An Oral History Project with Elderly Montagnard Refugees

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Abstract - This article presents an oral history project with elderly Montagnard refugees at a North Carolina multi-cultural senior center. The objective of this qualitative research project was to give a voice to elderly refugees, marginalized within U.S. society by limited language skills, poverty, and non-citizen status. The project provided validation that their lives had meaning and inherently became a therapeutic exercise. The participants had kept details of imprisonment and torture among themselves, excluding close family members. Only after assurance of anonymity, would participants begin to tell their stories. Typical of survivors of torture and abuse, these individuals still do not feel safe. In the process, information was gleaned relative to issues facing immigrant and refugee elderly, which can be used to direct programmatic needs at the senior center. Themes emerged that gave insight into the unique needs of elderly refugees, including concerns with medical care, job opportunities, transportation and poverty. Unlike native born American elders, a unique concern was over family members left behind in Vietnam, combined with feelings of betrayal, and have emerged. Life here in the U.S. was noted to be “difficult”. Yet, most Montagnard seniors verbalized hope for their family’s future in the U.S. They have found a sense of identity, unity, and kinship within their religious institutions, and within the greater Montagnard Community at large.

Keywords - Refugee Assimilation, Refugee Resettlement, Montagnard, BAJARAKA, Ethnic Minorities, Healthcare Disparities

1. Background: Demographics and Population Trends of Immigrants and Refugees in North Carolina

With the passage of the Immigration and Nationalities Act of 1965, which reversed previous quotas limiting the number of immigrants allowed into the U.S., the first of large waves of immigrants and refugees began arriving on both the east and west coast of the U.S. A second piece of major legislation, the Refugee Act of 1980, again increased the number of refugees entering the U.S. The first Asians, who began coming in 1965, were professionals, educated and skilled as teachers, accountants, medical personnel. The Asians who came in the 1980’s were often neither educated nor skilled in ways defined by the U.S. labor market. It was during the second wave of immigration that large numbers of refugees from Vietnam, Laos, Thailand, and Cambodia, arrived in North Carolina.

The Refugee Act of 1980 had a significant impact on North Carolina, as the federal government relocated refugees fleeing civil war and genocide to three of the state’s major cities, Raleigh, Charlotte and Greensboro. The government was assisted by several non-governmental organizations, such as World Relief, Jewish Family Services, Hebrew Immigrant Aid Society, Lutheran Family Services, and Church World Service. As refugees arrived from Africa, Asia, Eastern Europe (Bosnia, Serbia, and the former Soviet Union), the local NGO’s provided assistance with housing, job training and procurement, basic health services, and English classes. Such a support system was designed to aid refugee assimilation into mainstream society (Bailey, 2005).

For the last three decades, the demographics of North Carolina have been shifting toward greater immigrant diversity. In 2006, the state ranked 15th in the nation for number of admitted foreign immigrants (US Dept of Homeland Security, 2007). US Census estimates indicate that Latinos in North Carolina increased by 138,654 between 2000 and 2004, a gain of nearly 37%. The state has experienced an increase of over 25% in the Asian immigrant population during the same years (US Census Bureau, 2008). Additionally, there are tens of thousands of immigrants from Eastern Europe living in North Carolina today (American Community Survey, 2006). Many new immigrants are settling in urban areas. Yet, rural and medically underserved parts of the State also have experienced an influx of immigrants (Kochlar, Suro, & Tafryla, 2005). Western North Carolina, which is rural, has a large Hmong population, estimated to be greater than 10,000. The Hmong, an ethnic minority from the mountainous Highlands of Laos, are similar to the Montagnards in their culture and lifestyle.

Guilford County, North Carolina, has seen a significant growth in immigrant populations over the last decade, due in some part to the presence of refugee resettlement agencies
noted earlier. Approximately 60,000 immigrants and refugees live in Guilford County, including 3,000 Montagnards from the highlands of Vietnam (Center for New North Carolinians, 2007).

