Juggling Multiple Roles: Working Within the Vietnamese Community

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In this narrative, the authors describe their experiences delivering mental health services to the Vietnamese community. They discuss the importance of gaining credibility, and how their status within the Vietnamese American community affected this process. Case examples are used to illustrate the age and gender dynamics, as well as cultural factors that affected the delivery of mental health services.

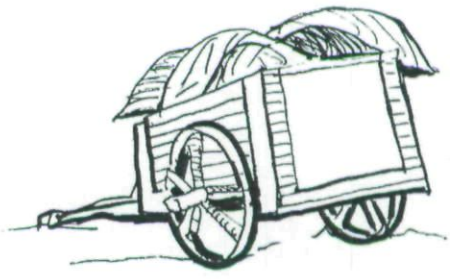
Who We Are

Over the past 30 years, more than 700,000 Vietnamese refugees have resettled in the United States, with over 135,000 leaving immediately after the fall of Saigon in April 1975 (Freeman, 1995). We are part of the more than 1.2 million Vietnamese Americans living in the U.S. (U.S. Census Bureau, 2002). Each of our families took different routes to come to the U.S. and resettled in different regions, but we have shared the experience of becoming bicultural Vietnamese-Americans and providing mental health services to the Vietnamese community.

Duy's family left Vietnam two days before the fall of Saigon. After spending several months at Camp Pendleton in Southern California, the family was resettled in the Washington, D.C., area where he was born later that year. He grew up on the periphery of the Vietnamese community, visiting only to shop and eat. Not living in an area with a high Vietnamese concentration, he had few Vietnamese friends growing up. Upon choosing a career in social work, he did not intend to work with the Asian and Vietnamese communities. His interactions with a young Vietnamese client while at a therapeutic day camp offered him a glimpse into the importance of language and culture within the therapeutic relationship, and he changed his career direction.

Chaffee's family left Vietnam by boat in the days leading up to the Fall of Saigon. Initially sent to a military base in Arkansas, her family was resettled in the growing Vietnamese community in Chicago. Although she attended mostly White parochial schools, her family lived in the Vietnamese community, and they attended a Vietnamese Church. With an enduring commitment to strengthening her community, Chaffee has been engaged in many community-specific activities that range from youth programs to mental health casework.

Having been born in the U.S., Duy and Chaffee are members of the second generation, while Ha belongs to the 1.5 generation, after, as a young girl, traversing land and sea with her aunt to come to America. Eventually arriving in Boston, she and her family settled in the Dorchester area, where many Vietnamese refugees were living. For several years her grandmother worked as a housekeeper for a non-Vietnamese couple living in the Boston suburbs. This couple offered to welcome Ha into their family, thereby enabling her to attend school in a better district. Blending a background in art with therapeutic skills, she is trained as an art therapist. Over time, working with the Vietnamese community has evolved from a



part-time endeavor to a full-time commitment.

Although we had different family structures, and lived in different communities, we shared many experiences common to our place in the 1.5 and 2nd generations. We have observed our families and communities as they worked to find success in a new land. Growing up in Vietnamese homes and attending American schools taught us how to bridge cultures. While sharing mainstream experiences, as a racial minority we have learned to negotiate the world around us. We have benefited from having the perspective of living in between two worlds and are admittedly highly acculturated.

Maybe it was because we grew up in mostly White communities, attended mixed-race schools, or negotiated the pressure from our families to pursue medical or engineering careers that we chose career paths that led us to be mental health professionals. Coursework and practice experiences attempted to prepare us to work with the predominant groups in American society: White, Black, and Hispanic. Undergraduate and graduate courses emphasized a humanistic perspective. Theory and practice examples reflected helping knowledge generated by thinkers from majority culture with little input from minority communities. Our heritage, the experiences of past generations, was inconsequential to our academic preparation for professional practice.

