Operationalizing Culture: Refugees, Migration, and Mental Health in the Wake of the Vietnam War

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Operationalizing Culture: Refugees, Migration, and Mental Health in the Wake of the Vietnam War

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ABSTRACT

The end of the Vietnam War led to the migration of hundreds of thousands of Vietnamese refugees to the United States after political and economic upheaval. As another result, the refugees’ years of warfare, trauma, death, and injury began to manifest as unprecedented mental health issues that American physicians and researchers sought to understand. In this paper, I argue that American medical professionals—in good faith—operationalized [Vietnamese] culture to help themselves and their colleagues understand the mental health issues of Vietnamese refugees. Yet this operationalization acted as a double-edged sword. Viewing Western mental health discourse through the lens of Vietnamese culture aimed to help experts better understand Vietnamese refugees’ perceptions. But it also acted as a means to exclude, ostracize, and ultimately define the refugee population as the “other.” Through this inclusion of culture as a player in medical and mental health intervention, the psychological treatment of Vietnamese refugees demonstrates a longstanding tension that surrounds the role of culture, tradition, and ethnicity in public health work.

INTRODUCTION

Public health interventionists have struggled to evaluate the role that culture plays in the distribution and evaluation of healthcare services for decades. More often than not, a population’s culture has served as a way to stereotype and define the group as the atypical “other.” This is particularly relevant for vulnerable minority populations. For example, “Puerto Rican syndrome” (otherwise known as ataque nervios or a general, sudden onset of emotional distress) was coined in the latter half of the 20th century, inspired by the increasing Hispanic population in the United States. Patricia Gherovici’s aptly-named historical analysis The Puerto Rican Syndrome argues that the establishment of such a definition obstructed and obliterated Hispanic patients’ personal experiences and cultural references; “Puerto Rican syndrome” and thus Hispanic culture became a way to essentialize differences in terms of nationality and race (Gherovici, 2003). In a similar framework, I wish to examine the role that Vietnamese culture played in [the language of] healthcare in relation to incoming Vietnamese refugees to the United States after the Vietnam War. As these refugees sought political and economic haven after the fall of Saigon in April 1975, the need arose for mental health counseling to address the refugee-related trauma these immigrants experienced, not only in Vietnam but also during their journey to the States. This novel type of treatment demanded a working knowledge and incorporation of Vietnamese culture and tradition into the Western medical dialogue surrounding mental health in hopes of better understanding and treating depression, anxiety, and post-traumatic stress disorders (PTSD)—common conditions with which these refugees struggled. In this paper, I argue that American mental health professionals and researchers operationalized Vietnamese culture in good faith when discussing mental health treatment. I define “operationalizing” culture as applying Vietnamese culture to and viewing it through the lens of Western ideals. Throughout this work, I have framed operationalization as a double-edged sword: On one hand, this application of Vietnamese culture aimed to assist experts in better empathizing and understanding mental illness in Vietnamese refugees. Yet simultaneously, it excluded, ostracized, and ultimately defined the refugee population as the “other,” the atypical. Through this inclusion of a “non-Western” culture into a larger discussion of Western mental health intervention, the psychological treatment of Vietnamese refugees demonstrates a lasting tension that surrounds the role of culture, tradition, and ethnicity in public health work.

1 Before employing the term “culture” throughout my paper, I have defined this term as the collective of customs, traditions, attitudes, beliefs, and nature of interpersonal interactions of a given population. In this case I am considering native Vietnamese culture, and not Vietnamese-American culture, which is still unfolding today.
historical tension surrounding the roles that culture, tradition, and ethnicity play in public health work.

