

**Making Sense of Fractured lives: The Intersection of Migration, Culture, and
Mental Health Among Vietnamese Americans**

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Abstract

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Refugee mental health is a critical global health problem. For refugees, exposure to war, violence, torture, and other forms of trauma can leave deep physical, psychological, and emotional imprints with long-term consequences on mental health. But beyond the exposures to the violence happening in their homelands, refugees' migration journeys, resettlement, and on-going acculturation experiences also add to their mental distress. Without treatment, mental distress continues to surface to disrupt the recovery and adaptation of families and communities. Using a community-based participatory research (CBPR) approach, this qualitative study examines the long-term consequences of exposure to trauma, resettlement and on-going acculturation stress on refugee communities' mental health. The study focuses specifically on the Vietnamese refugee community in King County, Washington as a case study.

Vietnamese refugees make up one of the largest and oldest refugee communities in the United States since the establishment of the Refugee Act of 1980. There is a sense that many Vietnamese refugees have "made it" as an acculturation story. Across major U.S. cities, we see the presence of the Vietnamese people establishing roots and rebuilding families and communities. But underneath this layer of success lies a great many untold stories of pain that have been overshadowed by the need to move forward. Many Vietnamese continue to face challenges connected to past exposure to trauma as well as on-going acculturation stress.

The findings from this case study will further our understanding of the long-term impacts of exposures to trauma, migration, and acculturation on the community's recovery and adaptation with implications for research, practice, and community education.

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“We have to listen and learn from each other, from our children, and grandchildren. Only then can we connect, unite and heal as a community.”

(Vietnamese Elder, Focus Group)

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Background

Refugee mental health is a critical and growing global health concern as the number of people fleeing their home for safety continues to rise. Refugees are part of a larger group of the ever-growing but often forgotten displaced population. Currently, the number of displaced people is at the highest level the world has ever seen with an estimated 70.8 million. [1] Exposure to war, violence, torture, and other forms of trauma can leave deep physical, psychological, and emotional imprints with long-term consequences on refugee mental health. [2-4] In addition to the exposure to the violence happening in their homelands, for refugees, mental health concerns also include an accumulation of stress that stems from their migration journeys and resettlement experiences.

The different periods of a refugee's experience are often classified as *pre-flight*, *flight*, to *resettlement* periods. [5] *Pre-flight* refers to the period prior to fleeing when the person is experiencing the social, cultural, political, and economic turmoil and violence in their homelands. This is the period that is most defining in a refugee's history, as it is the time that pushes them into an unknown journey and marks them as displaced. The events during this preflight might include "losses of family members, livelihoods, and belongings paired with possibly physical and emotional trauma to the individual or family, the witnessing of murder, and social upheaval" (Kim, 2016, pp. 5-6). It is in the experiencing of these incidents that push people to seek safety outside of their homelands.

Flight for refugees includes arduous and risky journeys and long stays in refugee camps. These journeys can involve added trauma, including the separation of family, especially young children from their parents. [2] And, as refugees resettle, either in refugee camps long-term or in a third country, their process of *resettlement* often brings new challenges and stress. As many are coming to grips with their new reality, they realize the "loss of culture, community, and language as well as the need to adapt to a new and foreign environment" (Kim, 2016, p. 6). These experiences, encounters, and stressors, that build over the main phases of the refugee's journey, become an integral part of their personal, social, communal and historical contexts.

The Vietnamese American Experiences

Pre-flight and Flight of the Vietnamese Refugees

The Vietnamese refugees make up one of the oldest and largest refugee communities in the United States since the establishment of the Refugee Act of 1980. [6-8] Its population is approximately 1.5 million [6]. The Vietnamese refugee community is made up of a diverse group of people whose backgrounds and experiences vary greatly. As a group, they consist of people from a variety of ethnic, social, cultural, political, language, and religious backgrounds. [5 9] While they are bound by their country of origin, their experiences connected with the Vietnam war, flight, resettlement, and acculturation are distinct depending on their social, political, ethnic, and religious positions and affiliations.

The Vietnamese started arriving to the U.S. in 1975 after the end of the Vietnam-American war. Their arrival marks the largest refugee experience in this country's modern history. [5 8 10] Vietnamese refugees arrived in the U.S. in three major waves. [5 8 10] The first wave took place after the fall of Saigon in 1975. During this time when the U.S. military began withdrawing from Vietnam, they also evacuated more than 120,000 Vietnamese. [5 6 11] The people who fled during the U.S.

withdrawal consisted of military families and social and educational elites with resources and connections to the U.S. military.

After the war ended in Vietnam, social and political unrest in the region continued, and mass persecution and imprisonment of former South Vietnamese government and military personnel led to the second and largest wave of Vietnamese refugees. This second exodus took place between late 1970s to the 1980s. This group that fled Vietnam was diverse, consisting of people from different ethnic, socio-economic, and religious backgrounds. [5 12] This second wave of refugees is often referred to as the “Boat People.” Many of these boats were raided and sunken by Thai pirates, leaving thousands stranded on deserted islands. Thousands more perished out at sea from boat capsizing, hunger, and thirst. [5] Most of their names and stories will remain forgotten. In addition to leaving by boat, thousands, including young children, left on foot and walked hundreds of miles through thick jungles to Thailand. [8] As their journeys by land and sea scattered them across the region, the United Nations established refugee camps across Southeast Asia, in Thailand, Malaysia, and the Philippines, to begin the resettlement process. Resettlement often took decades. After the end of the mass exodus in the 1980s, the third wave of refugees began and continues to seek resettlement under the Family Reunification Act. [5]

Early Years of Resettlement

In the early years of their arrival, the new refugees did not have pre-existing communities to help ease the stress and challenges of adaptation. These social and community support structures not only help to link communities to mainstream culture; they protect against mental distress. [13] During these early years, cultural misunderstanding between the refugee community and the mainstream culture frequently occurred, including incidents related to health practices. [14] Cases of refugees reporting being “haunted by ghosts” or “possessed by spirits” presented in healthcare facilities on numerous occasions. For instance, mental health professionals at a community mental health center were at a loss when a Vietnamese family brought in a family member who said that she had been taken over by a ghost. [11] In another case, a refugee woman arrived at a hospital and shared that a spirit had taken over her body. [15] Many of these incidents were connected to mental distress, but presented in ways that were not commonly seen in the western mental health frame. [11]

There were other cultural health practices that were misunderstood. In a tragic case related to a common Southeast Asian health practice of coin rubbing, a young Vietnamese refugee child arrived at school with red striped marks on his body. The school nurse reported it as child abuse. The father was arrested. It was later realized that the red marks were a result of a cultural health practice called coin rubbing, “cao gio” to help with common ailments, such as headaches, coughs, or having a weak body. [16 17] The Vietnamese father was so distraught with shame from being accused of abuse that he died by suicide while in prison. This story made national news and reverberated throughout the Vietnamese and other Southeast Asian communities. It brought a realization to many Southeast Asian refugee communities that their cultural health practices were not understood or valued, and people became hesitant to seek treatment in the American health care system. [14] This story reflects what Arthur Kleinman suggests that Westerners tend to do when

they encounter unfamiliar narratives or experiences. They take the practice and narrative away from people whose cultures are different and pathologize behaviors within a western frame. He writes: “We take their cultural narratives away from them and impose ours. It’s a terrible example of dehumanizing people” (p. 107). [18] These cultural misunderstandings in the early years of the Vietnamese refugee resettlement period created a serious barrier to refugees seeking health or mental health treatment.

Despite the early resettlement challenges, there is a sense that the Vietnamese refugees have “made it” as an acculturation story. They have become a new American ethnic group as they integrate into American social and cultural life. Across major U.S. cities, we see the presence of the Vietnamese Americans establishing roots as “indications of the growth and stability of the population. Today these Vietnamese towns seem to be a normal part of the established community” (Nguyen, 2012, p. 38) [10]. But underneath this layer of success lies a great many untold stories of pain that have been “overshadowed” by the desire to resettle and move forward. [10 11 13] Within the community, many suffer from deep depression. [15 19] Past trauma compounded with new daily stress can “exacerbate mental health problems that impede adjustment to a new country” (Hilado and Lundy, 2017, p. 66). [20] In addition, other risk factors of mental distress for the Vietnamese community include grief, social isolation and disconnect from the new cultural and linguistic contexts, and a general loss of social and cultural support structures [21]. While they continue to find ways to adapt to their host country, traces of past trauma keep surfacing and disrupting aspects of their new lives. Gold (1992) writes: “Although the Vietnamese have made impressive progress in adjusting to life in the United States, many still suffer from various difficulties rooted in wartime experiences, their flight from home, culture shock, racial prejudice, the loss and separation from loved ones, and economic hardship” (p. 290) [22]. Studies indicate that many Vietnamese refugees suffer from PTSD, anxiety, depression and other mental health disorders. [4 11 13] In particular, the group that may be at the highest risk of mental distress is the ex-political detainees as a result of “torture, humiliation, deprivation, brainwashing, and other forms of indoctrination, and punishment for their past collaboration with the United States” (Birman & Tran, 2008, p. 109). Thus, 40 years after their initial arrival, mental health concerns remain a problem in the Vietnamese American community.

Barriers to Mental Health Care for Refugees

While mental distress is a major concern for refugee communities, their rate of mental health care utilization tends to be low. [20] Access to care is reported as one of the main barriers to utilization. [20] There are many institutional and logistical issues, such as language, familiarity of the healthcare system, transportation, insurance, and availability of trained professionals that contribute to the refugees’ barriers to seeking and receiving mental health care. In addition, stigma, culture, and general perception of mental health are also factors that influence their decision on seeking care. [20]

Study Purpose

The purpose of this exploratory study is to gain a better understanding of how accumulated mental distress affects refugee communities long-term. The study is part of a larger community-based participatory research (CBPR) project led by the Community Health Board Coalition (CHBC)

of King County, which consists of 12 communities, consisting of Black, indigenous, and People of Color communities (BIPOC) including refugee communities. The main aim of the CHBC's community assessment project was to explore and gain understanding of mental distress in the BIPOC communities across the King County region. Each of the 12 communities involved in the community assessment followed the larger aims outlined by the CHBC. However, each community developed its own data collection approach that worked best for the community. For the assessment focusing on the Vietnamese American community, the main goal was to understand the effects of historical trauma and on-going acculturation stress have on the community. After more than 40 years of resettlement, what mental health concerns exist in the Vietnamese American community in the King County region?

Conceptual Frame: A Socio-cultural Approach to Mental Health and Mental Illness

The conceptual frame that will guide this study situates mental health and mental illness within a biological and socio-cultural context. The Lancet Commission on Global Mental Health and Sustainable Development recognizes an individual's mental health as a "unique product of social and environmental influences...interacting with genetic, neurodevelopmental, and psychological processes and affecting biological pathways in the brain" (p. 1557). [23] The exposure to each and both of these dimensions – the biological components and the socio-cultural environments – affects the ways in which mental health and mental illness are experienced and interpreted. Taking an inclusive approach helps to focus my study on understanding how mental health and mental illness have been experienced and explained in cultural contexts that are distinct from the Western cultural context. Kleinman (1980) explains that "the health care system, like other cultural systems, integrates the health-related components of society. These include patterns of belief about the causes of illness; norms governing choice and evaluation of treatments; socially-legitimated statuses, roles, power relationships, interaction settings, and institutions" (p. 24). [24] This approach will provide a frame to examine how Vietnamese American perceive, understand, and respond to mental health and mental distress and illness within a social, cultural, political and historical context.