The Montagnards are tribal people who lived in the rugged Highlands of Vietnam. Prior to the Vietnam War, they were peaceful folk, living as farmers and hunter/gatherers. This explains their limited education and lack of skills applicable to the U.S. labor market. For many years they were “isolated” from other Vietnamese groups due to the remote nature of the Highland mountains. They are distinct from the mainstream Vietnamese in ethnicity, heritage, culture, language, and appearance. They are darker skinned and do not possess the typical Asian eye shape, known as “epicanthic folds”. Their heritage is most likely Malayo-Polynesian, whereas most Vietnamese have Chinese ancestry (Bailey, 2002).

The Montagnard population is composed of more than 30 different tribes, with five primary ethnic groups, Jarai, Rhae, Bahnar, Koho, and M’Nong (also called Bunu). Each of the five ethnic groups speaks a distinct dialect. Many also speak French and some English. The Montagnards embraced Christianity in the early 20th century, and are primarily Catholic or Christian Evangelicals. Prior to adopting Christianity, the Montagnards were animists, believing that good and bad spirits exist to control such things as one’s health.

In the 1950’s, the Vietnamese government, in an effort to gain geographic and political dominance of the Highlands, began to interject itself into Montagnard life. The resistance movement BAJARAKA (which brought the tribes together) was established. The BAJARAKA goal was to maintain land ownership and self government (Montagnard Foundation, 2007). The Montagnards joined forces with the United States when the U.S. entered the conflict in Vietnam during the 1960’s. Working closely with U.S. Special Forces, Montagnards developed strong loyalties with U.S. military. Following the fall of South Vietnam along with the retreat of U.S. troops, the persecution of the Montagnards escalated. This persecution continues even today (Human Rights Watch, 2006). The Montagnards did not flee, choosing instead to continue the fight for their homeland (Montagnard Foundation, 2007). However, many South Vietnamese did leave, ending up in refugee camps in nations bordering Vietnam.

In the 1980’s, as part of a U.S. sponsored refugee resettlement program, the first Montagnard refugees came to the U.S. The first group arriving in North Carolina in 1986 included 300 men. The Montagnard exodus continued and by 2004, there were approximately 4,000 - 5,000 Montagnard refugees in North Carolina (Center for New North Carolinians 2007). Although the majority of Montagnards living in North Carolina came as part of a U.S. led resettlement program, some came through the family reunification program, uniting wives and children with men who came earlier. Currently there are more than 7,000 Montagnards living in North Carolina, with more than 5,000 in the Greensboro area (Center for New North Carolinians, 2007).

Fong (2004) reminds us that it is important to distinguish between the words immigrant and refugee. Immigrants are “foreign born persons who have left their nation of birth to dwell in another country” (Fong, 2004). A refugee is “a person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country” (Fong, 2004). The Montagnards suffered persecution, torture, long sentences in jail, because of ethnicity, as well as their opposition to the communist controlled government (Center for New North Carolinians, 2007).

Refugees and immigrants face many obstacles when they leave one homeland for another, including poverty, prejudice, language barriers, and immigration issues. Families struggle with role reversal. The use of children as language translators shifts the position of power in the family structure, weakening the position of elders. Traditionally men have been the ones in the workforce. In the U.S., women may become the sole source of income, obtaining jobs in housekeeping and food service. Family structures and practices that strengthened the family in Vietnam may not hold in the U.S. Disciplinary practices that were the norm in Vietnam may be considered child abuse here, resulting in conflict between families and the legal system. Separating “good values from bad” in a new culture is difficult (Piper, 2002).