I divide my research into four sections: First, I situate Vietnamese refugees within the context of the chaos of the Vietnam War during the mid-20th century. This lays the foundation to, secondly, discuss the development of mental health programs and clinical research concerning the mental health status of incoming refugees. The next two sections describe the duality of operationalizing culture. I discuss both the progress and pitfalls of mental health professionals, physicians, and researchers while utilizing [Vietnamese] culture in their understanding of mental illness in this specific population. Through this work, I reveal the complexities of effectively incorporating culture into treating populations that may not share a “typical American” background, socioeconomic status, or language. Lastly, I briefly touch upon the present—what the mental health landscape looks like today for the former Vietnamese refugees, the first-generation Vietnamese Americans. Finally, as a daughter of two Vietnamese refugees, alongside academic contributions, I acknowledge that this work has fostered a more intimate and nuanced connection to my ethnic and family history.

WAR, POLITICS, AND MIGRATION: THE JOURNEY TO AMERICA

American interference in Southeast Asian countries, particularly during the Vietnam War, led to the abrupt emergence of Vietnamese immigrants in the United States. The War laid its foundation starting with the French colonization of Vietnam in the mid-19th century. Decades later, the occupying French army was defeated by Ho Chi Minh—a Communist revolutionary leader—and his Viet Minh Front army. This resulted in Vietnamese independence from French Indochina and the formation of two distinct Vietnamese countries: the [Northern] Democratic Republic of Vietnam, led by Ho Chi Minh himself, and the [Southern] Republic of Vietnam led by Ngo Dinh Diem, a prominent Vietnamese politician (“Vietnam War,” 2009). While the Democratic Republic of Vietnam incorporated and enforced a Communist government, the United States wished to quell and contain any instances of international Communism. This led to the States supporting Diem’s Anti-Communist ideals: The United States wished to stifle the potential expansion of Communism to neighboring Southeast Asian countries (Zhou & Bankston III, 2000).

For decades, United States presidents sent military personnel, advisors, wartime weapons, and other resources to assist the Southern Vietnamese government. Yet due to religious factioning and Diem’s inability to unite South Vietnam forces into an organized front, the Viet Cong (i.e. the National Liberation Front, a group of political insurgents and guerrilla fighters) formed, internally opposing the South Vietnamese government. The Viet Cong weakened, and ultimately overthrew, Diem in 1963, prompting then president Lyndon B. Johnson to send more ground troops in 1965 to avoid the complete collapse of the Southern Republic. But after a series of devastating attacks on South Vietnamese cities and towns (known as the Tet Offensive) in 1968, the United States withdrew American troops in 1973. Unable to defend itself, the South Vietnamese government submitted to the Northern Democratic Republic and relinquished its capital, Saigon, in late April 1975. Surrounding the days before the fall of Saigon, Vietnamese refugees were already beginning to organize their evacuation plans. Vietnamese refugee migration was divided into two periods, each with distinct “waves” of refugees arriving, each varying in background, socioeconomic status, and mode of transportation. Period One began in April 1975 and continued throughout 1977; Period Two began in 1978 and continued through the 1980s. Period One consisted of three primary waves of refugees; their evacuation was made possible by the American enactment of “Operation Frequent Wind,” the assisted departure of the most at-risk Vietnamese from the American and Vietnamese military base in Saigon via helicopters and navy vessels (“Operation Frequent Wind: April 29–30, 1975,” 2010). In both of these waves, Vietnamese individuals were relatively well-educated, spoke some English, and came from metropolitan areas. While some could purchase their way out of the country, many were also affiliated or worked with the United States government and military or the South Vietnamese government. These were the populations most vulnerable for capture and “re-education” by the North Vietnamese government.

