

Delivering Clinical Services to Vietnamese Americans: *Implications for Speech–Language Pathologists*

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In order to prepare for a future in which speech–language pathologists (SLPs) might provide clinical services to an estimated 5% to 10% percent of the Vietnamese American community, this article offers a review and summary of the best of what we currently understand with regard to (a) Vietnamese history and immigration patterns; (b) probable demographics of consumers within the Vietnamese American community who would need services; (c) the culture and structure of the Vietnamese American family, including the influence of the community on the family; and (d) traditional Vietnamese medical practices contrasted to those of the European American community. The article summarizes six broad guiding principles for SLPs to follow when contemplating the provision of service delivery to Vietnamese American clients. Additional references are provided for practitioners wishing to extend their competencies beyond the scope of this preliminary review.

Over the past 25 years, there has been a large influx of Vietnamese immigrants and refugees to the United States. In 1997, the U.S. Bureau of the Census estimated that there were 849,000 Vietnamese Americans in the United States, representing 8.4% of the total Asian and Pacific Islander popula-

tion (T.-U. Nguyen, Dale, & Gleason, 1998). By the year 2000, Vietnamese Americans were projected to be the third largest Asian and Pacific Islander population in this country.

Although the Vietnamese American population in the United States is growing, relatively little about its specific history or culture is known by most speech–language pathologists (SLPs). This population shares some characteristics with other Asian and Pacific Islander groups, but many aspects of its history and culture are unique. Of particular importance to the field of speech–language pathology is the Vietnamese attitude toward individuals with disabilities. Even fewer reports are available to help clinical practitioners understand the attitudes of the Vietnamese American population toward persons with communication difficulties. Anecdotal reports and studies of other Asian American populations have indicated that some Asian immigrants have difficulty understanding or accepting individuals with disabilities (Ryan & Smith, 1989; Sonnander & Claesson, 1997).

This article provides an introductory overview of Vietnamese American culture and traditions in order to assist SLPs in preparing clinical service delivery to consumers within this growing population. The objectives were to (a) outline the history and immigration patterns of this community, in both the distant past and projected future; (b) provide information

about demographics and the little that is known concerning Vietnamese Americans' attitudes toward disabilities; (c) describe the structure of the family, including the influence of the community on the family; and (d) summarize traditional Vietnamese medical practices and contrast them with those of the European American community.

In 2000, SLPs as a group were still predominately European American by ethnicity and culture. If SLPs are going to be expected to provide clinical services to the Vietnamese American population, they will need access to information about the values, beliefs, traditions, and practices of members of this group in order to make reasonable and culturally appropriate recommendations regarding clinical interventions. Using demographic data and the clinical experiences and observations of a group of professionals with expertise in diversity training, this article will map out preliminary culturally appropriate implications for SLPs wishing to provide services to consumers within Vietnamese American communities. Each historical summary of the literature is followed by a brief discussion of the implications for SLPs. Readers seeking more in-depth discussions are referred to the extensive reference section on "Additional Resources" at the end of this article.

VIETNAMESE HISTORY

Prior to 1975

Throughout their long history, the Vietnamese have been proud of their ability to maintain a distinct cultural identity while incorporating positive aspects of the different cultures that sought to rule them. The first country that sought to control Vietnam was China, which governed Vietnam directly from 111 B.C. to A.D. 939 (Duiker, 1983, cited in Holleman, 1991). During that time, a variety of Chinese beliefs and traditions—including the religions and philosophies of Confucianism, Buddhism, and Taoism; the system of Chinese medicine; and the Mandarin system of examination for government positions—were introduced to Vietnam. In A.D. 939, the Vietnamese overthrew their Chinese rulers and remained independent of China, with the exception of a short period during the 15th century (Holleman, 1991). Powerful Vietnamese lords governed various sections of the country, with one group controlling the North and another controlling the South, and they expanded Vietnam's boundaries.

During the 16th and 17th centuries, European merchants and missionaries arrived (Holleman, 1991). Although most of the Europeans eventually left, the French formally took control of Vietnam in 1883. They instituted a variety of changes in government and in the education system, including the introduction of the Romanist alphabet version of written Vietnamese and Western medical practices (Holleman, 1991).

