong & Ham, 2001, pp. 121). This tactic helps to distance the client from open disagreement. In response, the clinician could state “But there are
others who say…” in an attempt to remain non-confrontational (Hong & Ham, 2001, pp. 121). These oral dynamics are long-standing cultural expressions that help distance speakers from the disagreement and help save face for both the client and the clinician. However, because Asian clients are less willing to have direct disagreements with the clinician, should a client disagree with the clinician, they are likely to sit politely through the session and perhaps accept to schedule the next appointment intending not to return (Hong & Ham, 2001; Lee, 1997).

A client’s particular acculturation level is often a good predictor of therapy outcomes (Akutsu, 1997; Leung, 1986). For example, first and second-generation refugees and immigrants are less likely to endorse mental health services while third-generation individuals have a pattern of service utilization similar to the general American population (Abe-Kim et al., 2007). Therefore, the client’s perception of therapeutic interventions changes depending on the client’s level of acculturation. In a parallel study, Kim et al. (2002) studied the effects of cultural values, session goals, and clinician perceptions among Asian American college students at a large mid-Atlantic university. The results suggest that of those clients who reported high adherence to Asian cultural values, those who were exposed to immediate resolution conditions perceived a stronger working alliance with the clinician than those clients exposed to insight attainment conditions. These findings suggest that the clinician should be sensitive and responsive to the client’s acculturation level when determining culturally appropriate approaches.

**Application of theoretical approach.** Once the level of a client’s acculturation has been discerned, the clinician must next determine the most appropriate therapeutic technique for effective therapy delivery. The applicability of Western approaches toward persons of non-Western cultural origins should be approached with caution (Lee, 1997). In this context, family orientation is an important trait which can be easily misinterpreted from a Western perspective.
(Hall, Hong, Zane, & Meyer, 2011), and an untrained clinician fostering individuation and disregarding the client’s cultural interdependency is at higher risk of early termination than a clinician proposing a cultural/family approach (Hong & Ham, 2001).

As previously discussed, it is recommended that mental health clinicians working with Vietnamese clients use a directed approach in building trust and engaging the client (Lee, 1997). Nonetheless, there is no definite answer to the continued debate between effective therapeutic approaches (insight-oriented versus directed approach) (Akutsu, 1997; Lee, 1997; Leung, 1986; Tung, 1991), so that while a directed approach is the focus during the initial stage of rapport building, many clients also benefit from an insight-oriented approach. Thus, a combination of both approaches may be appropriate for working with Vietnamese Americans.

From a different perspective, insight-oriented approaches to therapy can even be appealing to Asian clients (Roland, 2006). For example, psychoanalytic approaches emphasize insights through uncovering the client’s unconscious thoughts, feelings, and actions, which is a fundamental perspective congruent with Asian cultural beliefs (Hong & Ham, 2001). However, clinicians applying this approach should be aware of cultural blind spots when working with this population. For instance, a psychoanalyst could misinterpret the client’s attachment to her parents as manifesting dependent personality traits with accompanying boundary confusion between the client and the parents (Bracero, 1994). An example frequently present in the Asian milieu is that a client’s cohabitation with her parents is not due to a psychological handicap, but rather to the client’s own internal motivation to take care of her parents and to remain connected with them (Yi, 1995). Although the clinician may have good intentions for the client, this possible misattribution could potentially damage the work between clinician and client.
**Psychoanalytic approach.** For psychoanalysts, transference and countertransference are core components of the therapeutic experience. Because the transference process is based on trust, Asian clients experience challenges establishing transference toward the clinician during the initial phase of the relationship (Hong & Ham, 2001; Roland, 2006). When the clinician integrates the client’s race and culture in analyzing the relationship, the client may manifest *hierarchical transference* toward the clinician (Yi, 1995). Hierarchical transference refers to the client’s assumption about authority figures (e.g., parent-child, teacher and student, husband and wife) (Hong & Ham, 2001). This culturally based transference is influenced by the Asian value of respect and obedience to authority figures and personal restraint (Roland, 2006; Yi, 1995). Within this dynamic, client verbal input will be minimal, while expectations for guidance and structure from the clinician will grow. Thus, the clinician should not automatically assume that a quiet client is pathological (Yi, 1995).

Psychoanalytic approaches are best utilized in assisting clients who suffer from severe and chronic trauma (Bracero, 1994). Experienced clinicians are able to help clients achieve insight through uncovering a client’s unconscious thoughts, feelings, and motivations in a way that is congruent with traditional Asian cultural concepts of seeking self-understanding and developing self-control (Hong & Ham, 2000). Further, this approach can allow clinicians to help clients discover their center of healing, strengths, and resiliency so they can regain or reintegrate their broken lives.

**Client-Centered Approach.** When working with Asian clients, empathy can become a bridge connecting the cultural differences between the clinician and the clients (Hong & Ham, 2001), but in utilizing this perspective, a clinician should consider the client’s worldview in order to demonstrate an appropriate empathy. Although a solution-focused approach is desirable,
clinicians are reminded to refrain from rushing to solutions that are not culturally acceptable and may not fit with the client’s interests, issues or needs. Hong and Ham (2001) urge clinicians to remain aware of cultural biases and place themselves in the clients’ cultural perspective. To fulfill this goal, Hong and Ham (2001) suggest that the clinician should first be sensitive to the client’s emotions despite being unfamiliar with the client’s life experiences. Second, the clinician should exercise sensitivity toward the client’s unique social and cultural experiences along with an understanding of cultural traditions, values, and worldviews. Lastly, the clinician should understand and verbalize the client’s expectations while addressing the client’s needs (offering directions or rationale to certain problems) when necessary. In the end, the client must realize that the clinician truly cares and understands them not based solely on words but also through actions (Hong & Ham, 2001).

Despite progress on clinical work with Asian Americans, current research on best practices for therapeutic approaches applying psychoanalytic and client-centered approaches remains scarce. Unlike the Cognitive Behavioral approach, there are only a handful of existing articles that provide recommendations for applying psychoanalytic and/or humanistic theories. Regrettably, no longitudinal studies were found to support the theoretical application for Asian American clientele. This absence has added to the challenges of investigating therapeutic effectiveness and facilitating future discussion.

**Cognitive-behavioral (CBT) approach.** CBT is popular among clinicians and has gained favorable attention from researchers. Voss Horrell (2008) reviewed 12 studies and concluded CBT is a more effective treatment for clients from different ethnic minority groups. The author suggests that CBT is effective in reducing symptoms from a variety of disorders including depression, posttraumatic stress disorder, generalized anxiety disorder, and panic disorder.
Current literature suggests that the CBT approach is congruent with Asian American clients (Chen & Davenport, 2005). Similar to other Asian cultures, Vietnamese cultural values are rooted in respect for authority and have a preference for structural, immediate, and practical solutions (Chen & Davenport, 2005). This cultural frame intersects well with CBT therapeutic relationships in which the clinician’s role is that of expert or teacher. In addition, clients positively perceive CBT clinicians who demonstrate expertise and knowledge by introducing concrete problem-solving strategies. CBT approaches are noteworthy in that they provide important reassurance to Asian clients by empowering the clinician as expert and leader during therapy (Hong & Ham, 2001).

A clinician should be cautious when using Socratic questioning in challenging dysfunctional belief statements, because this approach is generally unhelpful for Asian clients (Voss Horrell, 2008). Within Vietnamese culture, the perception of verbal challenges is often paired with shame and incompetence if the right response is not elicited. In a clinical setting, the client’s anxiety will certainly rise as they struggle to find the correct response (Chen, 1995). Rather than Socratic questioning, it is helpful to provide the client with more reasoning and alternatives, such as rational thinking strategies or action plans. Thus, one way to elicit positive responses from the client is by asking the client to complete a sentence (Chen & Davenport, 2005). As a general cultural norm, Asian clients avoid social interactions that are perceived to disrupt personal harmony. In this vein, being assertive is rather difficult since Asian cultures emphasize harmony, patience, and respect. Chen and Davenport (2005) recommend clinicians help clients recognize situations where the context is permissible to show appropriate assertion. The authors go on to suggest it is also helpful for clients to practice assertiveness when they are outside of their community, where assertiveness is considered acceptable. However, a culturally
responsive assertiveness training intervention needs to include discussion of social cultural contexts to help the clients learn different ways of behaving assertively in different settings (Hong & Ham, 2001). It is important to note that Vietnamese individuals are taught to refrain from expressing emotion, and therefore a clinician applying CBT could well encounter a client reluctant to express emotions during the initial meetings (Hong & Ham, 2001). In order to progress, the clinician should utilize culturally acceptable concerns such as career, education, or physical issues as inroads to discussing greater problems (Chen & Davenport, 2005).

Summary

Vietnamese Americans are among the most recent immigrants to the United States (Min, 2006). Many have witnessed traumatic events and struggled adjusting (i.e., acculturation stresses, discrimination, and language barriers) to the host country (Cargill & Huynh, 2000; Desbarats, 1990; Do, 1999; Do, Phan, & Garcia, 2001; Gold, 1992; Le, 2001; Pumariega et al., 2005; Rutledge, 1992; Sagan & Denney, 1982; Vo, 2006). Unfortunately, there is a significant deficit of culturally appropriate mental health service providers in working with this specific population (U.S. Department of Health and Human Services, 2010). Vietnamese Americans and Asian Americans alike are stereotypically viewed as model minorities and often overlooked or ignored by the mental health profession. Asian Americans are often mistakenly categorized as a homogeneous group with a shared culture and experience instead of actually comprising several heterogeneous groups with much celebrated and intricate differences (Sue et al., 2012).

For many Vietnamese Americans, low services utilization does not equate to a lesser mental health need. Nonetheless, there are many barriers toward seeking mental health services. First, the Western concept of mental health is often misunderstood by many Vietnamese due to differences in cultural beliefs and practices, which then leads to the stigmatization or rejection of
mental health services (Barret, 2006; Gellis, 2003; Hampton et al., 2007; Nguyen & Anderson, 2005). In consequence, many Vietnamese rely on alternative medicine for treatment of mental disorders instead of the traditional mental health system. Second, because language communication is often difficult for immigrant families, affected individuals may be more reluctant to receiving mainstream services due to the fear of not being understood (Kim et al., 2001; Leong & Lau, 2001; Sue & Sue, 1990). Therefore, interpreters are used as cultural-brokers, although they may lack training within the mental health field (Gong-Guy et al., 1991). However, progress has been made in recent years in order to work with language interpreters more effectively (Pollard, 1997; Searight & Searight, 2009; Schuchman et al., 2007).

Drawing from the current literature, an assumption about Vietnamese American mental health services utilization can be viewed as: Vietnamese Americans lack knowledge and are unaware about available mental health services, lack familiarity with Western-based mental health treatment, and lack the language skills to utilize treatment. All these limitations affect their ability to utilize mainstream services, which thereby render them reliant on the closed family system, and only seeking help when conditions become severe (Jenkins et al., 1996; Kale & Syed, 2010; Kung, 2001; Nguyen & Anderson, 2005).

Mental health professionals, however, are also responsible for creating service barriers. First, a large majority of mental health providers are White, most of whom are trained to deliver Western-based therapeutic approaches only (U.S. Department of Health and Human Services, 2010). The lack of cultural competency is a clear barrier between working with the culturally diverse. This leads to service ineffectiveness and early terminations (Sue & Sue, 2008).

Second, although clinicians are often encouraged to become culturally sensitive when working with ethnic minorities (American Psychological Association, 2002), an effective
clinician must also reflect an awareness of his/her own cultural identity, values, and biases (Sue & Sue, 2008). This awareness enables the clinician to be open to new experiences and remain nonjudgmental. This may require that the clinician explore and immerse him/herself in a particular culture, and in this circumstance, the Vietnamese.

Third, culturally competent mental health professionals are encouraged to develop culturally specific intervention skills when working with ethnic minorities (Hong & Ham, 2001; Lee, 1997). Pursuing such development would help the clinician be able to build a strong therapeutic relationship with the client by using solution-focused approaches and being able to address the client’s immediate need. Additionally, clinicians who understand the culture may be capable of addressing cultural nuances and empowering clients toward culturally appropriate treatment goals (Lee, 1997; Sue & Sue, 2008).

Finally, clinicians are advised to be mindful in their selection of a theoretical approach when working with Vietnamese Americans (Lee, 1997). This enables clinicians to adapt culturally relevant practices in tandem with Western-based theory. For example, clinicians using psychoanalysis may adapt a directive approach during the initial phase of therapy to build the therapeutic relationship prior to engaging the client with insight-oriented therapy.

As discussed, cultural barriers (i.e., shame, stigma, language, and acculturation) and help-seeking preferences (i.e., self-disclosure practices) are commonly identified factors inhibiting Asian American clients from seeking mental health services (Chung & Lin, 1994; Fung & Wong, 2007; Hampton et al., 2007; Kim & Omizo, 2003; Lin & Cheung, 1999; Luu et al., 2009; Nguyen & Anderson, 2005). Possible solution may include an engagement program to raise mental health awareness for Vietnamese clientele seems to be a viable option and is warranted for future development. However, a clinical training curriculum for health professionals on
becoming effective mental health providers when working with the targeted group is also much needed.

The current literature lacks training resources to assist mental health professionals in working with Vietnamese Americans. Although researchers are diligently working to identify barriers and attitudes toward help-seeking behavior, none have studied the challenges and identified effective ways to assist mental health professionals when working with Vietnamese Americans. The absence of a clinical training manual for working with this specific population is troubling.

Consonant with Hong and Ham (2001), there is a need for the development of a curriculum relevant to mental health services delivery for Vietnamese Americans. This is likely to encourage practicing mental health professionals and current trainees to gain cultural proficiency in working with this specific group. Therefore, a culturally appropriate training curriculum will ensure that future clinicians are better equipped with a developed cultural awareness, with the knowledge and the skills to work with Vietnamese Americans, and with the ever-increasing diverse community.
Section III: Original Contribution to Practice

Introduction

The goal of this curriculum is to enlist and assist mental health professionals in building cultural competency in their work with Vietnamese Americans. This curriculum can be used as a continuing education program or as an in-service training program.

Although there are limited resources available for working with Asian American clients (Lee, 1997), there are none for working with the Vietnamese community specifically. The current resources provide a general overview across all Asian ethnic groups without providing specific details on how to deliver effective mental health services to a particular group. Therefore, clinicians are at risk of overgeneralizing and may miss important details when working with their clients. This doctoral project clinically illuminates the relationship between cultural and therapeutic work with Vietnamese American clients. It draws from both research and clinical practice to provide an in-depth experience by reviewing cultural factors and practice strategies to increase service effectiveness.