Though warfare had ceased, reconstruction in Vietnam was precarious with many oppressive, socioeconomic reforms instituted by the Northern Communist leaders. Thus, Vietnam’s dismal state created the second period of refugee migration. Between 700 to 800 thousand

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2 The day when the Southern capital was overthrown, April 30, 1975, is formally known as “the fall of Saigon.”
Vietnamese refugees, known as the “boat people,” sought to escape their country’s economic and political turmoil via hand-made, weakly-constructed boats and vessels starting in 1978. Many of these boats were simply-crafted fishing boats, meant for only two to three people at one time; instead, these vessels often had more than fifteen, even twenty, refugees at a time. These refugees floated at sea aimlessly for days—even weeks—without adequate food, water, protection, or navigation. Given the lack of appropriate provisions, the journey was very deadly: sea pirates often plundered the ships, murdering passengers and enslaving and sexually assaulting women and children; deceased bodies of family members, children, and adults alike, were thrown off of the side of boats if they had died from dehydration or starvation (Do, 1996). Many of these refugees waited for foreign ships to notice their plight or waited until they washed up on the shores of nearby Southeast Asian countries asking for refugee. Given the incredible danger of mass boat departures from between 1978 to 1979, the Orderly Departure Program (ODP) was established between the Socialist Republic of Vietnam and the United Nations High Commission for Refugees in 1979 to establish an international effort with more than forty countries ready to receive these refugees (International Catholic Migration Commission). This program lasted until 1997. Though many of these refugees would first have to stop in a refugee processing center in the Philippines or Thailand, other countries such as the United States, Canada, Australia, France, and Germany would become their permanent homes. I limit the scope of this research to the work done in the United States, though other countries may have invested in similar efforts as well.

VIETNAMESE MENTAL HEALTH AND TREATMENT DEVELOPMENT

Vietnamese refugees began to resettle at the refugee camps crafted out of existing military base camps, such as Camp Pendleton in California and Fort Chaffee in Arkansas. Though emergency medical services and immediate physical needs were prioritized (e.g. treatment for infectious diseases such as tuberculosis or malaria, warm clothing, food, water, and shelter), mental health services gradually became more well-known and made more available, particularly at Camp Pendleton (see page 9). Psychiatrists, mental health workers, and other professionals hypothesized that these illnesses were the result of many traumatic life events in a relatively short period: many refugees experienced the death and/or abandonment of loved ones and family members, the abandonment of their home town, region, and country, the abandonment of familiar traditions, customs, food, and clothing (International Catholic Migration Commission). Many refugees also experienced homesickness, loneliness, and a general disconnect from the unfamiliar people and the foreign environment around them. It also did not help that, overall, Vietnamese culture treated any form of mental illness as very taboo. “Emotional disturbances” could not be shared with others outside of the family household including medical professionals: mental deviations often had spiritual or religious solutions to excise maddening spirits or ghosts (Schultz, 1982). Mental illnesses were also often somatized—appearing as fixable, more-accepted physical ailments (i.e. persistent feelings of malaise would be attributed to a “weak nervous system” or a “weak kidney” instead of a neurochemical or psychological cause) (Muecke, 1983). This psycho-somatization was also referred to as “refugee syndrome” in the 1985 book “Cross Cultural Caring: A Handbook for Health Care Professionals in Hawaii,” published by the School of Medicine in Honolulu, Hawaii. Though not necessarily recognized by the Vietnamese refugees themselves, many American/Western medical professionals noted that this “syndrome” was distinctive among the Indochinese refugees as well as Cuban refugees who relocated to the US mainland several decades before (Palafox & Warren, 1980).

Met with these differences, there was an increase in research to discover the most effective and meaningful means of mental health care for this population. For instance, as refugees relocated into the greater Seattle area, two local community service agencies, the Employment Opportunity Center (EOC) and the Asian Counseling and Referral Services (ACRS) proposed a program called Project Pioneer (Lin, Tazuma, & Masuda, 1979). This program not only offered English courses and counseling to “ease [the] transition of the Vietnamese into American life and helping them find employment,” but also distributed clinical questionnaires to document the physical and mental health status of refugees in the “different stages of adaptation” (Lin et al., 1979). Dr. J.D. Kenzie of the Oregon Health