Epistemology

The question of what constitutes knowledge is highly debated as scholars across different social, cultural, and political institutions conceptualize and offer diverse and often contrasting ideas and perspectives on the meaning and formation of knowledge. Positivists asserts that knowledge is objective and value-neutral [25]. Code (1995) defines objectivity in this sense, "as a perfectly detached, neutral, distanced, and disinterested approach to a subject matter that exists in a publicly observable space, separate from knower/observers and making no personal claim on them" (p. 15). This notion of value-neutrality suggests a high level of disinterest on the part of the knower as he/she pursues to form knowledge.[25] The knower's main intention seems "purely" to pursue knowledge unhindered and untainted by values. As this particular discourse of objective knowledge

continues to dominate many traditional academic disciplines and social and political institutions, feminist and multicultural education scholars contend that positionality plays a critical component to the knowledge production enterprise. In aligning with constructivism, Code and others posit that knowledge is socially constructed and influenced by the lens of those generating new knowledge. The idea of positionality originates from feminist scholarship. [25-27] Tetreault (2003) defines it to mean “important aspects of our identity, for example, our gender, our race, our age...are markers of relational positions rather than essential qualities” (p. 4). [28] These social, cultural, and political markers, which shape our worldviews, cannot be disconnected from the process of knowledge construction – they continuously work to influence how we examine, interpret and represent knowledge.

As a researcher, I adhere to the constructivist and interpretivist theories of knowledge production. Knowledge is socially constructed [25-27 29]. Because knowledge is intricately linked to the knower’s race, gender, class, religion, political affiliations, and various other identification markers, knowledge is interpreted through these lenses. Thus, the question of who constructs knowledge becomes just as critical as what constitutes knowledge. The exploration of these questions raises additional questions: Who benefits from the process of knowledge construction and who is excluded or marginalized by this process? Holding these questions as I conduct my research helps me to keep thinking about how, as a researcher, I am interacting with and representing participants’ ideas, experiences and narratives.

Positionality

As a researcher, it is important to recognize one’s positionality [27 30 31] in the process of collecting, transcribing, interacting and analyzing data. In my work with refugees, I have to consider how my being a middle-class Vietnamese American woman doing research on refugees may influence the process and interactions with participants. My position as a researcher from the University of Washington, woman, and someone who has been in the United States longer may create many power dynamics between myself and the participants. It is important to be conscious of these dynamics and how they may influence my way of interpreting the data.

In addition, my Vietnamese ethnicity and access to the Vietnamese language position me as an “insider,” when working with the Vietnamese refugee community. My access to the Vietnamese participants’ cultural knowledge and their first language provided an important connection between us. However, my insider position could have also been tricky. For instance, being an insider can create a context where participants may censor themselves on sensitive topics, such as mental distress, because they may not want members of their own community to know their experiences due to stigma. In these cases, it is important that I reiterate the confidentiality of the research but also encourage and reassure participants to share at the level that they feel comfortable.

Methodology

Study Design

This qualitative study explores the different ways that the Vietnamese refugees make sense of and talk about mental health and mental distress. Qualitative research methods are useful and appropriate in this case as they provided opportunities for participants to share their thoughts and ideas in more depth and in their own words. As this study is part of a larger community based participatory research (CBPR) study, the research design for the Vietnamese community aligns with the CHBC's assessment project, which includes both quantitative (survey tools) and qualitative measures.

Study Setting

This research project took place in King County, Washington. As one of the top destinations for refugees in 2019, [6] this region provides an important context for understanding the impact of mental health on refugee communities. In the last fifteen years, Washington has resettled approximately 33,000 refugees, most of whom reside in King County. [32]

Study Participants

Participant Recruitment

Study participants consisted of members from the diverse Vietnamese American community across King County. We used purposive sampling as a recruitment strategy to identify community members “that are especially knowledgeable about or experienced with a phenomenon of interest” Palinkas et al. (2015, p. 534). [33] To recruit participants, members of the Vietnamese Health Board (VHB) first reached out to people whom they knew might be interested. Many of the VHB members are healthcare professionals who work with a wide range of people in the community. From the initial group of people recommended by the VHB, we then used a snowball sampling approach, where we asked for recommendations from people who had agreed to participate in the focus group discussions or semi-structured individual interviews.

Participant Selection Criteria

Participant selection criteria for focus group discussions and semi-structured interviews included people who were 18 or older and identified as Vietnamese or Vietnamese American. For focus groups, age and gender representation was important. Language was not a criterion. An additional selection criterion for semi-structured individual interviews, included members who were professionals with extensive experience in the Vietnamese American community. We recruited community leaders, social workers, counselors, or health care professionals, who were able to offer insights into the larger population's experiences.

Data Collection

The data collection took place between August to September of 2019. Data collection included focus group discussions and semi-structured individual interviews. Having a combination of data collection methods provided varied perspectives of participants across social contexts. [34]

Focus Group Discussions

Focus groups discussions allowed the researchers to observe and understand how social dynamics may contribute to conversation flow and depth. The researchers were able to observe similarities and differences in responses from group members. I along with six other members of the Vietnamese Health Board conducted four focus groups, each with 5-7 members, stratified by age (18-30; 31-54; 55+). Focus groups were conducted in English for the 18-30 and 31-54 age groups and in Vietnamese for the 55+ age groups. Each group had two facilitators except for the 31-54 age group, which only had one. Focus group discussions were audio-recorded. In addition, a note taker was present in each focus group. Focus group discussions lasted two hours and took place at a neighborhood housing community space. Each participant received a stipend of \$25.00.

Semi-structured Individual Interviews

Semi-structured individual interviews provided researchers an opportunity to explore topics in more depth. For topics that are sensitive, such as mental health, participants may be more willing to share their thoughts away from other community members. In total, I conducted 14 semi-structured individual interviews, eight in person, five over the phone and one over e-mail per the participant's request. Interviews lasted between 45 minutes to an hour and a half. Interviews were conducted in Vietnamese, English or both depending on the participant's language preference. Participants responded in the language that was most comfortable for them during interview. Interviews were audio-recorded. Interviews took place away from community centers or spaces to allow for privacy and more honest responses. Interviewees were offered a stipend of \$50. Few accepted the stipend.

Data Analysis

Data analysis was on-going and took place throughout the data-collection process.[35] Focus group discussions and interviews were translated and transcribed at the same time. Notes from the focus groups were typed up immediately following the data collection activities, to help keep the event details more accurate. The transcripts underwent two different coding processes. Codes consisted of single words, phrases, or sentences. The initial coding process was a collaboration with other members of the VHB. Four collaborators participated in the initial coding process. To generate a list of codes, we first selected two transcripts, one focus group and one interview. We independently reviewed these two transcripts to note words, phrases, patterns, and themes that the participants' responses and stories revealed. We reviewed everyone's notes, comments, and phrases to generate a list of codes. The list of codes was applied to all of the transcripts. This initial coding process and analysis led to a report, which was submitted to the Community Health Board Coalition, our sponsor.

The transcripts were imported into ATLAS TI, a qualitative analysis software, for a second coding process. Using ATLAS TI, the initial stage of analysis included reading through the transcripts and providing commentaries [35 36] which were notes that researcher used to provide initial thoughts of the data. This process of meaning-making was a key analytical step of narrative analysis. From this initial stage of meaning-making, coding of data followed. Codes for this second analysis were generated from the code book used in the initial coding process. Additionally, codes

were added based on ideas from the conceptual framework, the research question and existing research literature. [35] These codes then formed a new code book, which was used to code or link with the data.[35]

Using an inductive analysis approach, patterns and themes were identified from the codes. [35] The themes that arose from the data were then examined and interpreted within the broader sociocultural and historical context. Inductive analysis involved connecting, illustrating, and shedding light on the situation, experience, event or context. This process not only involves both a close examination of the data and an understanding of the cultural context, but also an acknowledgement and understanding of how the researcher’s own positionality, perspective, and experience can shape meaning. A second discursive analysis was used to illustrate how language is used to represent participants, their knowledge.[31 37] Some questions to guide the discursive analysis included: What language do the participants use to describe their experience with mental health – is the language connected to the western concept or connected to their cultural context? How does language connect to the discourse around mental health and mental distress or illness?

Findings

In total, we conducted four focus group discussions and 14 semi-structured individual interviews. Study participants are categorized by focus group discussions and semi-structured interviews in Table 1 and Table 2 below. The four focus groups were stratified by age. And of the 14 semi-structured individual interviewees, eight were female and six were male. Their ages ranged from 29-64. 12 out of 14 received their higher education in the U.S. and two completed higher education training in Vietnam and the U.S.

Table 1: Focus Group Participants, Stratified by Age

Focus Groups	Men	Women	Total Participants
Focus Group 1 Elders (age: 55+)	3	3	6
Focus Group 2 Elders (age: 50+)	1	4	5
Focus Group 3 Age Group (18-29)	4	3	7
Focus Group 4 Age Group (30-49)	1	5	6
Total:	9	15	24

Table 2: Semi-structured Individual Interviews

Main Professional or Community Role	Men	Women	Total Participants
Community Leader	1		1
Counselor		1	1
Educator		1	1
Interpreter	1	1	2
Health Professional		2	2

Physicians	1	2	3
Researchers	2	1	3
Social Workers	1		1
Total:	6	8	14

The findings for this study provide further understanding on the mental health concerns of the Vietnamese American community. They help to shed light on the various elements that influence how people perceive and interpret mental health and mental distress, including the ways in which the cultural lens contributes to this process. In addition, the findings include factors that support or hinder the process of seeking mental health care. Emerging from the data, the findings are organized under three categories, each followed by sub themes.

- Impacts of pre-arrival, resettlement, and on-going acculturation on the mental health of the community.
- Perceptions, understanding, and responses to mental distress in the Vietnamese American community.
- Meeting the mental health needs of the Vietnamese American community

Impacts of Pre-arrival, Resettlement, and On-going Acculturation on the Mental Health of the Vietnamese American Community

This section explores how the various critical periods of the Vietnamese American experiences affect the mental health of the community. Those periods include pre-flight, flight, resettlement and acculturation. To better connect with participants’ representation of these major time periods of their lives, the categories of pre-flight and flight are grouped as pre-arrival and resettlement as resettlement and on-going acculturation. The findings in this section are structured under these sub-themes:

- “Intersectionality of trauma” and stress
- Resettlement and on-going acculturation stress
 - Family dynamics and inter-generational challenges and stress
 - Neighborhood safety and community spaces
 - Elderly concerns

“Intersectionality of trauma” and Stress

In describing the factors that contribute to the mental health concerns of the Vietnamese American community, participants related events prior to their arrival to the U.S. as well as challenges of resettlement and on-going acculturation. Pre-arrival conditions including war, labor camps, and flight contributed to the trauma, loss, and grief that many individuals and families experienced. Additionally, challenges of resettlement and on-going acculturation generated additional layers of stress. The quote from a counselor below who works closely with Vietnamese American families illustrates these intersecting layers of trauma and stress.

There is a lot of intersectionality of trauma. We came from a very traumatized culture... historical trauma, way back with thousands of years of fighting. And moving forward, we already have a layer of issues. Then you add on a layer of coming to American, you add the layer of cultural differences – the whole acculturation stress. So, you begin to see the dynamics between the parents and children because they have

different acculturation. Then you layer in socio-economic. People come over here and there are role loss...And then you add in a layer of racism and discrimination. And, so it makes for a really nice mess.

(Female counselor, Interview)

These intersecting layers of trauma and stress have significant consequences on the mental health of individuals, families and the community. In particular, PTSD and its ripple effects on families and the community are concerning.

In the Vietnamese community – the fathers, the uncles, the brothers went to war, especially in the front line, so those suffering or have PTSD will mostly be the men...But we see that those suffering from PTSD can develop other problems, like alcoholism, drugs, and can also have unstable mind. These men can abuse their families, wives because they have unstable minds or feel troubled. The impacts include self-destruction and can spread out to family and community.