Curriculum goal, rationale, and target group

Although a client mental health literacy educational program is crucial for increasing services utilization, the clinician should also be trained in working with this specific population. Current literature suggests there is a great need to develop a cultural competency program to assist mental health and medical professionals working with Vietnamese immigrants and refugees. This doctoral project serves this need by developing a clinical training curriculum that specifically and effectively bridges the cultural gap between mental health practitioners working with first and second generation Vietnamese-Americans. Through this contribution, the practitioner will be better equipped to serve this population.
In order to increase services utilization and reduce early service termination, a practitioner must be a culturally competent provider (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003; Sue et al., 2012). Adequate clinical guidelines for mental health professionals working with Vietnamese Americans are crucial in providing proper mental health services. A lack of cultural training regarding the client’s background renders the practitioners ineffective in their craft. A carefully constructed clinical curriculum will help direct the practitioner through various cultural complexities while minimizing ethical missteps. With such guidance, practitioners will broaden their scope of practice and increase the availability of effective services for Vietnamese Americans. Thus, this curriculum focuses on developing awareness and knowledge in cross-cultural work among mental health professionals. This allows the clinician to gain cultural awareness and knowledge about the culturally different clientele. Although a skill component is equally important, this can be acquired when working with the client in clinical practice.

**Curriculum design**

The present clinical training curriculum follows Sue et al.’s (1992) conceptual framework of cross-cultural counseling competency, in which most of the cross-cultural skills can either be organized or developed. In this model, Sue et al. suggests that culturally competent counselors possess an awareness of their own assumptions, values, and biases; an understanding of culturally different clients; and an ability to develop appropriate intervention strategies. Each of these characteristics has three dimensional areas: beliefs and attitudes, knowledge, and skills. The objective of this training is to assist culturally skilled clinicians develop awareness and
knowledge to enrich their understanding and effectiveness when working with culturally different populations (Sue et al., 1992).

The curriculum consists of five modules with optional sessions (i.e., guest speaker, movie, and/or group sharing experience), each session spanning approximately 2 hours and 30 minutes. This training curriculum includes two sharing activities: (1) cultural identity and (2) cultural immersion experience. The first activity aims to raise the trainees’ cultural awareness by making an earnest exploration of their cultural identity (D’Andrea & Daniels, 2001). The second activity allows participants to be immersed in a culture other than their own. This encourages participants to become aware of cultural differences and gain deeper appreciation for multiculturalism (Hong & Ham, 2001). A detailed instruction on these exercises can be found in Appendix A.

The curriculum material can be modified to fit the needs of the training facility. All the materials needed to implement this curriculum are included in the Appendices. Appendix A is the trainer’s manual. A trainer that is knowledgeable working with the Vietnamese American community is recommended to facilitate this training. If the trainer does not have a strong cultural background about Vietnamese Americans, it is recommended that a guest speaker from the Vietnamese community should be present to serve as co-trainer and to answer any questions the trainer may not know.

Module description

Module I: Cultural values, biases. Cultural self-awareness is a critical component for effective multicultural work (Sue et al., 1992). In order for the practitioner to grow in the empathy and professional insights required to treat diverse cultural groups, he/she must become cognizant and sensitive towards their own background (Richardson & Molinaro, 1996). In this
module, the clinician develops sensitivity to their own cultural heritage, respect for other cultures, and a positive orientation toward multiculturalism (Sue et al., 1992). Further, the dimension of awareness is the first of the three components of the Sue et al. model necessary for a clinician working with the culturally diverse (Hong & Ham, 2001). The continued absence of cultural self-awareness and its attendant privileges (i.e., white privilege) will interfere with any positive outcomes with diverse clientele. This first module will help the practitioner-learner identify and assess cultural awareness through various identity models and assessment tools (Roysircar, 2004). The instructional segment is followed with discussion exercises and suggested readings. Special emphasis is given to the discovery of bias within one’s cultural background prior to working with diverse clients.

**Module II: Vietnamese cultural background and perception of mental illness.** Work with different ethnic groups necessitates profound practitioner understanding regarding the client’s cultural and historical background. The second module empowers the practitioner with a working knowledge of Vietnamese cultural and historical backgrounds. Even though obtaining this expertise is challenging, such a step greatly enhances the practitioner’s professional effectiveness with diverse cultures as identified in the previous module.

However, in addition to understanding the Vietnamese historical background, it is crucial to also be aware of the client’s cultural perception about mental health in order to improve the practitioner’s treatment approach (Gong-Guy, Cravens, & Patterson, 1991). This module will identify cultural barriers known as root causes impairing a client’s ability to seek clinical services (i.e., conceptualization of mental illness, traditional practices, religion, philosophy, stigma) (Hampton et al., 2007; Fogel & Ford, 2005; Barret, 2006; Chen, Song-Jae, Donnel, 2004; Kim et al., 2001; Kroll et al., 1989).
Module III: Working with language interpreters. The third module discusses working with Vietnamese clients through language interpretation. This skill set defines an essential component for clients with limited English proficiency. It is the main method for a practitioner when building a communication bridge with such a client. However, this is a challenge for both the client and the practitioner since it involves a third person in the counseling relationship (Avery, 2001; Downing, 1992). This module will help the practitioner develop a working relationship with the interpreter to deliver effective services (Miller, Martel, Pazdirek, Caruth, & Lopez, 2005).

Module IV: Assessment skills and application of major theories. Having a firm grasp of assessment skills helps the practitioner gain accurate information regarding current problems. This module will address clinical interviewing skills and case conceptualization when working with Vietnamese Americans (Lee, 1996; Axelsson, 1993). Additionally, the practitioner will learn about the application of major cultural and clinical theories emphasizing cultural sensitivity when working with this population. Although this module will not go into detail with each specific theory, it will provide some guidelines to help the practitioner navigate through practice. Additionally, clinical vignettes will facilitate discussions in applying the theoretical approaches (Hong & Ham, 2000).

Module V: Counseling interventions. The fifth module includes a component of counseling practice for optimal intervention skills. An effective practitioner must consider the client’s cultural background and social environment when considering appropriate interventions (Fung & Wong, 2007; Kim, Atkinson, & Umemoto, 2001; Hong & Ham, 2000). The practitioner will learn cultural considerations when working with Vietnamese clients (e.g., building rapport, ethical dilemmas) that may interfere with an effective counseling process.
Evaluation plan. This training manual will be evaluated in two stages. First, clinicians who have experience working with Vietnamese Americans will be recruited to evaluate this training manual in the following areas: content, clarity, and applicability. The feedback received will then be evaluated, common themes will be identified, and the training manual will be revised accordingly.

Second, the clinical training will be taught to an identified group of clinicians interested in working with Vietnamese Americans. The California Brief Multicultural Competence Scale (CBMCS) (Gamst, Dana, Der-Karabetian, Aragon, Arellano, & Martenson, 2004) will be used before and after training to measure change in cultural competence. Data will be collected anonymously to protect individual identity. Further, the overall learning experience will be evaluated through a pre and post training survey. Participants will be given a pre-training survey (included in the training curriculum) prior to commencing training to assess knowledge and identify learning needs. The surveys will help the trainer understand the participants and tailor the training program as needed. Participants will also complete a post-training survey upon course completion for the purpose of determining participants’ opinions on the effectiveness and significance of the program. Finally, a course evaluation will be used for quality assurance. The course evaluation will provide useful feedback to improve his/her quality of instruction. The course evaluation form can be found on page 144.

Ethical and diversity considerations.

This training curriculum provides a general overview of clinical issues when working with Vietnamese Americans. However, it does not address in-depth areas (e.g., youth, sexual orientation, psychological evaluation, and treatment for specific mental disorders) for the targeted group. Trainees are encouraged to explore beyond the basic training curriculum for a
better understanding on the topic of interest. Further, this training curriculum offers a framework that allows the flexibility to adapt training materials to specific needs.

In order to effectively and ethically implement training materials, this curriculum should only be taught by a trainer with knowledgeable experience working with the Vietnamese American community. The trainer is reminded to be familiar with the curriculum materials prior to implementing this training.

The recommended number of participants for the curriculum is a group size of 12-15 participants to allow for both didactic and experiential content. This is to ensure that the participants are able to understand important concepts, be comfortable in sharing personal information, and discuss case vignettes in a proper manner. Further, the smaller group size helps to develop trust among all participants and allows them to engage in meaningful conversations. Therefore, it is appropriate to limit the number of participants, and doing so helps to assure that the learning objectives, agenda, and content are commensurate with the training process.

**Distribution plan.**

A finalized version is to be provided to users free-of-charge. The plan is to obtain a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for training purposes. A website will be developed and maintained to assist with training and the sharing of ideas. The grant will also allow training opportunities throughout the United States, especially in areas with high Vietnamese American populations.
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Appendix A

Original Contribution to Practice:

Working with Vietnamese Americans: A Clinical Training Program for Mental Health Professionals
Working with Vietnamese Americans:
A Clinical Training Program for Mental Health Professionals

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# Curriculum Outline

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Introduction

The goal of this curriculum is to enlist and assist mental health practitioners to build cultural competency in their work with Vietnamese Americans. This curriculum can be used as a continuing education program or as an in-service training program.

Although there are limited resources available for working with Asian American clients (Lee, 1997), there are none for working with the Vietnamese community specifically. The current resources provide a general overview across all Asian ethnic groups without providing specific details on how to deliver effective mental health services to a particular group. Therefore, clinicians are at risk of overgeneralizing and may miss important details when working with their clients. This doctoral project, as an essential resource for practitioners, will clinically illuminate the relationship between cultural and therapeutic work with Vietnamese American clients. It draws from both research and clinical practice to provide an in-depth experience by reviewing cultural factors and strategies to increase service effectiveness.

Curriculum Goal, Rationale, and Target Group

Although a mental health literacy educational program is crucial for increasing services utilization, the clinician should also be trained in working specifically with Vietnamese populations. Current literature suggests there is a great need to develop a cultural competency program to assist mental health and medical professionals working with Vietnamese immigrants and refugees. This doctoral project serves this need by developing a clinical training manual that specifically and effectively bridges the cultural gap between mental health practitioners working with first and second generation Vietnamese Americans. Through this contribution, the practitioner will be better equipped to serve this population.

In order to increase services utilization and reduce early service termination, a practitioner must be a culturally competent provider. Adequate clinical guidelines for mental health professionals to work with Vietnamese Americans are crucial in providing proper mental health services. A lack of cultural training regarding a client’s background renders practitioners ineffective in their craft. A carefully constructed clinical guideline will help direct the practitioner through various cultural complexities while minimizing ethical missteps. With such guidance, practitioners will broaden their scope of practice and increase the availability of effective services for Vietnamese Americans.

Curriculum Design

The present clinical training curriculum will follow Sue et al.’s (1992) conceptual framework of cross-cultural counseling competency, in which most of the cross-cultural skills can either be organized or developed. In this model, Sue et al. suggests that culturally competent counselors possess an awareness of their own assumptions, values, and biases; an understanding of culturally different clients; and an ability to develop appropriate intervention strategies. Each of these characteristics has three dimensional areas: beliefs and attitudes, knowledge, and skills. The objective of this training is to assist culturally skilled clinicians in developing awareness and
knowledge to enrich their understanding and effectiveness when working with culturally different populations (Sue et al., 1992).

The curriculum consists of five modules with three optional sessions (i.e., guest speaker, movie, and/or group sharing experience), each session spanning approximately 2 hours and 30 minutes. This training curriculum includes two sharing activities: (1) cultural identity and (2) cultural immersion experience. The first activity aims to raise the trainees’ cultural awareness by making an earnest exploration of their cultural identity (D’Andrea & Daniels, 2001). The second activity allows participants to be immersed in a culture other than their own. This encourages participants to become aware of cultural differences and gain deeper appreciation for multiculturalism (Hong & Ham, 2001).

The recommended number of participants for the curriculum is a group size of 12-15 participants to allow for both didactic and experiential content. This is to ensure that the participants are able to understand important concepts, be comfortable in sharing personal information, and discuss case vignettes in a proper manner. Further, this helps to develop trust among all participants and allows them to engage in meaningful conversations. Therefore, it is appropriate to limit the number of participants, and doing so helps to assure that the learning objectives, agenda, and content are commensurate with the training process.

Module Description

**Module I: Cultural values and biases.** Work with different ethnic groups necessitates profound practitioner understanding regarding the client’s cultural and historical background. The second module empowers the practitioner with a working knowledge of Vietnamese cultural and historical backgrounds. Even though obtaining this expertise is challenging, such a step greatly enhances the practitioner’s professional effectiveness with diverse cultures as identified in the previous module.

However, in addition to understanding the Vietnamese historical background, it is crucial to also be aware of the client’s cultural perception about mental health in order to improve the practitioner’s treatment approach (Gong-Guy, Cravens, & Patterson, 1991). This module will identify cultural barriers known as root causes impairing a client’s ability to seek clinical services (i.e., conceptualization of mental illness, traditional practices, religion, philosophy, stigma) (Hampton et al., 2007; Fogel & Ford, 2005; Barret, 2006; Chen, Song-Jae, Donnel, 2004; Kim et al., 2001; Kroll et al., 1989).

**Module II: Vietnamese cultural background & perception of mental illness.** Work with different ethnic groups necessitates profound practitioner understanding regarding the client’s cultural and historical background. The second module empowers the practitioner with a working knowledge of Vietnamese cultural and historical backgrounds. Even though obtaining this expertise is challenging, such a step greatly enhances the practitioner’s professional effectiveness with diverse cultures as identified in the previous module.

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Module III: Working with interpreters. The third module discusses working with Vietnamese clients through language interpretation. This skill set defines an essential component for clients with limited English proficiency. It is the main method for a practitioner when building a communication bridge with such a client. However, this is a challenge for both the client and the practitioner since it involves a third person in the counseling relationship (Avery, 2001; Downing, 1992). This module will help the practitioner develop a working relationship with the interpreter to deliver effective services (Miller, Martel, Pazdirek, Caruth, & Lopez, 2005).

Module IV: Assessment skills & application of major theories. Having a firm grasp of assessment skills helps the practitioner gain accurate information regarding current problems. This module will address clinical interviewing skills and case conceptualization when working with Vietnamese Americans (Lee, 1996; Axelson, 1993). Additionally, the practitioner will learn about the application of major cultural and clinical theories emphasizing cultural sensitivity when working with this population. Although this module will not go into detail with each specific theory, it will provide some guidelines to help the practitioner navigate through practice. Additionally, clinical vignettes will facilitate discussions in applying the theoretical approaches (Hong & Ham, 2000).

Module V: Counseling Interventions. The fifth module includes a component of counseling practice for optimal intervention skills. An effective practitioner must consider the client’s cultural background and social environment when considering appropriate interventions (Fung & Wong, 2007; Kim, Atkinson, & Umemoto, 2001; Hong & Ham, 2000). The practitioner will learn cultural considerations when working with Vietnamese clients (e.g., building rapport, ethical dilemmas) that may interfere with an effective counseling process.
Suggested Readings and Videos

Books:

1) *Culture and customs of Vietnam* by Mark W. McLeod and Dieu Thi Nguyen
   This book offers an overview of the Vietnamese culture and customs. It helps the reader have a better understanding of cultural practices (e.g., land, people, language, history, religion, literature, art and architecture, family, cultural celebrations, etc.).

2) *Psychotherapy and counseling with Asian American clients: A practical guide* by George K. Hong and MaryAnna Domokos-Cheng Ham
   This is a comprehensive guide for clinicians interested in working with Asian Americans. It is easy to understand. It presents to the reader both conceptual and cultural issues in working with Asian Americans as well as strategies for addressing clinical concerns. It also offers practical suggestions and case examples for delivering mental health services.