1I note here that though all Vietnamese refugees experienced the isolation and unfamiliarity, those who struggled the most with traumatic events such as death, disease, starvation were the “boat people”—refugees from the second period of mass migration. I provide an example in the next section of how the initial period refugees often assisted latter waves of refugees in mental health treatments.
Science University Clinic and the founder of the Indochinese gradually developed the Vietnamese Depression Scale to gauge clinical depression in refugees in a linguistically compatible way. And though there is very little feedback on how well these surveys conveyed language, emotion, and familiarity, common treatments for mental illnesses often included therapy and counseling. Oftentimes, refugees would meet with a counselor and/or mental health professional along with a translator; more uniquely, some clinics also offered group therapy in a way that shifted the focus of the session on achieving distinct goals (i.e. self-reflecting, learning English greetings and conversational phrases, socializing with others) rather than strictly changing mental states or emotions (Kinzie et al., 1988). In tandem, practitioners also prescribed psychotropic medication as needed.

I note that the focus of this work is not necessarily to discuss the detailed inner-workings of the mental health treatments and assessments; it is to examine the discourse amongst experts of health and wellness and how those experts operationalized Vietnamese culture in their conclusions regarding Vietnamese refugees and their health. But providing this context is crucial to understanding what was available at the time. These treatments were, and are, not considered perfect, but instead continuously developing.

CULTIVATING CULTURAL EMPATHY AND UNDERSTANDING

The flux of Vietnamese refugees entering the United States naturally produced mixed reactions from American citizens. Some expressed sympathy while others expressed disdain for their new neighbors. Americans attributed these reactions to cultural difference: these refugees simply did not know the typical ways of American life. Los Angeles Times writer Tracy Wood demonstrated the variety of reactions toward the refugees in context of the “Great Santa Ana Squid Stink”:

Following their own customs, the Vietnamese hung the catch [of squid] out to dry—on every available foot of fence in their Santa Ana neighborhood… Americans with some knowledge of Vietnamese customs acted quickly, telling the Vietnamese ‘you just don’t do that here…” To one policeman it proved what he had known all along: Vietnamese are dirty, different, and don’t belong here… To another police officer on the same force, the incident was a humorous but unfortunately cultural lapse…(Wood, 1978)

To some American citizens, events like that reaffirmed their prejudices against Vietnamese folks. To others, this incident was a mistake, something that could be adjusted through education of American customs. Throughout her article, Wood demonstrates the tension that surrounded the Vietnamese reputation: one of praise for the (primarily economic) adjustments that the Vietnamese population had made, yet one of scorn for the cultural and social progress that was yet to be made. While the average American citizen struggled with their sentiments toward Vietnamese culture, in this section, I argue that culture was operationalized with good intentions and with partial success by American mental health professionals in their mental health care interventions and discourse. These professionals utilized culture (and cultural experts) to assist in better understanding and sympathizing with the refugees and their traumatic experiences. The incorporation of Vietnamese culture also made these professionals more sensitive to the inadequacies of pre-existing “American” mental health treatment. This sensitivity helped to promote efforts to appropriately adjust such treatment.

One way that mental health professionals demonstrated this discretion was by encouraging the employment of Vietnamese counselors, therapists, and social workers—those who were often refugees from the very first waves of migration. For example, the psychological research of Jacquelyn Flaskerud and Nguyen Thi Anh determined the mental health status of Vietnamese refugees at two Los Angeles County mental health centers. These researchers then drew their conclusions based on records of psychiatric patients treated at the center and interviews conducted with choice “informants” such as clinical or administrative personnel who worked intimately with refugees regularly. Flaskerud and Nguyen concluded that the primary aspect of services that were “given priority by the informants included culturally relevant mental health counseling…,” that there was a need for “bicultural, bilingual mental health workers or cultural and language interpreters” (Flaskerud & Anh, 1988). The authors demonstrated professionals actively acknowledged the inadequacies of the American mental health treatment at the time. Besides identifying other issues that refugees faced such as the need for financial assistance for housing or the need for more vocational training, these informants ultimately identified the need for more individualized treatment for the refugee population. They wanted to make care more effective. These
demands came to fruition with the active and conscious inclusion of Vietnamese authority figures; there was gradual incorporation of Vietnamese professionals into healthcare leadership positions. These professionals were allowed to speak and contribute to the dialogue surrounding mental health, especially in newspaper publications. Writers of The Washington Post Ronald D. White and Jane Freundel included the voice of Dr. Tran Minh Tung, a psychiatrist at the George Washington United Medical Center. Dr. Tung commented on the attitude toward mental health care in Vietnamese culture:

“Our [Vietnamese] culture has taught us to avoid our emotions, to look upon psychological need as a weakness. Yet the emotions must be released. There is no equivalent to the psychiatrist or the psychologist in Indochinese society... the face that it is considered a weakness for a person to seek emotional help, they have a tendency to hold it all inside.” (Freundel, 1979)

Readers were also able to hear the expertise of non-physician Vietnamese voices, such as Jackie Bong Wright, a mental health paraprofessional and former refugee. Wright commented on the migration and the resulting “culture shock” experienced by Vietnamese refugees: “The first wave of refugees in 1975 had worked closely with Americans and spoke fluent English. They could more easily adapt to American life. But that has changed. These [refugees] speak no English, have ever seen a toilet or a street light. The culture shock is amazing” (Freundel, 1979). Wright was able to use her experiences to hold weekly support groups with other Indochinese paraprofessionals for incoming refugees dealing with newly-formed trauma in the Washington D.C. and Virginia areas. Finally, the distribution of power was present even in the leadership positions of mental health services, particularly in Camp Pendleton with the establishment of the “Crisis Clinic” in June 1975. This clinic accommodated psychiatric emergencies. The Pendleton administration decided to make the head of the clinic a Vietnamese physician that had served as the head of the Department of Psychological Medicine at Minh Duc Medical School in Saigon, Vietnam (Richard & Rahe, 1978). The administration offered to sponsor this physician to carry on with his clinical work even after the camp was disbanded. Regrettably, the physician’s name was not mentioned. Through these three examples of inclusion, the presence of Vietnamese authority in academic discourse as a public fact, enough for not only for other professionals but for the broader communities that viewed such media coverage.

Another way that the mental health care community incorporated Vietnamese culture in a meaningful and impactful way was through the active acknowledgment and respect of Vietnamese customs and ethnic tradition in academic literature. This was revealed in Imogene C. Brower’s journal article “Counseling Vietnamese,” an analysis of the relationship between the certain cultural behaviors of Vietnamese refugees and their effects on the relationship between these refugees and their counselors. Brower pointedly called for more discretion and sensitivity from mental health professionals, asking counselors to “check their personal feelings about [their] clients, particularly because of the residues of strong and deeply divided emotions that the United States involvement in the Vietnam War created in American public opinion,” where emotions have ranged from “contempt and antagonism to guilt and deep sympathy” (Brower, 1980). Brower emphasized the importance of keeping personal emotions at bay to ensure that the focus was on building the counselor-patient relationship. To achieve a successful counselor-patient relationship, Brower predicted that mental health counseling and therapy would need to be more relatable to Vietnamese clientele. By focusing on topics such as the proper structure and pronunciation of a Vietnamese name, potential communication barriers, and the hierarchal framework of a Vietnamese family,
Brower actively encouraged anyone that interacted with Vietnamese refugees to be more aware, sensitive, and respectful toward these differences.