Ultimately, we wanted to apply our skills within the Vietnamese community, which has lacked professionally trained mental health professionals. We sought to apply our unique perspective, linguistic ability, and cultural knowledge with Vietnamese American mental health consumers. Once we began working at an ethnic-specific mental health agency in the Midwest, our culture became our work. Vietnamese was no longer simply the language we used to communicate with our grandmothers, but it became our professional language. We supplemented our vocabularies with psychological terms translated to Vietnamese. From our clients, our peers, and personal reflection, we discovered the challenges and rewards associated with serving our community.

Mental Health and the Vietnamese

Mental health need among Vietnamese immigrants and refugees has been well-documented in the literature. Though Vietnamese have resettled in the U.S. for over 30 years, most research has focused on new arrivals. Health clinic screenings for mental health symptoms and disorders reveal relatively low incidence of diagnosable conditions (Hinton et al., 1998; Buchwald et al., 1995; Hinton et al., 1993). Among recent arrivals, defined as those who have lived in the U.S. for less than six months, rates of depression range from 5.5% to 9% (Hinton et al., 1993; Buchwald et al., 1995; Hinton et al., 1998;). The majority of our clients had been in the U.S. for several years and came to seek services after their psychosocial complaints became unbearable.

Seeking to uncover the factors that affect adjustment, Tran (1993) reports that Vietnamese adults with more negative premigratory experiences, such as traumatic experiences associated with war and the refugee process, have higher levels of mental health need. Furthermore, status losses associated with resettlement in the U.S. have been observed to negatively affect adjustment; persons with high educational achievement and higher occupational status in Vietnam reported poor adjustment to life in the U.S. (Tran, 1992).

Once receiving mental health services, Vietnamese consumers receiving ethnic and language-specific mental-health services report positive outcomes. Studies have found that ethnic matching predicted an increased number of outpatient treatment sessions for Asian Americans (Gamst, Dana, Der-Karabetian, & Kramer, 2001; Lee, Lei, &

Sue, 2001; Uehara, Takeuchi, & Smukler, 1994). A study of Australian community mental health consumers found that Vietnamese clients who were matched with a Vietnamese caseworker had more frequent and longer contact with continuing care teams, less contact with crisis teams, and fewer hospitalizations, that were shorter in duration than non-matched clients (Ziguras, Klimidis, Lewis, & Stuart, 2003). Thus, matched clients were better able to receive treatment in the community as compared to an often unmatched inpatient setting.

Professional Practice

Our narrative describes our experiences working in an ethnic-specific mental health program in the Midwest. Formed during the 1970's to respond to the growing needs of refugees from Southeast Asia, the agency has been located where Vietnamese and Cambodian families live and work. Today, the pan-Asian mental health program has the staff capacity to serve clients from South Asia, Southeast Asia, China, Japan, and Korea. For each of us, this was the first opportunity to deliver mental health services within the Vietnamese community.

Very early on, the issue of credibility came to the forefront of our practice. Sue and Zane (1987) discuss two types of credibility that are needed to engage ethnic minority groups successfully in mental health services: ascribed and achieved. Ascribed credibility is assigned by individuals outside of the profession based on perceived status, while achieved credibility refers to the outcomes of the helping process. Before we could work with our clients towards desired goals, however, social factors affected how they viewed us as helping professionals. At the outset, clients perceived our credibility to be limited by our age and gender as we were relegated to lower statuses within the Vietnamese social structure, where men and elders occupy high social positions (Frye, 1995). Furthermore, most clients were unfamiliar with the concept of a mental health professional, leaving only a few who could assign a status to our professional role.

At the outset, the levels of ascribed credibility varied among the client population. Generally, older men attributed us less credibility due to our age or gender. Higher levels of credibility were assigned by women, especially those in early adulthood and middle age. Finally, younger clients were more likely to view us as professionals, compared to other adult clients.

