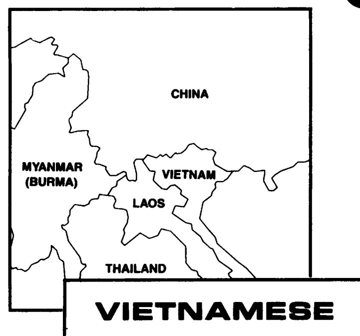
- Since 1975, over 700,000 Vietnamese have resettled in the United States
- Initial immigrants were an educated, wealthy elite; by 1978, a second wave of poorer refugees from a more mixed occupational, economic, and regional class were leaving Vietnam by boat



Cross-cultural Medicine
A Decade Later

Mental Health and Illness in Vietnamese Refugees

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Despite their impressive progress in adapting to American life, many Vietnamese still suffer from wartime experiences, culture shock, the loss of loved ones, and economic hardship. Although this trauma creates substantial mental health needs, culture, experience, and the complexity of the American resettlement system often block obtaining assistance. Vietnamese mental health needs are best understood in terms of the family unit, which is extended, collectivistic, and patriarchal. Many refugees suffer from broken family status. They also experience role reversals wherein the increased social and economic power of women and children (versus men and adults) disrupts the traditional family ethos. Finally, cultural conflicts often make communication between practitioners and clients difficult and obscure central issues in mental health treatment. Rather than treating symptoms alone, mental health workers should acknowledge the cultural, familial, and historical context of Vietnamese refugees.

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A recently arrived Vietnamese woman who believed she was taken over by a ghost was brought by family members to the Community Mental Health Agency. Our staff was unable to help her. After a period of time, she asked us to take her to a Buddhist Temple. We did. She was exorcised and prayed over. After that, she was fine.

In retrospect, we have many questions. What really happened? Is this an appropriate modality of treatment? Can we bridge between the client and an outside source of assistance or are we legitimizing a method of treatment that is totally unscientific but may work?

INCIDENT REPORTED BY MEDICAL SOCIAL WORKER IN SAN FRANCISCO, CALIFORNIA

More than 700,000 Vietnamese currently live in the United States. By century's end, they will be the third largest Asian-American group.[1] They are a socially diverse population whose members range from Western-educated professionals to rural peasants. 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 of and separation from loved ones, and economic hardship. As indicated in the epigraph, addressing these issues offers unique challenges for mental health professionals. In this article I outline the resettlement experience of Vietnamese refugees and describe their efforts to obtain mental health services in the United States.

Flight and Adjustment for Three Subgroups

The Vietnamese refugee population is made up of three distinct subgroups—the first-wave elite, the boat people, and the ethnic Chinese. These three groups share a common experience as refugees, with similar cultural values and frequent interaction, but they also retain many social and cultural differences and have developed fairly disparate patterns of adaptation to the United States. Accordingly, their mental health needs and ways of relating to professional helpers are frequently distinct.

The first group of Vietnamese refugees entered the United States between 1975 and 1977. As former US employees and members of the South Vietnamese military and government elite, many arrived with families intact. Their links to Western culture are indicated by their high levels of formal education and the fact that almost half were Catholic, even though more than 80% of all Vietnamese are Buddhists.[2,3] Drawing on their skills, education, competence in English, familiarity with Western culture, and extended families, many adjusted rapidly. By the mid-1980s, the Office of Refugee Resettlement reported that the average income of first-wave refugees matched that of the larger US population.[4]

The second wave of Vietnamese refugees—commonly called the boat people—began to enter the United States after the outbreak of the Vietnam-China conflict of 1978. Generally hailing from more plebeian origins and characterized by less education and lower levels of English competence than the first wave, these refugees lived for three or more years under Communism, sometimes laboring in re-education camps or remote "new economic zones" before leaving Vietnam. Their exit, involving clandestine escapes and open-sea voyages in leaky, overcrowded boats or long journeys on foot across revolution-torn Cambodia to Thailand, was subject to attack by pirates and military forces. Reportedly as many as half of those who attempted such an escape from Vietnam

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perished in flight. Those lucky enough to survive spent several months in the overcrowded refugee camps of Thailand, Malaysia, Indonesia, the Philippines, or Hong Kong before entering the United States.[5]

Owing to the dangers of escape, far more young men than women, children, or older people left Vietnam as boat people, yielding broken families and imbalanced sex ratios.[6] The boat people had more severe troubles in adapting economically than earlier arriving Vietnamese—including high levels of unemployment and welfare dependency (64%) and low rates of labor force participation (37%, more than 1½ times the national average). Thousands continue to live below the poverty level (Table 1).[7,8]

