Health and Health Care of

Vietnamese American Older Adults

http://geriatrics.stanford.edu/ethnomed/vietnamese

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IN THE DIVISION OF GENERAL INTERNAL MEDICINE
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CONTENTS

DESCRIPTION

This module presents information on issues in geriatric care for Vietnamese older adults living in the United States. Information on demographics and health risks are presented to emphasize the effect of tradition as well as immigration and refugee experiences on the health of Vietnamese American older adults.

Also included are information on barriers to care and suggestions for assessment and treatment of Vietnamese American older adults.

MODULE CHARACTERISTICS

Time to Complete: 1 hr, 20 mins

Intended Audience: Doctors, Nurses, Social Workers, Psychologists, Chaplains, Pharmacists, OT, PT, MT, MFT and all other clinicians caring for older adults.

Peer-Reviewed: Yes

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LEARNING OBJECTIVES

After completing this module, learners should be able to:

1. Describe common traditional health beliefs of the Vietnamese population.
2. List at least three illnesses facing older adults from the Vietnamese population.
3. Evaluate the major strategies for communicating with an older Vietnamese American patient who speaks a language not spoken by the provider.
4. Develop a strategy for providing culturally appropriate health screening and education for Vietnamese American older adults to address their high risk conditions.
5. Describe the important issues health care providers should consider when working with Vietnamese American older adults and their families in end-of-life care.

INTRODUCTION AND OVERVIEW

Early Vietnamese Immigration History

The initial wave of Vietnamese refugees was shortly before the fall of Saigon, which included South Vietnamese military officers, government officials, professionals, business leaders and their families.

The second wave was after the fall of Saigon, which included Vietnamese "boat people" fleeing persecution from the Communist government. Those who fled during the second wave were "boat people" because they mainly fled by boat to asylum camps in Thailand, Malaysia, Singapore, Indonesia, the Philippines or Hong Kong. The second wave also fled by land through Cambodia and Thailand.

The last wave of Vietnamese refugees followed 1979 when the United Nations sponsored the Orderly Departure Program (ODP) to provide a safe and legal method of departure for Vietnamese refugees and to help reunite family members.

Amerasian Homecoming Act

Later programs also helped re-education camp survivors, persecuted ethnic minorities and Amerasian offspring to leave Vietnam (Tran et al., 2006). Pearl Buck was the first to elicit the term Amerasian and according to the Amerasian Foundation:

> *"an Amerasian is any person who was fathered by a citizen of the United States (an American servicemen, American expatriate, or U.S. Government Employee…) and whose mother is, or was, a National Asian."*

In 1987, the Amerasian Homecoming Act also helped reunite and resettle many Amerasian children and family members.

Prior to the Amerasian Homecoming Act, the U.S. Congress passed the Refugee Act of 1980 to deal with the ongoing problems of immigrating Vietnamese boat people. The Act defined what a refugee was, capped the number of refugees entering the United States per year, aided in the resettlement of refugees, and allowed refugees to apply for lawful residency after a year and to declare citizenship after four years.

FAST FACTS

According to the United States Census (2001)

- There are over 1 million Vietnamese people residing in the United States.
- Of this total, 5% of them are Vietnamese American older adults age 65 and above.
- Many are refugees or immigrants who arrived to the United States as the Vietnam War escalated and when it ended after the fall of Saigon in 1975.

For further information, see the census web site: www.census.gov

Comprehensive Plan of Action

On June 1989, seventy countries adopted the Comprehensive Plan of Action to deal with the increasing number of Vietnamese boat people in camps throughout Southeast Asia and Hong Kong. This international policy reduced the number of disorderly refugee flights from Southeast Asia. When the Comprehensive Plan of Action for Indochinese Refugees ended in June, 1996, the Vietnamese in refugee camps throughout Southeast Asia were either approved for resettlement or given incentives to return voluntarily to Vietnam. By 1999, about 1.75 million Vietnamese had left Vietnam and had been resettled.

PATTERNS OF HEALTH RISK

Most empirical research on Vietnamese older adults has primarily focused on mental health conditions. There is not much empirical research on medical illnesses and specifically chronic illness in Vietnamese older adults. However, the current research shows that in general Vietnamese population in the United States is susceptible to chronic illnesses such as

- cancer
- heart disease
- stroke
- hypertension
- diabetes

Their susceptibility to these chronic illnesses results from nutritional deficiencies in the Vietnamese diet and other practices common to the Vietnamese culture. Currently, there is no national data on the health status of Vietnamese older adults in the United States. Most of what is currently known comes from smaller studies at the state or local level.

> **"... Vietnamese consume more low nutrient foods with high fat content and less nutrient-rich foods like grains, fruits and vegetables."**

Dietary Habits

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Studies on dietary habits of newly immigrated Vietnamese group show that through the acculturation process, the Vietnamese consume more low nutrient foods with high fat content and less nutrient-rich foods like grains, fruits and vegetables (Ikeda, 2002). This is a due to lifestyle change requiring busier work and school schedules and readily available food items that are nutrient rich and are part of traditional Vietnamese dishes. However, not all Vietnamese foods are nutrient rich.

Cardiac and Hypertensive Problems

The Vietnamese diet consists of high glucose starches, such as white rich and noodles, and high sodium ingredients such as fish sauce (nước mắm, pronounced "nook mahm"), which tends to worsen conditions such as diabetes and hypertension (Tran et al., 2006).

Also related to the risk of cardiac and hypertensive problems may be the high rates (35%-42%) of smoking among Vietnamese men. The prevalence of heart disease and hypertension within the Vietnamese community may be increasing as a result of minimal awareness and understanding (Pham et al., 1999). Research also shows that cardiovascular and cerebrovascular diseases are the second leading cause of death for Vietnamese of both genders in seven U.S. States (Hoyert & Kung, 1997).