Faced with the interaction between social roles and professional identity, our narrative will describe how we approached practice and the processes involved in achieving higher levels of credibility with different clients. We will present three case examples to help elucidate the prominent themes we encountered as mental-health clinicians from the perspective of acculturated Vietnamese Americans. We will focus on the social and cultural forces that impacted how we served our clients and other staff members. We were struck by how similar our reactions to the effects of age, gender, language, and acculturation, and how these themes resonated with other Vietnamese and Asian Americans of our generation working in the social services.

The Importance of Making Progress

T.D. is a 63 year-old War veteran who came from Vietnam seven years ago under the Humanitarian Operations program. After the War, he spent six years in a communist reeducation camp. He has trouble sleeping at night and reports frequent nightmares that contain scenes from the War. He has been diagnosed with PTSD. He is looking to apply for Supplemental Security Income (SSI) because the lack of sleep has had negative effects on his job performance at the manufacturing plant.

During intake, T.D. and his counselor develop a treatment plan comprised of medication management, case management, and individual counseling. He keeps his regular appointments with the psychiatrist and is eager to resolve his case management issues. Initially, however, he is reluctant to make regular appointments for individual counseling, but after several months, he begins to open up to his counselor's inquiries about his life and experiences. At the end of one session, he remarks pleasingly: "No one has ever listened to what I have gone through." After a few months, he begins attending a men's counseling group while discontinuing individual counseling.

We were all aware of the roles our ages and genders would play in establishing our professional credibility. We anticipated some of the challenges of engaging clients who were contemporaries of our parents and grandparents. Quickly, we found that clients could transfer credibility to us from established workers. For example, it was socially acceptable for T.D. to seek help from a psychiatrist, who held a high status because of his or her medical training. Working with a psychiatrist also provided relief for T.D.'s most frequent complaints of difficulty sleeping and poor mood associated with PTSD and depression. Interpreting for T.D. during his appointment, we could work with his psychiatrist to coordinate care and provide supportive counseling. Co-facilitating a group with a paraprofessional staff member whose credibility had been established afforded T.D. and other clients the opportunity to view us positively. Having a certain amount of credibility transferred to us enabled clients to be introduced to us and served as a point of departure for our future work.

For men such as T.D., it was easier to seek services that would help them fulfill their role as a provider for their families. Due to older age, the onset of chronic health and psychological conditions, and the difficulties of performing manual labor, we found men were more likely to seek help accessing public benefits programs rather than for affective complaints (Tran, Ngo & Conway, 2003). We observed the range of reactions from T.D. to receiving help from young mental health professionals. While he was uncertain of our ability to help him due to our ages, he demanded our time for case-management support. In this situation, our abilities to speak English and navigate the social-service system superseded T.D.'s discomfort surrounding the role reversal of seeking help from a younger person. The juxtaposition of seeking help from a younger person while being in need reflects his level of dependence on us as social workers; he relied on us for everything from sorting his mail to applying for public benefits, and interpreting and advocating at appointments.

Over time, as T.D. observed positive outcomes, such as receiving SSI or gaining relief from medication that we helped him access, we were able to build trust and credibility. He came to respect our abilities, which provided an opportunity to engage him to discuss stressors during individual therapy. Most men had never had the opportunity to verbalize their experiences during and after the War. Having an inviting and acceptable setting to discuss their reactions to past events and their lingering effects through individual and group services complemented the other services they received from our agency.

A Warm Reception

K.L is a 46-year-old mother of three. She has frequent crying spells and has been diagnosed with depression. She complained of many family problems, including her relationships with her husband and their children. She has been receiving SSI for a combination of physical and emotional complaints.

Her symptoms have improved over the course of a year of services that included

individual and group counseling as well as medication management. During one group session with other mothers, she revealed that she has been worried about her daughter for several months. Her daughter had not been performing well in school, had arguments with her siblings, and exhibited a range of depressive symptoms, including poor moods and social withdrawal. She was hopeful that her daughter could receive services to improve her school performance,and alleviate K.L.'s worries.