The French fled Vietnam during World War II, and the Japanese occupied parts of it (Holleman, 1991). Although the French returned to Vietnam after the war ended, they found themselves in an armed struggle to retain political control,

culminating in the final surrender in 1954. The Geneva Agreement of the same year divided Vietnam into two parts at the 17th Parallel and mandated elections to reunite the country. The South Vietnamese government's cancellation of the planned elections in 1956 precipitated a campaign of guerrilla warfare by North Vietnam.

The United States became involved militarily in Vietnam in 1961 and was heavily involved in the conflict between North and South Vietnam by 1966 (Holleman, 1991). After years of warfare, negotiations to cease the bombing of the two countries began. North Vietnamese forces then moved into South Vietnam and took control of the country in April of 1975. The civil war took a heavy toll: Roughly 10% of the Vietnamese population was killed or wounded (Karnow, 1984, cited in Holleman, 1991). Immediately after the fall of Saigon, the capital of South Vietnam, former South Vietnamese military officers and other individuals involved in the government were imprisoned or confined for weeks, months, or years. They risked death if they attempted to escape (Lynch, 1997; Zhou & Bankston, 1998).

Emigration to the United States

With the fall of Saigon, numerous Vietnamese immediately fled the country. Most of the individuals in this first wave were middle or upper class, well educated, and Catholic, and they spoke English (Egawa & Tashima, 1982). Many of them had also been associated with the government of South Vietnam. Refugees initially moved into various communities throughout the United States; however, many refugees later resettled near friends or relatives in the country's warmer regions (Zhou & Bankston, 1998).

In 1978, tensions with China precipitated a second wave of emigrés of Sino-Vietnamese heritage (Zhou & Bankston, 1998). Other Vietnamese also left at that time on foot or in leaky, aging boats, facing the dangers of storms and pirates. These "boat people" were less wealthy and less educated than the first wave of emigrants, and an estimated 50% perished in transit (Trueba, Cheng, & Ima, 1993; Zhou & Bankston). Survivors were sent to refugee camps in Southeast Asia, where many suffered from anxiety and stress while sometimes waiting months or years for sponsorship and resettlement in other nations (Zhou & Bankston).

In response to the plight of the people in this second wave, the United States passed the Refugee Act of 1980 and widened the scope of resources available to assist refugees, defined as people who left their native country and could not return because of fear of persecution and physical harm. Refugees became eligible for cash assistance, medical benefits, and other services (Kibria, 1993, cited in Menjivar, 1997).

Continuing persecutions in Vietnam resulted in a third refugee wave that consisted primarily of soldiers, political prisoners, and Amerasian individuals. Under the Orderly Departure Program of 1979, more than 200,000 former military officers and soldiers in Vietnamese prisons or reeducation camps were allowed to fly to the United States with their fam-

ilies (Zhou & Bankston, 1998). The Humanitarian Operation Program of 1989 also permitted more than 70,000 current and former political prisoners to emigrate. Finally, the Amerasian Homecoming Act of 1988 allowed the children of Vietnamese civilians and American soldiers to come with their families to the United States. Many of the Amerasian children were orphans who had lived on the street, had received no formal education, and had been subjected to prejudice and discrimination in Vietnam (Zhou & Bankston).

Implications for the SLP

Although the Vietnamese individuals in all three waves suffered hardships in Vietnam, they differed in their socioeconomic, political, and educational status and represented a variety of backgrounds. This diversity has continued to be characteristic of the Vietnamese American population in the United States. Consequently, SLPs need to ascertain the background and immigration circumstances of their Vietnamese American clients. In addition, some Vietnamese Americans may believe certain issues, such as survival, education, or culture, are more important than speech–language pathology. The SLP who is educated about the history and hardships of Vietnamese Americans may be better able to adapt to the needs and concerns of the client and his or her family.

U.S. DEMOGRAPHICS

California is home to approximately half of the Vietnamese American population in the United States, with more than three quarters of that number residing in Orange County, San Jose, Los Angeles, and San Diego (Zhou & Bankston, 1998). The Vietnamese American community in Orange County, California, is the largest in the world outside of Vietnam, and it represents an estimated 4.5% of the county's population and 10% of the public school children with limited English proficiency. Other states with large Vietnamese American populations include Texas (the only other state with more than 10%), Virginia, Washington, Louisiana, Florida, Pennsylvania, New York, and Massachusetts. The Vietnamese American population has also been concentrated in such cities as Houston; metropolitan Washington, DC; Seattle; and New Orleans (Zhou & Bankston).