Within the second cohort of Vietnamese refugees, a sizable subpopulation exists. This group comprises members of Vietnam's ethnic Chinese minority, most of whom arrived after 1978 as boat people. Constituting an entrepreneurial class, these refugees frequently create Chinese-Vietnamese organizations and businesses in the United States. Because of ethnic differences and economic conflicts with the ethnic Vietnamese, relations between Chinese-Vietnamese and ethnic Vietnamese were often strained in the country of origin, and many of these conflicts continue in the US.[10,11]

TABLE 1.—*Characteristics of Vietnamese Refugees in the United States: First Wave and Boat People**

	Vietnamese Refugees	
Characteristic	First Wave (1975-1977)	Boat People (1978 and after)
Average years of education	9.5	7.05
No English on arrival, %	30.6	50
Age		
% <36 yr	30.6	58
% >56 yr	10	5
White collar occupation in Vietnam, %	78.7	49.2
1980 Household income		
<$9,000, %	27.6	61
>$21,000, %	31	4.6

*From Office of Refugee Resettlement[7] and Nguyen and Henkin.[9]

Because few Chinese-Vietnamese have a Western education, they seldom work as high-level professionals, such as resettlement workers or Western health care professionals. Many are practitioners of Chinese traditional medicine, however. The existing network of refugee professionals and agencies that provides services to the refugee community is staffed by the ethnic Vietnamese, a group that many Chinese-Vietnamese consider hostile, making them reluctant to use such services. Health care professionals need to be aware of such interethnic conflicts when dealing with clients and supervising refugee staff.[8,12,13]

Family Issues Among Recently Arrived Vietnamese

The traditional Vietnamese family is perhaps the most basic, enduring, and self-consciously acknowledged form of national culture among refugees. It is customarily a large, patriarchal, and extended unit including minor children, married sons, daughters-in-law, unmarried grown daughters, and grandchildren under the same roof. Individualism is discouraged, whereas collective obligations and decision making are emphasized.[3,14] The traditional family has been altered as a consequence of Western influence, urbanization, and the war-induced absence of men. Nevertheless, many Vietnamese continue to uphold this social form as the preferable basis of social organization in the United States.

Positive adaptation is often facilitated through family-based cooperation.[15-19] Because of wartime casualties and tenuous conditions of escape, however, many Vietnamese refugees must contend with broken families in the US. This, combined with cultural factors, such as the American emphasis on nuclear families, makes family adjustment traumatic for many Vietnamese. Prizing family connections, groups of recently arrived unattached male refugees create "pseudofamilies"—households made up of close and distant relatives and friends.[20] Sharing accommodations, finances, and fellowship, these collectives form an important source of social support in the refugee community. Although refugees find some comfort in household networks, their ability to establish regular families is often limited by poor economic status and the scarcity of Vietnamese women in the United States.[21,22]

Role Reversals

Vietnamese refugees of all subgroups have various degrees of reversal of the "provider" and "recipient" roles that existed among family members in Vietnam.[23] A common shift of roles occurs between husband and wife, with the wife taking on the breadwinner role and some of the status and power that accompany it. This is because women's jobs—hotel maid, sewing machine operator, and food service worker—are more readily available than the male-oriented unskilled occupations that the husband seeks. In other cases the wife becomes the breadwinner and supports the family by working in a menial job while the husband attempts to find professional employment. Finally, some women have to assume breadwinner roles because of the absence of a spouse in the US. Role changes also occur in families where both the husband and wife work because the wife was generally not employed outside the home before the family came to this country.

Role reversals between parents and children are also common because children often learn the English language and American customs rapidly and may be able to find employment more quickly than older members of the family. Such role reversals often yield generational conflicts within refugee families in which the traditional culture is collectivistic and emphasizes the deferential treatment of elders, whereas American society is individualistic and youth oriented.[24] For young refugees, the pressure to conform simultaneously to American and Vietnamese cultures—which are in many ways incompatible—is a major source of strain.

Since the late 1980s, thousands of survivors of re-education camps, mostly former government and military officials and nearly all ethnic Vietnamese men, have been permitted to leave Vietnam and join their families who are already well established in the United States. These families are especially susceptible to traumatic role reversals and other family troubles because of the long period of separation. Further, although the husband may wish to retake his role as breadwinner and patriarch, he is ill-equipped to accomplish this task because he is unaccustomed to American society and must overcome the effects of years of incarceration.[25]

The process by which women or children rather than men become the primary source of refugee family income indicates the adaptability of Vietnamese families. At the same

time, however, the inversion of traditional family roles often provokes hostility and resentment. Social workers with refugee clients comment that self-destructive, violent, psychosomatic, or antisocial reactions—such as wife or child abuse, depression, or alcoholism—occur as a result of family role reversals.[26-29] Role reversals are especially traumatic for the Chinese-Vietnamese because they often maintain more traditional family patterns than the ethnic Vietnamese.[30]

Media reports and academic research reveal—and often overemphasize—the bipolar adaptation of Vietnamese youth. One group, most often children of first-wave refugees, are "academic superstars," graduating first in their class at many top schools and colleges including the US Naval Academy.[19,29] At the other end of the social spectrum is the involvement of Vietnamese youth in various criminal and gang activities, which are often directed toward other Asian immigrants.[31] Although these two groups illustrate the diversity of Vietnamese adaptation, most refugee youth fall somewhere between the sensationalized polarities of superachiever and delinquent.

