Community Ment Health J (2015) 51:63–70
DOI 10.1007/s10597-014-9745-4

ORIGINAL PAPER

Exploring the Role of Ethnic Media and the Community Readiness to Combat Stigma Attached to Mental Illness Among Vietnamese Immigrants: The Pilot Project *Tam An* (Inner Peace in Vietnamese)

Meekyung Han · Lien Cao · Karen Anton

Received: 27 December 2012 / Accepted: 16 June 2014 / Published online: 3 July 2014
© Springer Science+Business Media New York 2014

Abstract Vietnamese Americans are at high risk for developing mental health disorders due to multiple risk factors such as trauma and acculturative stress. However, the utilization of mental health services has been low. The pilot project Tam An was implemented to raise mental health awareness by engaging community resources in the Vietnamese population. Informed by the Community Readiness Model and through local ethnic media sources, messages to destigmatize mental health and promote the willingness to initiate mental health treatment were presented. Using an exploratory perspective, findings from focus group data suggest that the project improved the community's stage of readiness.

Keywords Mental health stigma · Vietnamese Americans · Ethnic media · Community readiness

Introduction

Vietnamese began arriving in the United States in large numbers as refugees at the conclusion of the Southeast Vietnamese Wars in 1975. By 2006, the number of Vietnamese immigrants residing in the United States was 1.1 million (Terrazas 2008) and is currently one of the fastest growing ethnic groups (Sorkin et al. 2008). Since their arrival in the United States, extant research has examined the psychological functioning of this refugee population and found that war trauma and acculturation stress greatly contributed to their mental health problems (Hein 1995; Hsu et al. 2004). For example, even after more than two decades of resettlement in the US, many Vietnamese adults suffer from war-related psychological problems such as Post-Traumatic Stress Disorder and depression (Sorkin et al. 2008). What is more, studies worriedly pointed out a significant discrepancy between the need of mental health treatment and the utilization rate of services in Asian immigrant communities including the Vietnamese (Ida and Ya 2007; Kim and Park 2009; Lee et al. 2009; Luu et al. 2009).

In an effort to combat this disparity between the needs and service utilization, growing empirical studies focused on exploring how cultural barriers affect mental health utilization within the Asian population populations including the Vietnamese, and have found mental health stigma to be the most imperative factor (Takayama 2010). The root of stigma in Vietnamese community is heavily influenced by cultural beliefs, where mental illness is oftentimes viewed as the result of bad thoughts, a lack of will power, personality weakness, malingering, possession by demons or spirits, fate, and *karma* repayment (Lee et al. 2009; Lien and Rice 1992). Therefore, having a mental illness is considered an extreme shame and formal intervention such as seeking professional help is often considered dishonorable since it indicates the inadequacy of family members causing the family to "lose face" within their community (Nguyen and Anderson 2005; Umemoto 2004). Simply, *saving face* and the ability to preserve the public appearance of the family in the community is particularly important (Akutsu and Chu

M. Han (✉)
School of Social Work, San Jose State University, San Jose, CA 95192, USA
e-mail: meekyung.han@sjsu.edu

L. Cao
Vietnamese Mental Health Network (VMHN), San Jose, CA, USA
e-mail: lien.cao12@gmail.com

K. Anton
Asian American Recovery Services, Inc./HealthRIGHT 360, 1735 Mission Street, San Francisco, CA 94103, USA

2006; Lee et al. 2009; Wong et al. 2010). Therefore, in order to promote mental health awareness for “help-seeking behaviors” among the Vietnamese people, interventions must not only occur at the individual level but also the community level. In fact, understanding the willingness and readiness of a community to initiate a program at the local level is an important factor because differences in readiness indicate what can be done and what needs to be done around culturally sensitive topics such as mental illness. In order to develop a mental health anti-stigma program that may work with Vietnamese immigrant communities, practitioners need to assess the community’s stage of readiness and systematically use findings to choose strategies that will best move the program forward.

Current Study: The Pilot Project *Tam An*

Inarguably, to combat stigma among the Vietnamese immigrant community and to educate them about mental illness and mental health care, the anti-stigma program should be culturally tailored and delivered in a culturally effective manner. However, very little is known in the literature and in practice about effective anti-stigma programs with Vietnamese immigrants within the cultural context. In an attempt to fill this gap, the current study presents a pilot project Tam An (“Inner Peace” in Vietnamese), developed by Asian American Recovery Services, Inc. (hereinafter referred to as *AARS*[1]). More specifically, this paper, by using an exploratory perspective, addresses the following areas:

(1) How the community readiness as the conceptual framework was utilized to develop a culturally sensitive anti-stigma program for Vietnamese immigrants;
(2) How local ethnic media sources were incorporated in reducing stigma and educating the community about mental health; and
(3) Whether this pilot project utilizing the ethnic media to enhance community readiness might have potential usefulness in fighting stigma with Vietnamese community.