(Male researcher 2, Interview)

One patient of mine was in the labor camp after 1975. He stayed there for a long time, 17 or 18 years. This impacted him.

(Female physician 2, Interview)

I worked with a patient who suffered from PTSD. He was a soldier. He relives the experience related to his war and what he saw during war. He could not escape those images. They replayed in his head. He lived in the past. He often felt very paranoid about things around him. He distorted things around him, small, insignificant events or encounters with a stranger could become enormous problems meant to trap or harm him.

(Male community leader, Interview)

Scars of past injustice and PTSD - A side effect might be an intense feeling for a cause that people may not share, particularly political causes. Again, the cause might be good, but carrying the burden of the cause can be quite stressful.

(Male researcher 1, Interview)

[P]eople that are my age, who did not serve as a soldier but who left after the war, there were a lot of experiences that scarred people emotionally and psychologically. I would imagine that many people in the Vietnamese community experience PTSD because of the war or from their experience escaping the country after the war. War and refugee experiences have a great impact on the community, and I think there was a lot of trauma connected to those experiences.

(Male community leader, Interview)

Resettlement and On-going Acculturation Stress

Faced with resettlement and acculturation concerns, Vietnamese families shift their minds and attention to the challenges that adjusting to new social, cultural, linguistic and economic circumstances present. In addition, enduring the stress of racism and microaggression is a

component of on-going acculturation that new ethnic communities of color encounter in adapting to their new social and cultural context. A community social worker shared his observation of the various challenges that the community encountered in their acculturation processes.

We have the normal amount of mental health challenges as many communities. We have stress and anxiety. But I also think that there is a layer that is unique to immigrants, refugees and People of Color, like systemic racism, micro-aggression that we have to deal with. And then culturally there is a lot of stuff that we face, such as parental challenges - parents not understanding things or the gap, the dissonance between the kids who were born here and then having to deal with relatives, elders who have dual or Vietnamese specific perspective. A lot of the issues can revolve around politics, perspective on race, who you decide to marry, choices on jobs – you know a lot of the younger generation has so much stress related to their interactions with their families. There is the tension between their family's ideas and what the younger kids want to do with their lives.

(Male social worker, Interview)

Family Dynamics and Inter-generational Challenges and Stress

Family dynamics and intergenerational tension are major concerns for the Vietnamese American community as they continue to adapt to life in the U.S. These issues consistently surfaced in focus group discussions and semi-structured individual interviews. While parents work to provide for their families, their long absence also disrupts family life and adds stress and emotional distance.

I understand the situation that many new immigrants face when they first arrive. The first priority for these families is that they need to survive. They have to find shelter, buy a car, and find jobs to feed their families. This is the first priority. So, if the parents are concerned about these basic needs, asking them to spend time with their children is a challenge.

(Male researcher 1, Interview)

Stress and pressure are major issues in families. In many families, we see parents working long hours, sometime with two jobs to support the family. Because they work so much, they are not present in the home, which can create a lot of pressure between children and parents and between spouses too. Often parents don't have time for their children. They provide for the children with food, shelter, and financial security but not time. They give money, not time, as the saying goes. So, the children feel a loss of connection from their parents. Stress and depression are very common in many of these family situations.

(Male social worker, Interview)

I think parents should have more involvement with their children. We cannot just assume that the schools will take care of the children. The teachers do not always know what is going on. The kids are exposed to the drugs nearby. I see so many kids smoking... There is so much freedom here and the kids are so free to roam. Parents are often not around.

(Female elder 1, Focus Group 2)

There are so many different things that can create stress and pressure. My generation, the one in the middle between the elders and the youth, is often trying to work and create a good, sound family. People work hard, but they may feel disconnected from the children but also with spouses. I would say that the Vietnamese people, because most of us came here with nothing and have to rebuild everything, we have become hard workers and can provide for our families, but in the process, many families have incurred a lot of tension and stress from lack of connection and communication.

(Male community leader, Interview)

Another on-going acculturation concern connects to the tension between parents and children, partly attributed by the development of incongruous cultural perspectives and beliefs. These tensions tend to surface around family obligations and expectations. Every member must follow their expected role. Parents provide and have concerns for their children while children fulfill their sense of “filial piety” or respect and duty to the parents. These beliefs and practices contrast with the mainstream cultural context, which values and encourages independence. Below a researcher explains these contrasting cultural values.

Family is a big component of our belief. Family and family concern, worry, connections – family is almost like a duty. You are raised with this concept. Family comes first. Parents worry and care for their children. And children express or carry a sense of filial piety. This is an essential cultural value of the Vietnamese culture. This is different from the American value of independence. When you are an adult at 18 and the parents’ responsibility towards you can cease. And children are raised to become independent.

(Male researcher 2, Interview)

These contrasting values and expectations are a cause of great tension in the family. Parents and elders worry about the lack or loss of connection with the younger generation while the younger generation experiences pressure and conflict trying to live up to parents’ expectations while wanting to explore their own interests. These cultural and language barriers across the generations add strain on the mental health of families as the voices, stories, and perspectives illustrate.

As a group living here, the biggest challenges to our community’s mental health is language and cultural practices. If our children are just learning English and do not want to learn Vietnamese, then this is difficult to interact with them...If the parents and children do not share a common language or culture, then it is hard for them to interact. But it is not the fault of the parents. We live in a different society. We live in a society where our language and culture are not part of the norm outside of our homes. For example, just a simple act of helping an elderly who has fallen can be tricky. In Vietnam, it is part of our culture to help and respect the elders...You see, these small differences and practices can create a lot of misunderstanding.

(Male elder 2, Focus Group 1)

In my case, because my English is not sufficient, I have a great difficulty connecting with my granddaughter. When I speak to her in Vietnamese, she doesn’t want to hear

me...Language is a great barrier for our relationship. Also, because my English is lacking, she doesn't always respect me.

(Female elder 2, Focus Group 2)

Maybe it's just like the fear of change. I feel like that's something my family kinda doesn't get used to. Like change. We kind of stick to what we know because if it's already something they got their hands on. They already understand that so just thinking like it could be something else.

(Female youth 3, Focus Group 3)

For the younger generation, parental expectations and pressure create enormous stress as they are learning and exploring different ideas, and interests in school, work, or other spaces in their lives. Below are some of the stories that the youth shared about living with the tensions in their lives.

[M]y family expected me to go to school, go to college, and become a doctor, lawyer, and especially my grandpa, an engineer, but I didn't choose any of those. And the stigma in the Asian culture is that you cannot [be] creative, you can't do what you want to do. You owe it to your family that brought you over here and that you should do what you tell them to do. And I became an IT technician, so I'm working the IT field and even then, they don't want me to do it. So just like last week, my parents were telling me you should go back to school, and you should have time to be a doctor or study engineering... It affects you.

(Male youth 4, Focus Group 3)

When I told my parents that I wanted to join the military and go for Army Rangers or something like that, they didn't really support it because my parents grew up in Vietnam where they saw the catastrophes. My grandpa, or both of my grandpas were taken as prisoners, so my parents were like why are you trying to join the military for! They think that oh you're going to join the military, you're going to go die, you're going to get your limbs blown off or whatever...They came from a different era of war...So, they don't really support me.

(Male Youth 2, Focus Group 3)

Speaking from a female perspective, I'm always told I should always take care of people first, my needs are constantly being put below others... It's always to take care of others first and make sure their needs are met. And then you can take care of yourself if you have some time.

(Female Youth 2, Focus Group 3)

In addition to the on-going acculturation stress that families face as they grapple with contrasting cultural views, past trauma and stress that parents carry further complicate family life. In the excerpt below, we see an example of youth trying to understand the consequences of trauma across generations.

I think our parents do that to us...I was thinking...our parents come from trauma and we are left to deal with the outcomes of that. But if you're not helping yourself

deal with the effects of your parents' trauma on your own, then you're continually perpetuating that into your kids.

(Female youth, Focus Group 3)

Living with the trauma of their parents and elders, children also deal with the repercussions. However, parents do not easily understand their children and tend to dismiss these conditions. This dismissal and lack of understanding from parents further complicate family relationships and widen the misunderstanding and disconnect.

Intergenerational...for the younger folks, they may be experiencing some intergenerational trauma of their parents. They may have some anxiety, or they have things that their parents don't know how to deal with that. And their parents may see them as lazy or view them as being unmotivated or seeing them as a bad child. "Why are you depressed when we brought you from Vietnam? Do you know how bad people there have it? Why are you anxious when we were able to escape?" So, this...so these are the issues. The kids don't know why they are feeling this way, and the parents can't help them with their mental health problems. This further breaks down the family.

(Female counselor, Interview)

Elderly Concerns

Another growing concern for many Vietnamese American families is the caring of the elderly. Many elders are adapting to living on their own or in senior homes, a contrast to their traditional practice and expectation of living within a multi-generational household. An outcome of this new living situation is that elders can feel isolated and lonely.

And for the elders, there are many issues that also impact their mental health. One thing they may lament about is the disappointment over their expectations not being met. They may have expected that they would live with their children. But this might not be the case. And for many if they live on their own, they might not be very mobile. They can't drive or know how to take the bus. They are in their home and are isolated.

(Male community leader, Interview)

Loneliness among the elderly is a big problem. Most often their children are married and have their own children and the older generation, they are lonely. So, being alone all day and night, they get pretty lonely. They can't drive much. They often don't talk to anyone. I'm seeing a patient right now. He's in a retirement home and there are gatherings, but not with his family. He gets pretty sad. So, for many of my patients, they feel sad but also guilty. They feel guilty that they can't help their kids. They feel useless so they become sad and guilty.

(Female physician 2, Interview)

Another concern that surfaced for many elders during the focus group discussions is their "unbearable" sadness and guilt about the conditions of their homeland or "que huong." For many,

their feelings about “que huong” impacts their physical and mental health. Seniors in the focus groups shared that they were unable to eat or sleep when this sadness, guilt, or regret arises.

Well, as a group of grandparents or parents of older children here, I think the things that impact our mental health might be different. For me, I think often of “que huong” (homeland). I think about the news that is coming out of Vietnam, and this news causes a lot of distress and concern. I can often become overwhelmed by my sadness. The sadness is often unbearable. This is common for many of us as we think about our “que huong” and the difficulties in Vietnam.

(Male elder 1, Focus group 1)

Neighborhood and Community Spaces – A Source of Support, Discord, and Distress

Social and cultural spaces are a vital part of community life for the Vietnamese community members. Community represents a variety of spaces, events, and functions for people. For most, community generally means small social or religious groups or spaces that offer opportunities for “personal and on-going connections” and understanding.

I would say that we have a lot of smaller groups that serve as our main community. For example, if you belong to a church, you attend church and meet your friends there. This is a community. Or, if you go to a Vietnamese language school, then this is also a community. But in terms of a bigger community, I don’t necessarily think that we all come together and connect as a community. Maybe have some commonality but I think the smaller groups are important for personal and more ongoing connections. I also belong to a medical association, which serve as professional and social connection. These smaller groups serve as part of my community.

(Male physician, Interview)

Community also means larger gatherings or events that forms around a cultural celebration or identity. These spaces are less conducive for personal connections, but they “offer an important collective voice.”

There are a lot of different groups and activities, but we don’t all pull together as a large group. Tet in Seattle is the biggest community wide event. I think the small groups that I mentioned are important – they connect people with common interests. But the larger community is important too. They offer an important collective voice.

(Male physician, Interview)

Within these various community spaces that offer support and opportunities for connection, division and tension can also arise due to distrust. Participants shared both praises for the importance of community as well as concerns for discord and division due to distrust and gossip.