3) *The Vietnamese boat people, 1954 and 1975-1992* by Nghia M. Vo
   This book discusses the Vietnamese diaspora after the Vietnam War. It offers in depth experiences of the many Vietnamese refugees in search for freedom.

4) *The Vietnamese Americans* by Hien Duc Do
   An overview of Vietnam, culminating with a brief history of the refugee/immigration experience to the U.S. This is a good start for those seeking background information about Vietnamese Americans.

5) *Working with Asian Americans: A guide for clinicians* edited by Evelyn Lee
   This is an essential resource for clinicians that explores the relationship between cultural and interpersonal issues in therapeutic work with Asian Americans. It provides an overview of working with different Asian American cultural groups, development and life cycles, therapeutic issues, treatment modalities, and special issues (i.e., gay and lesbian, women, intermarriage, domestic violence, mental health care delivery).

Videos:

1) *CAN* - a documentary film by Pearl J. Park is the story of a young Vietnamese man, Can Truong, struggling with bipolar disorder. The movie follows Can through his daily life and his struggles to integrate Vietnamese cultural traditions with Westernized mental health interventions. For ordering information, please visit http://www.amongourkin.org

2) *Heaven and Earth* – directed by Oliver Stone, is the story of a young Vietnamese woman’s traumatic experience growing up in a war-torn country, her adjustment to her new homeland, and her emotional return to her home country.

3) *Shame and Silence* - produced by the New York Coalition for Asian American Mental Health (www.asianmentalhealth.org) 2-hr video: The DVD consists of five simulated interviews between clinicians and actors who play the roles of simulated patients. The cases include: 1) a South Asian-American woman with bipolar disorder, 2) a Vietnamese-American man with somatic presentations of depression and PTSD, 3) the parents of a Filipino-American child with ADHD, and 4) a Korean-American woman with Major Depression and substance abuse. (Abstract taken from http://amongourkin.org/res-books.html)
4) **Working with Asian American Clients** – Part of the multicultural counseling video series by the American Psychological Association. Dr. Jean Lau Chin demonstrates an approach that addresses cultural issues in therapy. In the video, Dr. Chin works with a 40-year-old Vietnamese woman dealing with issues surrounding her family’s reaction to her separation from her husband.

Websites:

1) **National Asian American Pacific Islander Mental Health Association**  
   http://www.naapimha.org

2) **New York Coalition for Asian American Mental Health**  
   http://www.asianmentalhealth.org/

3) **Southeast Asia Resource Action Center (SEARAC)**  
   http://www.searac.org
Orientation Session

Objectives

Within this session, the trainer helps the trainee obtain an overview of the training curriculum, build group cohesion by getting acquainted with participants, as well as introduce instructions for class procedures.

Introduction

- Welcome all training participants.
- Introduce the trainer/facilitator:
  i. Name
  ii. Educational/Professional Background
  iii. How you become involved in the Vietnamese American community
  iv. What you are hoping for out of this group

Important Points:

- Although this training will not automatically make participants culturally competent clinicians, it will provide helpful information on how to work with the Vietnamese American community.
- This training provides a general overview of the Vietnamese American community and may not addresses specific issues (e.g., GLBT, children, family). However, participants are encouraged to reflect on these issues and contribute to the in-class discussion.
- It is important to discuss the need for showing CONFIDENTIALITY and RESPECT for each participant’s experience.

Activity: Name introduction

- Name
- Ethnic/cultural background
- Current employment/institution
- Reason(s) for attending the training

Encourage the participants to keep their sharing to no more than 3 minutes.

Training Curriculum

- Minimum of 5 sessions
- 2 hours 30 minutes each
- Consists of group sharing activities, lectures, and group discussions.
- Participants are expected to share personal experiences.
- No new member is accepted after the orientation session.
- Participants are encouraged to do outside reading. Personal exploration is encouraged.

**Sample of session format**

- Welcome (10 minutes)
  - Check-in
- Presentation (example: Cultural Competence) (40 minutes)
  - Break (10 minutes)
- Activity: Cultural sharing (50-60 minutes)
  - Break (10 minutes)
- Discussion (20 minutes)
- Wrap-up (10 minutes)

**FRAMEWORK OF CROSS-CULTURAL COMPETENCY**

<table>
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<tr>
<th>Beliefs &amp; Attitudes</th>
<th>Awareness of Own Assumptions, Values, and Biases</th>
<th>Understanding Cultural Worldview of the Client</th>
<th>Appropriate Intervention Strategy/Technique</th>
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<tr>
<td></td>
<td>➢ <em>Activity:</em> RESPECTFUL</td>
<td>➢ Cultural perception and beliefs.</td>
<td>➢ Working with Vietnamese clients.</td>
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<td></td>
<td>➢ Guest speaker <em>(optional)</em></td>
<td>➢ <em>Activity:</em> Interview a Vietnamese student, refugee individuals <em>(optional)</em></td>
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<td>➢ Movies/ Lecture videos</td>
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<td>➢ <em>Activity:</em> Personal sharing (culture, values, and beliefs).</td>
<td>➢ <em>Activity:</em> Field experience sharing.</td>
<td>➢ Counseling intervention.</td>
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<tr>
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<td>➢ <em>Activity:</em> Vignettes and group discussions.</td>
<td>➢ Assessment of skills.</td>
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*Adapted from Sue, Arredondo, & McDavis’ (1992) conceptual framework of a cross-cultural counseling competency.*

**Group Sharing Activities**

There are two sharing activities throughout this training. Please provide sign-up sheets for recording available times.
1) **Cultural identity**: In order to work with culturally diverse clients, each participant is expected to make an earnest exploration of his or her own cultural identity. This group sharing activity is designed so that participants can gain greater appreciation for each other and bring awareness to personal cultural values that others may not know based solely on physical appearances.

RESPECTFUL (D’Andrea & Daniels, 2001)

*Instructions*: Each participant has approximately 10 minutes to share. You do not have to provide a response to every letter but try to respond to at least 5 letters. Each participant will take turns sharing during the first and third sessions.

- R- religious/spiritual identity
- E- economic class background
- S- sexual identity (gender identity, gender roles; sexual orientation)
- P- psychological maturity
- E- ethnic/racial identity
- C- chronological/developmental changes (physical, growth, etc.)
- T- various forms of trauma and threats to well-being
- F- family background and history
- U- unique physical characteristics
- L- location of residence and language differences

2) **Cultural immersion**: Learning requires practice. This allows participants to be immersed in a culture other than our own. This also allows participants to become aware of cultural differences and gain deeper appreciation for the people we work with (Hong & Ham, 2001).

*Instructions*: Each participant will have approximately 10 minutes to share his/her experience. Each participant will take turns sharing during the fourth and seventh sessions.

a. **Option #1**: Each participant is expected to participate in a Vietnamese cultural activity (e.g., traditional/spiritual ceremony, community event). Equipped with a digital camera (or cell phone camera), take pictures that you find interesting to bring back for sharing with the group.

b. **Option #2**: Interview a first or second generation Vietnamese American and ask him/her to share their experience being a Vietnamese American. Possible areas to talk about: Immigrant/refugee experience, family practices and traditions, family expectations, spiritual practices, mental health.

**Sharing Rules:**

1. Respect
2. Confidentiality
3. Active listening
4. Nonjudgmental comments
5. Group input
6. Address comments to the trainer/facilitator

**Pre-training questionnaire**

Ask the group to complete the PRE-training questionnaire. This helps the trainer get to know the participants and will allow attempts to incorporate or answer any questions from the participants.

- **Participant’s Pre-Training Questionnaire** (p. 140)
Module 1: Cultural Values and Biases

Learning Objectives

Within this training module, participants will learn:

- The definition of and the need for cultural competency
- To identify current development of cultural awareness
- To discover bias within one’s own cultural background prior to working with diverse clients

Introduction Questions

- Why multicultural competency? Why is it important?

Definition

- **Culture** (American Psychological Association, 2002)
  - Culture is the belief systems and value orientations that influence customs, norms, practices, and social institutions, including psychological processes (language, care taking practices, media, educational systems) and organizations (media, educational systems) (Fiske, Kitayama, Markus, & Nisbett, 1998).
  - Inherent in this definition is the acknowledgement that all individuals are cultural beings and have a cultural, ethnic, and racial heritage.
  - Culture has been described as the embodiment of a worldview through learned and transmitted beliefs, values, and practices, including religious and spiritual traditions. It also encompasses a way of living informed by the historical, economic, ecological, and political forces on a group.
  - These definitions suggest that culture is fluid and dynamic, and that there are both cultural universal phenomena as well as culturally specific or relative constructs.

Culture is akin to being the person observed through a one-way mirror; everything we see is from our perspective. It is only when we join the observed on the other side that it is possible to see ourselves and others clearly, but getting to the other side of the glass presents many challenges (Lynch & Hanson, 1992).

- **Multiculturalism and diversity** (APA, 2002)
  - Used interchangeably to include aspects of identity stemming from gender, sexual orientation, disability, socioeconomic status, or age.
Are critical aspects of an individual's ethnic/racial and personal identity, and psychologists are encouraged to be cognizant of issues related to all of these dimensions of culture. In addition, each cultural dimension has unique issues and concerns.

The Iceberg Conception of Culture
(The National Center for Cultural Competence, 2004)

Similar to an iceberg, only 10% of our culture is apparent to others, while the 90% that is hidden requires a deeper personal exploration.

- Talk about the three cultural phases (Surface, folk, and deep culture).
  - Ask the group to identify and/or give examples of each phase.
- Ask the group to identify several cultural values in each of the three phases.
Why Multicultural Competency?

- A more diverse nation (U.S. Census Bureau Projection for 2060) (U.S. Census Bureau, 2012)
  - 1 in 3 U.S. residents would be Hispanic.
  - Black population would increase from 13.1% in 2012 to 14.7% in 2060
  - Asian population is projected to double from 15.9 million (5.1%) to 34.4 million (8.2%) in the same period.
  - Approximately 1.5 million Vietnamese Americans currently living in the U.S. (Nguyen, 2011)
- Mental Health professionals are susceptible to cultural bias (Sue & Sue, 2008), which may result in:
  - Insensitivity to the needs of their culturally diverse clients
  - Clients often complaining about being abused, intimidated, and harassed by non-minority personnel
  - Discriminatory practices in the mental health delivery system
  - Mental health professionals continuing to be trained in institutions that ignore multicultural issues
- Lack of cultural competency increases misdiagnoses, inappropriate treatment options, miscommunication between mental health professionals and clients, errors in clinical practice, poor quality of care and premature termination of treatment (Zane et al., 1994; Chow 2002).

Key Components of Multicultural Competence (Pedersen, 1988)

- **Self-awareness** of the role of culture in one’s own experience.
  - Do you have the accurate and appropriate attitudes, opinions, and assumptions about a culture?
- **Knowledge** about the nature and uniqueness of cultural groups and understanding the sociopolitical experiences of those cultural groups.
  - Do you have all the facts and information accurately under control?
- **Skill** acquisition focused on the quality and appropriateness of interventions between the counselor and diverse clients.
  - Are you able to identify appropriate ways to bring about changes in the culture or to be accepted by persons from that culture?
White Racial Identity Model Ego Statuses (Helms, 1995)

- **Contact**: Satisfaction with racial status quo, oblivious to racism and one’s participation in it. If racial factors influence life decisions, they do so in simplistic fashion.
- **Disintegration**: Disorientation and anxiety provoked by unresolved racial moral dilemmas that force one to choose between own-group loyalty and humanism.
- **Reintegration**: Idealization of one’s socioracial group, denigration and intolerance for other groups. Racial factors may strongly influence life decisions.
- **Pseudo-integration**: Intellectualized commitment to one’s own socioracial group and deceptive tolerance of other groups. Makes life decisions to “help” other racial groups.
- **Immersion/emersion**: Search for an understanding of the personal meaning of racism and the way one benefits and a redefinition of whiteness. Life choices may incorporate racial activism.
• **Autonomy**: Informed positive socioracial-group commitment, use of internal standards for self-definition, capacity to relinquish the privileges of racism. May avoid life options that require participation in racial oppression.

**Self-awareness for Developing Multicultural Competence** (Richardson & Molinaro, 1996)

1) **Worldview** – Involves two worldviews interacting in therapeutic relationships.
   o In-depth awareness of his or her worldview in order to facilitate a meeting of the minds with the client.
2) **Cultural values** – Nucleus of worldview.
   o Counselors unaware of their own cultural contribution tend to be unable to discuss those beliefs with clients and run the risk of intervening solely from their own value system.
3) **White racial identity** – Group identity based on one’s perception that he or she shares a common heritage with a particular racial group.

**Multicultural Counseling Competency Measures**

- **Cross-Cultural Counseling Inventory-Revised (CCCI-R)** (LaFromboise et al., 1991)
- **Multicultural Awareness, Knowledge, Skills Survey (MAKSS)** (D’Andrea et al., 1991)
- **Multicultural Counseling Awareness Scale – Form B (MCAS-B)** (Ponterotto & Alexander, 1996)
- **Multicultural Competency and Training Survey (MCCTS)** (Holcomb-McCoy, 2000)
- **California Brief Multicultural Competency Scale (CBMCS)** (Gamst, Dana, Der-Karabetian, Aragon, Arellano, & Martenson, 2004)
  o Designed to improve multicultural competence instrumentation as a precursor to consistent and replicable multicultural competence training for clinicians.
  o Embeds competence assessment and training within a quality-of-care model for ethnic minority populations.
  o Efficient and effective tool for examining self-reported mental health practitioner cultural competency.
  o **Advantages:**
    - Shorter length
    - Development from a strong theoretical foundation
• Utilizes a large number of practitioners from various ethnic backgrounds, education levels, ages, and experience.
  o Consists of 21 items – 4 factors (p. 135)
    • **Multicultural Knowledge**: Issues of acculturation, racial/ethnic identity, language, etc.
    • **Awareness of Cultural Barriers**: Challenges people of color experience accessing mental health services.
    • **Sensitivity to Consumers**: What does it mean to be a person of color AND a consumer of mental health services.
    • **Sociocultural Diversities**: (formerly Nonethnic Ability) Issues of gender, sexuality, aging, social class, and disability.
    • Cronbach’s alpha (a measure of internal consistency) .89
RESPECTFUL Counseling: An integrative model for counselors

Cultural Autobiography

I am.....

R - religion
E - economic
S - sexual identity
P - psychological maturity
E - ethnic/racial identity
C - chronological/development changes
T - trauma and threats
F - family background
U - unique physical characteristic
L - location of residence

(D’Andrea & Daniels, 2001)

[Figure 1.3]
Adapted from D’Andrea & Daniels, 2001

Discussion Questions

- What stands out to you in this section?
- How may the lack of cultural awareness affect a counselor’s work with culturally diverse clientele?
- Is being culturally aware of one’s cultural background necessary in working with culturally diverse clients?

Video
[DVD]. Available from http://www.emicrotraining.com
Suggested Readings


Module 2: Vietnamese Cultural Background & Perception of Mental Health

Learning Objectives

Within this training module, participants will learn to:

- Identify mental health needs among the Vietnamese American community.
- Understand the clinical implication of immigration.
- Identify the cultural perception and challenges of mental illness among those within the Vietnamese culture.