Although the greatest concentrations of Vietnamese Americans currently are in a few regions of the United States, states that historically have had relatively low percentages of Asians are experiencing great increases in the numbers of Asians and Pacific Islanders. Between 1990 and 1998, the Asian and Pacific Islander populations' greatest growth was in Nevada, Georgia, and North Carolina, with estimated increases of 80% or more (U.S. Bureau of the Census, 1999). It therefore is not unreasonable to expect that numbers of Vietnamese Americans in other parts of the country may grow as well, making information about them increasingly relevant to SLPs throughout the United States.

ATTITUDES TOWARD DISABILITIES IN THE UNITED STATES

Asian Americans and Pacific Islanders

In the United States, a reported 9.9% of Asian/Pacific Islander individuals have disabilities, and 4.5% have severe disabilities (Bradsher, 1997, cited in Bryan, 1999). It is important to note that these percentages tend to be far lower than those for any other ethnic or racial group. Given this discrepancy, it is quite probable that the incidence of disabilities has been underreported for Asians and Pacific Islanders (Bryan). Therefore, one must ask, Why might members within some populations underreport the incidence of disabilities within their own communities? It may be due to experiences of prejudice against individuals with disabilities. For example, Ehrmann, Aeschleman, and Svanum (1995) found that in the United States parents took their children with disabilities into the community to shop or do other chores, but they were less likely to participate in community activities for purposes of enrichment or entertainment. Joesch and Smith (1997) found that parents of children with many types of severe disabilities were two to three times more likely to divorce than were the parents of children without disabilities, and Sobsey, Randall, and Parrila (1997) noted that boys with disabilities were disproportionately more likely to be abused.

Although a U.S. study by Stevens and colleagues (1996) found that a sample of adolescents with physical disabilities had positive attitudes toward their families, schools, and themselves, they reported having less satisfying friendships with peers and lower aspirations for higher education. Indeed, Weiserbs and Gottlieb (1995) found that elementary and secondary students were consistently more willing to help students with disabilities than to befriend them. Ambivalent attitudes toward individuals with disabilities have also been evident in the employment practices of U.S. corporations, even though the Americans with Disabilities Act (ADA) of 1990 prohibited discrimination in hiring. In a study by Scheid (1998), only one third of a sample of U.S. companies reported having a plan for implementing nondiscriminatory employment practices mandated by the ADA, and less than half reported making a special effort to hire individuals with physical handicaps. In a study of managers, Thakker and Solomon (1999) found that approximately 40% had recruited, interviewed, or hired an individual with a physical disability within the past 2 years.

Although the attitudes of Vietnamese American families toward children with disabilities are less well known or studied than those of European American individuals, several studies of Chinese and Chinese American families exist that might shed light on the attitudes also experienced within the Vietnamese American community. Chinese influence on Vietnam's medical, social, and political systems has also been substantial due to its former control of Vietnam, its shared border, and the large number of Chinese immigrants in Vietnam.

Chinese Americans

In a study of Chinese American parents' reactions to their children with developmental and physical disabilities, Ryan and Smith (1989) found that nearly 50% of the parents did not understand their child's problem, due in part to their limited English ability and to complicated explanations by physicians. Parents had greater difficulty understanding invisible disabilities—including neurological impairment, autism, and learning disabilities—than more visible problems, and many regarded their children's problems as temporary. For some parents, the professional diagnosis was relatively unimportant because family members had made their own determination of cause, often looking to past events or careless acts that permitted heat or cold to attack their child. Because of their exposure to precepts of Chinese medicine, some believed that problems with "hot" and "cold," specifically, frequent high fevers, were the cause of their child's disability. It is reasonable to assume that similar belief systems are operating in the Vietnamese American community regarding a family's willingness to report or understand a disability.