Yes, our community has a lot of organizations and events throughout the region, but we continue to remain disunited. We are all broken into small pieces. So, to become a stronger community, we have to unite these broken pieces.

(Male elder 2, Interview)

The communal dimension most often help people, particularly the religious ones, whether Cao Đài, Phật Giáo (Buddhism), hay Công Giáo (Catholicism), hay đạo khác (other religions). Other organizations, such as Hướng Đạo (Scouts), have also done wonders. At the same time, organizations, possibly with good causes, may also bring more stress.

(Male researcher 1, Interview)

I think there are so many things that pull us apart. Sometimes, I wonder how we function together. I am not sure what holds us together ... Sometimes, I think people care more about their status and what can be gained from doing work in the community than from really serving and helping the community to thrive... It can be disheartening. I think this is something that may happen in many communities, but I think this is very prevalent in our community.

(Male community leader, Interview)

In addition to the tensions and concerns within the Vietnamese community spaces, conditions of the neighborhood and larger mainstream community can also affect the mental health of the Vietnamese Americans, such as access to transportation, housing, and neighborhood safety. An elder shared her observations of her neighborhood context.

My neighborhood is a place that receives homeless people. They set up tents in the park across from my house. In this homeless space, there are some people who do drugs and even sell drugs like cocaine. The people who sell drugs may or may not be from the homeless group, I am not sure. They move around on bikes, and they ride around the park where the homeless people are set up. In this exchange of drugs, I have seen the kids in the neighborhood get involved too... There are young people who go back and forth to school and then get caught up in the drug. I think the activities of this park have really impacted the health and the mental health of the people who live nearby.

(Female elder 2, Focus Group 2)

In summary, past exposure to trauma from pre-arrival contexts and challenges of resettlement and on-going acculturation experiences have led to an accumulation of stress that impact the Vietnamese population in a myriad of intersecting ways. These layers of stress are not only affecting individuals, they are creating tension and conflicts at the family and community levels. As individuals, families, and the community continue to experience mental distress, how are they talking about these concerns related to mental distress? What perceptions, understanding and interpretations do they have related to mental health or mental distress? I explore these questions in the next findings section.

Perceptions, Understanding, and Responses to Mental Distress

The findings in this section focus on how mental health and mental distress are understood and perceived in the Vietnamese American community and the various elements that shape these understanding and perceptions. The findings illustrate the ways in which cultural lenses influence how people cope with life's hardship as well as the processes of stigma creation. The findings are structured under these sub-themes:

- “Living ghosts – there but invisible”: Historical context of mental distress
- Fate, karma and learning to “bear it”
- Stigma, guilt and shame
- The stigmatized language of mental distress
- “Life is good now!” What do you have to be depressed about?
- Unexplainable pains: Somatic expressions of mental distress
- Connecting Perceptions and Talk of Mental Health Across Cultural Spaces

“Living Ghosts – There but Invisible”: Historical Context of Mental Distress

As a society that is open and accepting of new medical knowledge, diagnosis, and treatments, Vietnam has long been exposed to approaches that combine both traditional and modern/western treatments. [9] However, due to social, political and economic conditions, including wars and lack of resources, mental health concerns became less of a priority. People who were diagnosed with severe mental illness, such as schizophrenia, were often ignored or treated by confinement. This historical response contributed to the community's current understanding and perception to mental health and mental illness, including the stigma connected with mental illness. A researcher reflects on the historical treatments of mental illness of Vietnam during the past few decades.

When I was growing up, because of how poor the country was back then, if people see a person with mental disease like schizophrenia, they ignored them. There was a general feeling that we recognized the problem but there was not much that can be done to help with people with schizophrenia or other severe mental diseases. These people languish; they became living ghosts of society – there but invisible in society.

It is about having the tools and knowledge to diagnose. So, I think it is about education and training. So, I see it as a problem of resources. Governments don't have the resources to train people, so what we see is misinformation about the mental diseases...And governments are more worried about diseases that can kill people – infectious diseases, outbreaks, etc. So, to resolve this issue of dealing with chronic diseases, governments would have to train and retrain providers. Where would the resources come from to do this? So poor countries are not going to have the resources to do this. So, in the end, people who suffer from mental diseases are untreated and left to languish if their families can't care for them.

(Male researcher 2, Interview)

Fate, Karma, and Learning to “Bear It”

Without a biomedical frame to understand and respond to mental illness, many depend on other explanations or lenses that are available within their social and cultural contexts. For many Vietnamese, understanding and interpretations of mental health and mental illness are tied to their

cultural lens, informed by the context of the place and time, such as the beliefs, practices, availability of resources and treatment options. [24] Religious beliefs play a prominent role in shaping cultural perceptions of mental health in the Vietnamese culture. One dominant religious narrative that guides people's perception of illness – both physical and mental illness – derives from the Buddhist principle that life is not without suffering and hardship. [9] It is a belief that is deeply embedded in the culture and widely accepted [9]. This belief often serves as an approach that many people use to respond to hardship, suffering, illness, and other life circumstances. The excerpts below illustrate the thinking that many participants, especially the elders, shared about living with hardship and illness.

For people who are Buddhists, we have this belief that life is full of suffering, but we have to strive to live a joyous and contented life. Suffering is a condition of living, but we have to learn how to overcome our suffering and maintain a healthy mental state.
(Male elder 3, Focus Group 1)

You have to learn to accept some of the things that have happened to you even if you get sick. When you are older, sickness is expected and a part of life...But we cannot let it get us down. We should try to forget. For me, I have to follow this thinking. As an older person who will experience illness, I have to learn to not let it get me, even learning to forget about my illness in order to keep living. I have no other path to follow as I see it.

(Female elder 1, Focus Group 1)

Extending the principle that life includes hardship, many also believe that pain and suffering are part of their fate; something that they must endure. In describing different strategies that the Vietnamese community members use to cope with trauma, a social worker suggested that faith and culture play an important role. He elaborated:

I think there is a lot of tension and pain in the community. It would be an important way to get people to acknowledge their conditions, their pains, and their suffering instead of “ignoring” them or simply living with them as part of their karmic debt...This might have something to do with our religion...this idea of “số phận” or your fate. Like the “số phận con người.” This is your fate and you accept it, deal with it or bear it.

(Male social worker, Interview)

Accepting their fate and coming to terms with suffering does not mean giving up. For many, it means accepting the things that are beyond their control while finding ways to persevere.

It is challenging. If we are unable to resolve a condition that we are in, then I think we have to have some acceptance of the situation. We have to strive to create some good relationship in those situations. We cannot simply just hold onto the frustration and anger.

(Female elder 1, Focus Group 1)

I think for the Vietnamese, for the most part, they just learn to deal with things. They just deal with the hardship. They don't complain. They deal with the situation. They learn to move on. They don't want to complain about their past. Many of them are so appreciative to be alive and here. They think about the situation at home and do not want to complain. They have a sense of resilience.

(Female physician 2, Interview)

I think about the idea of suppressing yourself. I think my family culture is all about holding your emotions in. And...I can see why it can be valued in our culture. It is like we have to sacrifice our feelings by holding it in because that is our way. Staying positive is like coping.

(Female health professional 1, Interview)

The idea that life is full of hardship and suffering is not difficult for Vietnamese to understand. With generations witnessing trauma and stress from wars, the idea that hardship and suffering are conditions of life has become solidified in people's mind. Learning to accept and "bear" this hardship is widely accepted. Participants noted that learning to live with hardship can be a tool of perseverance and resiliency in the culture and community.

It's a whole system. There are so many layers...trauma, acculturation stress, discrimination...and all of the factors that lead to distress. So out that, when you think of communities that deal with so much...multiple factors...or at-risk factors...that as a whole, we're relatively "functional." And so, the flip side of that is post-traumatic growth and resiliency...our community has an amazing ability to be so resilient.

(Female counselor, Interview)

Stigma, Guilt, and Shame

While the cultural lens that supports the idea of accepting the burden of mental distress can help some to persevere and even develop resiliency, for many, living with mental distress in silence becomes a way of hiding stigma. Unable to speak about these mental distress or illness, many "resign" to the idea of living with their pain and conditions. Below, participants discuss how feelings of shame and fear due to stigma can silence people about mental distress and illness.

And people may be reluctant to seek help because they believe this is the bad karma that they have to live with and to repay from their past life. For example, families that have members with physical or mental illness would internalize these conditions as something that they have to bear because of their actions in their past life. The mother of the child who has mental illness could be seen as someone who owes that child something from the past life, and she has to care for the child in this way to repay the debt. This is a common understanding. And there is a lot of shame and guilt that families feel when they have family members with mental illness. This shame and guilt come from the belief that they did something terrible in their past life, and the mental illness is a karmic reincarnation of that past and a burden that the

family must bear... This thinking related to karma is deeply entrenched in our culture.

(Male community leader, Interview)

They [patients] don't volunteer any information. They are very hesitant to volunteer, especially the Vietnamese. They don't really tell. They are afraid of the stigma related to depression.

(Female physician 2, Interview)

I knew this woman who was very normal for most of her life. She then developed a mental health problem. Instead of finding ways to resolve the situation, the family just accepted it. They did not consider seeking treatment. They resigned to the idea that the woman must live with her mental illness. I told them that this condition could be treated with medication and not something that she has to live with. So, in the Vietnamese community, when a family experiences mental health related suffering, they generally don't think of seeking care as a first option. They come up with many other explanations first. They are afraid of the stigma. They also accept this as part of their burden, as part of their karmic debt.

(Community leader, interview)

The guilt and shame associated with mental distress create barriers for people in seeking mental health care. The excerpts from health professionals and community members below show the tensions connected with seeking care for mental illness.

[P]eople who access mental health services tend to be people who are at the extreme end. We, Vietnamese, try to keep things, and this is also my experiences with working with clients, is people try to deal with as much as we can. We try to hide it as much as we can until it gets to a point where the family can no longer function and then we ask for help. And by that time, the client has already gotten to the point where it is really hard to serve them, right. So, I see the stigma and people trying to hide the illness in the family.

(Counselor, Interview)

Stigma is a problem. But when a patient gets to know the doctor, they can learn to differentiate between depression and other severe mental illness like schizophrenia. Before when you mention anything about mental health, they immediately think of schizophrenia and will immediately say they are not crazy.

(Female physician 2, Interview)

No one wants to get labeled as a person who is crazy and needs to see a psychologist or mental health specialist. When you go see a doctor for hypertension or diabetes or eye sight problem, no one is going to label you, but when you see a psychiatrist or a mental health specialist, they think "oh, I go see a bác sĩ thần kinh or tâm thần," they tend to think that they would be labeled.

(Healthcare professional 2, Interview)

The Stigmatized Language of Mental Distress

The stigma connected with mental illness has tainted the language of mental health. Historically, mental illness was not considered a health priority in Vietnam. Only people with severe mental illness, such as schizophrenia, were treated, which included social distancing, including confinement. [38] The Vietnamese term that is used to describe people with mental illness is “bệnh tâm thần.” The words “tâm thần” translates as mental or mind, but because these words have been connected with severe mental illness, people associate them with illness. Because “tâm thần” has historically been used to describe mental illness, the term has become highly stigmatized. Even when health providers connect the phrase “health” to it, when people see “mental,” they immediately connect the term with illness. Below, participants provide some context.

I would say that when the Vietnamese community thinks about mental health, they think of the negative side – the conditions or the diseases rather than the general state of being healthy mentally. They think of it more as a disease, like schizophrenia, but they don’t see mental health as connected to daily life activities. They think of mental health as an issue. So mental health and mental diseases become the same.