[1] AARS provides culturally and linguistically competent health and mental health services to diverse groups and has been one of the most proactive community-based agencies serving Vietnamese with mental health problems in the Bay Area, Northern California. As of January 1. 2014, AARS officially merged with HealthRIGHT 360 and become a program of HealthRIGHT360, a San Francisco based nonprofit that gives hope, builds health, and changes lives for people in need by providing compassionate, integrated care, that includes primary medical, mental health, and substance use disorder treatment.

To provide better understanding about the development of the pilot project *Tam An*, we first describe about the background of the Vietnamese immigrants residing in the United States and the role of stigma among Vietnamese immigrants from the cultural perspectives. Then, we present what the community readiness model is and how this framework was utilized to fashion and implement the project *Tam An,* from the initial assessment (Phase I) to the implementation of the anti-stigma program (Phase II). Within describing Phase I and Phase II, we present a perceived readiness assessment outcome of each phase.

Literature Review

Background of the Vietnamese Immigrants in the United States

The Vietnamese Americans are considered a sub-ethnic group of Southeast Asians. When the South Vietnamese government collapsed in April 1975, more than 100,000 Vietnamese fled Vietnam to avoid incarceration, persecution, and discrimination by the North Vietnamese Communists (Haines 1985). The Vietnamese refugee movement typically had three major waves. The first wave of the Vietnamese refugees arrived from 1975 to 1978 and consisted, very small but mostly of highly educated, affluent, and elite individuals ((Sorkin et al. 2008; Nguyen 2008). The second wave, known as “boat people”, arrived from 1978 to 1984 and comprised the largest Vietnamese immigrants residing in America. These refugees were mostly comprised of farmers and fisherman with little education and suffered extreme danger such as torture and pirate attacks, hardship (lack of water, food, warm clothes), and loss (loss of possessions, status, money, lives, etc.) during the process of their escape (Segal 2000). The third wave arrived to America after 1986 through different relocation programs such as the Amerasian Program, the Humanitarian Operation (HO) Program, the Orderly Departure Program (ODP), and the Resettlement Opportunity for Vietnamese Returnees (ROV) (Nguyen 1992).

Stigma Attached to Mental Illness and Role of Community in Vietnamese Immigrants

Out of the three waves, the second wave of Vietnamese refugees, the interest of the current study, is known to suffer from a high level of mental health problems due to war-related trauma and acculturative stress related to their low socio-economic status. Studies have found that these Vietnamese immigrants as refugees suffer from mental illness such as Post-Traumatic Stress Disorder (Sorkin et al. 2008) and depression (Leung et al. 2010), but the

mental health service utilization rate is very low (Atkinson et al. 1984; Lee et al. 2009) due to cultural and structural factors. As a result, the lives and overall daily functioning of these Vietnamese immigrants continue to be disrupted because they have not been treated for their mental health conditions.

As briefly stated above, stigma is the well-documented prominent factor for the low service utilization and it is a socially constructed complex phenomenon related to loss of status and disrupted identity since it is associated with labeling of the individual, shame, and *loss of face* in the community (Kramer et al. 2008). In traditional Asian cultures including Vietnamese, many people believe that mental illness exists because one cannot control oneself or has bad thoughts and deeds in the past life. Therefore it is considered shameful to reveal that one has mental health problems. Further, since mental illness is often not considered solely the problem of the individual, but potentially represents a negative reflection on the family as well as ancestors, many families also deny signs of symptoms of mental illness to preserve their public appearance and "save face" for themselves and their family in the community (Kim and Park 2009; Wong et al. 2010). Simply, stigma is a mark or sign that disqualifies an individual from full social acceptance from the community. Thus, a stigma must be a shared evaluative belief by the community at large, not just a personal opinion on a matter, which requires the community level intervention.