THE “OTHER:” VIETNAMESE REFUGEES, AMERICAN STANDARDS

Despite the well-meaning intentions and progress toward the respectful and productive discussion and utilization of Vietnamese culture, culture has also been operationalized in ways that have ultimately disadvantaged the refugee population. Incorporating Vietnamese culture into mental health treatment has also excluded refugees from American society. One of the ways that culture was operationalized to “other” Vietnamese refugees was through the construction of culture as a tool to establish hierarchy and as a marker of societal success or failure: Vietnamese culture was ultimately considered inferior to American culture. If Vietnamese refugees embraced and embodied American culture, they would have completed a successful transition, and if they did not, they were considered outcasts, unsuccessful, and unwelcome. Vietnamese psychotherapist Kim Danh Cook commented on the adjustment process in a newspaper article published in The Washington Post: “There’s a certain level of cultural adjustment disorder that is sometimes so severe [that the patients] are being mislabeled as paranoid or schizophrenic” (Murphy, 1985).

This comment was problematic in multiple ways, but firstly, in the way that Cook labeled the struggle to adapt to an entirely new environment a “disorder.” By calling an inherently difficult and stressful refugee experience a “disorder,” Cook pathologized Vietnamese culture as something inherently disadvantageous to success in an American lifestyle. Vietnamese culture was an obstacle that needed to be overcome. By describing the way that other mental health professionals labeled this experience of adjustment in terms of paranoia and schizophrenia, Cook revealed how many mental health professionals, despite their expertise, were still ill-prepared to deal with the experiences of a Vietnamese refugee. Although refugees did have difficulties adjusting to new environments, new foods, and new practices, their experiences may not have always warranted a mental health diagnosis; mental health professionals pathologized struggle.

This concept was further demonstrated in the research study performed by Lin et al, “Adaptational Problems of Vietnamese Refugees,” where the Cornell Medical Index (CMI) was employed to gauge Vietnamese refugee mental health status. “Successful adaptation” was defined in their analysis: “Success in adapting to a new environment invariably involves losing old attachments and gaining new identities” (Lin et al., 1979). One can presume that in this context, the “old attachment” was Vietnamese culture, while the “new identity” to be embodied was a primarily “American” identity. This publication propagated the concept of a cultural hierarchy, where success was gauged on “how American” a refugee could be. There was no comprehensible compromise between the two cultures to achieve this success, as one was inevitably more acceptable than the other in this case.

Despite her recommendations for cultural sensitivity in the previous segment, Imogen Brower also contributed to this cultural dichotomy in “Counseling Vietnamese” by recommending that counselors “instruct the student in acceptable and unacceptable American social behavior, because adhering to social expectations enhanced acceptance and adjustment” (Brower, 1980). Given this context, it is reasonable to assume that Brower meant “Vietnamese behaviors,” in particular, were considered “unacceptable American social behavior.” Brower may have been correct in saying that if Vietnamese refugees adhered to “American social behavior,” they would be more accepted by their neighboring American citizens. Yet by making that recommendation, she ultimately endorsed the adherence to American culture as the only gateway to societal success. Again, there was no compromise possible between these two sets of behaviors.

“Yet by making that recommendation, she ultimately endorsed the adherence to American culture as the only gateway to societal success.”
Culture was operationalized in a way that fostered not only social segregation but also geographical segregation between Vietnamese refugees and American citizens; this was contrary to the sentiments of integration and acculturation that were emphasized at the time. This segregation arose from the plans made soon after the fall of Saigon in 1975 to reorganize and relocate refugees to various parts of the United States. Volunteer agencies (known as VOLAGs) were private charitable organizations under contract to the United States government responsible for creating small concentrations of Vietnamese refugees throughout the country; VOLAG officials believed that refugees would fare better if they had a smaller social network for mutual support and assistance (Zhou & Bankston III, 2000). According to Zhou and Bankston in “The Experience of Vietnamese Refugee Children in the U.S.,” “scattering Southeast Asian refugees around the country to minimize the impact of resettlement on local communities was an initial policy goal” of these volunteer agencies (Zhou & Bankston III, 2000). There was hesitation to disrupt local American communities with the relocation of these refugees: American citizens’ comfort seemed to be prioritized over the refugees’ integration. These refugees already struggled with a lack of familial support, a lack of an extensive social network, and a lack of general resources, whether those resources were economic, nutritional, emotional, or education. Lin et al. described these clusters of Vietnamese refugees as “forming conspicuous segments in metropolitan areas [that required] special consideration” (Lin et al., 1979). The description of these refugee populations as “conspicuous” conveyed a punitive connotation. These Vietnamese populations unacceptably stood out like a sore thumb from the typical American landscape and demographic. If Vietnamese refugees had adjusted to the American environment sooner or more seamlessly, they would no longer be considered “conspicuous” compared to their American neighbors, which would thus, negate any need for “special consideration” or efforts to acclimatize.