There is very little in the literature about the issues facing elderly Montagnard refugees and immigrants. Finding a job, obtaining welfare benefits, paying for health care add to the list of problems. Most Montagnard families, including the elderly, currently live below the poverty level. Major problems include lack of access to food, inadequate housing, and lack of health care (Fong, 2004). The lack of health insurance and limited access to social service programs compound the complexity of their lives. Language and cultural barriers are common. Navigating the intricacies of the social services arena and medical system can be overwhelming for immigrants and refugees, especially for non-English speakers. On average, Montagnard adults and elders have a 5th grade education, with a literacy rate of a third grader limiting employment to menial labor (Bailey, 2002).

Although some of the Montagnard refugees found jobs, most of these jobs remain minimum wage, and many remain unemployed. Language difficulties and lack of U.S. citizenship are significant deterrents to economic progress (Bailey, 2002). Between 1963 and 1996, most immigrants and refugees who had entered the U.S. legally qualified for some public assistance, including Food Stamps, Supplemental Security Income, WIC (Women, Infants, and Children’s nutrition assistance), Medicaid and TANF (Temporary Assistance for Needy Families). This changed in 1996, when Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), significantly
limiting non-citizen eligibility for public assistance. Yet, it is possible that PRWORA also encouraged many immigrants and refugees to pursue citizenship (Haider, 2004). Following the events of September 11, 2001, a new wave of anti-immigrant sentiment arose. Public dialogue has focused on the burden of financial care for non-citizens, and issues around immigration are often framed in the context of negative economic impact. In spite of the belief that immigrants and refugees use Medicaid disproportionately, research suggests that they rarely use it at all, out of fear of retribution and deportation (Haider, 2004).

Many elderly male Montagnards have experienced political persecution, war, jail, prison, and torture. “Re-education camps” used for indoctrination to the new Communist philosophy, were in reality jails and prisons. Whereas once they were “citizens” of Vietnam, they are now “refugees” in a foreign land. They left behind family members, with the awareness that they would most likely never be reunited.

A majority of elderly Montagnards suffer medical conditions common to aging, such as diabetes, high blood pressure, and heart disease. Some have lasting injuries from the war, others injuries from prison and torture (broken bones that were never set). Past illnesses such as TB, malaria, and Hepatitis B have become chronic illnesses. The incidence of cancer, secondary to untreated hepatitis is common; at a rate eleven times that of Caucasian men (McPhee, 2002). Montagnards may only seek medical care when presented with an emergency situation.

Disparities in health care services for minority populations have been well documented in the research. The National Office for Minority Health has developed Race and Minority Health initiatives. Capitan (2002) notes that “African American, American Indian/Aaskan Native, Asian/Pacific Islander and Hispanic citizens suffer poorer health and higher rates of premature death than the majority population” (Capitan 2002). Mary Piper, a psychologist who has worked with refugees in the Midwestern U.S., found that “admission to the medical system is dependent upon access to transportation, the refugee/immigrant’s financial status, and their ability to speak the language or to have use of an interpreter” (Piper 2002). The 2002 census noted that 33% of foreign born residents do not have health insurance nor do they qualify for public assistance for health care. Refugees are limited to medical care for the first eight months living in the U.S. Most refugees lack jobs that offer insurance, even when employed (Bailey, 2002).

Montagnard refugees may be at high risk for Post Traumatic Stress Disorder (PTSD). Refugees suffering with posttraumatic stress disorders are not likely to have access to mental health counseling (Mollica, 2006). Depression, anxiety, and mental illness are constructs and concepts that are non-existent within the Montagnard culture. In fact, the words depression and mental illness do not translate, as they do not have equivalents within most Asian dialects (Fong, 2004, pg 126). Mental health problems are often manifested as physical problems, such as stomachache or headaches, and may be easily overlooked by the medical community (Piper, 2002). Southeast Asians in America “underutilize mainstream mental health services”, in spite of the statistic that 87% were found to be in need of psychological care as compared to 33% of the general population (Balgopal, 2000).