Thus, in order to improve utilization of mental health services, prevention/intervention programs should target de-stigmatization of mental illness in Vietnamese immigrant communities from *community* perspectives, which consequently impacts individuals' perceptions and behaviors. Also, successful prevention/intervention efforts toward addressing mental health related issues, such as stigma, must be conceived from approaches that are culturally relevant and suitable to the community's level of readiness since communities vary in their interest and willingness to participate in a program which is focused on a culturally sensitive topic such as mental illness. Below, we present the development of the pilot project *Tam An* which addressed the community readiness of mental illness with the Vietnamese community.

Development and Potential Effectiveness of the Pilot Project *Tam An*

The following description offers a conceptual framework and strategy that AARS administered to identify the stage of community readiness with regard to combating stigma attached to mental illness and to improving mental health service utilization by Vietnamese community in the Bay Area. More specifically, this section is compromised with four areas: (1) the introduction of Community Readiness as the conceptual model, (2) the initial community readiness assessment (Phase I), (3) the effectiveness of mass media anti-stigma programs, and (4) the implementation of Tam An and its potential usefulness (Phase II).

The Conceptual Framework: Community Readiness

Community readiness, originally developed by Edwards et al. (2000) for use with alcohol and drug abuse prevention programs, is based on two research traditions, psychological readiness for treatment and community development (for review, see Edwards et al.). The model suggests nine stages of community readiness: (1) no knowledge: at this stage the behavior is no problem and accepted; (2) denial: there is the belief that the problem does not exist or that change is not possible; (3) vague awareness: beginning recognition of the problem, but no motivation for taking any action; (4) preplanning: recognition of the problem and agreement that something needs to be done; (5) preparation: active planning; (6) initiation: beginning implementation of a program; (7) stabilization: one or two programs are operating and are stable; (8) confirmation/expansion: recognition of limitations in programs and attempts to improve existing programs; and (9) professionalization: marked by sophistication, training, and effective evaluation (Edwards et al., pp. 29–31).

As described in a sequential stage of community readiness, this framework emphasizes that communities successively achieve a higher stage of readiness by assessing community readiness, realizing areas of improvement in their degree of readiness, and developing appropriate strategies to advance to the next stage of readiness (Center on Child Abuse and Neglect 2000; Edwards et al. 2000). For example, if a community readiness regarding mental illness is identified as *Stage 2: Denial*, the general goal at that stage should aim to raise awareness about the mental health problems in the community, prior to providing the actual intervention program. Below, we describe how this framework was utilized to implement the project *Tam An,* from the initial assessment (Phase I) to the implementation of the anti-stigma program (Phase II) in detail. In each stage, we present the findings of the assessment of the community readiness which were instrumental to identify the proper strategies to move toward the next stage of readiness.

Phase I: Initial Community Readiness Assessment

Prior to the development of the *Tam An* project, AARS formed an informal, internal task force, which consisted of three Vietnamese bilingual and bicultural mental health professionals who represented different generation groups and varying value systems based on their migration history.

Table 1 Initial assessment of the Vietnamese immigrant community regarding the mental health related problems and community readiness

Positive factors/driving forces	Negative factors/restraining forces
Agency is motivated to try a different outreach approach other than traditional ways (e.g., distributing a flyer etc.)	Vietnamese "losing face" culture is long-lasting and prevalent
Agency is strongly connected with Vietnamese community through its other services such as substance abuse services and cultural events and established strong support within the community	Limited knowledge about mental illness with many Vietnamese in the community
Vietnamese tend to be family-oriented and dedication to support family member's well-being including mental illness	Limited understanding how to get (professional) help—not aware of the resources available in the community
Some leaders in Vietnamese community are proactive in promoting and maintaining successful mental health. prevention/intervention program	There is a significant discrepancy in conceiving mental illness according to generation (inter-generational conflict)
Agency's bicultural/bilingual staff represent different generations (e.g., first generation, 1.5 generation, and second generation)™ and value systems within the Vietnamese immigrant community	Some Vietnamese immigrants have limited support from family
Culturally competent practice as an agency policy	

Please note that this table was created retrospectively based on the ongoing conversation logs between the first author and the informal internal task force

™First generation is one who was born in a foreign country and immigrated to America; 1.5 generation is one who was born in foreign country and immigrated to America before or during their early teens; and second generation is one who was born to refugee parents in America

The first goal of this informal task force was to understand the level of community readiness with regard to mental health service utilization and corresponding strategies to enhance the readiness level in a cultural context.