Introduction Activity

On the topic of Vietnamese Americans, think of:

- 3 words
- Write 2 questions
- Describe an image you see when you think about Vietnamese Americans.

Write the answers on the board for later discussion.

- Where do you learn about the Vietnamese population?
- How confident are you working with Vietnamese Americans in a mental health setting?

Overview of the Population

- Vietnamese ranks as the FOURTH largest Asian American group in the U.S.
- Over 1.55 million Vietnamese live in the United States (U.S. Census, 2010)
- States with the most Vietnamese include:
  - California, Texas, Florida, Virginia
- 68% are foreign-born (Nguyen, 2011)

Trauma Experiences

Vietnamese American immigrants, in general, have experienced significant stressors after the fall of Saigon in 1975. The trauma inflicted by twenty years of civil war, by Communist-Vietnamese reeducation camps, by the boat-person experience, and by detention in refugee camps continues to linger for years after resettlement (Cargill & Huynh, 2000; Desbarats, 1990; Do, 1999; Do, Phan, & Garcia, 2001; Gold, 1992; Le, 2001; Pumariega et al., 2005; Rutledge, 1992; Sagan &
Denney, 1982; Vo, 2006). Exposure to these traumatic events is in itself a major mental health risk (Beiser, 2005).

  - Various studies have identified depression, PTSD, anxiety disorders, and somatic complaints as correlated with victims of war and migration (Davis, 2000; Nicholson, 1997).
  - The number of reported traumatic events was positively correlated with the severity of PTSD-related symptoms.
    - Political refugees experienced greater amounts of trauma accompanied with higher rates of mental disorders (Fawzy et al., 1997b).
  - Vietnamese political refugees experienced over 12 traumatic events compared to the general Vietnamese population in the U.S. (Mollica et al., 1998).
    - Over 90% of those surveyed exhibit PTSD symptoms.
    - 49% show some symptoms of depression (i.e., of those who experienced on average 2.6 traumatic events, 79% had PTSD, and 15% had depression) (Mollica et al., 1998).
  - Those with high degrees of trauma exposure showed long-term psychiatric morbidity (Steel, Silove, Phan, & Bayman, 2002; Vaage et al., 2010).

- Vietnamese women refugees suffered higher rates of physical and sexual violence (e.g., pirate attacks) during the migration experience compared to Vietnamese men refugees (Chung & Bemak, 1998).
  - Vietnamese social mores strongly dictate that virginity and good behavior are normative for women (Chung & Bemak, 1998). This construct may:
    - Increase harm done to rape victims by adding self-blame for the abuse, thereby negatively affecting help-seeking behaviors. An accompanying loss of self-respect and honor leads to a psychological process of repression and fear of family disgrace.
    - Make many women hesitate sharing their experience with their husbands for fear this revelation could end their marriage.
    - Make it impossible for many victims to turn to family members for counsel, leaving the woman “to suffer in silence” (Chung & Bemak, 1998, pp. 377).

**Clinical Implications of Migration**

Three stages of migration (Ho, 1987):

- **Premigration:** These individuals establish a cultural value system, practices, and beliefs in what is often the most stable period and the individuals are likely well-adjusted (Hong & Ham, 2001). However, while this is often true for most migrants, family systems from
war-torn countries (e.g., Southeast Asia) are inherently unstable due to trauma related stress (Kirkmayer et al., 2010).

- **Migration:** Many immigrants and refugees are separated from their families, support network, and cultural norms. The disruption of family life, in addition to trauma and isolation, contribute to higher levels of stress, which further affects the experience of acculturative stress during the postmigration phase (Ho, 1987; Hong & Ham, 1992; Mollica et al., 1998).

- **Postmigration:** Immigrants continue enduring stress that is now exacerbated by unpredictable societal and cultural issues brought on by adjustment problems, economic situations, and racial or ethnic prejudice (Ho, 1987; Hong & Ham, 1992; Mollica et al., 1998).

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**Ecological Fit System (Falicov, 1988)**

A modification of Brofenbrenner’s (1977) ecological model. This system considers environmental stresses (i.e., acculturation, economic, lack of familial support, and racial or ethnic prejudice) through interrelated and defined layered contexts: Microsystem (family members), Mesosystem (interrelationships among the community: e.g., extended family, friends and peers, and religious affiliations), Exosystem (institutions or society: e.g., political, educational, and governmental), Macrosystem (overarching beliefs and values) (Falicov, 1988).
For many immigrants, the individual and their family systems experience significant disruption during migration, such as separation from nuclear family members (microsystem) as well as from extended family and community support (mesosystem). Given their new American context, immigrants then struggle to adapt to or define social, medical, and educational services (exosystem). Finally, these immigrants then learn to function and adjust within their new social cultural context and challenges (culture, language, overt/covert racism) (macrosystem) (Hong & Ham, 2001).

Within this context, the more disruption or dissonance in the new ecological system, the greater the adjustment stress and the subsequent likelihood of dysfunction (Falicov, 1988).

**Vietnamese American Prevalence Rates of Mental Disorder**

Refugees (the majority of forced migrants) who experienced severe exposure to violence often have higher rates of trauma-related disorders such as PTSD, depression, and other somatic complaints (Kirmayer et al., 2011).

- A survey conducted by the Commonwealth Fund found that 30% of Asian American girls in grades 5 through 12 reported depressive symptoms (Ida & Yang, 2003).
- Longitudinal studies on Cambodian adolescents who had suffered severe trauma suggest that between 25-50% were diagnosed with PTSD years after the trauma (Pumariega et al., 2005).

Mental health issues strongly correlate with migration stressors (i.e., premigration trauma and postmigration stress) (Berry, 2006; Davis, 2000; Nicholson, 1997), which in turn lead to adjustment difficulties within a new culture (Berry, 1997; Chung, 1993).

- **Discrimination**
  - Studies on discrimination among Asian Americans report an association between discrimination and an increased risk of depressive and/or anxiety symptoms (Gee et al., 2007).
  - Mereish, Liu, and Helms’ (2012) study on the effects of discrimination on Chinese, Filipino, and Vietnamese Americans’ mental and physical health suggests that all three ethnic groups’ experiences of discrimination are positively related to psychological distress.

- **Economic stressors**
  - Educated and skilled people are unable to obtain employment that is appropriate to their previous education and training (Saechao et al., 2011).
Unemployment or underemployment is found to have negative impacts on the immigrants’ mental health, impacts that also extended to their family members (Dean & Wilson, 2009).

For immigrant women, serving as a wage earner fostered independence and autonomy, which also worked to destabilize traditional Vietnamese cultural paradigms that also created significant tensions within the traditional Vietnamese family (Chung & Bemak, 1998; Do, 1999).

Some husbands sensed such role changes as threats to their traditional patriarchal view of the family, which led to increases in domestic violence and divorce (Luu, 1989).

- Intergenerational Conflict
  - Intergenerational conflict (e.g., challenging parental authority) between parents and children often occurs after resettlement in the U.S. (Chung & Bemak, 1998; Kibria, 1993).
  - Vietnamese and Cambodian youth report higher rates of disagreement and arguments with their parents if they perceive gaps in cultural values (Chung & Bemak, 1998).

Cultural Conceptualization of Mental Health

Vietnamese cultural practices

Philosophical and religious practices, which define Vietnamese culture, are significant parts of the Vietnamese American identity.

- **Buddhism** – It teaches adherents to be highly tolerant of suffering and to value the enduring of pain through acceptance; in essence, they permit fate to take charge (Hampton et al., 2007).
  - With this view, it is divine intervention, such as punishment for one’s transgressions in a previous life, which result in psychological disabilities (Chen et al., 2004; Nguyen & Anderson, 2005).

- **Confucianism** – It considers disabilities as a dissonance between the ideal states of harmony, which in turn bring shame to the family of those who need psychological help (Chen et al., 2004).
  - Individuals who believe strongly in these spiritual causes of mental illness have negative attitudes about seeking professional psychological help (Luu, Leung, & Nash, 2009; Morrow, 1987).

- **Animism** - In traditional Vietnamese families, ancestral veneration and worship occupies an important position, since it is believed that ancestral spirits care about their descendants’ well-being (Leung, Boehnlein, Kinzie, 1997; McLeod & Nguyen, 2001).
Ancestral worship is also practiced in Vietnamese families of different spiritual traditions, even among Christians (Leung et al., 1997).

- Children are constantly reminded to never commit an act that would shame the ancestors (Leung et al., 1997).

- **Taoism** - Taoism proposes that human beings exist in oneness with the universe. The task of the individual is to maintain the balance of the energies of heaven (yang) and earth (yin) (Chen et al., 2004).
  - If the two energies are disharmonious with each other, the body becomes susceptible to illnesses and diseases (Chen et al., 2004).
  - Illness is defined through the action of spirits/energy. In the presence of illness, thây (meaning master or teacher), similar to a shaman in animistic societies, are asked to identify the culprit, invoke the spirit, and beseech it to accept offerings in exchange for the afflicted (McLeod & Nguyen, 2001).

**Perception of mental disorder**

- Vietnamese perceive the symptomology of mental illness as negative reflections on the immediate family as well as family ancestors (Nguyen & Anderson, 2005).
  - Traditional husbands or fathers resist attending family sessions and resist allowing mental health professionals to influence the family system (Lee, 1997).
- Mental disturbance is viewed as merely the result of bodily imbalance (Kung, 2001).
- Vietnamese and other Asian Americans alike rely on alternative medical care (CAM) for various afflictions, including those with psychiatric origins.
  - Education and acculturation levels are predictive factors for the use of CAM (Jenkins, Le, McPhee, Stewart, & Ha, 1996).
- **Stigma** - Confucianism, in particular, discourages open displays of emotion in order to maintain social and familial harmony and avoid the exposure of personal weakness (Office of the Surgeon General, 2001).
  - Shaming serves as a negative reinforcement for individual behaviors, while harmony encourages the individual to follow socially acceptable lifestyles within the community (Gellis, 2003).
  - Mental illness reflects poorly on the individual’s family and jeopardizes future employment, marriage, and family status (Barret, 2006; Hampton et al., 2007).
- **Somatization** – Somatization of mental health symptoms is ubiquitous in all cultures and more common among non-Western cultures (Kirmayer & Young, 1998).
  - Somatic symptoms are viewed universally as calls for help.
  - The most common somatic symptoms of depression and anxiety are musculoskeletal pain and fatigue; many medical professionals are unable to provide physiological explanations for the cause of these illnesses (Kirmayer, 2001).

**Mental Health Services Utilization**

- Asian Americans do in fact underutilize mental health services when compared with the general American population (Bui & Takeuchi, 1992; U.S. Department of Health and Human Services, 2001; Zhang, Snowden, & Sue, 1998).
• The 2010 rate of utilization of mental health services for American adults (18 and older) is broken down into racial groups: Asian Americans, 5.3%; Hispanics, 7.9%; African Americans, 8.8%; and Non-Hispanic Whites, 16.2% (SAMHSA, 2012).

Attitudes toward help-seeking Behavior

• Acculturation level (Luu et al., 2009)
  o There is a positive correlation between healthy acculturation and healthy help-seeking attitudes.

• Unfamiliarity with the Western mental health concept (Nguyen & Anderson, 2005).

• Practice of self-disclosure
  o Problems are often kept within the family (Hong & Ham, 2001; Nguyen & Anderson, 2005).
  o Community leaders (e.g., priests, monks, community elders) are sought before seeking help from mental health professionals (Schultz, 1982; Yeh & Wang, 2000).

• Language barrier
  o Open communication, exploration of feelings, and individuation.
  o Language is not the primary method of expressing emotions.

Acculturation assessment tool:

- The Suinn-Lew Asian Self Identity Acculturation (Suinn, Ahuna, & Khoo, 1992)

Discussion Questions

• What stands out for you in this section?

• How did your answers on the topic of Vietnamese Americans match up to the information presented?

• Did your perceptions about Vietnamese Americans change after this presentation?

Videos:

- CAN- a documentary film by Pearl J. Park is the story of a young Vietnamese man, Can Truong, struggling with bipolar disorder. The movie follows Can through his daily life and his struggles to integrate Vietnamese cultural traditions with Westernized mental health interventions. For ordering information, please visit Link: http://www.amongourkin.org
- **Journey from the Fall** – a documentary film by Ham Tran (writer/director/editor) depicts the Vietnamese experience through detainment at a reeducation camp, escape as a boat refugee, and then adjustment to the host country following the fall of Saigon in 1975.

Link: [http://www.journeyfromthefall.com/](http://www.journeyfromthefall.com/)

- Consider watching one of these movies as an optional class session.

**Suggested Readings**


Module 3: Working with Language Interpreters

Learning Objectives

Within this training module, participants will learn to:

- Identify current challenges in working with language interpreters.
- Develop effective strategies on how to work with language interpreters.

Introduction Questions

- What has been your experience in working with language interpreters?
- What are the pros and cons in working with language interpreters?

Language Problem

The 2001, the U.S. Surgeon General report on mental health states that “major disparities exist in the access, utility, and quality of mental health services for racial minorities.” In particular, the report noted “a major barrier to effective mental health arises when clinician and patient do not speak the same language” (p. 163).

Language difficulties play a significant role in either underestimating or overestimating a client’s clinical symptoms (Drennan & Swartz, 2002; Kennedy, Jerar-Dunne, Gill, & Webb, 2002). Thus, the use of language interpreters is a necessity for clinicians working with non-English speakers (Kale & Syed, 2010).

The major hurdle to appropriate diagnosis and treatment of mental health disorders among immigrants remains language: “trained interpreters were not readily available, leading to incomplete assessments and probably lack of empathy and treatment in many cases” (Kennedy et al., p. 7).

Legal requirements for interpretation services:

- Title VI of the 1964 Civil Rights Act (88th Congress, 1964):
  - Prohibits discrimination based on national origin and guarantees access to linguistically sensitive health care services (Snowden et al., 2007).
  - Establishes that individuals cannot be denied access to education, health care, or legal services because they do not speak English.

Use of Interpreters in Psychotherapy

- To date, the use of interpreters in mental health settings often focuses on the medical model and is often underutilized (Kale & Syed, 2010).
Interpretive challenges arise in the accurate assessment and diagnosis of mental illness (Gong-Guy, Cravens, & Patterson, 1991). Challenges include:

- Mainstream clinicians lacking training on the clinical use of interpreters.
- Relying on family members or individuals from the community who have no training in either interpretation or mental health concepts and terminology.
- Interpreters being undervalued in many clinical settings, as illustrated by reports of clerical or janitorial staff being asked to interpret during psychiatric evaluation.
- Clinicians often having difficulty understanding whether interpreters are struggling to follow what clients are saying, or whether clients are merely exhibiting loose association or a flight of ideas (Drennan & Swartz, 2002).
- The addition of an interpreter as representing a significant alteration to the traditional dyadic therapy relationship (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005).

Definitions

- **Simultaneous versus sequential interpreting** (Searight & Searight, 2010)
  
  - **Simultaneous interpretation**: Interpreter speaks concurrently with slight time lag.
    - A highly complex cognitive activity that requires the interpreter to listen, analyze, comprehend, convert, edit, and reproduce in real time while the speaker continues to speak or sign, in a specific social context.
  