The problem of social isolation has been documented by Mui and colleagues. Mui encourages access to community resources as a way to reduce isolation (Mui et al, 2006). Chung (2004) encourages programs for elderly to include culturally appropriate activities and non-verbal methods of expressing feelings, as a “characteristic” of the Asian culture is to “avoid verbal expression of strong emotions and the need to maintain control over feelings” (Chung, 2004). Asian immigrants and refugees were described as a “model minority” during the civil rights movements, due to their passive nature and quiet demeanor (Balgopal, 2000). There is pressure to show control over emotions, something considered to be a desirable character trait in Asian culture. This may unfairly stereotype Asian immigrants as strong, untroubled by health or social problems (Abramson et al, 2002).

Within most Asian cultures, including the Montagnard culture, the concept of filial piety continues to be a strong determinant of who is responsible for taking care of elders. Filial piety may indirectly keep families from seeking outside assistance for care of their elderly family members, including home health care and hospice services.

### 2. Research Objective

In Guilford County, North Carolina, approximately 50 elderly Montagnard men and women participate weekly in a program of activities at Senior Resources of Guilford. This program includes activities such as intercultural bingo, citizenship and English classes, plus outings to events like the local farmer’s market. The Montagnards mix easily with ethnic Vietnamese, Cambodians, and other Southeast Asian minorities, as well as with African American and Caucasian Americans attending the Senior Center.

To achieve the project’s objectives Montagnard elderly were invited to participate in an oral history process. Participants were invited to provide a narrative of their lives and to share ideas on programs at the center. This narrative process is designed to give a “voice” to those “marginalized” within society. Dr. Richard Mollica, a Harvard professor of psychiatry and director of the Harvard Program in Refugee Trauma, has worked for more than thirty years with trauma victims. Oral history projects offer therapeutic benefit to refugees who may have witnessed or suffered traumatic events. Dr. Mollica illustrates how storytelling becomes “a healing art”, when victims of abuse or trauma are given the opportunity to voice events of their past (Mollica, 2006). By not allowing victims to speak of those traumatic experiences we “reinforce the survivor’s humiliated feelings, instilled by their aggressors, that they are worthless and their stories.
meaningless” (Mollica, 2006). Dave Isay, the founder of National Public Radio’s StoryCorps, and editor of “Listening is an Act of Love”, reminds us that “we all want to know our lives have mattered and we won’t ever be forgotten” (Isay, 2007).

Information from this project will inform those who work with immigrants and refugees, particularly elderly immigrants and refugees. It will provide direction for future research particularly with respect to the issue of framing and financing elder care policy for immigrants and refugees. Traver, who utilized oral history in her work with immigrants and refugees, reminds us that the stories of immigrants and refugees demonstrate “themes of resiliency, family, children, work, community, education, language, and quality of life” (Traver, 2004). For programs and policies to be effective, immigrant and refugee populations must be understood and be included in the decision making processes of their future. Host cultures and societies must understand, appreciate, and become inclusive of other cultures as communities are developed.

3. Methods: Recruitment and Sampling

The target population (N=50 for this research) was a group of elderly Montagnard men and women who regularly participated at Senior Resources of Guilford, a facility that offers weekday social, recreational, and nutritional programs for persons, aged 60 and up, in Guilford County North Carolina. Senior Resources provides a Refugee Outreach Program that includes language and citizenship classes for immigrants and refugees. Excluded from the sample population were non-Montagnards, those ages 60 or younger, and anyone not active at Senior Resources. Males and females are both well represented in the target population. The ability to speak, read, and write English was not a prerequisite as a professional translator was utilized.

The method used was “volunteer” sampling. Using an interpreter, the primary researcher provided a presentation to the target population to explain rationale and purpose of the project. Twelve volunteers from Senior Resources participated in the research study. Two were disqualified. One was ethnic Vietnamese, and the other was Nung, an ethnic minority of Chinese heritage. Limited demographic data was collected, including age, gender, marital status of the participants, and number of years living in the U.S.