A NOTE ON TODAY AND CONCLUSION

More than 45 years have passed since the arrival of the very first wave of Vietnamese refugees to the United States; those who were once considered refugees are now considered first-generation Vietnamese Americans. They have given rise to the second and even third generations of Vietnamese Americans. Though much has changed and progressed in terms of mental health advocacy in the 21st century, mental health issues continue to afflict first-generation [elderly] Vietnamese Americans. The Vietnam War and its traumatic effects continue to play a role in the lives of this population. According to a 2008 study conducted by the UC Irvine Center for Health Care Policy, these former refugees continue to suffer from higher rates of mental health problems (Tran, 2008). Psychiatrist Dr. Quyen Ngo-Metzger of the Center, who served as the principal investigator of the survey, stresses, “The message I want to bring across is that the medical community needs to realize that Vietnamese Americans are a high-risk group. I hope people realize that mental health is still a problem and not to view all Vietnamese as doing really great” (Tran, 2008). Coupled with the fact that 90% of Vietnamese American seniors have limited English proficiency and that 40% of Vietnamese American households are linguistically isolated (i.e. do not speak English or speak very sparse English), there exist barriers that prevent those from receiving the care that they need (Kandil, 2020). Though, again, discussion regarding the efficacy of the “culturally-considerate” mental health treatments is outside of the scope of this research, we can understand that the initial operationalization of Vietnamese culture into mental health discourse has not been the most effective nor long-standing decades after its genesis. Work is still being done for this population to this day by Vietnamese Americans.

In conclusion, I showed that culture was operationalized by mental health professionals with well-meaning intentions: by considering Vietnamese culture when researching the mental health needs and status of Vietnamese refugees, health care providers operationalized culture as a means of mobilizing Vietnamese leadership and fostering sensitivity to better understand and treat Vietnamese patients. Despite this progress, culture was also operationalized in a way that disadvantaged, excluded, isolated, and defined Vietnamese refugees as the “other.” This particular study of the mental health treatment of Vietnamese refugees demonstrated that incorporating culture into health care and public health intervention and discourse was and still is difficult. There is progress still to be made to operationalize culture in a way that does not outcast one population from another.

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4 There have been valiant efforts to make mental health resources more widely available to Vietnamese Americans in general—not only first generation—especially in places with large Vietnamese populations such as Southern California. For example, the Orange County Association for Vietnamese Mental Health Awareness and Support was formed in 2007 to provide mental health programs for children, youth, adults of all ages and families.
It is difficult to suggest concrete solutions to determine what is the most appropriate way to utilize culture in health care. But what I have found is that the language, tone, and attitude that is used when discussing culture is crucial—all of these factors contribute to the way that a certain population’s customs and traditions are distributed to and conveyed by the broader public. It is disheartening to see that the mental illnesses of the Vietnamese refugees that immigrated to the United States over 30 years ago have not been and may not be completely healed any time soon. Public and/or mental health services have not yet deciphered the most appropriate way to operationalize culture to reach those who are suffering. But as I have shown, progress is not linear: for every two steps forward in the right direction, there may be one step backward. Yet the fact that there is progress at all is encouraging. Through my research, I have also conveyed that there is optimism for the future, that there can be some faith in the work that can be done that will inspire future mental health professionals and public health interventionists for generations to come.

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