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(PATTERNS OF HEALTH RISK CONT'D)

Cancer

The primary leading cause of death for Vietnamese of both genders in the U.S. is cancer (Hoyert & Kung, 1997).

- Both genders have the highest incidence of lung and liver cancer than their Asian counterparts (http://www.aancart.org).
- Vietnamese men have the second highest incidence of lymphoma in the United States and they have the highest rates for liver and nasopharynx cancer.
- As for Vietnamese women, they have a two and half times higher incidence of cervical cancer than any other racial or ethnic group (http://www.nci.nih.gov/statistics/).

Mental Distress

Aside from physical ailments, mental health problems due to traumatic experiences during the Vietnam War are also prevalent amongst Vietnamese older adult refugees or immigrants who have re-established themselves in the U.S.

Close to 50% of Vietnamese refugees from a general medical clinic suffered major depression. Mental health studies of Vietnamese refugees show that they have high levels of depression, anxiety and post-traumatic stress (Hinton et al., 1993) due to years in squalid refugee and/or re-education camps, sudden and involuntary transplantation from a familiar cultural setting to a completely unfamiliar cultural setting, and difficulties with acculturating and adapting to Western culture.

CULTURALLY APPROPRIATE GERIATRIC CARE: FUND OF KNOWLEDGE

Traditional Health Beliefs

Core cultural values based on Confucian ideals are important to note in order to effectively provide care to Vietnamese older adults. Confucian ideals emphasize filial piety, loyalty, social harmony and hierarchical order. Unlike American culture, Vietnamese culture values interdependence of an individual within the family and the group (Timberlake & Cook, 1984; Jamieson, 1993; Shon & Ja, 1982) to promote harmony and order. There is less emphasis on individuality and more on social unity.

> **"Confucian ideals emphasize filial piety, loyalty, social harmony and hierarchical order."**

Each family member adheres to a specific hierarchical role. For example, a son or daughter is expected to show utmost respect and love to his/her older adults as well as demonstrate his/her filial piety unquestionably. This is a key reason why nursing home or other institutional placement may be viewed negatively by the Vietnamese community. Institutionalized care is thought to be particularly offensive to Vietnamese older adults who may expect to be cared for in a home setting by their family. However, with the widening of the generational gap between Vietnamese older adult immigrants and younger U.S. born Vietnamese, there is a conflict on how to care for their older adults while still maintaining filial piety.

> **"Another important belief and practice in Vietnamese culture is Eastern medicine or oriental medicine (Thuốc Đong Y), which incorporates traditional Chinese and Vietnamese medicine."**

The Concept of "Losing Face"

Traditional beliefs in Vietnamese culture regarding shame and guilt are also important to understanding how Vietnamese older adults report symptoms. Since the Vietnamese culture is oriented towards the family and the group, the individual is thought to represents the family as a whole. Thus, if an individual loses respect or status in the community, the whole family "loses face" too. The individual and the whole family feel shame and guilt because of the decline in social status. This concept of "loss of face" may be why some Vietnamese older adults and their families are reluctant to report distressing symptoms (Tran et al., 2006). They are vulnerable to the stigma of chronic and severe mental illness and so their fear of losing face and embarrassing the family can be stigmatizing for Vietnamese older adults.

Eastern (Oriental) Medicine

Another important belief and practice in Vietnamese culture is Eastern medicine or oriental medicine (Thuốc Đong Y), which incorporates traditional Chinese and Vietnamese medicine (Thai, 2003). Western medicine views the body and mind as dual components whereas Eastern medicine views the body and mind as unified components. Thus the mind can affect the body and vice versa. In Eastern medicine, emphasis is also placed on balance of yin and yang, or hot and cold.

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(FUND OF KNOWLEDGE CONT'D)

This balance refers to the internal structures of the body.

To stay healthy, one must maintain this balance by controlling inner mental and physical states. For example, self control of emotions, thoughts, behavior, diet and food and medication intake are all important in maintaining health and balance. Excess eating or worrying can lead to an imbalance of excess "heat," thus resulting in mental and physical illness

Other Traditional Beliefs

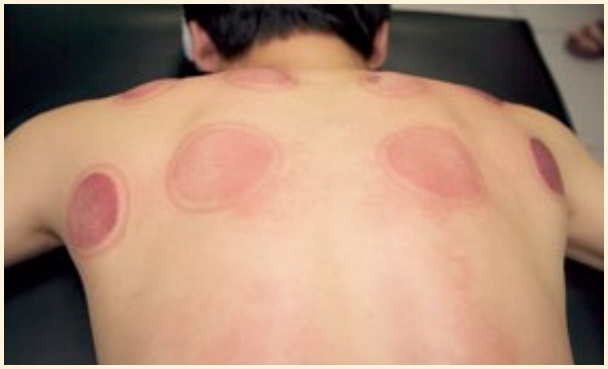
Traditional Vietnamese older adults also hold complex spiritual and religious views. Folk religion, Confucianism, Buddhism, Taoism and Catholicism are all important traditions of Vietnamese culture. (Ho Tai, 1985) It is not uncommon for Vietnamese older adults to draw upon several traditions. For example, a Vietnamese-Catholic may also practice Buddhist concepts such as ancestor worship, fate, perseverance and enduring suffering. Another complex religious belief is spiritual possession, which stems from folk religion, ancestor worship and Taoism. For instance, in a documented case by Yeo and colleagues (2001), a Vietnamese man believed that his demented wife was "possessed" by spirits and only the extraction of these spirits would heal her.

Traditional Health Practices

Eastern medicine (Thuốc Đong Y) considers environmental influences such as wind and spirits that can offset the internal balance of a person leading to illness. For example, it is common for a Vietnamese person to refer to a cold or a flu as being exposed to "poisonous wind" (gío độc) or "catching the wind" (trung gío) instead of "catching a cold".