Ryan and Smith (1989) also found some commonalities with other Asian cultures in terms of reactions to a diagnosis of disability. Like many middle-class European American parents, some Chinese American parents thought they had done something wrong. Some parents feared being blamed for the problem, others blamed spouses, and some became depressed and socially isolated. Other parents denied that their child had a serious problem or reported partial acceptance of the disability.

In a review of studies of parents of children with intellectual disabilities in mainland China (Sonnander & Claesson, 1997), Pearson and Chan (1993, cited in Sonnander & Claesson) found that mothers of children with intellectual disabilities underwent significantly more stress, had significantly less emotional support from others, and frequently felt isolated, trends also seen in Western families (Friedrich & Friedrich, 1989, cited in Sonnander & Claesson). Unlike the United States, daughters-in-law were traditionally blamed when a baby had a problem (Sonnander & Claesson), and they received less support from in-laws than from natural family members (Pearson & Chan, 1993, cited in Sonnander & Claesson). Cheng and Tang (1995, cited in Sonnander & Claesson) also found that parents frequently avoided taking their children to public places to avoid unfriendly stares, rejection, and excessively sympathetic reactions. Finally, families of individuals with disabilities often refused services (Mitchell et al., 1993, cited in Sonnander & Claesson).

Implications

For some Vietnamese Americans, traditional attitudes toward disabilities, in conjunction with family traditions of privacy and limited English capabilities, have acted as barriers to understanding and accepting their child's disabilities. Because of

limited knowledge of special education services, some families have found it difficult to seek or obtain such services.

Although there have been a number of anecdotal reports that Vietnamese American individuals with disabilities are sometimes stigmatized, negative attitudes toward these persons have not been limited to Asian populations. Western countries historically have had varying attitudes toward such individuals, ranging from more neutral attitudes to actual policies of genocide (Gallagher, 1995).

FAMILY STRUCTURE AND COMMUNITY INFLUENCE

Although there are no typical families, and we as authors run the risk of oversimplifying the description of the family, we believe that it is important to compile a history of the evolving family as it was often found in Vietnam and is now observed in the United States. Such an historical and evolutionary examination of the family should assist the SLP in understanding how a Vietnamese American family may or may not be different from his or her own, thereby providing for increased awareness and appropriate expectations during initial meetings with families.

Collectivist and Individualist Cultures

In Vietnam and the United States, the Vietnamese family is part of a collectivist culture in which the desires of the individual are subordinate to the needs of the group, which often includes extended family members (Sue & Sue, 1999). A number of attributes are associated with collectivist cultures (Gudykunst, 1998). One notable aspect of communication in this type of culture is the preservation of "face" or one's image in communicative interactions with important others. In any communicative interaction, speakers may be concerned with *self-face* (their own positive or negative image) and/or *other-face* (the image of others in the interaction). Members of collectivist cultures are socialized to be concerned about self-face and other-face and will often take pains to ensure that all participants in communicative interactions do not lose face or feel embarrassed. Consequently, they may take care to preserve harmonious relations with members of their family and friends and may avoid conflict in order to preserve face, hesitating to openly state concerns or preferring to rely on a mediator in a potentially uncomfortable situation.

As part of their emphasis upon preserving face with important others, members of collectivist cultures often rely on *high-context communication* (Gudykunst, 1998) in which much of the content is conveyed nonverbally. In this way, they can avoid conflict by sending indirect messages that are less likely to result in disagreement or conflict than are more direct requests or refusals.

Members of collectivist cultures often feel an obligation to assist others in their family or important social groups and

to expect the same behavior from others in turn (Gudykunst, 1998). Consequently, the concerns of one family member may be viewed as the concerns of all persons in the family. In addition, many collectivist cultures, including Vietnamese culture, have a hierarchical family structure in which younger members defer to older members for advice and direction.

The collectivist communication style may be contrasted with the individualist communication style more characteristic of the United States (Gudykunst, 1998). In individualist cultures, there is less concern about other-face, leading to less hesitancy in openly stating disagreements with others. Individualist cultures often rely on *low-context communication* in which a greater part of the content is communicated through words and there is more concern for precision in communication. Individualist cultures, such as that of the mainstream culture of the United States, may have a less hierarchical family structure and may also expect individuals to be more independent of their families and friends and to pursue their own interests.