Like other female clients in middle age, K.L. had mixed perceptions of our credibility. On one hand, she did not have an understanding of what a mental health professional did, so she could not ascribe value to our professional role. She did, however, value our empathy and ability to handle case management tasks. Being able to attend to her concrete and emotional needs helped us achieve higher levels of credibility.

When we joined the staff, many coworkers argued that group work was not an effective treatment modality for Asian American consumers because of social values that discourage sharing personal problems with non-family members. In contrast to the prevailing ideas, we have found group work to be extremely useful to engage adults in treatment and to meet treatment goals. Having open-ended, semi-structured groups enables participants to meet old and new acquaintances to build social support. By attending groups, K.L. had the opportunity to relate with other women's experiences. The women found greater communality within the group setting and were committed to attending scheduled groups.

Individual and group sessions with K.L. often focused on the family challenges imposed by the strain of daily life and rapidly acculturating children. As we achieved higher levels of credibility with K.L., she was open to referring her daughter for an assessment after identifying her daughter's psychosocial needs. The referral process reflected her trust in our abilities and her hope that her daughter would benefit from services. In this situation, K.L. ascribed us more credibility because of our age and bicultural experiences. She perceived us as having achieved success in the U.S., having negotiated the challenges of acculturation and attained academic and professional success.

Supporting Individuals and Families Affected by Serious Mental Illness (SMI)

V.H. is 30 years old and was recently hospitalized for a psychotic outburst. Two years ago, he had been hospitalized for Bipolar Disorder but dropped out of treatment. At the time, he lived with his mother, who insisted that the outburst was not due to a mental illness, but caused by spirits that will go away once a healer visits.

Since his initial episode, V.H.'s symptoms have persisted. He has unsuccessfully tried to return to work several times, each attempt resulting in a lengthy hospitalization. After the most recent hospitalization, he was discharged to a nursing home in the neighborhood. Working with the nursing home staff, he is able to attend our agency's psychosocial rehabilitation program because of language and cultural congruence.

Unlike consumers seeking services for PTSD or depression, V.H. had prior contact with mental health professionals, which enabled him to ascribe a status to our profession. For example, V.H. had worked with social workers during his prior hospitalizations and at the nursing home, so he was familiar with social workers. Since V.H. had positive experiences with his most recent social worker, he was able to ascribe high levels of credibility to our role.

Generally, clients and their families had varied beliefs about the etiology of mental illness (Frye, 1993; Phan & Silove, 1997). Many consumers diagnosed as having a SMI

and their families shared V.H.'s family belief of spirits caused their condition. V.H. and his family did not have the language to label the conditions they experienced (Phan & Silove, 1997); without words they described the behaviors associated with the illness, such as disturbances with cognitions, hallucinations, or paranoia. While we worked with their belief system, we focused on basic treatment goals: managing symptoms, maintaining community living, managing medication, and planning for the future. Focusing upon how his symptoms affected his life enabled us to provide concrete outcomes that kept V.H. engaged in treatment and increased our credibility (Sue & Zane, 1987).

Although our roles as mental health professionals were clear with V.H., cultural, age and gender dynamics continued to shape our practice. While many of our clients were middle aged or older, we were much closer in age to VH. In addition to being in the same age cohort, most of the consumers with SMI were male, which affected our interactions differently depending upon gender. VH viewed DN as a model of health and success and lamented his life challenges. This provided an opportunity to discuss his situation and to identify coping strategies. For CT and HT, the age-gender dynamic provided additional obstacles. In an attempt to overcome the challenges of age and gender, CT and HT maintained an older position by having V.H. address them as "ChË," or older sister, which served several cultural functions. First, this facilitated the helping process by allowing V.H. to seek help from an older person and save face from having to receive help from a younger counterpart. Secondly, being slightly older served as a social boundary discouraging unwanted advances. Though exceptions exist, most heterosexual couples are composed of an older male and a younger female; the perception that CT and HT were older allowed them the opportunity to address V.H.'s relationship desires constructively.