Two treatment methods of wind illnesses include:

- Coining or Cạo Gío is the rubbing of aromatic medicated oils onto the chest and back in parallel lines in order to release the poisonous wind.
- Cupping or Giác hơi is the burning of a candle in a glass cup and the placing of the cup onto the skin. Traditional treatment methods for wind illnesses may be mistaken for abuse because of the dark bruise-like marks resulting from the treatment methods.



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Because of the dark bruise-like marks, resulting from the treatment, cupping may be mistaken for abuse.

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CULTURALLY APPROPRIATE GERIATRIC CARE: ASSESSMENT

Use of Interpreters

Cultural competence and linguistic competence are important components in order to provide effective health care to Vietnamese older adults.

- Cultural competence is the willingness to understand and respond to diversity. It is also the continuous development and promotion of skills and practices through training, self assessment and implementation of policies and objectives, to improve services to diverse populations.
- Linguistic competence as defined by the office of Civil Rights in the U.S. Department of health and Human Services (1999) is the "skills to communicate effectively in the native language, or dialect of the targeted population, taking into account general educational level, literacy and language preferences."

> **"Interpreters must be adept in Western and Vietnamese cultures, medical concepts, beliefs, vocabulary and physical examination procedures."**

Proper interpretative service is vital to providing quality health care to Vietnamese older adults. It is very important to provide cultural and linguistic competence in aging services because more Vietnamese older adults are non-English or limited English speaking in comparison to younger Vietnamese (Jackson, 1998).

Interpreters must be adept in Western and Vietnamese cultures, medical concepts, beliefs, vocabulary and physical examination procedures (Hoang et al., 1982). Interpreters need to be certified and trained in order to provide proper interpretative service.

IMPROPER INTERPRETATIVE ASSISTANCE

Examples of improper interpretative assistance includes, but are not limited to, interpretation through family or friends-especially children, untrained bilingual staff (e.g., janitors, secretaries, security guards etc…) or community volunteers. Improper interpretation may often result in mis-perceptions and mis-understandings thereby compromising the quality of care.

For example, a Vietnamese older adult may complain of feeling "hot" and a non-certified/ untrained interpreter may literally translate this complaint as being "hot" and feverish thus leading to erroneous treatment of the illness.

The long term savings in financial and human costs of providing quality health care interpretation are enormous in spite of short term costs since adequately trained interpreters can lessen common issues that arise during bilingual clinical encounters such as bad paraphrasing, impatience, lack of linguistic equivalence, interpreter beliefs, ethnocentrism and role conflicts.

Standardized Measures

Effective and culturally competent health care requires adequate assessment and measurement tools. Research focused on the Vietnamese population in this area is just beginning. Current research shows that issues arise when using assessment tools to diagnose cognitive impairments in Vietnamese older adults because most tools are in written format, and not all Vietnamese older adults are able to read or comprehend the written tools. Assessment tests are insufficiently adjusted to the patients' education levels (Yeo et al. 2006) thus there may be under- or over-diagnosis of cognitive impairments in Vietnamese older adults.

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(ASSESSMENT CONT'D)

Currently there are two well-established and validated instruments for depression for the Vietnamese population: Vietnamese Depression Scale (Buchwald, Manson, Dinges, Keane, & Kinzie, 1993; Kinzie et al, 1982) and the Hopkins Symptom Checklist (Mollica, Wyshak, Marneffe, Khuon, & Lavelle, 1987). Both of these instruments appear to accurately identify Vietnamese with clinical depression at established cut-offs with high sensitivity and specificity (Hinton et al, 1994), although neither instrument has been validated in Vietnamese older adults.

A scale that effectively evaluates the neuropsychological and cognitive state of older adults is the Cross-cultural Neuropsychological Test Battery (CCNB). Linguistic and cultural aspects were considered in developing this scale to make it an effective tool (Dick et al., 2002). In order for the CCNB to be applicable cross-culturally, Dick and colleagues placed emphasis on:

- minimizing testing time;
- incorporating 5 well established measures to easily compare the English and non-English speaking groups;
- using oral or pictorial information to reduce the disparities concerning education levels
- including tests appropriate for varying stages of dementia;
- administering the test by a bilingual staff.

DEPRESSION SCALES ONLINE

Vietnamese Depression Scale
http://www.stanford.edu/~yesavage/Vietnamese.html

Translation of Assessment Instruments

Current research examining cross-cultural equivalence of assessment tools primarily focuses on college students and young adults. Little research in this area has been done on Vietnamese older adults. Brislin and colleagues (1973) suggest a translation protocol to lessen discrepancies in translating assessment tools. This process includes translating the instrument from English to the target language, and then the document would be translated back into English by another person. Discrepancies between the original English version and the back-translation version are resolved by consensus and clarification to produce conceptual equivalence.

The caveat is that even under ideal circumstances, a translated/back translated instrument may not be able to assess concepts that have no conceptual equivalence or are culturally bound concepts (Dunnigan, McNall, Mortimer, 1993).

Eliciting the Patient's Perspective

For information on eliciting older adults' perception of their conditions, sometimes called "explanatory models of illness" and issues in the domains of clinical assessment, see Culture Med, Ethnogeriatrics Overview: Assessment—
http://geriatrics.stanford.edu/culturemed/overview/assessment/

CULTURALLY APPROPRIATE GERIATRIC CARE: DELIVERY OF CARE

Providing health care that is effective and culturally appropriate demands more than just medical interpretation by well trained interpreters, it also requires follow up care and education of both health professionals and patients (Jackson-Carrol, Graham & Jackson, 1996).

Health Promotion

Preventive care is increasingly being promoted to improve the health of Vietnamese people especially as they age. According to the Public Health Functions Steering Committee, it is important to encourage a target population to maintain and adopt healthy behaviors with regular physician checkups by educating them about health issues and services and by designing and disseminating resources tailored them (Woodall et al., 2006).