(Male physician, interview)

In our language...if we want to talk about mental health, we use words like “sức khoẻ tâm thần.” But these words have really bad connotations; people immediately think about someone who is crazy. We can also use words that describe the symptoms, like a person who is confused or unstable mentally. The Vietnamese words that are related to mental health are much more about illness than health. The mental health concept gives off very bad feelings or images for people, so they avoid talking about it. When mental health is used or brought up, it is usually connected to abnormal conditions. There is a lot of stigma tied to the words.

(Male community leader, Interview)

Lacking a common language to express mental health and mental illness is challenging as these issues remain critical concerns in the Vietnamese community. When people try to discuss mental health, they lack adequate terminologies. In the quote below, an elder member is trying to define health as both physical and mental health but struggles to describe mental health.

So, I ended up splitting up good health into physical and mental and where physical is more easily measured. You have tools to diagnose it. We have rules for good health physically should look like. When you’re at this age, you should be exercising, eating this type of stuff. But when it comes to mental health, it gets much more complicated. I personally don’t think I have the vocabulary to express what mental health really is, but I think it’s more closely related to our core, our overall well-being. It’s made up of trauma and moments of abuse and memories – good things bad things, hobbies and habits...Outlets of stress, having a good support group, being able to beat the challenge of not holding on to the really bad things too close to us and especially in bad ways.

(Male elder 3, Focus Group 1)

“Life Is Good Now!” What Do You Have to be Depressed About?

Over time, as the idea of learning to accept or “bear it” becomes a cultural norm for dealing with hardship. When people encounter mental distress in themselves or in their families, they often dismiss these conditions. They often ask: “how can we be depressed when we are living in this land and have freedom?” Or, “what have people got to be depressed about?” Elders, especially, are reluctant to talk about their mental distress while parents fail to understand their children’s anxiety and depression.

A person who is older can often fall into this state of depression. We have had many great experiences that have led us to this state too...But, look we are here. We are in this land. We have a lovely, peaceful and happy life. We live in this land where we don’t have to worry about basic things. We are well fed. We have homes. We are free. This is the most precious and beautiful “hạnh phúc” or joy in one’s life.

(Female elder 1, Focus Group 1)

I think about the patient that I was helping who was very depressed. He felt a sense of depression...It was difficult for him to accept that he was not physically ill but possibly mentally distressed. He recognized how fortunate he is to be in the U.S. He tried his best to not think about his past. What does he have to complain about?! He is living in the U.S., and life is good now. This was his thinking. He tried to stay active with gardening and enjoying time with his family. His kids are successful. He often thought how fortunate it was that his family is here. If they were in Vietnam, they may not even be alive. So, what does he have to complain about? Why couldn’t he pull himself from that depression?

(Female Elder 2, Focus Group 1)

If I say it to my family member...they won’t acknowledge that it actually exists. That’s the hardest part with my family, like if I say “Hey, I’m clinically diagnosed with depression,” they won’t understand...they’ll think it’s a mood, not much of a disease or status and that oh in just a couple of days it’ll go away or if you eat ice cream or something like that you’ll feel much happier.

(Male Youth 3, Focus Group 3)

This idea of living with or getting over hardship and depression was frequently raised by the elders expressed in the focus groups. While many of the elders experienced and witnessed tremendous trauma, there is a sense that they should not suffer depression because they “are the lucky ones” who have made it here to the U.S. During the focus groups, while the youth (ages 18-29) and middle-age groups (30-50) raised concerns about trauma tied to pre-arrival experiences, the elders themselves did not offer any stories of pre-arrival trauma. The absence of trauma stories among the elders seem to support the idea that the female physician raised above – that the elders just want to “move on. They don’t complain about their past.” However, over time as these layers of trauma and stress become fixtures in people’s minds and bodies, they begin to intersect and push on each other, causing mental distress and unexplainable physical manifestations. For many, the various

manifestations of traumas and stress in family life also affect the next generation. A social worker explains below.

I think the elders have a lot of mental health issues that come from the war and they have not yet recovered, PTSD. So, that is an ongoing mental health challenge that they constantly carry with them, in their bodies, in their minds. And the other problem is that we have a lot of stigma with mental health.

I do think that not addressing these issues have significant impacts on a personal level. For example, imagine an elder who still has PTSD from the war. These people are really affected, and they pass this trauma, depression, anxiety onto to the next generation. We pass these anxieties from one generation to next because we haven't been able to talk about them or address them. Also, it affects the community in a lot of ways. These elders like in my own personal work experience, they join boards or organizations. And because these folks have not dealt with their own personal stuff, they cause a lot of challenges...I think one of the underlying issues is that many of these people have not healed.

(Male Social Worker, Interview)

Unexplainable Pains: Somatic Expression of Mental Distress

Without a familiar biomedical frame or adequate language to express the distress that persists in their minds and bodies due to stress, anxiety, fear, worries, depression, trauma, many of these symptoms manifest physically in ways that many western providers cannot diagnose. [15]

[A] lot of the manifestation of certain disorders are different, like depression, Asians tend manifest it more in a physical manner. This is again connected to the feeling of shame or the feeling that "I have a weak mind." There is so much associated with that. It speaks to a karma...you must have done something wrong in your past life or your parents did something wrong and now you suffer from it...There is a whole religious, cultural side to how we see mental illness. So, it prevents people from articulating mental illness in a socially acceptable way. So, instead, they share that they have a headache or a backache.

(Female counselor, Interview)

For many Vietnamese, there is a lack of understanding of how depression or anxiety happens in the body. They may not understand how this condition came about. Because health has been so tied to the physical body that when something like depression takes place, they may not recognize it as a health condition. But in reality, even though they cannot connect it to the physical body, manic depression or other mental health conditions are manifested by the body, but many people do not understand it. So, depression is almost like an abstract concept instead of a physical, concrete part of health. And because many people do not understand how conditions form from our bodies, they often associate their depression with things like having a weak body. Some even believe that they might be possessed or that bad karma is causing this illness.

(Male community leader, Interview)

Participants in focus groups shared some of their persistent and unexplainable pains. These incidents tend to happen with elders.

I had a terrible pain in my heel. It was excruciating. I went to the doctor, but he couldn't find anything wrong with me. He said there was nothing. I said that there had to be something that was causing me that much pain. How can there be nothing?! So, the doctor sent me to get a scan for my heel. But the scan found nothing. This happened several times and each time this happened, my belief and trust in the doctor lessened. I begin to not believe them; how could they tell me that there is nothing when the pain in my body is so excruciating?

(Male elder 2, focus group 1)

I had a terrible back pain, but I went to see three different doctors about this pain in my back. I went to the doctors, but no one was able to help me with the pain. I begin to believe that the doctors can't really help me.

(Female elder 1, focus group 1)

Connecting Perceptions and Talk of Mental Health Across Cultural Spaces

The meaning and responses connected to mental health and mental distress are culturally situated, as the above findings suggest. People's interpretations are based on the social and cultural landscapes and the influences of the beliefs and practices of those social and cultural spaces, including medical practices. But in studying social and cultural spaces, we understand that these spaces are not stagnant but dynamic. [39 40] This is especially true in this age of globalization and interconnectedness where ideas and information can be shared with the simple taps on our keyboard. As new ideas, understandings and exposure to other perspectives of mental health enter people's purview, their cultural lens also expands to incorporate these new meanings – to give new ways to differentiating between mental health and illness and language and ideas to understand and express about mental illness. As people are exposed to other perspectives and understanding of mental illness, their cultural lens becomes reshaped.

In studying how the Vietnamese refugee community is adjusting to a new cultural context in the U.S., we are afforded an opportunity to understand how a cultural frame on mental health can shift and be reshaped as new perspectives and expressions enter the traditional cultural frame. For instance, in the case of youth, as they become exposed to and have access to the mental health language that is used in the U.S. mainstream cultural context, they begin to integrate some of that language into their cultural frame. In many cases, participants who are exposed to the language and frame of mental health from the mainstream or other cultural contexts consider themselves as having a bicultural lens, which allow them to connect between the Vietnamese culture and the mainstream American cultural contexts.

Because I have lived here for quite a while, I feel that mental health is more acceptable in a western country, like America, more than back where I came from. In Vietnam, we don't have the term of mental health [mental illness]. We tend to call people 'crazy,'

so it always has the negative connotation...But in the U.S., and for me, working in the health care setting, when I think of mental health, I think it is very inclusive. It could mean that you are going through a rough patch of your life. Let's say that someone is going through life and a loved one passed away, then their well-being is affected. This could be a mental health issue, such as not being able to sleep or having nightmares or having anxiety. These are part of the person's health, but they are characterized as mental issues, but they don't have the negative connotations like in Vietnam.

(Healthcare provider 2, Interview)

There is BA and AA – before adulthood and after adulthood. So, a lot of unlearning has happened for me. So, growing up and even into adulthood, actually, because these things are so deeply ingrained, my family norms and cultural and bicultural norms were very much...you were not supposed to discuss anything negative, let alone mental health. Like anything negative, like conflicts, should not be presented to the world...I am the youngest and the influence of western culture on me was way more than any of my siblings...those [Vietnamese cultural] norms just didn't sit quite well with me. I didn't understand why. I didn't understand why we were supposed to suppress our negative feelings. I felt quite alienated with a lot of stuff that we were not supposed to bring up as a family.

(Healthcare provider 1, Interview)

Not talking about the pains and wounds of the past do not suggest that the traumas have disappeared. In fact, they are very much present and impact families. I was officially diagnosed with depression and anxiety. When I first heard it I was very much in denial as was the rest of my family because I think that in the Asian community having a sense of mental health and understanding your own limits in that sense is perceived as being weak and I guess having a weak mentality is supposedly what leads to mental health issues and I've tried really hard since then to convince my family, my aunt and mom especially to understand that this isn't something that I chose to have had happen to me. This is something that was caused by unresolved trauma from my childhood days that I never got to speak up because I wasn't allowed to feel sadness. Now that I do understand what mental health is, I try not to feel ashamed to seek help. I think that's a really, really big thing like people think they are not allowed to seek help even when they know they are suffering.

(Female youth, Focus Group 3)

Yes, in younger Vietnamese, I see this a lot. They have a different language to use to describe mental health compared to the elderly. The young people are more influenced by the Western culture and can talk about these issues more. But it is English. There is still a lack of terms or ways to talk about these issues in Vietnamese. Older Vietnamese still do not have sufficient ways to describe in more depth what they are experiencing. For example, with my patients, we have them mark down different symptoms or conditions they are experiencing. Some may mark down depression. But then the interpreter would say "tram cam" but would stop there and there is no further explanation of what it means.

(Male physician, Interview)

In summary, perceptions and understanding of mental health and mental illness are tied to a cultural lens that is shaped by a social, cultural, and political-economy contexts. [24] A cultural lens, however, is not fixed but is adaptable and can be reshaped depending on the shifts and changes offered by new or alternative perspectives that arise within a culture or society. As illustrated by the findings above, how youth and professionals talked about mental health and mental distress and illness differed from the elders' language of accepting and learning to live with hardship. As people become more exposed to different perspectives and ideas on mental health, their cultural lenses began to shift. But the introduction of new understanding and language of mental health and mental illness is not always easily accepted by family members. In fact, it generates tremendous tension and discomfort as the different generations grapple with how these ideas intersect with traditional approach and beliefs. While these tensions are challenging, they might lead to new possibilities of understanding across the generations.

Meeting the Mental Health Needs of the Vietnamese American Community

While evidence indicates that mental distress is a growing issue in the Vietnamese community, treatment is under-utilized and remains a big challenge for community members. Barriers to mental health treatment consists of social, institutional, economic, and logistical concerns. In addition, issues of cultural perspective play a big part in determining community members' care seeking behaviors. This section focuses on the findings that connect to some of these challenges. Further, it explores what community members define as strengths and support for the mental health. The findings for this section are organized into the following sub-themes:

- Institutional and logistical barriers to care
- Cultural barriers to care
- Community spaces as sites for healing

Institutional and Logistical Barriers to Care

There are many societal and institutional level challenges and barriers to mental health treatment for Vietnamese refugees, including transportation, language barriers, childcare, and insurance coverage. A healthcare provider sums up these various institutional challenges below.