4. Ethical Issues

Approval for this research was obtained from the Institutional Review Board of the University of North Carolina at Greensboro. The Montagnards are survivors of war, and many suffered persecution, torture, and prison in their native country. Because of this, they are considered a vulnerable population. Informed consent was obtained from all participants through the services of a trained interpreter. This included a written statement given to each participant that participation was optional. It was explained to the participants that they could withdraw from the project at any time. Included in the IRB plan was a process for referral to a pastor or mental health professional should the respondent show emotional distress during the narrative process. Participants signed a consent form in the presence of a witness.

All data collection and interviews took place at Senior Resources. Informed consent was obtained from each volunteer participant, with the assistance of a professional translator. Informed consent forms were translated into each of the five dialects spoken by the Montagnard participants. The participants were encouraged to ask questions at the beginning of the narrative process in order to help them relate their stories and experiences as an elder in Montagnard society. The primary researcher compiled the narratives as they were told and translated through the interpreter. The participant, translator, and primary researcher were in a private room and the participant was encouraged to discuss any aspects of his/her life that he/she considered to be important. A critical factor in this process was that Montagnard elders felt safe in discussing any and all aspects of their life stories. Frequently heard were comments such as “I’ve never told this to anyone before”, “I am afraid that if the Vietnamese government heard me tell this, my family would be hurt”, and “this is very difficult to talk about”. Most participants showed emotional distress at times, becoming tearful when discussing past experiences in jail.

5. Results and Discussion

Twelve participants volunteered to tell their story. Two were excluded as they did not meet the criteria for Montagnard ethnicity. Two (20%) were female, and eight (80%) were male. The ages of the participants ranged from 64 to age 82. The average age was 73.1 years. Half (50%) were not citizens, and half (50%) had become citizens. Eight (80%) were married, one (10%) was divorced, and one (10%) was widowed. The average number of years lived in the U.S. was 11.5 years.

The unstructured interview sessions ranged from one to four hours per participant. Two of the male participants came to the session with 6-8 pages typed in Vietnamese, including detail of dates, events, and places of importance. One of the female participants brought drawings that expressed her “pain” and “hope”. Several themes emerged. The most prevalent are listed in order of frequency mentioned. These are:

1. Served time in prison, jail, or “re-education camp” not for any actual crime, but for serving in army, for being Montagnard, and/or for political beliefs (80%). The time spent in jail varied from months to years.
2. Participants spoke of seeing other prisoners poisoned, beaten, and tortured. They spoke of feeling “not-human”, of being perceived as “an animal” by their captors. Most expressed anger toward their
captors. Many were starved, and not given access to medical treatment.

2. Expressed pride in their service in the South Vietnamese Army (70%). There was never a sentiment of regret for military service, as the participants frequently spoke of fighting for their homeland, what was considered rightfully theirs.

3. Expressed sense of community with Vietnamese/Montagnards in Greensboro (50%). This included their neighborhoods, which were primarily composed of other Montagnard families, their churches (Montagnard Christian Church or Montagnard Catholic Church), and their fellow participants at the Senicr Center.

4. Expressed worry or fear about the family left behind in Vietnam (50%). Most of the participants expressed fears that their family members remained at risk for discrimination with regards to education, career and work opportunities. Most described the current Vietnamese government as unfair in how decisions are made as to which family members can leave to join family in the U.S.

5. Discussed personal experiences with torture in Vietnam (40%). Stories of beatings, being hung upside down, being placed into garbage pits where human excrement was dumped on top of the prisoner were common. One gentleman described having most of the bones in his arms and legs broken by beatings, without access to medical care, so that the broken bones were never set. Most of these participants cried as they spoke of the torture and abuse. All refused mental health referrals offered by the researcher. Many of the participants spoke of support from their community and church leaders, who had suffered the same type of abuse.

6. Expressed appreciation for the opportunity to tell their story (40%). Comments such as “this needed to be told”, “I've never told anyone this, not even my wife”, “the truth needs to come out”, were common themes heard over and over. Most participants said “thank you” for this opportunity, which supports the idea that the project was somewhat therapeutic.