In a study by Woodall and Colleagues, four of the most common sources of health information used by more than fifty percent of Vietnamese American men were:

- Vietnamese newspapers/magazines,
- Vietnamese and English language television,
- Vietnamese radio and friends and family members.

These four commonly used sources can be implemented to reach out to the Vietnamese community about health awareness and prevention. For example, some health issues and preventative measures can be providing the Vietnamese community with resources on healthy behavior and regular health checkups.

Healthy behaviors include regular exercise, well-balanced diet, stress management and smoking cessation. Since 35% to 42% Vietnamese males smoke, smoking cessation campaigns will help decrease the prevalence of lung cancer and other health conditions such as asthma and respiratory related illnesses. Regular physician checkups such as screening are also vital.

Since Vietnamese women have one of the highest incidences of cervical cancer, regular pap smears can help decrease the prevalence of cervical cancer in this group. Other recommendations to aide in promoting regular pap smears are having a female provider, support groups, and health education classes or seminars to explain the rationale behind regular screenings and procedures and equipment involved.

“Providing health care that is effective and culturally appropriate demands more than just medical interpretation by well trained interpreters, it requires follow up care and education of both health professionals and patients.”

Medication

Most Vietnamese American older adults will seek medical treatment from physicians who practice Thuốc Đong Y before they will even turn to physicians who practice Western medicine. Some do so because they are more familiar with oriental practices and may have been disappointed or frustrated with the outcomes of Western medicine.

Vietnamese American older adults may also combine oriental medical treatment with Western medical treatment without disclosing this combination to either practitioner. It is necessary for clinicians to be aware that Vietnamese American older adults may interpret medication side effects as evidence that the medications are causing the body to become “too hot” or “too cold.” Decreased compliance with medications included beliefs such that Western medicine is “stronger,

(DELIVERY OF CARE CONT'D)

faster, and curative" while Eastern/folk medicine is "weaker, slower, but preventive" (Pham, Rosenthal & Diamond, 1999). This may lead to use of diet/herbal remedies as compensation, or to decreased compliance with prescribed medications. The beliefs that Western medicine is "stronger, faster, and curative" while Eastern/folk medicine is "weaker, slower, but preventive" have major implications for adherence to medical regimens by Vietnamese American older adults.

Decreasing drug doses is a cultural response to their perceptions about these Western medications and to their being "too hot" or "too cold." To the degree that this is systematically done by Vietnamese American older adults, some medications may not be effective.

Working with Families

In caring for Vietnamese older adults, the hierarchical tradition places the eldest male as the primary decision maker in the family. If there is no son in the family, the eldest son-in-law or the eldest male relative becomes the primary decision maker. However, the caregiving of Vietnamese older adults usually fall upon the eldest son's wife or unmarried family members. For a much more detailed description of working with families of older adults with dementia and of caregiving and family issues, see Tran et al., 2006.

Advance Directives and End-of-Life Issues

Issues surrounding death and dying are always difficult regardless of cultural background, but attitudes toward end-of-life issues are diverse among different cultural backgrounds.

Attitude Toward Death

Many Vietnamese people see death as a natural phase of the life cycle. This attitude toward death may be influenced by the fact that older adults are highly respected in Vietnamese culture, and therefore, aging and death may not conjure up as many negative connotations as within Western cultures. Further,

> **"Decreased compliance with medications included beliefs such that Western medicine is 'stronger, faster, and curative' while Eastern/folk medicine is 'weaker, slower, but preventive'"**

Vietnamese immigrants in the United States are influenced by spiritual beliefs linked not only to Catholicism or Buddhism, but also to Taoism, animism, and Confucianism. For example, reverence for ancestors and the use of home altars, where homage is paid to family ancestors, are common even among Vietnamese Christians. These religious and cultural/societal norms influence Vietnamese views of death, allowing them to reframe the process and the event. For instance, concepts of reincarnation prevalent among Buddhists, ancestor worship, and the belief of going to heaven after death, may cause death to be viewed as something fortunate, and fitting with life's natural cycle. In addition, many Vietnamese people have lived through wars, witnessing deaths and suffering as results of such wars. This fact, as well as historically higher mortality rates among infants and adults in Vietnam, can make the Vietnamese view death more as a normal part of life.

End-of-Life Preparations

While general discussions about death and dying may be viewed as inauspicious and in poor taste to the Vietnamese family, it is a common practice among Vietnamese older adults to make concrete preparations for death. These preparations include setting aside money to pay for the burial, choosing a burial site with a favorable orientation in accordance with the laws of feng shui, buying a coffin, and even buying or having burial clothes made long before they are actually needed. In a study conducted in Hawaii by Braun and Nichols (1996), both Christian and Buddhist

(DELIVERY OF CARE CONT'D)

Vietnamese participants said that preparations for death included praying and preparing wills for distribution of property. The act of making concrete preparations for one's own death is seen as a common responsibility that older adults carry out for themselves as well as their children. Even though Vietnamese older adults may prepare for the rituals of death, active end-of-life care planning is a foreign and unfamiliar undertaking for most Vietnamese families. It was reported in the Hawaii study that few Vietnamese older adults were aware of their options with regard to advance directives. Issues related to "Do Not Resuscitate" orders or removal of feeding tubes was usually not considered (Braun & Nichols, 1996). This is perhaps multifactorial, attributable to older adults' reliance on their children for interpretation and the possibility that their children may be uncomfortable with the subject matter.

Diagnosis Disclose Issues

Some Vietnamese families may also prefer that the diagnosis of a serious or terminal illness not be disclosed directly to an older family member to prevent additional stress for the older adult, making informed consent and decisions regarding code status awkward. Whatever the intent, know that families may not be forthcoming with reasons. The clinician may need to specifically ask the patient about presenting information and discuss the family's preference for what information they feel the older adult may want to have. Again, because there is such variation in acculturation and beliefs among Vietnamese, clinicians and providers should remain attuned to these variations.