Family Structure in Vietnam

Vietnamese extended families have traditionally included paternal relatives; however, a study of present-day Vietnam (Hirschman & Vu, 1996) found more nuclear families—and more frequent interaction of these families with nearby paternal and maternal relatives—in the northern part of the country. Although the Vietnamese legal code gave women equal rights (Heifetz, 1990; Hirschman & Vu) in practice, the genders filled different roles. The traditional Vietnamese family was hierarchical, with the father having the power to make decisions regarding matters outside of the family. The Vietnamese mother managed the family's finances and was a decision maker regarding family matters. Traditionally, women also became part of their husband's family when they married and were expected to assume greater responsibility for their spouse's family than for their own. Divorce was considered a disgrace to the families of both marriage partners.

In Vietnam, the father was the primary or sole wage earner, although in less affluent households many women were involved in a business or other money-earning activities (Phan, 1994). Both mother and children were expected to defer to the father, and older children were frequently given responsibility for younger ones. Sibling relationships, even in the United States, were often close (To, 1993). The eldest son was often accorded a special status and took over as family head if the father died (Locke, 1998). When his parents became elderly, he was expected to care for them; public assistance was almost unknown in Vietnam (Nisewan, 1995).

Parents continued to play an important role in the lives of their adult children. They could influence their son or daughter's choice of a career or marriage partner. Furthermore, family members were expected to turn to the family for help with physical needs, emotional problems, and other crises. Sharing information about the family's problems to

strangers resulted in a loss of face and was highly frowned upon (T. Nguyen, 1986).

Family Structure in the United States

With the move to the United States, changes often occurred in family structure. Although Vietnamese refugees frequently brought their children, many left extended family members in Vietnam, particularly the elderly, and, possibly, those with severe disabilities (To, 1993). In other cases, family members were executed or died during the trip. As a consequence, some groups of unattached individuals formed informal fictive kin groups that functioned as a family during and after emigration (Gold, 1992).

Many Vietnamese men suffered downward mobility upon their arrival in the United States and were initially unable to find jobs in the professions they had practiced in Vietnam (Grunkemeyer, 1991). Wives were often able to find work more easily than their spouses or worked for the first time to supplement the family's income (Gold, 1992). Older children took on greater responsibilities than they had in Vietnam by caring for young siblings or working to help support the family (Lynch, 1997).

With these changes in family responsibilities, some fathers felt that they had lost respect and power in the family constellation (Gold, 1992). Many women, in turn, gained a stronger voice in family affairs. Children also sometimes gained influence as interpreters for their families because they more easily acquired English than did their elders. These changes were disruptive for some families, and the divorce rate increased (Grunkemeyer, 1991). One study reported that 15% of Vietnamese American families were headed by a woman (Rumbaut, 1997).

Many Vietnamese American families, however, were able to maintain much of the traditional structure while adapting to changes. In fact, surviving difficult times brought some families closer together (Lynch, 1997), although many families regretted leaving friends and family members behind in Vietnam.

Vietnamese American families' distrust of outsiders was often intensified during the refugee process. The poor treatment of many individuals by the Communist government made their distrust of government and authority even greater (Heifetz, 1990; Lynch, 1997, To, 1993). In addition, the military and ideological turmoil of the civil war and its aftermath led to a fear of inquiries, especially from government agencies (To). The use of a trusted person of authority as a mediator has been found to be helpful in gaining the cooperation of Vietnamese Americans (To). Lynch also found that many Vietnamese American families did not wish to be perceived as refugee families with difficulties, but as educated, happy, and emotionally close families with above-average incomes.

Vietnamese American individuals have varied widely in their adaptation, or acculturation, to the United States. One

common model (Locke, 1988) used to describe acculturation has employed the following four categories:

1. *bicultural*, in which individuals adapt to the new culture yet retain strong ties with the old;
2. *acculturated*, in which individuals adapt to the new culture and lose vestiges of the old;
3. *traditional*, in which individuals do not adapt to the new culture and continue to strongly adhere to the old; and
4. *marginal*, in which the individual has few ties to either the old or new culture.