In this study, AARS utilized an informal retrospective assessment to better understand the factors that influenced community readiness to accept a mental health program at the time of the project design period; this method is congruent with an analytic format of "Force–Field analysis" (Lewin 1947). While the exact language of "Force–Field analysis" includes "driving forces (forces that drive toward change)" and "restraining forces (forces that resist change)", these phrases were not utilized during the initial assessment; instead the AARS initial informal assessment mentioned "positive factors" and "negative factors" referring to Lewin's terminology of driving forces and resisting forces respectively.

Findings of the Initial Assessment on Community Readiness

An evaluation of the initial assessment (Table 1) showed several positive factors/driving forces and negative factors/restraining forces. Positive factors/driving forces included the staff's bicultural and bilingual competence, the agency's policies and procedures pertaining to cultural competence, and established relationships with the Vietnamese community and other community-based agencies. Meanwhile, cultural beliefs toward mental illness, lack of understanding about the mental illness itself and lack of available resources in the community were identified as negative factors/restraining forces. After the initial assessment, the team prioritized the tasks and determined that decreasing negative factors/restraining forces is the most significant task for achieving change. While all negative factors/restraining forces would be equally important to address, the lack of awareness and knowledge about mental illness in the Vietnamese community and the corresponding negative attitudes was noted as the most significant one. The informal task force reached the conclusion that enhancing community readiness appeared to be crucial to tackle stigma and mental health disparity in the Vietnamese community.

Further, based on the Community Readiness model, the agency identified that the Vietnamese community in relation to mental illness programs was in between *Stage 2: Denial* and *Stage 3: Vague Awareness*. For this stage of the Community Readiness model, outreach to the community by utilizing a mass media was recognized as the appropriate strategy. Thus, to address the identified gaps in the community and to provide an effective and culturally sensitive anti-stigma program, AARS developed and implemented a community outreach strategy by using a mass media, which is this pilot project called "*Tam An*" to raise mental health awareness in the Vietnamese community. The informal task force developed the following five principal messages: "*Mental health is a part of every community and family*", "*Mental illness is real and must be acknowledged*", "*No one is to be blamed*", "*Mental illness can be treated*", and "*Resources exist and treatment works*" (AARS, Asian American Recovery Services [AARS] 2010). Before describing the implementation of the anti-stigma program using the local ethnic mass media, it is important to illustrate whether and how mass media anti-stigma programs in general can be effective.

Anti-Stigma Programs Using Mass Media

Regarding the role of media related to mental illness, it is well known that the media can perpetuate stigma since it

oftentimes focuses on stories, which reinforce stereotypes (Vogel et al. 2008, 2006). On a positive note, however, the media is also known to be a valuable and suitable place to begin anti-stigma campaigns since it can widely target large populations with aim to improve awareness about mental health, combat stigma by replacing stereotypes with facts about mental health and illness. A growing number of empirical studies have shown the effectiveness of mass media interventions on reducing stigma related to mental health (Demyan and Anderson 2012; Kaplan 2009; Stuart 2006). Such anti-stigma programs have been based on psycho-educational interventions presenting truthful information while countering some commonly held negative and incorrect beliefs about mental illness (Essler et al. 2006; Morrison and Teta 1980). In fact, educational campaigns, printed information, billboards (Gonzalez et al. 2002), and videotaped interventions (Baker et al. 1993) have been utilized to enhance the knowledge base about mental health and to increase help-seeking behaviors by reducing stigma attached to mental illness.

It is important to note that there are several aspects to consider when developing successful mass media campaigns for effective mass media interventions. These aspects include frequency, message content, emotional appeals, and messenger characteristics. Each element is briefly elaborated as follows. First, it is well documented that increasing the *frequency* of audience exposure to the message enhances campaign effectiveness. In addition, the *content* of information presented is crucial for the successful use of mass media. For example, highlighting the symptoms of mental illness may actually trigger negative stereotypes which result in promoting negative attitudes. Thus, interventions targeted at improving attitudes towards help-seeking need to highlight the positive aspects of the person with mental illness or treatment results. Third, the use of *emotional appeals* may also influence audiences' attitudes and behaviors in a positive way. For example, in addition to the information presented, emotional materials can alter one's negative beliefs on issues like mental illness and create a greater readiness for action. Lastly, the *characteristics of the messenger* significantly influence message acceptance. For example, when the messenger who delivers information has credibility, intelligence, social status, or expertise, the media intervention may be well received by the public (Kaplan 2009).