Cultural Beliefs

There are a number of cultural beliefs related to death and dying that are likely to affect decisions at the end of life for Vietnamese older adults and their families. These include:

- an aversion to dying in the hospital because of the belief that souls of those who die outside the home wander with no place to rest,
- an avoidance of death and dying in the home for fear opening up one's home to bad spirits,
- the perception that consenting to end-of-life support for a terminally ill parent contributes to his/her death and is an insult to one's ancestors and parent, and
- Buddhist beliefs in karma that interpret difficult deaths as punishment for bad deeds in former lives by the dying person or another family member.

ACCESS AND UTILIZATION

Health Care Utilization Challenges

Delay in Seeking Medical Attention

The general Vietnamese population seeks medical attention less often than the Caucasian group (Kuo & Porter, 1997) because Vietnamese, especially older Vietnamese hold health beliefs that impede recognition of symptoms and delay their seeking treatment crucial to their health. For example, they hold misconceptions that tuberculosis is an infectious disease without a latent phase (Carey et al., 1997). Long and colleagues (1999) found that Vietnamese believed that there are four types of tuberculosis:

1. Inherited tuberculosis (lao truyền) that is passed down from one generation to the next through genetics,
2. Physical tuberculosis (lao lực) that results from hard physical work,
3. Mental tuberculosis (lao tâm) that is caused by excessive worrying and
4. Lung tuberculosis (lao phổi) that is caused by the spread of tuberculosis germs through the respiratory system.

Traditional health beliefs such as these delay help seeking, increase social stigma and cause misconceptions about transmission routes.

Lack of Knowledge Regarding Health Care

Little or no knowledge about correct health care and illness also contribute to the delay in help seeking. For example, a large number of Vietnamese did not know or knew very little about chronic disease such as AIDS, cervical cancer and preventive behaviors and tests. Jenkins and colleagues (1990) emphasize that more education, awareness and preventive practices need to be aimed at the Vietnamese population in order to improve the current health status especially the growing number of Vietnamese American older adults.

> **"...a large number of Vietnamese did not know or knew very little about chronic disease such as AIDS, cervical cancer and preventive behaviors and tests."**

Other common reasons for delay in or lack of health care access are:

- lack of linguistically and culturally competent health services,
- lack of insurance,
- unaffordable health care costs,
- not being able to access specialty care with language or cultural understanding.

Among Vietnamese who saw a physician in the last year, 47% did not receive preventive care services such as pap smears, cholesterol checks or blood pressure tests. (The Commonwealth Fund, 1995).

> **"More education, awareness and preventive practices need to be aimed at the Vietnamese population in order to improve the current health status of Vietnamese especially the growing number of older Vietnamese."**

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(ACCESS AND UTILIZATION CONT'D)

Ignorance of Preventive Care

Poor knowledge of preventive care and health information put Vietnamese people at risk for developing more diseases as they age.

To improve the health of Vietnamese as they age and thus help the older adult Vietnamese population, more education, awareness and health care access are pertinent.

For example, Lesjack and colleagues (1999) found that female practitioners, free screening, and more health information improved recruitment of Vietnamese women for cervical cancer screening. Education and awareness help break the barriers that many Vietnamese women have regarding cancer screening tests.

Such barriers to screening include the embarrassment felt during the examination, discomfort of being touched by a stranger or a male physician, the belief that cancer is incurable, and the fear of medical facilities and equipment (Kelley, et al., 1996; Mahlock, et al., 1999; Tu, et al., 2000; Yi, & Prows, 1996).

Ways to Improve Health Care Utilization

In order to improve the health system to better serve the needs of Vietnamese people especially Vietnamese older adults, successful programs include the following characteristics:

- ✓ use of cultural lay health workers/interpreters, peer health educators,
- ✓ family/community interventions to bridge language and cultural gaps,
- ✓ decrease of cultural health barriers such as fear of surgery and preference of female patients for female physicians to conduct health examination with similar preferences for males or improvement of health knowledge for chronic disease conditions and preventive health strategies by ethnic specific videos or health fairs,
- ✓ use of after hours access, community based and "one stop" integrated services (e.g., medical, mental health, social services),
- ✓ decrease of financial and medical coverage barriers and logistical barriers such as transportation,
- ✓ significant improvements in health education targeted at Vietnamese consumers.

(Cory, 1995; Free, White, Shipman & Dale, 1999; Lesjak, Hua & Ward, 1999; Mahlock, et al., 1999; Nelson, Bui & Samet, 1997; Pham, Rosenthal & Diamond, 1999; Siganga & Huynh, 1997; Stuer, 1998).

INSTRUCTIONAL STRATEGIES: CASE STUDIES

Case Study 1

Mr. N. is a 71 year-old Vietnamese former lieutenant colonel who was imprisoned for 12 years by the Socialist Republic of Vietnam. He was physically and emotionally tortured with stories of family members being killed or imprisoned in other re-education camps. Mr. N. felt lucky to be alive since 165,000 people died in Vietnam's re-education camps since 1975.

He came to the U.S. in 1989 and had nightmares every night for the first couple of years. He felt estranged from his family since he was imprisoned for 12 years and his family became American strangers to him. His doctor said that he suffered from Post-Traumatic Stress Disorder from his long imprisonment and torture.

Now he has nightmares only when he feels stressed out. He deals with this stress by smoking 4 packs of cigarettes a day and drinking beer. He has a hoarse cough and sometimes coughs up blood. His family brought him to see a physician because his herbal medicines did not work on his cough anymore and he cannot get to sleep at night.

Questions for Discussion

1. What would a health provider's problem list include for the cases above?
2. How could an understanding of the cultural health beliefs and/or cohort experiences assist the health care provider in giving effective care?
3. What kind of treatment, management, or referrals might the health care provider consider?