  - **Sequential interpretation**: Each person finishes a sentence or short sequence before his or her verbalization is interpreted.
    - A highly complex cognitive activity that requires the interpreter to listen, analyze, comprehend, convert, edit and reproduce the original message after the speaker pauses, in a specific social context.
    - Takes longer than simultaneous interpretation because the interpreter does not interpret while the speaker is speaking.

- **Interpretation versus translation** (Searight & Searight, 2010)
  
  - **Translation**: Converting text from one language to another.
  
  - **Interpretation**: Converting language into another through spoken language.

Interpreters’ Roles and Qualifications (Victorian Transcultural Psychiatry Unit, 2006).

- **Advocate** – Acts on behalf of the speaker instead of merely interpreting the communication of the speaker.

- **Clarifier** – Identifies linguistic differences between the languages of the provider and the client (cultural equivalencies).

- **Conduit** – Interprets word for word, using the closest linguistic equivalents possible (this is the most common role).

- **Cultural Broker** – Provides cultural information in addition to the linguistic interpretation of the message given.
Mental Health Interpreting Dynamics

- **Therapist-interpreter relationship** (Miller et al., 2005)
  - Therapist may feel excluded from the intimacy of the interpreter-client relationship during the early phase of therapy.
  - May feel self-conscious by having a third person present in session.
  - May feel frustrated at what may be perceived as inappropriate interpreter behaviors.

- **Ethical consideration for interpreters** (Minnesota Department of Health)
  - Confidentiality
    - Interpreters are reminded to keep the same level of confidentiality as the clinician.
    - Refer to the code of ethics for interpreters below.
  - Truthfulness, accuracy
  - Neutrality – role boundaries
  - Fidelity
  - Impartiality
  - Appropriate manner
  - Compensation for services rendered
  - Proficiency – continued education

- **Vicarious Trauma** (Miller et al., 2005)
  - Interpreters are vulnerable to trauma related problems possibly due to their own personal history of trauma experience themselves.
    - Interpreters need to be debriefed after a difficult session, have a supervisor to talk to, and express frustrations, sadness or other feelings.

Guidelines for Working with Interpreters: General Principles
(Searight & Searight, 2010)

**Pre-session**
- Introduction—get to know the interpreter.
  - Obtain correct pronunciation of the client’s name.
- Be clear about confidentiality expectations and dual relationships.
  - Verify that the interpreter does not know the client socially.
- Become familiar with, acknowledge, and respect cultural differences but recognize your limitations of knowledge.
- Review the purpose/goals of meeting/session, type of information to be discussed, instructions, questions, etc.
- Review the forms, tools, activities or reports that will be presented.
In-session

- Introduction
  - Introduce yourself and the interpreter at the beginning of the session.
  - Describe your respective goals.
  - Clarify mutual expectations and the purpose of the session.

- Assure clients of confidentiality
  - Do not assume the client(s) present do not understand English.
    - Do not assume that just because a client seems to understand English that he or she can also read or write English.

- Communication style
  - Address your remarks directly to the client.
  - Look at the client and listen when he/she speaks.
  - Observe non-verbal communication: be alert to indications of anxiety, confusion or difficulty in understanding.
  - Avoid body language or gestures that may be offensive or misunderstood.
  - Avoid side conversations, whispering, and/or writing when the interpreter is interpreting.
  - Use a positive tone of voice and positive facial expressions that convey respect for and interest in the client, and address them in a calm, unhurried manner.
  - Speak clearly and somewhat more slowly (not loudly): allow adequate time for the interpreter to interpret and listen carefully to the client’s response.
  - Limit your remarks or questions to a few sentences.
  - Give information in a clear, logical sequence using key words but avoid over-simplifications.
  - Avoid technical jargon, idioms, slang and abstractions.
  - Check periodically if the client understands by asking the client to repeat what has been communicated.
  - Offer more explanations for specific recommendations as needed.
  - Reinforce verbal information with some translated materials if possible.
  - Be patient and be prepared for the needed additional time.

Post-session

- Post-session with the interpreter is recommended.
- Review the content and process issues with the interpreter.
- Ask the interpreter for feedback about the conduct of the session and provide the interpreter with any observations.
- Share any significant underlying concerns.
- Be alert to the possibility of secondary traumatization from the interpreter.
- Be alert to provide emotional support.

Discussion Scenarios:
1) You are working with a mental health interpreter who you have worked well with for several months. The two of you have been working with a severely traumatized client for two months. The client has been gradually sharing the details of her trauma. During one session, the interpreter sits up straight in the chair as the client is talking. Once she has stopped talking, the interpreter looks at you and says, “I do not believe this. It is not true. I am not going to interpret this.” You look at the client; she is looking down at the floor and appears absorbed in her own thoughts. What do you do?

2) You have been working with an interpreter and client for several sessions and feel that the triadic relationship is developing well and that the client is engaged in a therapeutic process. During one session, the interpreter starts crying during the session. What do you do?

3) You have been working with an interpreter and client for a few sessions now. You are a little uncomfortable with the process, but believe that it can work as you become more at ease working with an interpreter. During one session, you begin to notice that the interpreter is speaking for a longer period to the client than you think is necessary. You begin to wonder what they are talking about. What do you do?

Resources:

1) Guidelines for Providers in Working with Interpreters (Schuchman, Goh, & Yang, 2007)
   - Included in this manual

2) Mental Health Interpreting: A Mentored Curriculum (Pollard, 1997)
   An exceptional curriculum assisting interpreters and clinicians alike in learning how to work together to best serve the mental health needs of their clients. This useful guide comprises 9 chapters, a resource list, and an accompanying 33-minute video of eleven interpreting vignettes to help orient interpreters with the mental health field.

3) Guidelines for Working Effectively With Interpreters in Mental Health Settings (Victorian Transcultural Psychiatry Unit, 2006)

4) Refugee Mental Health: Interpreting in Mental Health Settings- Video Workbook
   (Minnesota Department of Health)
   Video request: http://www.health.state.mn.us/cgi-bin/idepc/refugee/lendlib/show_video.cgi?vid=211
   Workbook: http://www.health.state.mn.us/divs/idepc/refugee/topics/interpreting.pdf

5) Interpreters Code of Ethics
The National Council on Interpreting in Health Care (NCIHC), the California Healthcare Interpreting Association (CHIA), and the Massachusetts Medical Interpreters Association (MMIA) developed the National Code of Ethics for Interpreters in Health Care in 2004. This code can be accessed online at: http://www.ncihc.org/mc/page.do?sitePageId=57768&orgId=ncihc

International Medical Interpreters Association (IMIA) also has a code of ethics that was revised in 2006 and is available online at: http://www.imiaweb.org/code/default.asp

6) **Standards of Practice**

The National Council on Interpreting in Health Care (NCIHC), the California Healthcare Interpreting Association (CHIA), and the Massachusetts Medical Interpreters Association (MMIA) developed the National Standards of Practice for Interpreters in Health Care in 2005. This document can be accessed online at: http://www.ncihc.org/mc/page.do?sitePageId=57768&orgId=ncihc

International Medical Interpreters Association (IMIA) also has standards of practice that were revised in 2006 and is available online at: http://www.imiaweb.org/standards/standards.asp
Module 4: Assessment Skills & Application of Major Theories for Vietnamese Americans

Learning Objectives

Within this training module, participants will learn:

- Clinical interviewing skills and case conceptualization when working with Vietnamese Americans.
- The application of major cultural and clinical theories emphasizing cultural sensitivity when working with this population.

Introduction Questions

- In your opinion, which theoretical approach is most useful when working with Vietnamese Americans?
- What are some cultural considerations when diagnosing Vietnamese clients?

Bias in Mental Health Assessment and Intervention

One possible reason for mental health disparities is that clinicians make unwarranted judgments about people on the basis of race or ethnicity (Snowden, 2003). Misdiagnosis can occur when the clinician unintentionally narrows or broadens the pathological approach resulting either from overpathologizing or underpathologizing (Leong & Lau, 2001).

- Overpathologizing occurs when the clinician who is unfamiliar with client’s cultural framework makes an inappropriate judgment in determining psychopathology.
- Underpathologizing occurs when the clinician unintentionally applies a cultural explanation to a client’s current symptoms.

Cultural Factors for Consideration in Diagnostic Assessment (Hong & Ham, 2001)

- **Kinship association** – Similar to other Asian cultures, Vietnamese is a collectivistic culture. Great emphasis is placed on the family instead of individualism. The extended family has a strong bond among its members. Even family friends and community elders are often accorded the respect given to uncles and aunts.

  **Potential problems**
  - Clinicians may misperceive these individuals as enmeshed or lacking firm boundaries.
  - Clinicians may also unjustly be critical of parents who entrust daily care of their children to extended family members and may not take into consideration that this is culturally acceptable.
These families tend to be more hierarchical than the mainstream American family.

- Family members often consider family choices when making decisions.
- Members of higher rank and members of lower rank may be unwilling to discuss their problems openly in front of one another.
  - Clinicians must be careful about the kind of questions asked in front of family members.
- Clients may be unwilling to disclose intimate family issues.
  - Clinicians need to be patient and ease gradually into these topics.

❖ **Health and nutrition** - Influenced by East Asian medicine, the Vietnamese view psychological and physiological as related.
  - Somatization - Somatic symptoms are common expressions of emotional distress (Hong & Ham, 2001; Kirmayer & Young, 1998)
    - Clinicians must consider the underlying psychological issues manifested as somatic symptoms, and at the same time consider the possibly that the physical ailment is really present.
    - Common symptoms of psychological distress (Hong & Ham, 2001):
      - Insomnia
      - Poor appetite
      - Headaches
      - Diffused aches all over the body
      - General feelings of weakness

❖ **Beliefs and religion** – When an individual is experiencing psychiatric symptoms, the individual and family often consider the problem through spiritual or metaphysical beliefs (e.g., yin and yang) as possible explanations.

❖ **Values and norms** - Asian cultures operate through the principles of honor and harmony: all individuals of a family are responsible for keeping the family’s honor and dignity (Chung & Bemak, 2006; Nguyen & Anderson, 2005).
  - Confucianism, in particular, discourages open displays of emotion in order to maintain social and familial harmony and avoid the exposure of personal weakness (Office of the Surgeon General, 2001).
  - Shaming serves as a negative reinforcement for individual behaviors, while harmony encourages the individual to follow socially acceptable lifestyles within the community (Gellis, 2003).
    - Mental illness reflects poorly on the individual’s family and jeopardizes future employment, marriage, and family status (Barret, 2006; Hampton et al., 2007).

❖ **Art and folklore** – This is often manifested in metaphors and symbolism used by the clients. These can be found in the conversation between the clinician and client, and in response to projective testing. Interpretation of such information must be done within the cultural context (Hong & Ham, 2001). For example, the color *white* in Western culture is
considered to show purity and is often related to weddings. However, the color *white* in Vietnamese culture is the traditional color of mourning.

- Clinician’s understanding of symbolism is important in cases where one needs to determine whether the client’s ideation is unusual or normal, as in making a differential diagnosis concerning delusional disorders and other psychotic disorders.

- **Language** - Language difficulties play a significant role in either underestimating or overestimating a client’s clinical symptoms (Drennan & Swartz, 2002).

### Case vignette

Mr. C was a single, 60-year-old Vietnamese man, who was referred to treatment by his physician. He suffered from high blood pressure, severe headaches, and frequent nightmares from which he would wake up screaming. He was anxious, easily frightened and startled by sounds including any noise outside the room where we met. Mr. C complained of very poor concentration, finding it difficult to attend to his ESL (English-as-a-Second-Language) teacher for long. He has been working as a gardener. Due to his poor memory, he often misplaced tools, and was angry about his foreman’s reprimands. Mr. C. felt this job was beneath him. He lived with two other South Vietnamese men.

At the end of the war in 1975, Mr. C was sent to the reeducation camp for South Vietnamese Army officers. There he was given little spoiled rice to eat. His legs became paralyzed from the lack of nutrition and movement, but he was successfully treated by a fellow prisoner using acupuncture. He was required to attend political meetings and confess his crimes against the Vietnamese people. When he refused, he was punished by solitary confinement. He was chained and given condensed yolk to wash his face and a small portion of yam to eat. He was in the camp for thirteen years. He came to the United States in 1991 under the humanitarian operation to bring over former South Vietnamese army officers. Mr. C spoke about the loss of the war with much anger and stated that his greatest wish was to avenge himself by returning to the battlefield and fighting the Communists (Ying, 2001, p. 70).

### Discussion question:

- Describe your cultural formulation.
- What is Mr.C’s diagnosis?
- Any cultural considerations?

### Psychological Testing

Psychological tests are biased and often loaded with Western values, norms, and histories that may be unfair for less acculturated individuals (Hong & Ham, 2001). To avoid cultural issues of biases, the clinicians can sometimes use psychological tests that have been translated into the clients’ native languages.

- Autism
- **Vietnamese Vineland Adaptive Behavior Scales (VVABS)** (Goldberg, Dill, Shin, & Nguyen, 2009)
  - VVABS has acceptable levels of internal consistency reliability and construct validity, and could discriminate successfully between Vietnamese children with intellectual disabilities from those of typical development.

- **Depression & anxiety**
  - **Hopkins Symptoms Checklist (HSCL)** (Mollica, Wyshak, de Marneffe, Khuon, & Lavelle, 1987)
    - Measure of anxiety and depression
    - Link: [http://hpert-cambridge.org/?page_id=52](http://hpert-cambridge.org/?page_id=52)
  - **Phan Vietnamese Psychiatric Scale (PVPS)** (Phan, Steel, & Silove, 2004)
    - The PVPS consists of a 26-item depression subscale, a 13-item anxiety subscale and a 14-item somatization subscale. Estimates of internal consistency for the three subscales ranged from .87 to .95, with 4-day interval test-retest reliability ranging from .81 to .89.

- **MMPI**
  - **Tran’s Vietnamese version of the MMPI-2** (Tran, 1996).

- **PTSD**
  - **Posttraumatic Stress Disorder Interview for Vietnamese Refugees (PTSD-IVR)** (Dao, Portiz, Moody, & Szeto, 2012).
  - **Harvard Trauma Questionnaire (HTQ)** (Mollica et al., 1992)
    - A symptom checklist designed by the Harvard Program in Refugee Trauma (HPRT) to assess for PTSD symptoms.
    - Link: [http://hpert-cambridge.org/?page_id=42](http://hpert-cambridge.org/?page_id=42)

### Application of Theoretical Approaches

- The applicability of Western approaches toward persons of non-Western cultural origins should be approached with caution (Lee, 1997).

- Family orientation is an important trait that can be easily misinterpreted from a Western perspective (Hall, Hong, Zane, & Meyer, 2011).
  - A clinician fostering individuation and disregarding the client’s cultural interdependency is at higher risk of early termination than a clinician proposing a cultural/family approach (Hong & Ham, 2001).
  - Use of a directed approach is preferred when building trust and engaging the client (Lee, 1997).