Phase II: Mass Media Intervention and Its Potential Effectiveness

Based on anecdotal statements, Vietnamese immigrants are known to be heavy users of media (in Vietnamese) as a method of connecting to the culture, information, and feeling of belonging; therefore, mass media campaigns seem well-suited to meet these goals because of their wide reach. In collaboration with Immigrant Resettlement Community Center (IRCC), a leader in providing guidance through community opinions presented in programs, AARS reached out to the local Vietnamese population by producing and broadcasting 15-min weekly radio segments (e.g., *Dan Sinh Radio)* covering topics on mental health issues; these shows were then transcribed into 1–2 page weekly columns in local Vietnamese newspaper (e.g., *Dan Sinh Thoi Bao Daily News*) (AARS, Asian American Recovery Services [AARS] 2010). By the end of the project, the agency was able to have a repository of over 70 articles and corresponding radio shows which consisted of interviews and life stories of mental health consumers and family members, mental health professionals, health officials, youth and parents, and community members.

In congruence with the existent empirical studies, which asserted the importance of frequency, message content, emotional appeals, and messenger characteristics for mass media use to be successful as described above, *Tam An* applied these four qualities to its media campaign. First, it broadcasted radio shows frequently on a weekly basis with messages that were culturally sensitive and emotionally appealing in a non-threatening and non-intimidating manner. Additionally, the messenger was an expert with knowledge and skills in working with people with mental illness, and had a positive reputation within the community.

Testing the Potential Effectiveness of the Pilot Project Tam An

To assess the potential effectiveness of media in raising community awareness and readiness for mental health services in the Vietnamese community, a focus group comprised of seven Vietnamese immigrants was formed based on an exploratory phenomenology. In this section, we describe the following two areas: (1) focus group recruitment process and implementation including how the focus group participants were recruited, how it was implemented, who participated and what questions were asked during the focus group, and (2) The main findings of the focus group.

Focus Group Recruitment Process and Implementation To recruit participants for the focus group, AARS hosted a weekly radio show on local Vietnamese radio stations. AARS recruited participants by airing 1–2 min announcements about the focus group at the end of these radio shows. The announcement included a brief introduction of the focus group and solicited interested audience members to call AARS for more information. AARS bilingual staff then contacted the participants who identified an interest in the focus group. In the initial phone

contact, the staff explained to the prospective participant about the purpose of this study, its significance, confidentiality, and the focus group procedures, including the use of audio-recording equipment for transcription and consent form. Once receiving the participant's verbal agreement of their participation, the staff specified the location and time of the focus group.

The duration of the focus was approximately 3 h, and it took place at AARS' parent site in East San Jose. Facilitation was conducted in Vietnamese by two bilingual AARS staff—one of whom was the program manager of *Tam An* and tone staff who was charged with recording and later translating the transcription word-for-word from Vietnamese to English. During the focus group, questions to assess the potential impact of *Tam An* were posed using a semi-structured format. Some example questions include: "Before the media program, what was your attitude and/or understanding toward mental illness?", "What did you learn about general well-being of your family from the media program?", "How does the media program impact your understanding of general well-being of your family?", and "Based on your opinion, how has the media program helped to address the above question in our community?".

In total, seven community members participated in the focus group. While specific demographic information was not asked in an attempt to reduce social stratification and create a more open environment for discussion during the focus group, there were four males and three females who were between 40 years old and 60 years old who came to this country as refugees. To raise the level of *accuracy and consistency of translation, cross-references on the English transcription of the focus group* were carried out by two Vietnamese bilingual staff at AARS. If there was any discrepancy on the choice of words or the transcription on the meaning of words, the discrepancies were discussed and reached an agreement on what words would be linguistically and culturally appropriate in context. Furthermore, the authors each independently read the transcript and identified preliminary themes that were prevalent in the data. The authors then consulted with one another about the preliminary findings and discussed the common and unique themes identified.