(INSTRUCTIONAL STRATEGIES CONT'D)

Case Study 2

Your patient 66 year-old lady, who is being cared for by her 78 year husband. Both husband and wife have little formal education. Early in the medical interview the husband framed his wife's confusion and erratic behavior as a consequence of somatic causes, such as her pain from the Western medication that was "too strong" for her. He has tried multiple avenues of treatment. As the husband put it, "With the Eastern medication, she at times drinks about 50 preparations of herbal formulas and it doesn't improve the condition at all. We turned to Western medicine and it caused heat and discomfort/hot temperament, so we turned back to traditional medication, which included traditional medication with herbs and acupuncture."

She is currently seeing more than three Western doctors, including a psychiatrist, a family practitioner, and a gastroenterologist. Later in the interview, he enthusiastically related a story about how he had put his faith in a spirit medium and the Buddhist Goddess of Mercy in order to heal his wife. The day before the interview, he had taken his wife to a spirit medium for the first time. The medium practices in a local Buddhist temple, and the ceremony appears to combine elements of both Buddhism and of folk religion.

The husband says that in order to cure his wife, "The first thing is that we have to pray/appeal to Buddha or the Lady Buddha Quan Am, so that Buddha can give us faith in the unseen forces or spirits. Pray/appeal, believe in Buddha, at night when we sleep light incense. We have faith in, we believe so that, have faith so that the pain will subside. Fasting/abstaining from meat, following Buddha, controling one's temperament, don't be hot tempered or often think and wonder about something so that the mind is stressed and eventually it will subside." The husband search for a cure for his wife is very pragmatic, by saying "If we are ill/hurt, we would go wherever people can do something, go to shamans/voodoo masters/spiritual masters too."

Questions for Discussion or Written Assignment

1. What would a health provider's problem list include for the cases above?
2. What are the salient cultural beliefs that are influencing this family's health behavior? How could an understanding of the cultural health beliefs and/or cohort experiences assist the health care provider in giving effective care?
3. What are possible strategies for increasing adherence to medications in this woman?
4. If the family reveals to the doctor that they have sought help from a spirit medium and taken herbal remedies, how should the health care provider respond? How might use of these alternative treatments influence their ongoing health care?
5. What kind of treatment, management, or referrals might the health care provider consider?

STUDENT EVALUATION

Essay Questions

1. The large majority of Vietnamese older adults were refugees fleeing Vietnam after the Fall of Saigon in 1975. How would the refugee experience influence their adaptation and aging in the U.S.?
2. What are the major health threats for the general Vietnamese population? How do these major health threats affect the older adult Vietnamese population?
3. What are some cultural health beliefs and lifestyle practices of Vietnamese older adults? How would they influence access and utilization of health services?
4. What are some strategies to improve the cultural competence of our geriatric services for Vietnamese older adults?
5. What are some best practice guidelines for use of language translators?
6. What are some key issues to consider when using assessment tools to evaluate Vietnamese older adults?
7. What are some end-of-life issues for Vietnamese older adults and their families?
8. What are some important issues to consider in developing a screening program for cervical cancer for older Vietnamese women?

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REFERENCES

Articles and Books

Braun, K. L., Pietsch, J. H., & Blanchette, P. L. (2000). *Cultural issues in end-of-life decision making*. Thousand Oaks: Sage.

Brislin, R. W., Lonner, W. J., & Thorndike, R. M. (1973). *Cross-Cultural Research Methods*, New York, NY: Wiley Inter-Science.

Buchwald, D., Manson, S. M., Dinges, N. G., Keane, E. M., & Kinzie, J. D. (1993). Prevalence of depressive symptoms among established Vietnamese refugees in the United States: Detection in a primary care setting. *Journal of General Medicine, 8*, 76-81.

Calhoun, M. A. (1985). The Vietnamese woman: Health/illness attitudes and behaviors. *Health Care for Women, 6*, 61-72.

Carey, J. W., Oxtoby, M. J., Nguyen, L. P., Huynh, V., Morgan, M., & Jeffery, M. (1997). Tuberculosis beliefs among recent Vietnamese refugees in New York State. *Public Health Reports, 112*, 66-72.

Commonwealth Fund. (1995). *National Comparative Survey of Minority Health Care*. New York: The Commonwealth Fund.

Conn, P. (1996). *Pearl S. Buck: A Cultural Biography*. New York: Cambridge University Press

Cory, J. (1995). *Innovative outreach and education for older Southeast Asian women* (p. 65). Paper presented at the tenth national conference on Chronic Disease Prevention and Control, Dec. 6-8, 1995, Atlanta, GA.

Cox, C. (1986). Physician utilization by three groups of ethnic older adults. *Medical Care, 24*, 667-676.

Day, J. (1969). *Pearl S. Buck: A Biography.* New York: The John Day Company.

Devins, G. M., Beiser, M., Dion, R., Pelletier, L. G., & Edwards, R.G. (1997). Cross-cultural measurement of psychological well-being: The psychometric equivalence of Cantonese, Vietnamese, and Laotian translations of the affect balance scale. *American Journal of Public Health, 87*, 794-799.

Die, A. (1988) Problems, sources of assistance, and knowledge of services among older adults Vietnamese immigrants. *The Gerontologist. 28*(4), 448-52.

Do, H., Taylor, V., Burke, N., Yasui, Y., Scharwtz, S., & Jackson, J. (2007). Knowledge about cervical cancer risk factors, traditional health beliefs, and Pap testing among Vietnamese American women. *Journal of Immigrant and Minority Health, 9*(2), 102-14

Dunnigan, T., McNall, M., & Mortimer, J. T. (1993). The problem of metaphorical nonequivalence in cross-cultural survey research: Comparing the mental health statuses of Hmong refugee and generational population of adults. *Journal of Cross-Cultural Psychology, 24*, 344-365.

Free, C., White, P., Shipman, C., & Dale, J. (1999). Access to & use of out-of-hours services by members of Vietnamese community groups in South London: A focus group study. *Family Practice, 16*, 369-374.