Studies of Vietnamese Americans' acculturation have reached a variety of conclusions regarding the relationship between acculturation and other positive aspects of adjustment to the environment. In a study of Vietnamese American high school students in a cohesive New Orleans community, Zhou and Bankston (1998) found that students were more academically successful if they held traditional cultural attitudes and had strong family and community ties. In contrast, Vietnamese American adolescents in the smaller Vietnamese American community of Lansing, Michigan, had better grades, more positive family/parent relationships, higher self-esteem, and less depression if they were involved in U.S. mainstream culture (H. Nguyen, Messé, & Stollak, 1999). In another study by Nguyen-Chawkins (1996), parents with a greater investment in U.S. mainstream culture had children with similar attitudes, and individuals with more traditional orientations experienced more cultural stress.

Some studies (Grunkemeyer, 1991; Zhou & Bankston, 1998) also cited the importance of Vietnamese American communities in reinforcing members' adherence to culturally valued behaviors. According to Grunkemeyer, members of some Vietnamese American communities have had multiple relationships with one another through participation in informal friendship circles and religious and social organizations. Consequently, individuals' actions have been visible to other group members, and problems with one role or relationship have often affected an individual's performance in other roles. In a confirmation of Grunkemeyer's hypothesis, Kibria (1996) found that informal Vietnamese American women's groups in Philadelphia gossiped about and subsequently ostracized community members who mistreated their spouses and did not reform their behavior.

Studies of native language retention in Vietnamese American communities have reported conflicting results. Portes and Hao (1998) found that Vietnamese was spoken in a large percentage of Vietnamese Americans' homes and that Vietnamese classes frequently were held to teach younger generations the language. Second-generation Vietnamese Americans were also found to be more likely to retain their language than were other Asian groups (Portes & Hao). In contrast, Rumbaut (1997) noted that Asian students were less likely to retain their first language than were Mexican American stu-

dents, even when attending a school with a large Asian population.

Implications for SLPs

There are a number of implications that arise from an understanding of Vietnamese American family structure and community influence. SLPs working with Vietnamese American children with disabilities and their families may note the following in their daily practices:

1. Vietnamese American family members vary widely in their degree of adaptation and acculturation to the culture of the United States and in their English capabilities, making communication sometimes difficult.
2. Because of concern about public perceptions of their family, some Vietnamese Americans may appear hesitant to share information about their child's disabilities with outsiders, including medical or school personnel.
3. They may additionally feel uncomfortable challenging or disagreeing with professionals because of their collectivist culture.
4. Placement and program decisions often may be made by the senior male of the extended family, the father, the mother, or any number of family members.
5. Finally, family members often expect to fully care for a child with disabilities in the family home, an expectation that will potentially influence treatment decisions, at least initially.

SLPs will see a difference between European American families and Vietnamese American families, especially with regard to the extent of independence sought by the client. SLPs may also experience differences in clients' familiarity with U.S. medical practices when providing services to clients in the Vietnamese American community.

VIETNAMESE MEDICAL TRADITIONS

It has been our experience that professionals within the European American community are often surprised at some of the medical beliefs and practices of persons within the Vietnamese American community. For this reason, a brief summary of Vietnamese medical traditions is included here.

In Vietnam

Historically, the Vietnamese have adhered to several medical traditions, with precepts of some systems contradicting the precepts of others. For example, spiritual beliefs have been an integral part of these Eastern medical belief systems, which is in contrast to their separation from Western medical tradi-

tions (Sue & Sue, 1999). In Vietnam, the medical traditions and belief systems date back over a thousand years. Western medicine has also been far less accessible and more expensive than more traditional medical practitioners, resulting in more frequent use of the latter.

Thuoc Bac, also called *Northern or Chinese medicine*, is based on Chinese medical lore and is practiced only by individuals able to read Chinese medical texts (Marr, 1987). Its basic principle is the interaction of *am* and *duong* (*yin* and *yang* in China) and the necessity of maintaining a balance between the two forces. The patient's body is believed to be linked to external forces; thus, adapting it to the environment and strengthening it against changes are important aspects of good health. Disease is characterized as the disruption of the balance between physical and moral or external and internal forces (Marr).

The practice of this medical philosophy depends on visual inspection, auditory perception, and questioning of the patient, in conjunction with taking the patient's pulse (Marr, 1987). The practitioner takes the patient's pulse rate at different parts of the body to judge the condition of internal organs associated with particular pulse points. The practitioner also inspects different parts of the head to ascertain the condition of traditionally associated organs (e.g., the nose is associated with the lungs).