Well, in my clinic, the first thing that comes to mind is the transportation issue...let's say that you live a little bit farther away and you have kids. Who is going to take care of your kids when you make an appointment to see a doctor? You just cannot drag along your kids. And who is going to give you a ride if you are out on a bus line? And you need a family member to give you a ride? And in America, everyone is working! Those who don't work might have other limitations, which may be why they don't work to begin with.

(Female healthcare provider 2, Interview)

Cultural Barriers to Care

Lack of culturally appropriate providers and trust in provider are also critical barriers to quality and meaningful care. In focus groups and interviews, this issue was repeatedly raised by participants.

[T]here is simply not enough people doing this work. And when people rely on caregivers who don't speak the language, those caregivers just don't understand the cultural elements. I really wish that we have more psychologists and counselors who come from our community. And then there is the fact there are young people who come through the programs, but they are not fluent in Vietnamese. A friend of mine is in this position. He understands the social context, but he cannot speak Vietnamese. This is very challenging. It is like finding a unicorn – someone who is bilingual in Vietnamese and English with a social work or counseling background.

(Social worker, Interview)

[A]s Vietnamese people, we are big on trust in terms of when we find people we trust, we are very willing to share who those people are. And that's huge because when we're talking about something like mental health that already is stigmatized, or often times silenced.

(Female Youth 3, Focus Group 3)

My father went through a tough grieving period after my mother died. I realized that we don't have grief counselors who are from our community...if you are going through trauma or mourning the death of someone, there's no support group, no counselor. And even if you go to a counselor, people only see crazy people as the ones who go to counseling. So, it's just like a double jeopardy game. First, we don't have very many counselors who can connect with the community. And even if we do, the cultural stigma is so thick that it is hard to break through.

(Social worker, interview)

Community Spaces as Sites for Healing

Community spaces, as discussed earlier, can be sources of tension and conflict due to mistrust. However, these sites also offer opportunities for members to connect. Participants indicated that these social and cultural spaces are strengths and are sources of support for mental health. They recognized that these spaces can provide opportunities for dialogue and healing through “storytelling” and education. Additionally, participants described community spaces and cultural events provide a sense of pride, connection, resiliency and belonging for many community members.

I think the Vietnamese community is extremely resilient. We have gone through so many wars and we survived. We have gone through so much and have also done so much to survive and thrive in some areas. We have been widely respected for “kicking ass” in terms of surviving and rebuilding.

(Social worker, Interview)

Participating in community activities is so helpful for our mental health. Because when we participate, we often find joy in connecting with people. It helps our mind...I think that our community is so important. There are many things that are not always good. But we have to love it and learn to forgive the many things that also happen there. If we can forgive and try to embrace the positive in our community, it really lifts us. It is like our mental health really expands and shines.

(Female Elder 1, Focus Group 2)

I think in some ways some of us has learned about our mental health is through story telling. And I think that as a community, our families talk shop, they spit out stories all the time and that's how they learn. Same for us, I think it's easier...An example of a family, they actually share their personal story of their journey and mental health, and their relationship with their parents. Even the parents sharing their story of learning what mental health is – someone that is from the community and can share...

(Female Youth 1, Focus Group 3)

Discussion

Refugee mental health concerns are a growing but often invisible or forgotten global health problem. Exposure to trauma and stress from war, violence, loss, migration, resettlement and on-going acculturation have significant consequences on the mental health of refugee communities. The aim of this study was to explore the long-term impacts of accumulated trauma and stress on the mental health of refugees. The study focused on the Vietnamese refugee community – one of the oldest refugee groups to settle in the U.S. since the establishment of the Refugee Act of 1980. [5] This discussion will focus on some of the key findings below.

Factors that Contribute to the Mental Distress of the Vietnamese American Community

In summary of the findings, the legacies of wars, conflicts and violence that took place over the past few centuries in Vietnam have left many indelible imprints and remains of wounds and scars on the country's culture, physical spaces, and people's minds and bodies. The layers of accumulated trauma and stress connected to pre-arrival, resettlement and on-going acculturation have significant consequences on the recovery and adaptation of the community. [20] Findings from the study reveal that across the different social levels – community, family, and individual – stress, anxiety, frustration, and depression are erupting and challenging the Vietnamese American community in complicated and intersecting ways.

Family and Intergenerational Tensions

For many refugee families, after leaving behind the wars, conflicts, and violence of their home countries and making it to the U.S., they are then met with the daunting process of resettlement and on-going acculturation, which bring with them new layers of stress, frustration, and worries. [20] As the findings in this study suggest, in the initial years of resettlement, parents' priorities focused primarily on providing for the basic needs of the family: food, shelter, and safety. Many parents take on two or three jobs which leave little time to process their previous stress and

experiences with trauma, loss and grief. And as they adjust to life in the U.S., they are met with a new set of challenges of social, cultural, language and institutional barriers. [20 41] Moreover, as many parents work to provide for the family, they lack time and energy to connect with their each other and their children. And over time, language and cultural barriers become points of tension and disconnect between parents and children. [8 42] Parents see a loss of authority over their children while children experience pressure and tension between wanting to fulfill their parents' expectations and wanting to explore their interests. In addition, the findings indicate as the youth live with and are exposed to their parents and grandparents' trauma and stress, these points of stress too have become part of their experience. Youth participants reported that their depression, stress and anxieties are connected to witnessing and experiencing their parents and elders' unresolved trauma. The transmission of trauma and stress across generations is a long-term outcome of the accumulation of exposure to trauma and stress. This is an area of great concern for families.

Elderly Concerns

On an individual level, elders in the study generally believe that they have no reason to be depressed since they now have "freedom." However, they shared having experiences of unexplainable and uncontrollable depression when they think about "que huong" or their homeland. The depression includes feelings of guilt, sadness, and regret for the social, economic, political conditions of their homeland. The depression that the Vietnamese elders described is often found in refugee populations and are tied to survivor guilt. [15] For the elders, while they would not admit to having depression, expressing this deep sense of sadness for their homeland is somehow socially acceptable as it shows their love of their homeland. While depression about one's personal state and condition is socially not encouraged or accepted within the Vietnamese cultural context, expressing a sense of sadness and regret for community, culture, or homeland is not only acceptable but also admirable and respectable. For many, experiencing depression over their homeland allows for a communal and public expression of grief and loss and can help to provide some relief and sense of connectedness among the elders.

In addition to these moments of deep depression about their homeland, many elders shared having severe, chronic, physical pains that tend to be unexplainable or undiagnosable. The elders described these pains as "excruciating." Among refugees, these somatic symptoms of pain are common and may be connected to untreated stress, anxieties or previous exposure to trauma. [15] While in the focus group discussions, the elders did not talk about their previous experiences with trauma, they repeatedly shared stories of pains that are chronic and severe. For many seniors, adopting the cultural lens that support accepting hardship may be preventing them from talking about or admitting to having experiences of distress. The long-term accumulation and bearing of stress, anxieties and trauma can result in these unexplainable somatic symptoms. [15]

Another concern for elders' mental health connects to their social, cultural, and physical isolation. In the Vietnamese cultural tradition and practice, it is commonly expected that elderly parents live with their children [9]. Multi-generation family pattern is the cultural norm in Vietnam. However, elders are finding that this is not the common practice in the U.S. Many are currently living on their own or in senior homes and are steep in social, cultural, and linguistic isolation. Most

do not drive and are physically isolated from their families and cultural communities. Loneliness and isolation can contribute to their mental health decline greatly. This is a growing concern among the Vietnamese American community as more families are unable to support their elderly family members in multi-generational households.

Perceptions, Understanding, and Responses to Mental Health

While the biomedical frame provides an important explanation for mental diseases, understanding, perceptions, and responses to mental health are socially and culturally contextualized. As a nation and culture that has for long been exposed to other cultures and perspectives, Vietnam has long been open to new approaches to medicine, research and ideas beyond the traditional practices. Approaches to health and healing combine both eastern and western medicines and practices. But research, training and treatments require resources. For much of the past century, Vietnam had been plunged into wars and conflicts, depleting many of its resources, making it challenging to support science and innovation beyond the essential needs. For these reasons, mental health concerns became a low priority. [38] In fact, only those with severe mental illness such as schizophrenia were treated, which consisted of confinement or sedation. [38] The historical treatment of schizophrenia and other severe mental illness had profound impact on how mental health has been understood, interpreted, and received in the Vietnamese community.

Without a sound biomedical approach to mental illness, the social, cultural, and religious interpretations helped to give meaning and understanding to these conditions. One of the long-held beliefs that is embedded in the cultural lens is derived from Buddhist principle that life includes hardship and suffering. As a nation that has experienced centuries of war and conflict, this principle seems to hold true for people. Learning to accept and live with hardship becomes a general condition of life.

Karma is another element that is derived from Buddhist belief. Karma, karmic debt or retribution are powerful interpretation of life's many conditions. Karma connects to the principle of cause and effect where an individual's actions affect the conditions of his/her future. [9 41] In connecting karma with another Buddhist concept of reincarnation, there is belief that the actions of one's past life influences the social conditions of that person's current life. [41 43] If a person was virtuous and good in their previous life then they would have earned good karma and have a good, prosperous and healthy life in this lifetime. Conversely, if a person committed a sin in their past, then those sins become the debt that they pay in this life. The thinking and belief in this karma and karmic debt generate a tremendous amount of guilt and shame, especially for illnesses and conditions that are less commonly known or understood, such as mental illness. While the cultural frame encourages people to accept these conditions that life has offered them, it also sanctions the stigma tied to those life conditions. The guilt and shame connected to acknowledging mental illness is profound; people are often socially and culturally forced into "bearing" the disease in silence. Without understanding or exposure to other approaches to mental illness, the traditional Vietnamese cultural lens becomes a prominent lens for interpreting mental illness in the Vietnamese community.

One consequence of the stigma that is tied to mental illness is that the language that was used to describe the illness is highly stigmatized. Mental health and mental illness have been associated with only severe mental illnesses, [38] and because the treatments of those with mental

illness had been so condemning – socially, culturally, and medically – people tend to shy away from using those terms. The various constraints and limitations of language to describe mental health conditions creates a challenge for moving forward these conversations. Participants in this study, for instance, used phrases that describe their spirit, inner-being or well-being and mood while avoiding phrases that describe mental health or mental illness. Exploring and developing a common language of mental health and mental illness would help to encourage the conversation of mental health in the Vietnamese community.

Bicultural Lens

The dominant cultural lens within the Vietnamese community that helps to connect mental health and mental illness with karma and other religious beliefs has long been established and reinforced. Cultural lenses are shaped by experiences, knowledge, and exposure to different ideas and ways of seeing the world and are not fixed and unchangeable. [10 39] Studying the Vietnamese refugee community grappling with and adapting to a new and different U.S. cultural context provides an opportunity to learn how a cultural lens shifts as it incorporates new ideas and interpretations of mental health. As the findings in this study show, exposure to another approach to and language of mental health within the mainstream cultural context has influenced the way that many participants think and talk about mental health and mental illness, especially the youth and professionals. As these different ideas enter the traditional Vietnamese cultural frame, they create tensions within the family and community settings. However, tensions can be a source of change. These new ways of talking about mental health can help to push against traditional views.