Gail Paradise, K. (1977). *From Vietnam to America: a chronicle of the Vietnamese immigration to the United States*. Boulder, Co: Westview Press.

Hai, T. B., Eastlund, T., Chien, L. A., Duc, P. T., Giang, T. H., Hoa, N. T., et al. (1999). Willingness to donate organs & tissues in Vietnam. *Journal of Transplantation Coordination, 9*, 57-63.

(REFERENCES CONT'D)

Hinton, W.L., Chen, J., Du, N., Tran C.G., Miranda, J., & Faust, S. (1993). DSM-III-R disorders in Vietnamese refugees: Prevalence and correlates. *Journal of Nervous and Mental Disease, 181*, 113-22.

Hinton, WL, Du N, Chen J, Tran CG, Newman TB, Lu F. (1994). Screening for Major Depression in Vietnamese Refugees: A Comparison of Two Instruments. *Journal of General Internal Medicine. 9*:202-206

Hoang, G.N. & Erickson, R.V. (1982). Guidelines for providing medical care to southeast Asian refugees. *Journal of American Medical Association. 248*(6), 710-714.

Hoang, V.M. (2006). Cardiovascular disease mortality and its association with socioeconomic status: findings from a population-based cohort study in rural Vietnam. *Preventing chronic disease, 3*(3), 1545-1551

Ho Tai, H. (1985). Religion in Vietnam: A world of gods and spirits. *In Vietnam: Essays on history, culture, and society*, (pp. 22-39), New York: The Asia Society.

Ikeda, J.P., Pham, L., Nguyen, K.P., & Mitchell, R.A. (2002). Culturally relevant nutrition Education improves dietary quality among WIC-eligible Vietnamese immigrants. *Journal of Nutrition, Education and Behavior, 34* (3), 151-158

Jackson, C. (1998). Medical interpretation: An essential clinical service for non-English-speaking immigrants. In S. Loue (Ed.), *Handbook of immigrant health* (pp. 61-79), New York: Plenum.

Jackson, J. C., Rhodes, L. A., Innui, T. S., & Buchwald, D. (1997). Hepatitis B among the Khmer: Issues of translation and concepts of illness. J*ournal of General Internal Medicine, 12*, 292-298.

Jackson-Carrol, L. N., Graham, E., & Jackson, J. C. (1996, May). Beyond medical interpretation: The role of interpreter cultural mediators. In *Building bridges between ethnic communities and health institutions*. Seattle: Community House Calls, Harborview Medical Center.

Jamieson, N. (1993). *Understanding Vietnam*. Berkeley: University of California Press.

Jenkins, C. N., McPhee, S. J., Bird, J. A., & Bonilla, N. T. (1990). Cancer risks and prevention practices among Vietnamese refugees. *Western Journal of Medicine, 153*, 34-39.

Jenkins, C. N., Le, T., McPhee, S. J., Stewart, S., & Ha, N. T. (1996). Health care access and preventive care among Vietnamese immigrants: Do traditional beliefs and practices pose barriers? *Social Science and Medicine, 43*, 1049-1056.

Kelly, A.W., Chacori, M.D. M.R., Wollan, P.C., Trapp, H.M.H., Weaver, A.L., Barrier, P. A., et al. (1996). A program to increase breast and cervical cancer screening for Cambodian women in a Midwestern community. *Mayo Clinic Proceedings, 71*,437-444.

Kinzie, J.D., Manson, S.M., Ving, D.T., Nguyen, T.T., Anh, B., & Pho, T.N. (1982). Development and validation of a Vietnamese-language depression rating scale. *American Journal of Psychiatry. 139*, 1276-1281.

Kuo, J., & Porter, K. (1997). Health status of Asian Americans: United States, 1992-94. *Advance Data from Vital and Health Statistics*, 298. Hyattsville, MD: National Center for Health Statistics.

Lesjak, M., Hua, M., & Ward, J. (1999). Cervical screening among immigrant Vietnamese women seen in general practice: Current rates, predictors and potential recruitment strategies. Australia & *New Zealand Journal of Public Health, 23*, 168-173.

(REFERENCES CONT'D)

Lipscomb, E.J., Webb, F.E., & Conn, P. (1992). The Several Worlds of Pearl S. Buck: Essays Presented at a Centennial Symposium, Randolph-Macon Woman's College, March 26-28, 1992. Westport, Connecticut: Greenwood Press.

Liu, D., Hinton, L., Tran, C., Hinton, D., & Barker, J.C. (2008). Reexamining the relationships among dementia, stigma, and aging in immigrant Chinese and Vietnamese family caregivers. *Journal of Cross Cultural Gerontology, 23*, 283-299.

Long, N. H., Johansson, E., Diwan, V. K., & Winkvist, A. (1999). Different tuberculosis in men and women: Beliefs from focus groups in Vietnam. *Social Science and Medicine, 49*, 815-822.

Mahloch, J., Jackson, J. C., Chitnarong, K., Sam, R., Ngo, L. S., & Taylor, N. M. (1999). Bridging cultures through the development of a cervical cancer screening video for Cambodian women in the United States. *Journal of Cancer Education, 14*, 109-114.

Marino, R., Stuart, G. W., & Minas, I. H. (2000). Acculturation of values and behavior: A study of Vietnamese immigrants. *Measurement & Evaluation in Counseling and Development, 33*, 21-41.

Mollica, R.F., Wyshak, G., Marneffe, D., Khuon, F., & Lavelle, J. (1987). Indochinese versions of the Hopkins Symptom Checklist-25: a screening instrument for the psychiatric care of refugees. *American Journal of Psychiatry. 144*, 497-500.

Nelson, K. R., Bui, H., & Samet, J.H. (1997). Screening in special populations: A "case study" of recent Vietnamese immigrants. *American Journal of Medicine, 102*, 435-440.