Practitioners try to determine whether an illness is due to poor physical maintenance, emotional strain, or external forces, such as the weather or improper foods, that may disrupt the system (Marr, 1987). They "locate" the illness within the body and look for possible excesses of "heat" or "cold." Practitioners prescribe medicines to produce desirable symptoms, such as heat reduction or sweating and stimulation or soothing of organs. Some practitioners also perform acupuncture to stimulate specific parts of the body.

Southern medicine is based on remedies using plants and animals native to Vietnam (Marr, 1987). Households in Vietnam often have a variety of home remedies for common illnesses, and some individuals with extensive knowledge work part-time as healers in return for gifts of food or other commodities. Since 1975, the Vietnamese government has encouraged the combination of traditional and cosmopolitan (Western) medical practices (Hoang, Pho, & Huu, 1993), training traditional medical physicians and acupuncturists at institutes, and encouraging other healers to increase their knowledge of traditional remedies. Consequently, recent immigrants from Vietnam have been exposed to a state-sponsored medical system based on traditional medical remedies.

Yet another Vietnamese medical tradition deals with *harmful spirits* (Marr, 1987). Historically, little or no counseling for mental illness has been available in Vietnam, and mental illness has been stigmatized as highly irrational, "crazy" behavior. In some cases, the unusual behavior of some individuals with disabilities has also been interpreted as requiring spiritual intervention. It is more socially acceptable to com-

plain of physical problems or difficulties with ghosts or spirits than to seek help for mental difficulties. Furthermore, some individuals who venerate ancestors believe that the spirits of ancestors, when honored, can aid living relatives and when neglected, can harm them (Holloman, 1991). Consequently, a variety of individuals—including sorcerers, mediums, Taoist priests, or Buddhist monks—are available to assist in spiritual healing.

The Western medical tradition introduced by the French in Vietnam was well regarded but typically was limited to the cities, the wealthy, and individuals in the Vietnamese armed forces (Egawa & Tashima, 1982). Western medicine developed a reputation of being fast-acting and "hot," quick to have its effects wear off, and inappropriate for illnesses considered to be "hot" (Holloman, 1991). It has been supplanted by Eastern traditions.

In the United States

Jenkins, Le, McPhee, Stewart, and Ha (1996) found that some Vietnamese Americans have continued to use or believe in traditional Vietnamese medical remedies, including using Chinese herbs (47% of respondents), employing Southern medical practices (84%), rubbing the back vigorously with a coin ("coining"; 65%), and keeping *am* and *duong* in balance (48%). At the same time, they found that the individuals surveyed did not generally believe in spirit-caused illness, preferred to see a Western doctor when ill (75%), and believed that Western medicine is more effective than Eastern medicine (90%). Recent immigrants and individuals with less English proficiency or education were more likely to follow traditional practices or beliefs, although there was no significant negative relationship between traditional medical beliefs and the use of Western preventative health care.

Implications for SLPs

The use of traditional medical practices in the United States has been complicated by important differences between the Vietnamese and U.S. medical systems. SLPs should be knowledgeable about such differences so that they do not misinterpret the behaviors of the people they serve. In addition, SLPs must have an understanding of the origins of some of the practices in order to adjust their expectations during initial meetings and diagnostic sessions.

In the United States, some Southern medicine practitioners have been forbidden to practice or have practiced illegally because their medical expertise has not been recognized in this country (Holleman, 1991). Some Southern medical remedies have also been misinterpreted, as when the marks or bruises that result from coining have been interpreted by police as evidence of child abuse (Holloman).