- Insight-oriented versus directed approach
  - **Insight-oriented**
    - Can be appealing to Asian clients (Roland, 2006)
For example, psychoanalytic approaches emphasize insights through uncovering the client’s unconscious thoughts, feelings, and actions, which is a fundamental perspective congruent with Asian cultural beliefs (Hong & Ham, 2001).

Clinicians applying this approach should be aware of cultural blind spots when working with this population. For instance, a psychoanalyst could misinterpret the client’s attachment to her parents as manifesting dependent personality traits with accompanying boundary confusion between the client and the parents (Bracero, 1994).

- Client’s cohabitation with her parents is not due to a psychological handicap, but rather to the client’s own internal motivation to take care of her parents and to remain connected with them (Yi, 1995).
- Although the clinician may have good intentions for the client, this potential misattribution could potentially damage the work between clinician and client.

**Psychoanalytic approach** - best utilized in assisting clients who suffer from severe and chronic trauma (Bracero, 1994).

- Transference and countertransference are core components of the therapeutic experience.
  - Because the transference process is based on trust, Asian clients experience challenges establishing transference toward the clinician during the initial phase of the relationship (Hong & Ham, 2001; Roland, 2006).
  - *Hierarchical transference* toward the clinician (Yi, 1995).
    - Hierarchical transference refers to the client’s assumption about authority figures (e.g., parent-child, teacher and student, husband and wife) (Hong & Ham, 2001). This culturally based transference is influenced by the Asian value of respect and obedience to authority figures, and also personal restraint (Roland, 2006; Yi, 1995).
    - Client verbal input will be minimal, while expectations for guidance and structure from the clinician will grow.
    - It should not be automatically assumed that a quiet client is pathological (Yi, 1995).

**Humanist approach** - Clinician should consider the client’s worldview in order to demonstrate an appropriate empathy (Hong & Ham, 2001).

- Clinicians should remain aware of cultural biases and frequently place themselves in the clients’ cultural perspective.
• Enhancing client involvement and self-expression (Hong & Ham, 2001).
  ○ Encourage clients to express themselves more fully as a way to gain insight and self-awareness and move toward self-actualization.
    ▪ *Expressing feelings in the client’s first language* – Helps the client enhance involvement and self-expression.
      ○ Opportunity for ventilation of feelings and free expression of thoughts.
    ▪ *Use alternative modes of communication* – Use metaphorical ways of communication such as acting, storytelling, music, drawing, and other activities to help increase comfort and involvement in therapy.
    ▪ *Checking the clinician’s perceptions and interpretations* – Check with the client about the accuracy of the clinician’s perceptions and interpretations in culturally appropriate ways.
    ▪ *Learn culturally meaningful phrases* – Learn culturally meaningful phrases used by the client to express inner processes.
  ▪ There is a lack of empirical evidence to support these approaches.

○ **Directed approach**
  ▪ **Cognitive-behavioral therapy (CBT)** – Supported by strong empirical evidence and is congruent with Asian American cultures (Chen & Davenport, 2005; Voss Horrell, 2008).
    • Vietnamese cultural values are rooted in respect for authority and have a preference for structural, immediate, and practical solutions (Chen & Davenport, 2005).
    • Intersects well with CBT therapeutic relationships in which the clinician’s role is that of expert or teacher.
    • Clients positively perceive CBT clinicians who demonstrate expertise and knowledge by introducing concrete problem-solving strategies.
    • Provides important reassurance to Asian clients by empowering the clinician as expert and leader during therapy (Hong & Ham, 2001).
    • Vietnamese are taught to refrain from expressing emotion, and therefore a clinician applying CBT could well encounter a client reluctant to express emotions during the initial meetings (Hong & Ham, 2001).
Clinicians should utilize culturally acceptable concerns (such as career, education, or physical issues) as inroads to discussing greater problems (Chen & Davenport, 2005).

Discussion Question

- Name the potential biases in using standard testing instruments (e.g., WISC-IV, CTONTI-2, MMPI-2)
- Which theoretical approach(es) do you prefer when working with Vietnamese American clients? Why?

Video:

Module 5: Counseling Interventions

Learning Objectives

Within this training module:

- The practitioner will learn cultural considerations when working with Vietnamese clients (e.g., building rapport, ethical dilemmas) that may interfere with an effective counseling process.

Introduction Question

- What has been your experience in delivering mental health services to Vietnamese or Asian clients?

Goals

General aims of clinicians working with Vietnamese clients (Chung & Bemak, 2006):

- To alleviate hopelessness
- To instill within clients faith in themselves and for the future
- To identify existing coping strategies
- To explore new alternative coping strategies
- To help clients attain a sense of mastery and confidence over their lives

Client-Therapist Expectations

- The Client:
  - Expects quick and direct correlative relief from their symptomology (Hong & Ham, 2001).
  - Has a lower tolerance of ambiguity, and a higher preference for more structured interventions and immediate resolutions to problems (as compared to Whites) (Leung, 1986).
    - Therapeutic alliances are likely to stagnate should Asian American clients not perceive immediate resolutions to their problems (Berg & Java, 1993; Kim, Li, & Liang, 2002).
- The Therapist:
  - Should refrain from overzealous or perceived indiscretions when inquiring about personal information, especially when the information is a source of shame (Lee, 1997).
Should empathize with the client and encourage them to verbalize feelings of shame as it relates to the therapeutic process. It is also important to reassurance the client about the confidentiality and anonymity of the therapeutic relationship (Lee, 1997).

- Focus on the immediate problem and ensure confidentiality during the initial stage of the therapeutic relationship.

Should exercise extreme sensitivity about intimate issues that the client may present, in particular sexual and family issues. Furthermore, acknowledging the client’s discomfort is helpful (Lee, 1997).

- The clinician may begin to inquire about the issue by saying, “I know it may be difficult for you to talk about this, but it is really important for me to know…” (Hong & Ham, 2001, pp. 122) to convey to the client that the clinician is aware of the cultural sensitivity around the issue.

- However, these probing questions should be reserved only after the clinician has developed a strong therapeutic bond with the client.

**Therapeutic Approach**

- Solution-focused, goal oriented, directive, and symptom-relieving approaches are best during the initial stage of treatment (Berg & Java, 1993; Kim et al., 2002; Lee, 1997; Sue & Sue, 2008).

- Once the client is engaged in the therapeutic relationship and gains a sense of success, the clinician can introduce more insight-oriented goals to help the client identify their illness and recognize its sources (Lee, 1997).

- The clinician should temporarily assume the roles of case manager, teacher, and advocate for clients and their family during the initial stage of therapy before delegating these roles to another agency (Kung, 2001; Lee, 1997).

  - Clinical case management is a good vehicle to develop trust and build better rapport with the clients and their family (Eng & Balancio, 1997).

- The clinician should demonstrate expertise in the field through an authoritative, albeit courteous and respectful attitude throughout sessions (Hong & Ham, 2001).

  - The clinician should be directive but also ensure full collaboration from the client in developing goals and intervention strategies (Sue & Sue, 2008), thereby creating opportunities for clients to try to intervene on their own, which promotes their cultural value of self-sufficiency.

- It is best to identify achievable goals within 8 to 12 sessions (Hong & Ham, 2001).

  - A clearly laid out, short-term, achievable treatment plan will help the client feel more comfortable and increase therapy attendance (Iwamasa, Hsia, & Hinton, 2006).

**Multilevel Model (MLM) of Psychotherapy** (Chung & Bemak, 2006)
Level I – Mental Health Education
- Educate the clients about mainstream mental health services.
- Discuss the norms and standards of a mental health clinic, the purpose of intake assessment, the roles and expectations for the client and clinician, the role of interpreter, the types of intervention, the appointment system, etc.

Level II – Individual, Group, and/or Family Psychotherapy
- Determine best intervention approach.
  - Group therapy may be effective for traumatized clients.
    - Discussion of somatic symptoms, cultural conflicts, and loss.
  - Emphasis on interdependence
    - Focus on the family and group rather than the individual, and address obligations and responsibilities to the family and group.

Level III – Cultural Empowerment
- Assist clients in gaining a better sense of the environment.
  - Refugees are more focused on survival issues (e.g., housing, finances, food, etc.).
  - Cultural broker – Educate clients about the legal system and certain practices and information that may be neglected.
  - Advocate for clients’ needs.

Level IV – Indigenous Healing
- Integrates Western and traditional Asian healing methodologies.

Case Vignettes:

Ms. Tran is a 52-year-old divorced Vietnamese woman who was abandoned by her husband shortly after they married in the United States 12 years ago. She has raised her three children by relying on a grant from the local welfare agency. She came to the clinic 7 years ago to seek treatment for her chronic headaches and was diagnosed as having a chronic dysthymic disorder. She has been receiving medication and therapy to deal with the symptoms. For the last 2 years she has been struggling with her 17-year-old daughter who has been bringing boyfriends home overnight. Ms. Tran is unable to stop that behavior and yet she cannot bring herself to “kick my own daughter out of the house.” Her 16-year-old boy is skipping school and involved in breaking into cars and stealing stereos. He has threatened his mother when she tries to admonish him. Her depression has been worsening and there is no additional help she can obtain due to the limitations of appropriate resources. (Leung et al., 1997, p. 157-158)
Discussion Questions:

1) How do you conceptualize Ms. Tran’s case?
2) What approach will you consider?
3) Any cultural considerations?

Video:


Additional Resources:

- Discussing depression with Vietnamese American patients (Fancher, Ton, Meyer, Ho, & Paterniti, 2010)

Suggested Reading:


References


Dean, J.A., & Wilson, K. (2009). ‘Education? It is irrelevant to my job now. It makes me feel
very depressed…’: Exploring the health impacts of under/unemployment among highly skilled recent immigrants in Canada. *Ethnicity & Health, 14*(2), 185-204.


Mollica, R.F., Mcinnes, K., Pham, T., Smith Fawzi, M., Murphy, E., & Lin, L. (1998). The dose-effect relationships between torture and psychiatric symptoms in Vietnamese ex-political detainees and a comparison group. *Journal of Nervous & Mental Disease, 186*, 543-553.


Certificate of Completion
CERTIFICATE OF COMPLETION

Presented to:

For the completion of the training “Working with Vietnamese American: A Training Program for Mental Health Professionals”

DATE

TRAINER
Evaluation Forms
California Brief Cultural Competence Scale (CBMCS)
CBMCS
Scoring Guide

By Aghop Der-Karabetian and Glenn Gamst
University of La Verne

Source

Description
The CBMCS is a 21-item scale that measures self-report multicultural competence of providers of mental health services. It was empirically developed using items from four existing measures of cultural competence: The CCCI-R, MAKSS, MCAS-B, and MCCTS. Participants in the normative sample were 1244 community mental health providers throughout the State of California. The scale is composed of 4 factors: Multicultural Knowledge (5-items), Awareness of Cultural Barriers (6-items), Sensitivity and Responsiveness to Consumers (3-items), and Socio-cultural Diversities (7-items). The names of the factors were somewhat modified to be more descriptive than what appears in the original source.

Scoring
The CBMCS items are rated on a 4-point Likert scale: 1 = Strongly Disagree, 2 = Disagree, 3 = Agree, and 4 = Strongly Agree. Higher numbers indicate higher competence. CBMCS yields one total score and four subscale scores from each factor.

For Training purposes, the subscale scores are obtained by adding the ratings of the subscale items as follows;

1. The Multicultural Knowledge items are 7, 12, 15, 17, and 19
2. The Awareness of Cultural Barriers items are 1, 8, 10, 11, 14, and 16
3. The Sensitivity and Responsiveness to Consumers items are 2, 4, and 9
4. The Socio-cultural Diversities items are 3, 5, 6, 13, 18, 20, and 21

Transformation tables are provided to transform raw scores to percentile ranks. Summated scores are used to obtain percentile scores. Percentile scores are more appropriate than raw scores for training and personal exploration. The use of the total score is not recommended because of the factor structure of the scale. If used, the total score should be interpreted with reservations. The transformation (normative) tables for the whole sample should be used for transforming raw
scores to percentile scores. Transformation (normative) tables for different ethnic groups and degree levels are available upon request.

A broader description of competence is provided at the bottom of each transformation table. These allow competence to be described as lower or higher using the median-split method. These are rough descriptions and do not imply absolute level of competence. They are derived from the percentile rank scores. Approximately bottom one-half of the scores below the 50th percentile, are characterized as lower, and the top one-half, at or above the 50th percentile, are characterized as higher. Scores below the 50th percentile on a particular subscale are indicative of lower multicultural competence in that area, suggesting the need for training.

For research and publication purposes that involve statistical manipulations, we strongly recommend the use of mean score for each subscale. The mean subscale scores may be obtained by adding the responses to the items and dividing the sum by the number of items in the subscale. This will provide a common reference point across different research studies as well as comparison of subscale scores with one another.
## California Brief Multicultural Competence Scale (CBMCS)

Below is a list of statements dealing with multicultural issues within a mental health context. Please indicate the degree to which you agree with each statement by circling the appropriate number.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>2.</td>
<td>I am aware of how my own values might affect my client.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>3.</td>
<td>I have an excellent ability to assess, accurately, the mental health needs of persons with disabilities.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>4.</td>
<td>I am aware of institutional barriers that affect the client.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5.</td>
<td>I have an excellent ability to assess, accurately, the mental health needs of lesbians.</td>
<td>1</td>
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<td>6.</td>
<td>I have an excellent ability to assess, accurately, the mental health needs of older adults.</td>
<td>1</td>
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<td>7.</td>
<td>I have an excellent ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons from different cultural, racial and/or ethnic backgrounds.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>8.</td>
<td>I am aware that counselors frequently impose their own cultural values upon minority clients.</td>
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<td>9.</td>
<td>My communication skills are appropriate for my clients.</td>
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<td>10.</td>
<td>I am aware that being born a White person in this society carries with it certain advantages.</td>
<td>1</td>
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<tr>
<td>11.</td>
<td>I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes.</td>
<td>1</td>
<td>2</td>
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<td>12.</td>
<td>I have an excellent ability to critique multicultural research.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>13.</td>
<td>I have an excellent ability to assess, accurately, the mental health needs of men.</td>
<td>1</td>
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<td>14.</td>
<td>I am aware of institutional barriers that may inhibit minorities from using mental health services.</td>
<td>1</td>
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</tbody>
</table>
15. I can discuss, within a group, the differences among ethnic groups (e.g. low socioeconomic status (SES), Puerto Rican client vs. high SES Puerto Rican client). 1 2 3 4

16. I can identify my reactions that are based on stereotypical beliefs about different ethnic groups. 1 2 3 4

17. I can discuss research regarding mental health issues and culturally different populations. 1 2 3 4

18. I have an excellent ability to assess, accurately, the mental health needs of gay men. 1 2 3 4

19. I am knowledgeable of acculturation models for various ethnic minority groups. 1 2 3 4

20. I have an excellent ability to assess, accurately, the mental health needs of women. 1 2 3 4

21. I have an excellent ability to assess, accurately, the mental health needs of persons who come from very poor socioeconomic backgrounds. 1 2 3 4

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## CBMCS Transformation Tables
### Total Sample (N=1244)

<table>
<thead>
<tr>
<th>Knowledge Items 7, 12, 15, 17, 19</th>
<th>Awareness Items 1, 8, 10, 11, 14, 16</th>
<th>Sensitivity Items 2, 4, 9</th>
<th>Socio-cultural Diversities Items 3, 5, 6, 13, 18, 20, 21</th>
<th>Total Scale 21 Items</th>
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<td>Sum</td>
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</tbody>
</table>
Working With Vietnamese Americans:
A Training Program for Mental Health Professionals

PRE-Training Questionnaire

Date: ________________

Ethnicity: __________________  Gender: ________________

Degree Completed: □ M.A.  □ M.S.W.  □ Ph.D.  □ Psy.D.  □ Ed.D.
□ M.D.  □ Other

Work Experience:

1) Have you provided services to Vietnamese clients prior to this training? YES  NO

2) Do you have prior experience working with client(s) of other ethnicities different than your ethnic background? YES  NO

If you answered yes to at least one of the questions above, please answer the following:

3) How confident are you in:
   - Taking into account multicultural constructs (e.g., acculturation, racial identity) when conceptualizing the client’s presenting problems?
     1  2  3  4  5  6  7
     Not Confident Completely Confident
   - Working effectively with interpreters?
     1  2  3  4  5  6  7
     Not Confident Completely Confident
   - Assessing relevant cultural factors (e.g., the client’s acculturation level, racial identity, cultural values and beliefs)?
     1  2  3  4  5  6  7
     Not Confident Completely Confident
   - Taking into account cultural explanations of the client’s presenting issues in case conceptualization?
     1  2  3  4  5  6  7
- Selecting culturally appropriate assessment tools according to the client’s cultural background?
  1  2  3  4  5  6  7
  Not Confident  Completely Confident

Learning Objectives:

- What are you hoping to learn from this training?