Parker Frisbie, W., Cho, Y., & Hummer, R.A. (2001). Immigration and the Health of Asian and Pacific Islander Adults in the United States. *American Journal of Epidemiology, 153* (4), 372-380.

Pham, T. M., Rosenthal, M. P., & Diamond, J. J. (1999). Hypertension, cardiovascular disease, & health care dilemmas in the Philadelphia Vietnamese community. *Family Medicine, 31,* 647-651.

Purnell, L.D. (2008) Traditional Vietnamese health and healing. *Urologic Nursing, 28* (1), 63-67.

Schulmeister, L., & Lifsey, D. S. (1999). Cervical cancer screening knowledge, behaviors, and beliefs of Vietnamese women. *Oncology Nursing Forum, 26*, 879-887.

Shon, S., & Ja, D. (1982). Asian families. In M. McGoldrick, J. Pearce, & J. Giordano (Eds), *Ethnicity and family therapy*. New York: Guilford Press.

Siganga, W. W., & Huynh, T. C. (1997). Barriers to the use of pharmacy services: The case of ethnic populations. *Journal of the American Pharmacy Association, NS37*, 335-340.

Stuer, F. (1998). Enhancing health programme efficiency: A Cambodian case study. *Health Policy & Planning, 13*, 263-276.

Strumpf, N., Glicksman, A., Goldberg-Glen, R., Fox, R., & Logue, E. (2001) Caregiver and older adult experiences of Cambodian, Vietnamese, Soviet Jewish, and Ukranian refugees. *International Journal of Aging and Human Development, 53*(3): 233-52

Timberlake, E.M, & Cook, K.O. (1984). Social work and the Vietnamese refugee. *Social work, 29*(2), 108-112.

Tran JN, Tran CG, Hinton L. (2006) Working with Vietnamese American Families. In G. Yeo and D. Gallagher-Thompson (Eds) *Ethnicity and the Dementias*. New York; Routledge, p. 263-283

(REFERENCES CONT'D)

Tu, S. P., Yasui, Y., Kuniyuki, A., Thompson, B., Schwartz, S. M., Jackson, J. C., & Taylor, V. M. (2000). Breast cancer screening among Cambodian women. *Cancer Detection and Prevention, 24*, 549-563.

Van Minh, H., Thanh, L. C., Thi, B. N., do Trinh, T., Tho, T. D., & Valensi, P. (1997). Insulinaemia & slight overweight: The case of Vietnamese hypertensives. *International Journal of Obesity Related Metabolic Disorders, 21*, 897-902.

Woodall, E.D, Taylor, V.M., Yasui, Y., Ngo-Metzer, Q., Burke, N., Thai, H., & Jackson, C. (2009). Sources of health information among Vietnamese American Men. *Journal of Immigrant and Minority Health, 8*(3), 263-271.

Yeo, G. (Ed.). (2000, October). *Core curriculum in ethnogeriatrics (2nded., module 4)*. Stanford, CA: Stanford Geriatric Education Center. (Developed by the members of the Collaborative on Ethnogeriatric Education, supported by Bureau of Health Professions, Health Resources and Services Administration, U. S. Department of Health and Human Services.)

Yeo, G. & Gallagher-Thompson, D. (Eds). (2006) *Ethnicity and Dementias* (2nd ed, pp. 263-83) New York: Taylor & Francis

Yi, J. K., & Prows, S. L. (1996). Breast cancer screening practices among Cambodian women in Houston, Texas. *Journal of Cancer Education, 11*, 221-225.

(REFERENCES CONT'D)

Internet Resources

http://www.aancart.org/Unequal%20Burden.htm

Amerasian Foundation (http://amerasianfoundation.org)

Asian and Pacific Islander Health Forum: (www.apiahf.org; http://www.apiahf.org/new featured/ssi.html).

http://www.boston.com/news/local/articles/2006/12/10/diabetes_afflicting_more_in_us_asian_population/

http://caonline.amcancersoc.org/cgi/reprint/48/1/31.pdf

US Census Bureau (2001) www.census.gov

http://www.culturalcompetence2.com/

http://www.diversityrx.org.

http://ethnomed.org/ethnomed/clin_topics/asian_br_cancer.html

http://www.epidemiology.vcu.edu/MPH_Program/Research/Do.htm

http://www.hhs.gov/ocr/lep/. (Tom Perez)

http://www.healthlaw.org.

http://iccnetwork.org/cancerfacts/cfs3.htm

Immigration and Naturalization Service: http://www.ins.usdoj.gov.

Immigration and Naturalization Service. This month in immigration history-July 1979: http://www.ins.usdoj.gov/graphics/aboutins/history/july79.htm

National Alliance for Multicultural Mental Health, The.: A program of immigration and refugee services of America. Lessons from the field: Issues and resources in refugee mental health: http://www.refugeeusa.org.

http://www.nci.nih.gov/statistics/

http://noah.potk.in/

http://jrs.oxfordjournals.org/cgi/reprint/17/3/319.pdf

http://www.prb.org/pdf05/PromotingHealthyBehavior_Eng.pdf

Southeast Asia Resource Action Center. 1628 16th St. NW, 3rd Floor, Washington, DC 20009, (202) 662-4690: http://www.searac.org

Southeast Asia Resource Action Center. (2000). Southeast Asian American Mutual Assistance Association Directory 2000: http://www.searac.org/maadirec.html.

http://www.suckhoelavang.org/

http://www.vamausa.org/m3_statisticsonbreastcancer.php

http://www.womancando.org/conditions/asian.htm

Yang, K. Y. (2000, February 23. The status of Southeast Asian Americans: (http//www.searac.org/kayingtest.html). Paper presented to InterAgency Working Group White House Initiative on Asian Americans and Pacific Islanders, Southeast Asia Resource Action Center, 1628 16th St. NW, 3rd Floor, Washington, DC 20009, (202) 662-4690, http://www.searac.org.