Findings In terms of the findings from the focus group, in addition to the anecdotal statements which the agency received from various Vietnamese immigrants about the *Tam An* project, suggests that *Tam An* improved the stage of readiness in the Vietnamese community from between Level 2 (Denial) and Level 3 (Vague awareness) to Level 4 (Pre-planning), indicating an increased interest and willingness to seek mental health services. Congruent with the initial assessment of the community's readiness by the task force, the participants agreed that they were not well aware of mental health-related issues, nor of available resources in the community prior to *Tam An*. For example, one person said "*The Vietnamese community in general is not well aware of this issue. This was the first time I, and I know most people, ever heard about this topic [until I heard it through Tam An]*". All participants also indicated that through this *Tam An's* media campaign, their level of understanding and openness about mental illness and resources in the community has improved. Comments included: "*My friends and I talked about the program and mental illness*", "*I believe so [mental illness can be cured], and I think in addition to the medication, the psychotherapy aspect is as important*", and "*Now I learned that there are experts out there who could help*". In sum, feedback from the focus group participants indicated a potential usefulness and effectiveness of the media intervention. Further, participants suggested directions on how to increase awareness of mental health issues in the Vietnamese immigrant community. Participants emphasized the need for continuation of the project [to enhance the awareness of mental illness and to reduce stigma attached to it] in the following comments: "*Yes, of course, but there needs to be more and more effort to get the message out*" and "*And make sure that as many people can listen to the shows as possible by syndicating the program to other time slots and other channels.*"

Discussion

It is important to reiterate here that the purpose of this paper was to suggest the usefulness of the community readiness as the framework to develop and implement the culturally sensitive anti-stigma program, the pilot project *Tam An*, with the Vietnamese community. This study presented the pilot project *Tam An* in terms of its conceptual framework, the initial assessment of the community readiness regarding the mental illness issue (Phase I), corresponding media intervention/outreach approaches as the targeted strategy to enhance the readiness (Phase II), and brief findings of this pilot project in terms of documenting the potential usefulness of the community readiness model and the mass-media intervention. The focus group finding as a preliminary assessment of the community readiness at the conclusion of the *Tam An* project shows that this pilot project had potential impact on enhancing community readiness in the desired direction, from a level of 2 (denial) ∼3 (vague awareness) to a 4 (preplanning).

Relatively few attempts have been made to develop mass media interventions that might improve attitudes toward mental health/illness and diminish stigma on a larger scale. Even when mass media was implemented,

these efforts have focused on the general, mainstream population (in English) and very little is known about whether mass media intervention would be effective with ethnic minority populations. The findings listed above are deemed to support previous studies on the effectiveness of using media in anti-stigma programs with the general population (Vogel et al. 2008, 2006).

The *Tam An* program was a product of the innovative and culturally competent infrastructure at Asian American Recovery Services. As numerous studies have underscored, an organization can be significantly instrumental to emphasizing, training, and implementing cultural competence since the organization poses the vision to promote culturally competent practice models for ethnic minority populations (Goossens et al. 2005). During the process of designing the pilot *Tam An* program, as shown in the initial assessment section, AARS recognized that identifying driving forces (strengths) and restraining forces (challenges) were vital to strategically developing the anti-stigma intervention in a culturally relevant manner. Through assessing the initial stage of community readiness and acknowledging community readiness as a process rather than a fixed state, the agency initiated the media intervention as an outreach strategy. This corresponds with Edwards and colleagues' proposed strategic actions (Edwards et al. 2000), and further supports that such media intervention is considered an effective tool to enhance readiness levels upward. For instance, Edwards and colleagues suggest, "publishing newspaper editorials and articles with general information, but relate information to local situation" and "publishing some sample media messages" (pp. 29–31) are the desirable corresponding course of actions to improve the level of readiness from Stage 2 and Stage 3 to Stage 4.

Another important aspect of the *Tam An* project is that its success is attributable to the strong, collaborative partnerships among the community partners. In order for the community to have effective and successful interventions, we know that the support and commitment of its members, along with resources are critical. As shown in the initial assessment analysis table, the agency has a strong connection with the Vietnamese community and other community partners from individual community leaders, media services, other community-based agencies, to the local government. Through the partnership with the ethnic media companies, the project could reach a broad range of the population to educate the public about mental health issues and de-stigmatize mental health disorders by promoting open, enlightened discussions in the Vietnamese language. In collective action to fight stigma attached to mental illness, *Tam An's* media outreach helped the community better prepare for implementing a mental health program and was instrumental in generating awareness regarding mental health issues.

It is important to note here that testing of the program's effectiveness is limited due to a very small sample size, sampling procedure (e.g., self-selected group), and assessment methods (e.g., pre-experimental design with the lack of a control or comparison group). To have more generalizable findings, future studies should recruit a more representative sample of Vietnamese immigrants living in America. Further, social desirability could also be considered as a limitation. In other words, information provided by focus group participants might not have been accurate. Indeed, some participants may have refrained from making hurtful and negative comments regarding the program or the community, and existing negative feelings might not have been expressed entirely. Therefore, conclusions cannot be drawn as to whether or not community readiness around mental health-related issues has increased in the Vietnamese community as a whole, or whether the enhanced community readiness occurred due to spontaneous progress over time.