Families play an important part in consumers' overall well-being. At times during V.H.'s illness, his family has served different functions. After his initial psychotic episode, his siblings were instrumental in helping him receive the necessary services. At the same time, however, his mother refused to acknowledge his condition and declined to support his treatment. Before his most recent hospitalization, VH had been relying on family members for housing, transportation to appointments, and assistance with medication management. Though the caregiving tasks were burdensome at times, his parents and siblings were open and supportive.

Socially, VH was stigmatized for his mental illness and was socially isolated, leaving him with few outlets to find alternative social support. Our agency offered a psychosocial rehabilitation program (PSR), and each of us has been involved with various facets of the program. By creating a culturally relevant milieu, we sought to overcome the social stigma by creating a space for the members to be able to socialize with one another and build support while learning community-living skills. Our program offered groups to cope with their distress, build social support among group members, and advance English skills. In addition, expressive groups focused on art and movement therapies. The format of PSR groups was consistent with the members' worldview; the program created a familial environment, while groups were led by a "teacher," who helped the members to develop the skills necessary to live in the community and meet their treatment goals. Though the members responded well to the educational aspects of the program, we strived to facilitate an equitable group that enabled all participants to succeed.

Maintaining a Professional Identity

As we established ourselves within the community through our professional work, we were faced with maintaining professional

boundaries. We lived in the community with our clients, where the potential existed to have dual or multiple relationships with clients. We attended the same churches or temples. We shopped at the same stores and ate at the same restaurants. At times, our social circles overlapped, and we delicately danced along the line that separates being a community member and being a mental health provider.

Oftentimes, clients came to view us as a part of their 'family,' which fit within their worldview, where family is loosely defined and is not limited to blood relatives. This may have facilitated the help-seeking process as it would be easier to seek assistance from a family member. Many clients brought us small gifts of appreciation, while others sought to include us in family events, such as weddings and holiday celebrations. The family view was reflected within the agency, where the staff organized an annual Tet celebration attended by clients and staff alike.

While it was welcoming to be received as family members, and gratifying to receive gifts in appreciation of our work, the gestures challenged us to set and maintain culturally appropriate boundaries. Though this facilitated the helping relationship, the process necessary to become comfortable with the idea of being in a client's family was not an easy one; in fact, it contradicts how we are socialized as professionals. Professional values, such as those expounded in the NASW Code of Ethics, dictate the necessity to have clear boundaries with our clients. The differences between our professional identity and the client's perception of us as helpers in the community lead us to struggle individually, collectively, and as a staff with how to set boundaries that adhere to professional standards while maintaining cultural relevance.

In the end, we each adopted a fairly conservative position, probably due to our newness in the field but also because of the difficulty to find guidance. Our supervisors, who were European Americans, had never dealt with such circumstances. Our older Vietnamese coworkers had no formal mental health training, so they were not indoctrinated with the same professional identity. Furthermore, they had worked in the community for many years and often had prior contact with clients through other positions. Coworkers of other Asian ethnic backgrounds worked within smaller communities that were more distant from our agency. Additionally, the bonds with their communities were weaker as they associated with their respective ethnic communities less frequently outside of work. Though we would accept small gifts, we felt uncomfortable attending social events outside of work, such as weddings and holiday celebrations. We felt the need to be present in the community to affirm our commitment to its health and well-being. Therefore, we did not seek to avoid clients in our social outings but remained aware of our professional role and respected our clients' privacy and confidentiality.

Organizational Dynamics – Straddling Two Worlds

Though his training was in another field, Mr. Pham was a senior staff member with many years' experience at the agency developing the mental health program and providing services. He is well known in the Vietnamese community and has been able to increase service use among local residents. He is particularly proud of having young, educated Vietnamese clinicians and tries to support their development.

Credibility and culture within an ethnic-specific agency created a staff dynamic similar to direct practice. Although we had credibility with Mr. Pham because of our educational accomplishments, he sought to help us overcome our youth and relative inexperience. Mr. Pham, as an older male from a patriarchal culture, set a decidedly paternalistic tone with us and other Vietnamese staff members, often dictating how a case ought to be handled.