- Do you have any question(s) for the trainer?
Working With Vietnamese Americans:  
A Training Program for Mental Health Professionals

POST-Training Questionnaire

Date: ______________

Ethnicity: ________________  Gender: ________________

Degree Completed:  
☐ M.A.  ☐ M.S.W.  ☐ Ph.D.  ☐ Psy.D.  ☐ Ed.D.  
☐ M.D.  ☐ Other

Learning Experience

1. Do you find this training program helpful in your work with Vietnamese Americans?
   - Not helpful  - Very helpful
   1  2  3  4  5  6  7

2. How confident are you in:
   - Taking into account multicultural constructs (e.g., acculturation, racial identity) when conceptualizing the client’s presenting problems?
     - Not Confident  - Completely Confident
     1  2  3  4  5  6  7

   - Working effectively with interpreters?
     - Not Confident  - Completely Confident
     1  2  3  4  5  6  7

   - Assessing relevant cultural factors (e.g., the client’s acculturation level, racial identity, cultural values and beliefs)?
     - Not Confident  - Completely Confident
     1  2  3  4  5  6  7

   - Taking into account cultural explanations of the client’s presenting issues in case conceptualization?
     - Not Confident  - Completely Confident
     1  2  3  4  5  6  7
- Selecting culturally appropriate assessment tools according to the client’s cultural background?

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<tbody>
<tr>
<td></td>
<td>Not Confident</td>
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<td></td>
<td></td>
<td></td>
<td>Completely Confident</td>
</tr>
</tbody>
</table>

Comments:
Thank you for your participation! Please evaluate this course and the trainer for the items by checking the appropriate box:

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Class time is used effectively</td>
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<td>2) The course objectives are clearly explained</td>
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<td>3) The trainer has an effective style of teaching</td>
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<td>4) The trainer appears knowledgeable about the subject matter</td>
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<td>5) The trainer encourages questions from the participants</td>
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<td>6) The trainer responds appropriately to participants questions</td>
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<td>7) The trainer displays interest in the participants and their learning.</td>
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<tr>
<td>8) The trainer used effective teaching methods (e.g., lecture, group discussion, vignettes, videos, etc.) to enhance my learning experience</td>
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<td>9) The course enhances my understanding in working with this cultural group</td>
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<td>10) The training materials offered is valuable and relevant to my learning</td>
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<tr>
<td>11) Overall: The trainer is effective</td>
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<tr>
<td>12) Overall: the training curriculum is effective</td>
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</tbody>
</table>

Please comment to the following:

13) What are the trainer’s strengths?
14) What could the trainer improve on?

15) What is the strength of this manual?

16) What could this manual improve on?

17) Other comments?
PROFESSIONAL DEVELOPMENT AND SUPERVISION OF INTERPRETERS

Establish Training Needs & Obtain Training

- Evaluate professional needs of mental health interpretation.
- Evaluate professional needs of cultural knowledge.
- Work with supervisors/agencies to obtain needed training.
- Receive training specifically on interpreting in mental health, basic mental health concepts, and cultural contexts of mental health.

Establish Supervision Norms

- Assess supervision needs of interpreter.
- Discuss roles and expectations of supervisors and interpreters.
- Create safety and flexibility for additional needs, such as ethical dilemmas and difficult sessions.
- Establish formal assessment of interpretation skills.

PREPARATION FOR CLINICAL SESSIONS

Establish Goals and Procedures

- Establish goals and procedures for the session.
- Explain confidentiality/limits, if necessary.
- Provide the interpreter with a brief summary of the client.

Establish Roles and Understand Relationships

- Consider the interpreter a member of the health care team.
- Discuss the client and interpreter’s background to learn about the impact of gender, age, social or ethnic issues, and dialects.
- Determine how the interpreter’s position in/relation to the community may impact interpreter and client relations.

Review Terms and Topics

- Explain the purpose of the session.
- Discuss sensitive topics to be discussed.
- Discuss whether the interpreter is likely to feel uncomfortable.
- Discuss interpreter “censorship/editing.”
- Learn some basic words and phrases in the client’s language.
BEGINNING THE SESSION

Discuss Confidentiality
- Explain how provider and interpreter keep confidentiality, and explain the limits to confidentiality.
- Explain to the client that the interpreter and provider will discuss everything the client says.
- Explain that the interpreter and provider may take notes to help achieve accuracy; it helps prepare the interpreter to paraphrase and summarize and allows the provider to understand and clarify.

Establish Speaking Time
- Remember to allow extra time since everything has to be said twice and explanations will generally take longer.
- Explain that the interpreter may interrupt dialog to allow for accurate interpretation.
- Explain that questions may need to be asked.
- Remember that there may be times when it is important for the client to speak to the interpreter without interruption.

DURING THE SESSION

Practice Good Communication
- Face the client and/or family members and speak directly to him/her/them.
- Speak slowly and clearly in a regular tone of voice.
- Use simple language and straightforward sentences; avoid metaphors, slang, and jargon.
- Use nouns rather than pronouns whenever possible; this way the referent will be clear.
- Practice good English communication; some clients may understand some English.

Allow Time for Questions and Clarification
- Allow time for the interpreter to talk with the client; this may be necessary if the client needs further clarification to understand what has been said, or if the client does not understand western practices or technical terms.
- Discuss with the interpreter concerns about client’s understanding or interpreter’s separate conversation with the client.
- Allow time for the interpreter to talk with the provider; this is important for the interpreter to gain clarification about practices and technical terms.
- Allow time for the interpreter to explain the culture to the provider when simply interpreting the words is not enough.

Allow Time to Summarize
- Ask clients to summarize or repeat information to help determine whether concepts have been properly interpreted. Providers and interpreters can summarize issues discussed.

Use the Time during Interpretation
- Observe body language and use the interpreter to help you understand nonverbal messages.
- Use the time to plan the next response.
- Use the time to evaluate what has happened in the session.
AFTER THE SESSION

- Allow time with the interpreter after the session to obtain information about nonverbal cues, speech pattern and tone, and cultural information that may be useful for understanding the client/context.
- Discuss the interpreter’s impression of the client’s problems or misunderstandings, other issues that could not be discussed.
- Seek feedback from the interpreter.

Additional Resources


Appendix B

Vietnamese historical background
BRIEF VIETNAMESE HISTORICAL BACKGROUND

Overview of Population Characteristics
The Vietnamese immigrant population ranks as the fourth largest among Asian population subgroups with over 1.55 million Vietnamese living in the United States (U.S. Census, 2010). California has the largest concentration of Vietnamese, followed by the states of Texas, Florida, and Virginia. Within the present Vietnamese American population, the majority is foreign-born (68%) and most are naturalized United States citizens (Nguyen, 2011). It behooves the practitioner to review some of the factors which caused this large mass of Vietnamese to depart from their homeland.

Historical Background
The fall of Saigon on April 30th, 1975, forever altered the lives of many Vietnamese. Vietnam’s history is characterized by a series of wars including Chinese colonization, Mongol invasions, French colonization, and Japanese invasion during WWII. Nonetheless, no military period has been more devastating and traumatic than the Vietnam War (1954-1975) (Corfield, 2008). Within this period, an estimated 3.76 million Vietnamese (military personnel and civilians) from both the North and the South were counted as casualties during the civil war and its aftermath (Rummel, 1998). Other studies count Vietnamese casualties during the war at approximately 1.2 million (Hirschman, Preston, & Vu, 1995; Lewy, 1978). The significant differences between studies suggest that there is no accurate report on Vietnamese casualties during the twenty years of war.

Following the war, between 1 million and 2.5 million people were sent to communist reeducation camps, of which approximately 165,000 died or were executed during their imprisonment (Desbarats, 1990; Do, Phan, & Garcia, 2001).

Reeducation Camp Trauma
The reeducation camp, known to the Vietnamese as trại cải tạo, was a series of prison camps operated throughout the country by the Vietnamese Communist regime after the reunification of the North and the South. This tactic, described by former political prisoners, aimed at identifying and imprisoning military personnel and former South Vietnamese government officials without formerly charging them of a crime (Le, 2001). A former prisoner commented that, “The purpose was to remove dissident elements and to produce conformity through hard labor and confinement” (Cargill & Huynh, 2000, p. 107).

Many prisoners assumed that they would be released within a month after turning themselves in to the new regime (Vo, 2006). However, the average prison time ranged between three and ten years. Some prisoners were even incarcerated until their release in the late 1980s (Le, 2001). Sagan and Denney (1982) report that during the early stage of the reeducation experience, the prisoners spent 8 hours per day undergoing indoctrination with Communist ideology. Following this phase, all prisoners were required to write confessions for their crimes in serving the former South Vietnamese government. The prisoners were then forced to labor in camps and tasked with dangerous work such as minefield sweeping without special equipment. Many were killed or wounded as a result of explosions.
The prisoners experienced significant hardships during their captivity in the reeducation camps. The lack of food and intense labor weakened their bodies through disease (e.g., malaria, dysentery, tuberculosis). The lack of medical care and nonexistent medical supplies in the camps resulted in high death rates (Sagan & Denney, 1982). Additionally, many prisoners were tortured inhumanely (Desbarats, 1990; Do, Phan, & Garcia, 2001; Le, 2001; Vo, 2006). An example of this experience is portrayed as follows:

Tru, a prisoner, became angry when he saw a guard using the flag of the former government of South Vietnam as a dustcloth. He took the flag out of the guard’s hand and yelled at him for desecrating it. The next day, Tru was brought before the prisoners in a "people's court," but instead of confessing his "crime," Tru remained unrepentant, praising the flag and criticizing the communists. The out-raged (sic) camp commander sentenced Tru to be tied to a wooden column outdoors, standing upright for three months. He was gagged and his hands were tied behind the back and around the post, his wrists lashed tightly with telephone wire. The wire cut through his flesh by the end of the first day. Forced to stand bareheaded all day long in the hot sun and in the unusually cool nights of the highlands, plagued by mosquitoes, Tru contracted malaria by the second week and became seriously ill. After a month, Tru was untied and carried to meet the camp commander's superior who was visiting the camp that day, and was given one more chance to repent. But Tru remained unrepentant and was taken out of the camp the next day (Nguyen, 1982, pp. 240-246; Sagan & Denny, 1982, para. 73).

Almost all prisoners experienced or witnessed near death experiences as a result of their false imprisonment. Therefore, survivors are likely to experience psychiatric disorder, especially PTSD, due to suffered trauma (Pumariega et al., 2005).

**Refugees Versus Immigrants**

As clinicians, we need to make a distinction between the categorization of immigrants and of refugees. This helps clinicians gain background perspective on the migration experience and assess for trauma related problems. Two categories define the Vietnamese population in America: individuals who are descendants, or those identified as “refugees” or “immigrants.” Refugees and immigrants are distinguished by their motivation for migration and the nature of their flight experience (Rumbaut, 1995).

In the first category, a refugee is defined as “a person, who ‘owing to well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country’” (International Organization for Migration, 2004, p. 53). It is important to note that refugees experience more stress during their flight than immigrants (Birman, 2008; Chung, Bemak, & Wong, 2000; Hauff & Vaglum, 1993). Refugees are at a higher risk of developing psychological problems and tend to have more difficulties adjusting to life in the new country (Ngo, Tran, Gibbons, & Oliver, 2001).

On the other hand, an immigrant is defined under “emigration,” which is an “act of departing or exiting from one state with a view to settle in another” (International Organization
for Migration, 2004, pp. 21). These motives influence the acculturation process and one’s response in the host country.

**Migration experiences.**

The reunification of Vietnam triggered a mass exodus of refugees out of the country by whatever means possible (e.g., U.S. military aircrafts, U.S. Navy warships, small boats, on foot) (Rutledge, 1992). Many of these refugees feared repercussion from the new regime since they had fought alongside American forces or had served under the South Vietnamese government. Many did not have a choice, as one survivor reported, “to stay is to die” (Rutledge, 1992, p. 2).

The first wave of refugees arrived in the U.S. between 1975 and 1977. This first group is estimated at approximately 132,000 people (Do, 1999; Rutledge, 1992), comprised mostly of high-ranking Vietnamese officials, family members of American servicemen, and other American allies who collaborated militarily and politically during the war. Demographically, this first group is defined as well-educated, wealthy, in command of the English language. Further, this group largely favored a strong political affiliation with the United States government (Rutledge, 1992; Vo, 2006). Although the South Vietnamese evacuation during the last two days of the war (April 30th, 1975) was intense, many of these collaborators were left behind. The result was that many individuals were either executed or sent to the various reeducation camps around the country (Vo, 2006).

The “boat people.” The second and subsequent waves of refugees, commonly called the “boat people,” began in 1977 and continued throughout the 1980s (Gold, 1992; Rutledge, 1992). Significantly, this second group contrasted markedly from the fate of those Vietnamese who preceded them. The journeys of this second wave included drifting at sea for days on leaky, overcrowded boats, where many drowned, experienced starvation, or suffered pirate attacks (Cargill & Huynh, 2000; Chan, 2006; Vo, 2006). While anecdotally many died during the escape (i.e., boat refugees), there is no record indicating the exact number who perished at sea. Nonetheless, it is estimated that more than half of escapees perished (Do, 1999; Gold, 1992).