Refugee Resettlement System

Vietnamese refugees in the United States must weave through a complex maze of agencies to address the social, economic, and adjustment problems they experience. In so doing they find that their indigenous approaches to problem solving, authority relations, and helping relationships are different from the outlooks maintained by the institutions and staff of the resettlement system.[32,33]

Resettlement and refugee-aid services are delivered and administered by a diverse network of government, religious, nonprofit, and profit-making agencies and organizations. For example, in 1983, there were over 40 agencies resettling Vietnamese refugees in San Francisco alone, with 15 or more in surrounding counties.[34] The large number of resettlement agencies providing service to Vietnamese refugees was inefficient in terms of coordination and allocation of funding and sometimes created interagency competition and hostility.[35-37]

A major role in the resettlement of refugees is carried out by 13 voluntary agencies funded by the federal government.[38] These agencies are decentralized, often overlapping, have few professional staff, and are subject to severe fiscal problems. They generally provide only short-term and survival-type aid. Because most are directed specifically toward the problems of Southeast Asian refugees, few existed before 1975. Further, after the peak of migration in the early 1980s, many agencies had heavy cutbacks in staff and funding or were phased out altogether.

Refugees have a hard time locating agencies that are capable of helping them. A Washington State study revealed that between 50% and 70% of refugees did not know how to obtain vital services such as legal help, free emergency medical care, English classes, free emergency food, or low-income housing that were available to them.[39] Refugees who do use services tend to be among the elite of the community—the 1975 cohort.[40] Refugee clients generally find word-of-mouth referrals from trusted peers to be the most useful source of information about helping agencies.

Interactions With Treatment Staff

Interactions with agency staff and helping professionals frequently take place in an environment of distorted communication and cultural incompatibility.[41] These misunderstandings become painfully apparent when refugees seek mental health assistance. Health assessments show that refugees suffer from various mental health problems that are far more severe than those of voluntary immigrants and the native born.[42] Those most frequently reported are major depressive disorders, schizophrenia, and anxiety and other neurotic conditions.[24,43-45] Vietnamese refugees also suffer from medical problems. Consequently, federal, state, and local governments have funded a number of mental health programs for this population.[46,47]

Unfortunately, most Vietnamese lack the cultural prerequisites of a successful American-style therapy interaction, such as a willingness to confide, a belief in the unconscious, and the ability to criticize parents openly. They have limited familiarity with the treatment of chronic health problems and regard Western medication with a combination of awe and fear. There is no equivalent word in the Vietnamese language for the term "counselor." Mental health problems are so highly stigmatized by the Vietnamese that it is difficult even to discuss these issues without provoking feelings of shame. For example, even highly educated long-established refugees use the terms "mental health" and "mental illness" interchangeably.[48] Most refugees do not see a connection between the process of therapy and the problems that for them are most pressing.[49,50] According to Kinzie, "Many Southeast Asians have an unwillingness or an inability to differentiate between psychological, physiological, and supernatural causes of illness."[43(p116)]

Finally, because of their experience as refugees, Vietnamese do not easily trust authority figures, including treatment staff. Accordingly, refugees often avoid seeking help until the situation is intolerable, and when they do, cooperative relations between helpers and clients are extremely difficult to establish. A Vietnam-born American-educated director of a refugee mental health program described his relations with clients as follows: "For an average Vietnamese, mental health would immediately mean that the person is crazy, acting crazy, saying crazy things."

As a consequence of refugees' difficulties in gaining access to helping agencies and because of their general reluctance to contact professionals to resolve mental health problems, few Vietnamese clients voluntarily seek mental health assistance. Most are referred to service providers by schools, the criminal justice system, and other agencies. Those who willingly seek professional help have often reached a level of desperation. Self-referred clients are generally one of two types. The first type contacts the agency not because of emotional problems but because of practical difficulties, which are often financial in nature—lack of basic necessities such as food, housing, a job, and child care—and the client has no other resource. This type of client comes to the agency out of desperation. Survival problems have become more common recently because of bad economic times and cutbacks in social service programs. Because of confusion in culture and communication, however, discovering the fact that clients' needs, however serious, are rooted in environmental rather than psychiatric difficulties often takes considerable time and effort, even with Vietnamese-speaking staff.