In spite of noted limitations, the findings are valuable as they suggest the potential usefulness of the pilot program. The current study suggests that more methodologically sound studies of the pilot program using the Community Readiness framework and the ethnic media intervention toward stigma would be very useful and informative. Having a control or comparison group may be needed to clarify whether reduced stigma and increased readiness would be due to the media outreach intervention toward the community *per se* or to compounding factors such as passage of time or exposure to other anti-stigma intervention programs. We hope that the current pilot program based on the cultural and conceptual framework shall be replicated with large number of Vietnamese in other communities with comparison or control groups to affirm the effectiveness of this pilot program.

In conclusion, this paper presented the conceptual framework of the community readiness model and examined its applications for an effective mental health anti-stigma program targeting the local Vietnamese community in Northern California. To be effective, a prevention program must address not only the scope of mental health-related issues itself, but also the relevant cultural and ethnic aspects of the community being targeted for prevention and intervention efforts. Therefore, it is important to match the program with the population it is to serve and the local community constructs within which it is to be implemented. Community readiness helps a community to create a shared vision and represents the extent to which a community is adequately prepared to implement an anti-stigma program. In order to make an anti-stigma intervention work in the Vietnamese immigrant community, practitioners have to acknowledge that the community must have the support and commitment of its members along with resources to implement an effective prevention/intervention effort.

Acknowledgment The pilot project *Tam An* was supported by the Robert Wood Johnson Foundation (RWJF) Grant # 61049 to Asian American Recovery Services (AARS) Inc. This funding source had no involvement in the preparation of this article and the writing of the report or the decision to submit this article for publication.

References

Akutsu, P. D., & Chu, J. P. (2006). Clinical problems that initiate professional help-seeking behaviors for Asian Americans. *Professional Psychology: Research and Practice, 37*(4), 407–415.

Asian American Recovery Services [AARS]. (2010). *Final narrative report. Unpublished internal report for RWJF*. CA: San Jose.

Atkinson, D. R., Ponterotto, J. G., & Sanchez, A. R. (1984). Attitudes of Vietnamese and Anglo-American students toward counseling. *Journal of College Student Personnel, 25*, 448–452.

Baker, C., Pistrang, N., Shapiro, D. A., Davies, D. A., & Shaw, I. (1993). You in mind: A preventative mental health television series. *British Journal of Clinical Psychology, 32*, 281–297.

Center on Child Abuse and Neglect. (2000). *Community readiness: A promising model for community healing*. Washington, DC: US Department of Justice.

Demyan, A. L., & Anderson, A. (2012). Effects of a brief media intervention on expectations, attitudes, and intentions of mental health help seeking. *Journal of Counseling Psychology, 59*(2), 222–229.

Edwards, R. W., Jumper-Thurman, P., Plested, B. A., Oetting, E. R., & Swanson, L. (2000). Community readiness: Research to practice. tri-ethnic center for prevention research. *Journal of Community Psychology, 28*(3), 291–307.

Essler, V., Arthur, A., & Stickley, T. (2006). Using a school-based intervention to challenge stigmatizing attitudes and promote mental health in teenagers. *Journal of Mental Health, 15*(2), 243–250.

Gonzalez, J. M., Tinsley, H. E., & Kreuder, K. R. (2002). Effects of psychoeducational interventions on opinions of mental illness, attitudes toward help-seeking, and expectations about psychotherapy in college students. *Journal of College Students Development, 43*, 51–63.

Goossens, M. E., Vlaeyens, J. W., Hidding, A., Kolesnijders, A., & Evers, M. A. (2005). Treatment expectancy affects the outcome of cognitive-behavioral interventions in chronic pain. *Clinical Journal of Pain, 21*, 18–26.

Haines, D. W. (1985). *Refugees in the United States: A reference handbook*. Westport, CT: Greenwood.

Hein, J. (1995). *From Vietnam, Laos, and Cambodia: A refugee experience in the United States*. New York: Twayne Publishers.

Hsu, E., Davies, C. A., & Hansen, D.J. (2004). *Understanding mental health needs of Southeast Asian refugees: Historical, cultural, and contextual challenges*. University of Nebraska, Lincoln. Retrieved from http://digitalcommons.unl.edu/psychfacpub/86.