These harrowing escapes by the survivors were well documented and recounted by the survivors themselves. The following is an account from one such survivor:

Hien Nguyen (survivor) – On the 17th day at sea, the woman who sat next to me began passing out from lack of food and water. The next morning she was dead. When I saw her dead body, I began to worry that in a few days I would become just like her. From that point on, I began believing that my life was in the hands of God. During the next two days, two more people died from hunger. From then on, every morning one or two people died. Most of the people who died were men ages 18 to 25. We men were weakened because we gave our rations to the women and children. We also lost a lot of energy from the effort of using containers to bail water out of the boat. I volunteered once to give out the rations, but from the 20th day on I became so weak that I couldn’t do this work anymore.

Whenever we saw a ship, we would throw a corpse overboard to show we needed help. None of us had been able to take a shower for 30 days, so our boat really stank. Our boat smelled of oil, sweat, open scabs, excrement, and death.
Even though we saw many ships, none of them paid attention to us. When I saw this, I became extremely discouraged, began to hate other countries, and began to lose hope for life (Cargill & Huynh, 2000, p. 154).

One especially traumatic factor encountered by the Boat People was pirate attacks during their escape. These fishermen turned pirates initially helped the disabled boats at sea. Unfortunately, they soon discovered a new way to extort money from the helpless refugees (Vo, 2006). Their original kind acts, now fueled by greed, turned them into menacing bandits, killing and raping people in cold blood (Vo, 2006). The following are accounts from survivors:

Mai and a few girls were taken aboard a pirate boat and raped over and over again. She fought them, but they just beat her and laughed at her. For the next few days, nine different Thai men continued to rape the girls. They terrorized them, thrust knives at their throats, and forced them to perform sexual acts which the girls found humiliating. As one girl froze because of horror and humiliation, they bludgeoned her to death and threw her into the sea. In the meantime, the pirates continued to raid other small boats and found new victims. They got tired of Mai and her companions and threw them into the sea. She lost track of time and was saved by a refugee boat that by chance spotted her. None of her companions survived (Vo, 2006, p. 145).

On another occasion, a boat with eight Thai men on board approached a refugee boat at sea. The Thais threw anchors on the deck of the Vietnamese boat and attempted to board, but the refugees resisted. The pirates used rags soaked with diesel fuel and got ready to torch the victim’s boat but the Vietnamese hurled gasoline back at them. Sensing resistance, the pirates got mad and summoned another boat that came by and rammed the refugee boat, splitting it in half. All the refugees fell into the water. Not happy with destroying the refugee boat, the Thais fished the refugees out of the water one by one. With their long knives, they chopped off their heads and dumped them into the sea; the water turned red. For days, the few survivors clung onto rafts until a Malaysian trawler picked them up. They were found to be dehydrated, hungry, scared, and looked disheveled. Only 16 out of 76 passengers survived the carnage (Vo, 2006, p.146).

Rather than risking the dangerous sea trip, many refugees also traveled on foot through Cambodia, into Thailand seeking asylum. It is estimated that only ten percent of these refugees survived due to constant attacks by various armed militias, including the North Vietnamese soldiers, Khmer Rouge, renegade Cambodian soldiers, and bandits (Vo, 2006). Young men and women were kidnapped, raped, and executed (Cargill & Huynh, 2000; Rutledge, 1992; Vo, 2006). The following is an example of such an experience:

Although Vietnamese women covered their faces with mud or scarves to hide their fair complexion, they were easily spotted. The soldiers came back at night to take young women away for a gang rape (Ha, 1997). They sometimes returned a shivering, tearful, scar-covered girl in tattered clothes the following morning. Non-returning women were presumed killed (Vo, 2006, p. 132).
The boat refugees sought refuge in various Southeast Asian countries. Thailand and Malaysia were countries of default since they were the nearest, by sea (Rutledge, 1992). Many of these countries were ill-prepared to receive the refugees. In response to the refugee influx, temporary camps were erected to accommodate their needs. Sometimes, what refugees experienced in these camps was little better than the journey. A survivor recounts his experience as follows:

We had landed on Pulau Bidong in Malaysia, and the conditions there were bad. There were public bathrooms, but they were very dirty. Rats as big as cats would bite your fingers at night while you slept. Most of the food was imported from the mainland and was often rotten. Every week they gave each of us seven packs of noodles. When they gave us chicken, it smelled, but we had to eat it because there was nothing else. Once I was so sick I almost died (Cargill & Huynh, 2000, p. 94).

Others were less fortunate as they were turned away due to overcrowding at these camps. The massive influx of refugees became a burden for the host countries. In response, merchant ships were ordered to stop rescuing the refugees and many were left at the mercy of the sea. The refugees drifted at sea for days. Many boats sank and drowned everyone on board (Vo, 2006).

A few survivors were more fortunate. After several months to several years of internment in refugee camps, some were able to resettle in wealthier host countries, mostly in the United States. Nonetheless, while waiting for their asylum status, Vietnamese refugees were limited to the camps’ physical boundaries and were not allowed to leave the camp. In this context, camps became viewed as a prison rather than a humanitarian mission (Vo, 2006). As before, refugees were physically and sexually abused, financially extorted, and lived in sub-human conditions. It was only natural that many began to feel despair, depression, and hopelessness (Vo, 2006). The following is an account taken from such a refugee:

Lan Nguyen (refugee) - The people who guarded the temporary camp were horrible. The guards were sometimes rapists. If they saw a young girl and they wanted to make her sleep with them, they might beat her if she resisted. My mother was worried for my cousin Huong, who was about 16 or 17 then, and Mom would tell my male cousins to watch out for her. Mom was also careful about our sleeping arrangements, always putting my female cousin in the middle (Cargill & Huynh, 2000, pp. 40-41).

The Orderly Departure Program (ODP). The Vietnamese diaspora during the late 1970s and throughout the 1980s posed tremendous humanitarian challenges for the international community. Compassion fatigue manifested in the continual overcrowding at refugee camps and in the sustained economic strain on the host countries (Rutledge, 1992). Many countries refused to take in new refugees and employed dangerous tactics to ostracize them. In one example, a Malaysian Navy boat intercepted a refugee boat with 237 Vietnamese on board heading toward the Malaysian coastline. The Malaysian Navy refused to let them disembark and towed the boat south toward Indonesia for 36 hours. The Navy officials were aware of the refugee boat’s engine problem and broken water pump but provided little assistance. The boat drifted for four days, causing 10 people to die of dehydration. They encountered a second Malaysian Navy boat, the Renchong, which tried to pull them further south. The Renchong pulled the boat at a high speed
in dangerous maneuvers that caused the boat to capsize. The *Renchong* pulled out 124 survivors after circling around the wreckage for half an hour taking pictures. One hundred and four refugees died during the incident (Vo, 2006).

In May 1979, the United Nations High Commissioner for Refugees (UNHCR) and the Socialist Republic of Vietnam signed a “Memorandum of Understanding” establishing a program for legal emigration from Vietnam, known as the Orderly Departure Program (ODP) (Kumin, 2008; U.S. General Accounting Office, 1990). This program attempted to regulate the flow of refugees and create safe alternatives to the dangerous boat departures. At the inception of this program, the UNHCR negotiated resettlement with more than twenty countries, with the United States becoming the largest resettlement country (Rutledge, 1992; Vo, 2006).

Vietnamese nationals qualified for entrance to the United States through ODP under three categories. The first category includes those who have family members in the United States; this is known as the *family reunification* program. The second category includes former United States government employees with a minimum of one-year in employment, members of South Vietnam’s military services, and all who had ties to the United States and South Vietnamese government (Rutledge, 1992; Vo, 2006). The third category includes “other persons closely associated or identified with the United States’ presence in Vietnam before 1975, including children of American citizens in Vietnam (Amerasians) and their immediate family members” (U.S. General Accounting Office, 1990, p. 3).

This third category included a previously invisible group of people: the Vietnamese Amerasians. An Amerasian is defined as a “person born in Vietnam following January 1962 and prior to January 1, 1976 and who was fathered by a citizen of the United States” (Rutledge, 1992, pp. 65). Most of the American servicemen left gradually before the fall of Saigon in 1975. When they left, they did so alone. The Amerasian children were abandoned along with their single mothers. This situation caused monumental stressors to the Amerasian family as the child was both disowned by family members and rejected by the society (Lipman, 1997). The Vietnamese Communist regime viewed Amerasians as traitors and immediately marginalized them (Lipman, 1997). As a result, the children were abandoned by their mothers to live with a relative or wander the streets (Lipman, 1997). The following is a statement from a Vietnamese Amerasian:

> My father was white and my mother is Vietnamese. My father deserted me when I was young and I never met him, and my mother left sometime after that. I was raised by some of my mother’s relatives, but I won’t really know who my parents are. Because I am not really Vietnamese, I couldn’t go to school in Vietnam, and I am behind in everything. Nobody really likes me. I don’t really fit in to any group (Rutledge, 1992, p. 135).

Under the ODP classification, Vietnamese Amerasians were not required to produce proof of American parentage in order to gain entry into the United States. Since family members of the Amerasian children were allowed to accompany them to the United States, these children became an overnight sensation, transformed from “children of the dust” to “children of gold” (Bass, 1996, pp. 19). Amerasian children were viewed as cheap tickets into the United States by many Vietnamese and were highly sought after. Many of these children were paid with gold by wealthy families to obtain U.S. visas (Branigin, 1993).
Religion/Philosophical Practices

Pre-colonial Vietnamese believed that spirits inhabited all animate and inanimate objects. Villagers were careful not to mention the spirits by name, since uttering their name could evoke the being and risk its wrath (McLeod & Nguyen, 2001). Traditional beliefs maintained that human persons have two kinds of souls: hồn (spirit) and vida (physical/material being) (McLeod & Nguyen, 2001), with the spirit entering the body at birth and departing at death. Since the individual spirit survives after the host’s death, they are capable of acting in the world of the living. Hence, with the aid of a medium, the living could ask for advice, protection, and material benefits (McLeod & Nguyen, 2001). For spirits of those who died far from home, it was believed that they became “wandering souls” (vong hồn) (McLeod & Nguyen, 2001, p. 45). These wandering spirits could harm anyone they encountered, causing illnesses or accidents.

Animism. There is little clear, historical data on the exact historical period when animistic beliefs entered the Vietnamese spiritual tradition. Nonetheless, animism plays an important role in the Vietnamese culture. For example, the belief that spirits might temporarily leave a living person’s body if the host suffers a fright is reflected by the expression “sợ mất hồn” (meaning: “frightened to the point of losing his soul”) (McLeod & Nguyen, 2001, p. 45). In traditional Vietnamese families, ancestral veneration and worship occupies an important position, since it is believed that the ancestral spirits care about their descendants’ well-being (Leung, Boehnelein, & Kinzie, 1997; McLeod & Nguyen, 2001). Ancestral worship is also practiced in Vietnamese families of different spiritual traditions, even among Christians (Leung et al., 1997). Ancestors are remembered during special celebrations (e.g., Lunar New Year, marriage, etc.), and children are constantly reminded to never commit an act that would shame their ancestors (Leung et al., 1997).

Confucianism. A second historical, cultural, and spiritual influence in Vietnam stems from China (Do, 1999; McLeod & Nguyen, 2001). Although the Vietnamese gained their independence from China since the 10th century, the two countries continued to share cultural practices. The Vietnamese adopted Chinese Confucianism with open arms and its code of conduct has governed Vietnamese society for centuries (Leung et al., 1997). Although Confucian practice had largely faded in the early 1900s, its belief system remains profoundly influential in modern Vietnamese culture (Do, 1999).

Confucianism has great influence on the Asian cultural and family system (Nguyen & Williams, 1989; Rosenthal, Ranieri, & Klimidis, 1996). Confucianism developed a well-defined hierarchical system defining personal and communitarian roles, duties, and moral obligations (Buriel & De Ment, 1997). From this traditional concept came such revered practices as: “filial piety, ancestor worship, reciprocal relationships within a hierarchical structure, high regard for education, social status, material welfare, family orientation, loss of face, and shame” (Chung & Bemak, 1998, p.374). Stemming from this belief, the family system is governed by the patriarchal system, and women are viewed as inferior to men. These psychological and behavioral norms play a critical (and often unacknowledged) role in the modern Vietnamese family. As a consequence, fathers enjoy both absolute authority while remaining emotionally absent in the family, whereas mothers have a lower standing but are typically involved in child rearing (Buriel & De Ment, 1997; Chung & Bemak, 1998; McLeod & Nguyen, 2001).
Confucian traditions also confer unacknowledged roles for children. Vietnamese children are expected to display obedience, family loyalty, and suppress personal feelings, desires or preferences for the greater good of the family (Buriel & De Ment, 1997). Filial piety is considered a bedrock virtue, toward which children are expected to adhere along with everlasting respect toward their parents (Chung & Bemak, 1998). Confucian values require the child to express loyalty, respect, dutifulness, obedience, love, and gratitude to their parents for a moral debt that the child could never repay (McLeod & Nguyen, 2001). The children are reminded of the proverb “ăn quả nhờ kẻ trồng cây,” whose English translation yields: “[remember] those who had planted the tree that gave the fruits that he is enjoying” (McLeod & Nguyen, 2001, p. 136). This and other sayings reinforce the belief that the child must be forever thankful to the parents who had sacrificed their lives to raise him or her. In this family system, an individual’s family members are obliged through their duties and responsibilities to uphold the collectivistic good over individual preferences. Children are constantly reminded to save face through proper conduct (Yamashiro & Matsouka, 1997), and therefore, parents hold great pride in their children and expect them to avoid shameful behavior while seeking to honor the family’s name (Buriel & De Ment, 1997). A common example of this can be found in the child’s academic accomplishment, which parents often consider a benchmark for family pride.

**Buddhism.** Buddhism, widely practiced throughout Vietnam, forms the third stem of Vietnam’s spirituality. Although there is no agreement on how Buddhism entered Vietnam (through China or directly from India), scholars agree that Buddhism in Vietnam is derived from India (Do, 1999). Buddhists are taught to follow the Four Noble Truths: (1) Life is suffering; (2) suffering is caused by desire; (3) to end suffering, desire must be eliminated; (4) the way to eliminate desire is to follow the eight-fold path of righteousness: right belief, right action, right livelihood, right effort, right mindfulness, right concentration, right understanding, and right thoughts (Do, 1999; McLeod & Nguyen, 2001; Yamashiro & Matsouka, 1997).

Buddhism emphasizes that life is suffering. To end suffering, a Buddhist must try to escape the endless birth-death cycle (reincarnation) by following the eight-fold path. That is, the individual must strive to do no harm to others, and endure life’s suffering by overcoming negative energy in order to prepare good karma for the next life (Chen, Song-Jae, & Donnel, 2004; Do, 1999).

**Taoism.** Similar to Confucianism, Taoism, the final strand of Vietnamese spirituality, arrived in Vietnam from China many centuries ago (Do, 1999). Taoism proposes that human beings exist in oneness with the universe. The task of the individual is to maintain within their lives the balance of the energies of heaven (yang) and earth (yin) (Chen et al., 2004). If the two energies are disharmonious with each other, the body then becomes susceptible to illnesses and diseases (Chen et al., 2004). In this school, illness is defined through the action of spirits/energy. In the presence of illness, thầy (meaning master or teacher), which are persons with roles similar to shamans in animistic societies, are asked to identify culprits and invoke the spirits, who they beseech to accept offerings in exchange for the afflicted (McLeod & Nguyen, 2001).