The second category of self-referred clients are those who are having acute mental health difficulties that family members or the affected person can no longer manage. As Muecke has noted,

Disturbed persons are usually harbored within their family unless they become destructive, at which point they may be admitted to hospital . . . or otherwise restrained, but at the great cost of bringing shame to the family.[51(p34)]

Through mutual misunderstandings, helping professionals and refugee clients often unwittingly engage in a "conspiracy of silence" that prevents direct confrontation of the problems at hand. This is further exacerbated by both parties' attempts to avoid embarrassment. Treatment staff resist asking specific questions about mental health problems, and refugees fail to volunteer relevant information. After finally identifying the source of a problem, a physician will state, "Why didn't you tell me?" to which the patient replies, "You didn't ask me."

Practical Suggestions for Clinicians

Practitioners familiar with Vietnamese clients recommend a variety of strategies for addressing the problems of Vietnamese refugee clients. The most general theme might be called a global approach. To untangle the nature of the clients' problems, clinicians need to know about their personal histories, including life in Vietnam, the experience of flight, stay in the refugee camp, and the nature of their current circumstances in the US, such as family, job, and health status.[43,48,52,53] Because refugees may suffer from physical health problems and frequently somatize mental health issues, treatment staff should have access to clients' medical evaluations.[43]

Because refugees are embarrassed by mental health concerns, practitioners should approach such matters in a straightforward manner. This can be fostered by obtaining background information about patients. When mentioned strategically, such information encourages clients to abandon their efforts to maintain a false front that "everything is okay."[45] For similar reasons treatment staff are encouraged to ask their patients direct and specific questions about symptoms. The general question, "How do you feel?" as asked by American physicians is all but meaningless to Vietnamese patients. Instead, the question should be, "How do you hurt?" or "Where does it hurt?"

Treatment staff need to be able to distinguish between mental health problems shaped by culture and those caused by life experiences. For example, although culturally sensitive mental health workers often assume that Vietnamese patients suffer from depression, passivity, interpersonal problems, somatization, and unemployment because of culture shock and the effects of "the Asian worldview," these symptoms may actually have their origins in war-induced posttraumatic stress disorder, a syndrome common to American Vietnam veterans.[52]

As refugees, many Vietnamese have adopted a survival-oriented approach to life. They are more likely to perceive physical symptoms and concrete needs as crucial sources of difficulty. Emotional or psychological problems are seen as less serious or immediate. Although this often serves as an obstacle to treatment, it is also a possible source of strength. Helpers are encouraged to remind refugee clients of their abilities used to overcome past personal challenges and to rely on these coping abilities to resolve contemporary concerns. Selective inclusion of past experiences is also suggested as an important element in therapy so that clients do not ignore traumatic experiences, dwell excessively on painful incidents, or long nostalgically for an idealized past.[28,54]

As a means of dealing with the stigma of mental health problems, Vietnamese refugees often indicate their symptoms by referring to physical problems. In helping refugees deal with physical and concrete matters, however, treatment staff can establish the trusting relations that are essential for addressing submerged psychological issues. Further, although Vietnamese are unfamiliar with the role of a mental health counselor or psychotherapist, their cultural experience is compatible with that of the physician-patient relationship and sick role. Hence, psychiatrists are encouraged to consider prescribing medication to relieve symptoms. Accustomed to traditional Asian herbal medicine, refugees endow Western medications with mythic power. Such treatments impress refugees, but care providers nevertheless report noncompliance, with clients reducing or forgoing doses because of the cessation of symptoms, the occurrence of side effects, or the advice of family members. Blood tests are warranted to assess patient compliance.[43]

In helping refugees deal with adapting to the American culture, the bicultural approach is generally most appropriate. Refugees who have connections with indigenous traditions and coethnic communities as well as the cultural and linguistic skills required for interacting with the larger society appear to achieve the highest levels of economic progress and emotional well-being.[30,55,56]

Finally, because of the central role of the family in Vietnamese life, health workers should understand that they are not only treating a person, but are also indirectly interacting with a group of kin. Treatment staff are advised to enlist the cooperation and trust of the family unit to avoid competitive relations with relatives that may become an obstacle to effective treatment. Because of patients' extensive involvement with their families, mental health professionals need to practice discretion rather than confidentiality in their interactions with family members.[48]

Conclusions

Vietnamese are a socially diverse group. Although their traumatic flight from home and resettlement in the United States often result in substantial mental health needs, their culture and experience make them wary of interactions with mental health workers.

To interact effectively with Vietnamese refugees, mental health workers need to approach them in a holistic manner—understanding that their needs are shaped by their experience as refugees, their economic status, and their unique familial and cultural background. Treatment staff are likely to achieve more satisfactory results if they relate to Vietnamese clients in terms of this complex than if they attempt to treat isolated symptoms.

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