Ida, D. J., & Ya, D. Y. (2007). Research and evaluation on programs for Asian American, Native Hawaiian, and other Pacific Islander populations. *Focal Point Research, Policy, and Practice in Children's Mental Health, 21*(2), 28–31.

Kaplan, S. A. (2009). *Changing perceptions of seeking help: A test of the effectiveness of an intervention video.* Theses and Dissertation. Paper 10771. Retrieved from http://lib.dr.iastate.edu/etd/10771.

Kim, P. Y., & Park, J. J. L. (2009). Testing a multiple mediation model of Asian American college students' willingness to see a counselor. *Cultural Diversity and Ethnic Minority Psychology, 15*(3), 295–302.

Kramer, E., Ton, H., & Lu, F. G. (2008). S*aving face: Recognizing and managing the stigma of mental illness in Asian Americans*. Study and Facilitator's guide, Retrieved from http://ethnomed.org/clinical/mental-health/SavingFaceFacilitatorGuide.pdf.

Lee, S., Juon, H., Martinez, G., Hsu, C., Robinson, E., Bawa, J., et al. (2009). Model minority at risk: Expressed needs of mental health by Asian American young adults. *Journal of Community Health: The Publication for Health Promotion and Disease Prevention, 34*(2), 144–152.

Leung, P., Cheung, M., & Cheung, A. (2010). Vietnamese Americans and depression: A Health and mental health concern. *Social Work in Mental Health, 8*(6), 526–542.

Lewin, K. (1947). Group decision and social change. In T. M. Newcomb & E. L. Hartley (Eds.), *Readings in social psychology* (pp. 330–345). New York, NY: Holt, Rinehart & Winston Inc.

Lien, O., & Rice, P. (1992). Concepts of mental illness of Vietnamese and the attitude toward psychiatric services. *Medical Journal of Vietnamese Medical Association in Canada, 115*, 69–77.

Luu, T. D., Leung, P., & Nash, S. G. (2009). Help-seeking attitudes among Vietnamese Americans: The impact of acculturation, cultural barriers and spiritual beliefs. *Social Work in Mental Health, 7*(5), 476–493.

Morrison, J. K., & Teta, D. C. (1980). Reducing students' fear of mental illness by means of seminar-induced belief change. *Journal of Clinical Psychology, 36*(1), 275–276.

Nguyen, A. N. (1992). Living between two cultures: Treating first-generation Asian American. In L. A. Vargas & J. D. Koss-Chioino (Eds.), *Working with culture* (pp. 204–222). San Francisco: Jossey-Bass.

Nguyen, B. H. (2008). *Cultural and the Vietnamese American spirit vision*. San Jose, CA: E-Print Solutions.

Nguyen, Q. C., & Anderson, L. P. (2005). Vietnamese Americans' attitudes toward seeking mental health services: Relation to cultural variables. *Journal of Community Psychology, 33*(2), 213–231.

Segal, U. (2000). Exploring child abuse among Vietnamese refugees. *Journal of Multicultural Social Work, 8*(3/4), 159–191.

Sorkin, D., Tan, A. L., Hays, R. D., Manione, C. M., & Ngo-Metzger, Q. (2008). Self-reported health status of Vietnamese and Non-Hispanic White older adults in California. *The American Geriatrics Society, 56*(8), 1543–1544.

Stuart, H. (2006). Mental illness and employment discrimination. *Current Opinion in Psychiatry, 19*, 522–526.

Takayama, J. (2010). *Ecological systems theory of Asian American mental health service seeking.* School of Professional Psychology, Paper 121. Retrieved from http://commons.pacificu.edu/spp/121.

Terrazas, A. (2008). Vietnamese immigrants in the United States. *Migration Policy Institute*. Retrieved 20 Sep 2012, from http://www.migrationinformation.org/USFocus/display.cfm?ID=691.

Umemoto, D. (2004). Asian American mental health help seeking: An empirical test of several empirical test of several explanatory frameworks. *Dissertation Abstracts International, 64B*, 5806.

Vogel, D., Gentile, D. A., & Kaplan, S. (2008). The influence of television on willingness to seek therapy. *Journal of Clinical Psychology, 64*(3), 276–295.

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology, 53*, 325–337.

Wong, Y. J., Kim, S., & Tran, K. (2010). Asian Americans' adherence to Asian values, attributions about depression, and coping strategies. *Cultural Diversity and Ethnic Minority Psychology, 16*(1), 1–8.