Being highly acculturated and having received training in Western models of helping, we found our plans for treatment often conflicted with Mr. Pham's thinking. Traditional social work values, such as a client's right to self-determination, were secondary to a patriarchal attitude. From what we observed, most clients did not seem to mind the lack of options in their treatment, which is consistent with the cultural expectation that elders must be listened to. Within this atmosphere, we found the patriarchal attitude difficult for us to cope with, as our status as young employees superseded our educational background and prior training. Under a parental dynamic, we followed cultural norms to respect our elders, but this contrasted with the emphasis on equality within professional interactions with staff of different cultural origins.

Our experiences consulting with our Vietnamese colleagues differed drastically from interactions with Mr. Pham. The words used to address other Vietnamese staff members reflected the family-like interactions experienced with clients. Addressing staff in Vietnamese as "Chú", and "ChË" – the terms used for Uncle, and Sister – increased the sense of intimacy among the Vietnamese staff beyond the English "You" and "I". This often fostered a sense of belonging among the Vietnamese staff and provided a source of positive social support. Collaborating on cases with our paraprofessional colleagues, we combined rich local knowledge with therapeutic training.

While the Vietnamese staff was loosely organized based on age, our relationships with non-Vietnamese coworkers were more collegial. Interacting with non-Vietnamese staff was more familiar to us as it was consistent with our experiences in other mainstream agencies. Working with staff from diverse backgrounds, we shared a similar socialization through education and training. Despite different levels of experience, all voices were respected creating a more equitable atmosphere compared to the paternal tenor among the Vietnamese staff.

Within the work setting, we were living in two worlds, constantly shuttling between cultures and languages, emphasizing different aspects of our experience with different people within the organization. Following our cultural norms, we respected Mr. Pham's position though we often disagreed with it. Meanwhile, we would have equitable exchanges with other colleagues as we worked through difficult cases. Though the two experiences are valuable, the values of the perspectives are incongruent. One is patriarchal and hierarchical, the other based in equality and valuing options and choices. We had to learn to adjust to the Vietnamese cultural working environment and were fortunate to have each other for consultation and support. Maybe our experiences were 'too Americanized' and incompatible with a traditional Vietnamese professional culture. We had been schooled and socialized in America, not Vietnam. Previously, we had worked with coworkers and clients who were not Vietnamese, and ort current work environment was unique. Our experience highlights the challenges of working in settings with staff with varying degrees of acculturation, which can result in distinctive challenges.

Conclusion

Over time, we were able to establish ourselves within the Vietnamese community as mental health resources. By our achieving credibility, our clients would reveal their experiences to their friends and refer them for needed services. In order to be successful, the work required us to have a flexible approach to practice. As bicultural workers, we would continually monitor the impact of age, gender, and acculturation as we interacted with clients, consulted with other staff members, and collaborated with other providers within the social service system. We

relied upon our knowledge of Vietnamese culture and norms to engage clients in the treatment process. Working within a diverse organization with a cadre of Vietnamese staff required us to rely upon an array of cultural skills.

We were challenged to take practices from other settings and adapt them to a cultural setting where mental health problems were not readily accepted. The constant need to adapt practices while processing the cultural dynamics of working within our community presented additional professional strains that we were able to cope with through informal discussion and supporting one another.

Our experiences at the ethnic-specific mental health setting have been challenging and rewarding. Working in our ethnic community encouraged us not only to apply our counseling skills, but enabled us to become advocates for Asian American health. Working with health and social justice leaders in the community, we were able to raise awareness of the pressing health and mental-health issues affecting Vietnamese and other Asian Americans. Our professional practice has been enriched by the experience, and our bonds with the community have been strengthened.

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Note: An earlier version of this paper was presented at the Asian and Pacific Islander American Challenges & Triumph Conference, University of Michigan School of Social Work, Ann Arbor, MI, March 2003.

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