Among participants in the study – from elders to youth – there was a sense that people were eager to talk about mental health, but they were in need of a different language and frame to talk about mental health that was not stigmatizing. Perhaps the youth, community leaders, health professionals and others' adoption of the language and interpretation of mental from the mainstream culture can be the catalyst to help shift the cultural lens to push against the stigma connected to mental distress and mental illness.

Meeting the Mental Health Needs of the Vietnamese American Community

Many challenges exist in meeting the mental health needs of the Vietnamese American community. These challenges include the institutional concerns as well as the social and cultural barriers. Stigma remains a great obstacle for people in seeking care. As a community whose experiences with trauma and stress have been building over decades, finding ways to meet the needs of this community is critical.

Challenges and Barriers to Mental Health Care

While mental health concerns have been a persistent and growing problem in the Vietnamese American community, it remains a challenge for many to seek mental health care. [22] There are many barriers to mental health care for the Vietnamese community. Barriers consist of societal (health and insurance policies), institutional level (navigating hospitals, insurance coverage, lack of culturally receptive/respectful care, etc.), and logistical concerns (transportation, interpreter services). [44] In addition, there are also challenges that come from the Vietnamese American community, family, and individuals themselves. Cultural perspectives, stigma and guilt are powerful

factors that often prevent people from acknowledging or seeking care for their mental health conditions [22 44]. Considering ways to address these many barriers to mental health care would be key to encouraging greater use of mental health care among Vietnamese American.

Implications and Limitations

The findings for this study have implications for policies, mental health practice, research, and community programs to address the mental health needs of the Vietnamese American community. To support greater access to culturally responsive care, policymakers should support and increase funding of culturally relevant health professionals who can better connect with members of the Vietnamese community. Additionally, to strengthen understanding of mental health information and resources, policymaker should support funding for community educational programs and resources on mental health and mental health care access. And to improve mental health care access and culturally relevant care, it is recommended that health care providers learn more about the social, cultural, historical contexts of communities in which they serve.

For the Vietnamese American community, supporting and strengthening family and community structures and programs can provide important protective factors social, cultural and emotional development. [8 15 41] While healing mental distress requires psychological treatments and support, it also involves a social dimension with social activities and connections. Mollica (2006) suggests: “Positive social behaviors such as altruism, work, and spirituality enhance neurobiological processes that promote health and reduce the negative consequences of stress. These behaviors and others, such as the use of humor, social support, and physical exercise, help the individual recover psychologically” (p. 100). Supporting and strengthening community based and culturally grounded programs are an important component of healing. In the Vietnamese tradition, participants shared that “story-telling” through conversations with elders are important cultural learning and healing tools – a way to pass down history and cultural knowledge to the next generation. Story telling can also provide opportunities for deeper connections across generations. Supporting this kind and other community-based and culturally grounded programs that encourage communication and understanding across the different generations can help to strengthen the mental health and recovery process of the community.

The findings from this study are not generalizable. However, they have important implications for further research examining how social, cultural, and historical contexts impact perception and understanding of mental health in other refugee communities. In addition, the findings from this study provide important information for the development of community-based and culturally grounded intervention models that could be useful for other communities.

Limitations

There were clear limitations that this study faced. Selection bias may have occurred based on the sample selection process. Participants who volunteered to participate in the study could have very different levels of awareness and understanding of mental health mental illness compared to those who declined to participate. The different factors that could have influenced participants’ decision to participate the study might have included level of education, age, years in the U.S.,

English language ability, and knowledge and trust of U.S. medical institutions. Additionally, time constraint contributed to the limitation of follow-up or expanding the number of focus groups or individual interviews of community members. Despite these limitations, findings on the emergent themes will be useful to build a greater understanding of the mental health needs of the Vietnamese American community and can help to support other refugee communities undergoing similar challenges.

Conclusion

Worldwide, there are over 70 million displaced people. Most endured arduous and traumatic events, including being survivors or witnesses to war, torture, and/or sexual assault. As refugees move from place to place in search of safety and peace, they often accumulate layers upon layers of trauma, grief, and stress. Their state of mental health is likely tender and fragile. But for many refugees, mental health care is often a neglected area of need. In many cases, refugees themselves do not even consider their mental state a condition. Without attention, trauma and stress can have long-term consequences.

As a case study, this project focused on the experiences of a Vietnamese refugee community – one of the oldest refugee groups since the establishment of the Refugee Act of 1980. The findings suggest that even though the Vietnamese refugee community has made great strides in rebuilding, mental health concerns remain a persistent and growing public health problem. Great challenges and barriers exist for Vietnamese community members to seek and access mental health care. In addition to the social, linguistic, institutional and logistic barriers to care, within the Vietnamese community, issues connected of stigma, guilt and shame, often perpetuated by the community's cultural lens, prevent people from seeking and accessing care. Without ways to support the mental health of the Vietnamese and other refugee communities, accumulated stress and trauma can leave deep and lasting impacts on individuals as well as on families and the community. Of great concern is the transmission of traumas and on-going stress to the next generation taking place through being exposed to parents and elders' trauma.

The findings for this study suggest that exploring ways to support education and access to culturally grounded and relevant mental health care is important. The findings while specific to the Vietnamese community can also serve as a model for other refugee communities that have similar experiences of accumulated traumas and stress. Continuing to study and focus on the mental health of refugee communities is critical as refugees are often a forgotten population whose health and mental health continue to be overlooked and underserved.

Appendices

Appendix A: Project Information and Resources – English Version

In collaboration with the Community Health Board Coalition of King County, the Vietnamese Health Board (VHB) conducts an assessment to understand the mental health concerns in our community. The information that we collect will help VHB better advocate for enhanced support and programming for our community as well as supporting overall mental health initiatives for communities of color. This project is funded by the Equity Fund and is being conducted in 12 communities across the Seattle Metropolitan Area.



We invite you to participate in an interview because we are interested in your thoughts, opinions, and experience related to mental health in the Vietnamese community. The interview will last one hour. We will audio record the conversation.

Your participation is voluntary and confidential. Your name will not be associated with your opinions. You may decline to answer any particular question. You can stop your participation at any time. We will collect some demographic information for statistical purposes.

There are no physical or legal risks for you to participate. However, the discussion may trigger unpleasant memories that you may have. Please only share what is comfortable for you. The back of this page has a list of resources available in case you need help for emotional wellbeing.

There is no direct benefit to you for your participation. The information that you provide will help VHB better understand the mental health concerns in our community to advocate for programs that will benefit the community in the future.

The project provides \$50 stipend to say thank you for your time, opinions, and experiences. You do not need to answer all questions to receive the stipend. You do not need to pay money to participate.

We appreciate your willingness to talk with us. Your participation in the project represents your consent to participate.

If you would like more information about our project, please contact

Vietnamese Health Board
Mental Health Assessment Project
Email — vietnamesehealthboard@gmail.com
Facebook — [@vietnamesehealthboard](https://www.facebook.com/vietnamesehealthboard)

Resources Should You Feel Any Emotional Distress:

King County: call King County Mental Health Services at 206-263-8997 or 1-800-790-8049.

Snohomish County: call Snohomish County Care Crisis Line-800-584-3578 or 425-258-4357.

Pierce County: call the Crisis Clinic at 866-427-4747.

Asian Counseling and Referral Services

3639 Martin Luther King Jr. Way S

Seattle WA 98144

(206) 695-7600 | In inclement weather, call (206) 774-2417 for hours.

(206) 695-7606 | TTY: (800) 833-6384 (WA Relay)

API Chaya

206-467-9976

info@apichaya.org

PO Box 14047

Seattle WA 98114

Helpline: 1-877-922-4292/206-325-0325

Helpline Hours: Monday-Friday 10am-4pm

Immigrant, Refugee, Undocumented Outreach Program (IRUO)

206-323-1768

IRUO@seattlecounseling.org

1216 Pine St Suite 300

Seattle WA 98101

The Well on Beacon

(206) 914-6797

3001 Beacon Ave S

Seattle WA 98144

Multicultural Counselors.org

(425) 310-2356

admin@multiculturalcounselors.org

<https://www.multiculturalcounselors.org/about>

Appendix B: Project Information and Resources – Vietnamese Version



Hợp tác với Liên hội các Ban Y tế Cộng đồng của quận King, Ban Y tế Cộng đồng người Việt thực hiện một cuộc khảo sát để thấu hiểu những quan tâm của cộng đồng chúng ta về đời sống tinh thần của cộng đồng mình. Những thông tin mà chúng tôi thu thập được hôm nay sẽ giúp Ban Y tế Cộng đồng người Việt làm tốt hơn việc tăng cường sự hỗ trợ và quy hoạch các chương trình cho cộng đồng chúng ta và cả các chương trình nâng cao đời sống tinh thần của các cộng đồng người da màu nói chung. Chương trình này được sự tài trợ của Quỹ Công bằng (Equity Fund) của quận King và được thực hiện với 12 cộng đồng trên toàn quận King.

Chúng tôi mời quý vị tham gia một cuộc thảo luận với những người trong cộng đồng vì chúng tôi muốn biết suy nghĩ, ý kiến, và kinh nghiệm của quý vị về vấn đề đời sống tinh thần. Cuộc thảo luận sẽ kéo dài khoảng 2 tiếng.

Sự tham gia của quý vị hoàn toàn tự nguyện và được giữ kín. Tên của quý vị sẽ không đi liền với những ý kiến của quý vị. Chúng tôi sẽ thu thập một số thông tin dùng cho mục đích thống kê. Xin quý vị không bàn về những gì nghe được trong cuộc thảo luận này với bất kỳ ai khác ngoài nhóm này vào bất kỳ lúc nào.

Xin quý vị phát biểu ý kiến của mình một cách tự nhiên và thoải mái. Quý vị có thể từ chối trả lời bất kỳ câu hỏi nào. Quý vị có thể ngưng tham gia vào bất kỳ lúc nào.

Sự tham gia của quý vị sẽ không gây hại gì đến cơ thể hay vấn đề pháp lý. Tuy nhiên, cuộc thảo luận có thể gợi lại những kỷ niệm không vui mà quý vị có thể có. Xin chỉ chia sẻ những gì quý vị cảm thấy thoải mái chia sẻ. Mặt sau trang này có danh sách những nơi mà quý vị có thể đến nếu cần giúp đỡ về mặt tinh thần.

Quý vị sẽ không được hưởng lợi gì khi tham gia. Những thông tin mà quý vị cung cấp sẽ giúp Ban Y tế Cộng đồng người Việt hiểu rõ hơn những quan tâm về đời sống tinh thần của cộng đồng mình để có thể thúc đẩy những chương trình có ích cho cộng đồng trong tương lai.

Chương trình sẽ cung cấp \$50 để tỏ lòng cảm ơn quý vị đã bỏ thời gian và chia sẻ ý kiến và kinh nghiệm của mình. Quý vị không cần phải trả lời tất cả các câu hỏi để nhận số tiền này. Quý vị không cần phải đóng tiền để tham gia.

Chúng tôi biết ơn quý vị đã sẵn lòng nói chuyện với chúng tôi. Sự tham gia của quý vị trong cuộc thảo luận là thay lời đồng ý tham gia.

Nếu quý vị muốn biết thêm chi tiết về chương trình này, xin liên lạc với

Ban Y tế Cộng đồng người Việt
Chương trình Khảo sát về Đời sống Tinh Thần
Email — vietnamesehealthboard@gmail.com
Facebook — @vietnamesehealthboard

Những Cơ quan Chăm sóc Sức khỏe Tinh thần

Ở quận King, gọi

King County Mental Health Services ở số 206-263-8997 hay 1-800-790-8049.

Ở quận Snohomish, gọi

Snohomish County Care Crisis Line ở số 800-584-3578 hay 425-258-4357.