7. Desired citizenship and ability to speak English (40%). Most of the participants attended both English and citizenship classes. Many had attempted to pass the citizenship test but struggle with understanding the questions asked in English.

8. Expressed distress over lack of a job (30%). Almost all of the participants had worked for the first few years that they were in the U.S. Many lost their jobs due to downsizing, or the result of an illness. Lack of transportation and English skills were noted to be the primary limitations over the inability to get employment.

9. Witnessed trauma, torture or other murder of family (30%). One gentleman spoke of seeing his pregnant wife murdered, and his shame at not being able to intervene. He relayed a desire for retribution had he been able.

10. Expressed fear that their story would be seen and they or family would be hurt (20%). Most participants wanted assurance that their names would never be revealed, as they still did not feel safe here in America. Some participants spoke of fear that family members in Vietnam would be “hurt” if the Vietnamese government became aware that they spoke of torture and prison. This is not uncommon for populations who have suffered trauma and abuse. They may never truly feel safe.

The narratives were reviewed and examined for emerging trends and reoccurring themes. The information gleaned from this qualitative style of research will serve to inform and direct those communities assisting immigrant and refugee elderly. The framing and financing of elder care policy in future endeavors must also include the needs of immigrants and refugees.

These narratives also demonstrated the strength of family and community. The process itself offered participants an opportunity for a therapeutic environment to share traumatic events of their lives as well as frustrations that may exist living in another culture. It is the belief of the researcher that this did occur, as participants often thanked the researcher for taking the time to hear their story. Several participants expressed the statement, “my story needs to be told”, or “it is important that my story be heard”. Some participants stated that their story had never been voiced to anyone before. Some cried or showed significant levels of emotion. For those who appeared emotional or distressed, professional counseling was offered but all declined. Stories were told by refugees who were already engaged in a social institution. Elderly Montagnards who are not socially engaged in the community at large also need the opportunity to tell their stories, begin a process of emotional healing, and voice their needs. Medical personal and mental health agencies must have an awareness of some of the events of the past, and how such experiences may impact physical and mental health years later.

6. Limitations

The sample size was small, and thus may not necessarily be generalized to the elderly Montagnard population in Guilford County. Also, the participants represented those attending the senior center, and may not represent Montagnards who are not socially engaged in the community at large. The project was time intensive, as participants frequently came with their individual stories written down or typed, and felt it necessary to read and discuss everything that had been recorded.

7. Implications

These findings may serve to encourage others working in the
field of gerontology to consider further research with immigrant and refugee elderly. It may assist those working in public policy to be inclusive of all elderly, regardless of race, ethnicity, or status as citizen or non-citizen. It may serve to increase public mindfulness of the struggles of immigrants and refugees when we encounter them in our daily lives. We need to show sensitivity to the "untold" stories hidden behind a public mask. Although immigrants and refugees demonstrate happiness there may still be underlying pain and emotional struggles.

Hayes-Bautista and colleagues first termed the phrase "the browning of the graying of America" to describe the increased diversity within the ranks of the elderly in America (Hayes-Bautista et al., 2002). This not so subtle change has the ability to impact both social programs and service delivery in significant ways. As the number of elderly in the U.S. grows exponentially, they will become increasingly diverse with continued immigration. AARP's Office of Minority Affairs predicts that between 2025 and 2050, the non-white elderly population will increase from 25% to 35% of the total population (AARP, 1995). According to the Census Bureau, by 2050, there will be approximately 27.6 million minority elderly in the U.S. (Pandazani, 2004). In spite of this demographic trend, very little research exists with regard to elderly refugees and immigrants. The increasing diversity of elders may affect public policy and funding of elder care significantly in the next few decades. It is vital that we focus attention on the provision of adequate medical care, access to social service programs, and development of communication pathways for elderly refugees and immigrants (Hayes-Bautista et al., 2002).

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