The system of varying medical traditions in Vietnam has also affected the medical beliefs and practices of Vietnamese Americans in the United States. First, some Vietnamese

Americans follow the culturally approved attitude of stoicism or tolerance of pain. As a result, they may delay visiting a doctor until symptoms are far advanced (Jenkins et al., 1996). Second, many Vietnamese American families are accustomed to selecting health-care providers from a variety of medical traditions and use medications or practices from different medical traditions simultaneously. It is not unusual for an individual to continue using Southern medicine remedies while following the recommendations of a Western-trained doctor. Third, some Vietnamese American patients do not take medications in a prescribed manner (Holloman, 1991). Because many Northern and Southern medicines may be taken as needed without causing side effects, some Vietnamese Americans dilute, decrease, or increase the dosage of Western medicines or do not finish the full course of an antibiotic. Fourth, many Vietnamese American families make collective decisions regarding a family member's medical care instead of deferring to a patient or parent as the decision maker (McLaughlin & Braun, 1998, Norman, 1996). Finally, some Vietnamese Americans deny using traditional medicines because some traditional medical practices have been deemed illegal (Holleman). All of these characteristics and often-observed practices will continue to have implications for those who work with Vietnamese American individuals with disabilities.

Speech-language pathology usually is not considered as a health-care option for many Vietnamese American families. Thus, SLPs must be patient when working with families for the first time and may need to become advocates for new and different methods of health care and health-care practices. Most importantly, SLPs may find themselves in the role of educating their clients about the health-care system, including introducing the concept of speech-language pathology and its importance. How might the SLP best accomplish the goal of delivering the most appropriate clinical services?

GUIDING PRINCIPLES FOR DELIVERY OF SERVICES

Clients from different ethnic groups bring a richness of traditions, values, belief systems, history, and understanding to sessions for planning the most appropriate clinical intervention, which should be accomplished through teamwork between the professional(s) and the family. This needs to be taken into account when planning interventions for a client from a particular group. The following are some guiding principles for practitioners interested in planning interventions for Vietnamese Americans with speech or language problems. These guidelines are also applicable for other culturally diverse groups.

1. Each person is a product of his or her total life experience at any point in time. This means that if the SLP and the family have had different life experiences, the SLP will need to make an extra effort when planning for service delivery.

2. The SLP should review the literature with regards to historical perceptions of disability, then select the conversa-

tional style most appropriate for first meeting a family. SLPs who understand that families may hide persons with disabilities or feel that they have caused the disability will better understand the nature of the family's response when first meeting to discuss a child's needs. When interacting with persons who may be experiencing feelings of shame or guilt, SLPs will need to adjust their expectations and communication style.

3. The SLP should understand the traditional structure of the Vietnamese American family. He or she should not assume that each and every family still maintains Vietnamese traditions but should not be surprised if he or she observes the following characteristics:

- A lack of English fluency may sometimes cause communication difficulties.
- Family members may be hesitant to share information about a child's disabilities with outsiders, including medical or school personnel, because of concern about public perceptions of their family.
- Decisions may be made by the senior man of the extended family or by any number of family members.
- Family members may expect to fully care for a child with disabilities in the home, an expectation that will influence treatment recommendations.

4. The nature of the service delivery plan will be dependant on the extent of the Vietnamese American family's comprehension of the traditional U.S. health-care delivery system. For example, if the SLP determines that the family typically follows traditional Vietnamese medical practices, then he or she should expect to spend more time in explaining the rationale for and process of speech-language service delivery before moving into a discussion of specific goals and objectives.

5. SLPs should know about Vietnamese medical practices so that they do not misinterpret the behaviors of the family members they serve. For example, the SLP who is educated regarding practices such as coining will be more patient with these practices and not interpret them as child abuse. SLPs must also realize that speech-language pathology is not a familiar health-care option for many Vietnamese American families. As a result, the SLP may find him- or herself becoming an advocate for new and different methods of health care and health-care practices or acting as an educator about the health-care system, answering questions such as, "What is speech-language pathology and why does a consumer need these services?" This is new and different role for many SLPs.

6. Relatively few SLPs have undergone hardships as difficult as those of many Vietnamese American families, and the SLP who is educated about the traditions and history of Vietnamese Americans will be better able to respond with

a culturally appropriate action plan. In order to do this, SLPs must

- examine their own cultural identity,
- connect with leaders in the Vietnamese American community who have had different life experiences,
- admit limitations with regard to professional training and competencies, and
- avoid reaching beyond their current personal scope of practice without further study and learning.

SLPs who follow these guiding principles should begin to experience success in linking with the families they serve and in selecting and delivering the most appropriate action plan for culturally sensitive interventions.

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ADDITIONAL RESOURCES

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