Ở quận Pierce, gọi Crisis Clinic ở số 866-427-4747.

Asian Counseling and Referral Services (ACRS)

3639 Martin Luther King Jr. Way S

Seattle WA 98144

(206) 695-7600 | Khi thời tiết xấu, gọi (206) 774-2417 để biết giờ mở cửa.

(206) 695-7606 | TTY: (800) 833-6384 (WA Relay)

API Chaya

206-467-9976

info@apichaya.org

PO Box 14047

Seattle WA 98114

Đường dây trợ giúp: 1-877-922-4292/206-325-0325

Giờ của đường dây trợ giúp: Thứ hai-thứ sáu 10am-4pm

Immigrant, Refugee, Undocumented Outreach Program (IRUO)

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<https://www.multiculturalcounselors.org/about>

Appendix C: Focus Group Facilitation Guide - English Version

Introduction:

Hello. We have asked you to take part in this focus group because we are interested in your thoughts, opinions, and experiences about mental health concerns in the Vietnamese community. The information that you provide may help us better understand the mental health of our community and better address mental health issues in the Vietnamese community. Do you have any questions before we get started?

10:00 – 10:15 AM

First, let's discuss a few ground rules. Please let us know if you disagree with any of these or would like to add, remove, or make changes.

1. All opinions will be heard.
2. One person speaks at a time.
3. All participants have a chance to express opinions.

10:15 – 10:25 AM

Let's start our discussion by reflecting on what good health means to you personally. **When you hear about good health, what comes to mind?**

- Self-reflection (3-5 minutes). As you think about this, write down a few thoughts, words, or feelings that means good health to you. You may also draw your ideas, or make a collage if that makes it easier.
- Let's take a few minutes to share your reflections/thoughts.

10:25 – 10: 40 AM

This next section focuses on what mental health means to us. **When you hear of mental health, what does that mean to you? What thought, feeling or image comes to mind for you?** (You can take a minute to think about it, write it, or draw it out.)

Thank you for sharing your thoughts on mental health in general. Now, **what thoughts, feelings, images come to mind when you think of mental distress?**

10:40 - 11:00 AM

In your opinions, what are some challenges or issues in mental health for our community?

In your opinions, what do you think are the root causes of mental health problems in the

Vietnamese community? (Or, what are some factors that contribute to mental health problems in our community?)

- Probe: In your opinions, what role do experiences related to being a refugee or immigrant have on mental health in our community?
- Probe: What other factors that may impact the mental health of our community?

What impact do you think mental health problems have on individuals? On families? And on the Vietnamese community? (*Or, how do you think individuals, families, and the community are affected by mental health?*)

11:00 – 11:15 AM

What are some factors that influence people to seek care or not seek care for their mental health problems?

- Probe: What role does stigma play in people seeking care?
- Probe: What role do cultural barriers play in people seeking care?

11:15-11:25

What are the community strengths that help us thrive?

(Probe if the conversation does not go in the direction of health or mental health): What are some strengths and approaches in the Vietnamese culture and community that can help support good mental health?

- Probe: Can you give some examples of how these approaches support good physical health or mental health?

11:25 AM

What kinds of support does our community need to improve mental health?

11:35AM

Do you have any additional thoughts or ideas about health or mental health concerns that we have not discussed?

11:40 AM Storytelling

- One member of each group takes 1.5 minutes to summarize what their table talked about

Thank you very much for all your thoughts, insights, and ideas. We greatly appreciate this. Before you leave, please take a moment to give us feedback by completing the evaluation form. Also, please don't forget to take home the health education materials that you may find helpful for yourselves or your loved ones.

Appendix D: Focus Group Facilitation Guide - Vietnamese Version

Mở đầu:

Xin chào quý vị. Chúng tôi mời mọi người đến tham gia buổi gặp mặt hôm nay vì chúng tôi quan tâm đến suy nghĩ, ý kiến, và kinh nghiệm của quý vị về đời sống tinh thần của mình. Những ý kiến và kinh nghiệm của quý vị sẽ giúp chúng tôi hiểu hơn về đời sống tinh thần của cộng đồng người Việt chúng ta và có thể giúp cải thiện đời sống tinh thần của cộng đồng mình. Quý vị có thắc mắc gì trước khi chúng ta bắt đầu không?

10:00 – 10:15 AM

Trước hết, hãy bàn về một vài điều nội quy. Xin cho chúng tôi biết nếu quý vị không đồng ý với bất kỳ điều nào hay muốn thêm, bớt, thay đổi điều nào.

1. Lắng nghe tất cả các ý kiến.
2. Mỗi lần chỉ có một người phát biểu.
3. Tất cả mọi người đều có cơ hội để phát biểu.

10:15 – 10:25 AM

Chúng ta sẽ bắt đầu bằng cách suy gẫm về ý nghĩa của sức khỏe đối với bản thân mình. **Khi quý vị nghe đến chữ sức khỏe, những gì hiện ra trong trí quý vị?**

- Suy gẫm riêng (3-5 phút). Nghĩ đến ý nghĩa của sức khỏe, viết ra trên giấy những ý tưởng, từ ngữ, hay cảm xúc liên quan đến sức khỏe tốt đối với quý vị. Quý vị có thể vẽ hay dán hình những ý tưởng, từ ngữ, hay suy nghĩ đó thay vì viết, nếu muốn.
- Hãy bỏ ra vài phút để chia sẻ những suy gẫm của quý vị.

10:25 – 10:40 AM

Bây giờ chúng ta quay qua đề tài đời sống tinh thần. **Khi nghe đến “đời sống tinh thần” quý vị liên tưởng đến gì? Quý vị thấy hình ảnh gì, có suy nghĩ gì, tâm tư gì khi nghe đến “đời sống tinh thần”?** (Quý vị có thể bỏ ra một phút để suy nghĩ, viết xuống cảm nghĩ của mình, hay diễn tả cảm nghĩ của mình bằng cách vẽ hình.)

Cám ơn mọi người đã bày tỏ cảm nghĩ của mình về đời sống tinh thần nói chung. **Vậy hình ảnh gì, suy nghĩ và cảm xúc gì đến với quý vị khi nghĩ đến đời sống tinh thần không tốt hay là yếu kém?**

10:40 – 11:00 AM

Theo ý kiến của quý vị, cộng đồng mình có những thử thách hay vấn đề trong đời sống tinh thần của chúng ta?

Theo quý vị, nguồn gốc của những thử thách về đời sống tinh thần của cộng đồng người Việt là từ đâu? (Hay, điều gì đã gây ra những vấn đề về sức khoẻ tinh thần của cộng đồng người Việt?)

- Theo quý vị, những kinh nghiệm của người tị nạn hay di dân có vai trò gì đối với đời sống tinh thần trong cộng đồng chúng ta?
- Còn yếu tố gì khác có thể ảnh hưởng đến đời sống tinh thần của cộng đồng mình?

Quý vị nghĩ đời sống tinh thần có ảnh hưởng gì đến cá nhân, gia đình, và cộng đồng chúng ta?

11:00 – 11:15 AM

Yếu tố gì khiến người Việt đến hay tránh gặp nhân viên y tế về vấn đề sức khoẻ tinh thần của mình?

- Theo quý vị, thành kiến xấu về bệnh tâm thần có vai trò gì trong việc người Việt chúng ta đến gặp nhân viên y tế để chăm sóc cho sức khoẻ tinh thần của mình?
- Theo quý vị, sự khác biệt về văn hoá, phong tục tập quán có vai trò gì trong việc người Việt chúng ta đến gặp nhân viên y tế để chăm sóc cho sức khoẻ tinh thần của mình?

11:15 – 11:25

Theo quý vị, cộng đồng người Việt có ưu điểm gì giúp chúng ta lớn mạnh?

Nếu cuộc đàm thoại không hướng về sức khoẻ hay đời sống tinh thần, hỏi câu sau: Điểm gì hay về văn hoá Việt và về cộng đồng người Việt giúp chúng ta có một đời sống tinh thần thoải mái?

- Quý vị có thể cho biết vài ví dụ của những cái hay trong văn hoá Việt hay trong cộng đồng chúng ta đã giúp chúng ta có sức khoẻ tinh thần và thể chất tốt?

11:25 AM

Cộng đồng chúng ta cần gì để tăng cường đời sống tinh thần của mình?

11:35 AM

Quý vị có những ý kiến hay suy nghĩ gì khác về sức khỏe và đời sống tinh thần mà chúng ta chưa bàn đến?

11:40 AM Kết luận bằng cách kể chuyện

- Mỗi bàn cử một người đại diện gút lại đại ý cuộc nói chuyện tại bàn họ trong vòng 1 phút rưỡi + thời gian để dịch lại.
- Mỗi phần trình bày sẽ bắt đầu bằng câu “*Ngày xưa ngày xưa...*”

Xin cảm ơn quý vị đã chia sẻ ý kiến, suy nghĩ, và cảm tưởng của mình. Chúng tôi rất biết ơn. Trước khi ra về xin bỏ chút thời gian để góp ý cho chúng tôi bằng cách điền vào mẫu đánh giá. Và cũng xin quý vị đừng quên cầm về những tài liệu về sức khỏe mà quý vị cảm thấy có ích cho mình hay người thân.

Appendix E: Semi-Structured Interview Guide - English Version

Introduction:

We have asked you to take part in this interview because we are interested in your thoughts, opinions, and experiences about mental health concerns in the Vietnamese community. The information that you provide may help us better understand the mental health of our community and better address mental health issues in the Vietnamese community. The interview will last one hour. We will audio record the conversation.

Your participation is voluntary and confidential. Your name will not be associated with your opinions. You may decline to answer any particular question. You can stop your participation at any time. We will collect some demographic information for statistical purposes.

There are no physical or legal risks for you to participate. However, the discussion may trigger unpleasant memories that you may have. Please only share what is comfortable for you. The back of this page has a list of resources available in case you need help for emotional wellbeing.

We appreciate your willingness to talk with us. Your participation in the project represents your consent to participate.

Do you have any questions before we get started?

Let's start the discussion by reflecting on what good health means generally. **When you hear of good health, what comes to mind? How would you define this?**

Thank you for that, now I would like to turn our conversation to mental health. **When you hear of mental health, what does that mean to you? What thought, feeling or image comes to mind for you?**

- **Probe:** Can you share with me how you would describe the phrase mental health in Vietnamese? What words would you use to describe mental health?

Thank you for sharing your thoughts on mental health. Now, **what thoughts, feelings, images come to mind when you think of mental distress?**

What would you say are some mental health issues or challenges for the Vietnamese community?

What do you think are some causes of mental health problems or distress in the Vietnamese community? (Or, what are some factors that contribute to mental health problems in our community?)

- Probe: From your experience and knowledge what role do experiences related to being a refugee or immigrant have on mental health in our community?
- Probe: What other factors that may impact the mental health of our community?

What impact do you think mental health problems have on individuals? On families? And on the Vietnamese community? *(Or, how do you think individuals, families, and the community are affected by mental health?)*

What are some factors that influence people to seek care or not seek care for their mental health problems?

- Probe: What role does stigma play in people seeking care?
- Probe: What role do language and cultural barriers play in people seeking care?
- Probe: What role does cultural belief play in influencing people's decision to seek or not seek care for mental health problems, do you think?

What are the community strengths that help us thrive?

(Probe if the conversation does not go in the direction of health or mental health): **What are some strengths and approaches in the Vietnamese culture and community that can help support good mental health?**

- Probe: Can you give some examples of how these approaches support good physical health or mental health?

What kinds of support does our community need to improve mental health?

Do you have any additional thoughts or ideas about health or mental health concerns that we have not discussed?

Thank you very much for all your thoughts, insights, and ideas. We greatly appreciate this.

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