



CULTURAL PREJUDICE AND GENERATIONAL GAPS: BARRIERS TO ACCESSING BUDDHIST PSYCHOLOGICAL TREATMENT

LE VAN TRUC¹, Pontappasarn Thanasak²,
Thanad Chiyaphan³

Doctor of Buddhist Studies Program in Buddhist Psychology Department of Psychology,
Faculty of Humanities Mahachulalongkornrajavidyalaya University, Thailand ¹⁻³

Corresponding Author E-mail: giacminhluat@gmail.com¹, pthana8911@gmail.com²
tu15.tu2007@gmail.com³

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ABSTRACT

Mental health within the Vietnamese community, encompassing both local citizens and Vietnamese immigrants residing in the United States, remains significantly stigmatized due to deeply rooted cultural beliefs, traditional belief systems, and significant intergenerational disparities in mental health literacy and acceptance. This article examines the anthropological, cultural, and psychological dimensions of these barriers, exploring how mental illness is often mischaracterized as a sign of personal weakness, moral failure, severe insanity, or the karmic consequence of past wrongdoing. Older generations, driven by collectivist imperatives to preserve family honor and a pervasive fear of community judgment, routinely dismiss psychological distress and actively resist professional psychological treatment. Younger generations, shaped by contemporary education and greater exposure to global mental health discourse, demonstrate considerably greater openness toward acknowledging and addressing mental health difficulties, yet remain constrained by familial expectations, intergenerational conflict, and the emotional invalidation of their struggles by elders. These cultural and generational disparities create significant barriers to accessing necessary psychological care, resulting in widespread silent suffering that exacerbates individual distress and undermines community well-being. To bridge this divide effectively, this article argues for the integration of Buddhist psychological principles particularly the Brahmavihara of loving-kindness (Metta) and compassion (Karuna) into culturally competent mental health practice. By framing psychological intervention within Buddhist contemplative traditions that are already deeply embedded in Vietnamese cultural identity, practitioners can destigmatize treatment, cultivate empathic understanding across generations, and encourage help-seeking behaviors among vulnerable populations. Furthermore, the synergistic application of mindfulness and forgiveness practices is examined as a mechanism for fostering social cohesion in multicultural environments, with evidence drawn from research conducted in Binh Duong province, Vietnam. The article concludes that culturally sensitive, Buddhist-informed interventions offer a viable and transformative pathway toward healing individual trauma, repairing intergenerational relationships, and building resilient, harmonious communities.

Keywords: mental health stigma; Buddhist psychology; loving-kindness; generational gap; social cohesion

INTRODUCTION

Mental health stigma represents one of a significant barrier to psychological well-being in Vietnamese communities, both within Vietnam and among Vietnamese diaspora populations in countries such as the United States. Despite growing global awareness of mental health as a legitimate health concern requiring professional attention and systemic support, deeply entrenched cultural beliefs continue to frame psychological distress through moral, spiritual, and reputational lenses that are largely incompatible with contemporary psychiatric and psychological understandings of mental illness (Nguyen-Luu, 2024). Within the Vietnamese cultural framework, mental illness is frequently conceptualized not as a biomedical condition with identifiable neurological and psychological etiologies but as an indicator of personal weakness, moral inadequacy, or the karmic consequences of past actions in this or previous lifetimes belief systems rooted in the syncretic blend of Buddhist, Confucian, Taoist, and animist traditions that have shaped Vietnamese cosmology and social values across centuries (Do, McCleary, Nguyen, & Winfrey, 2020). These culturally specific interpretive frameworks do not merely reflect passive misunderstanding; they may contribute to social environments in which acknowledging psychological distress carries serious reputational risks, and in which help-seeking behavior can be experienced as a public declaration of moral failure that brings shame not only upon the individual but upon the entire family unit.

The collectivist social structure that characterizes Vietnamese society amplifies the stigmatizing effects of these cultural beliefs by ensuring that mental health disclosure is rarely a purely private matter. In a social context where individual identity is fundamentally embedded within family and community networks, and where family reputation constitutes a primary social currency determining access to respect, opportunity, and social belonging, the decision to seek psychological treatment carries implications that extend far beyond the individual's personal welfare (Vu & Doan, 2019). The fear of social judgment colloquially understood in Vietnamese culture as the paralyzing awareness of being the subject of neighbors' and relatives' critical discussion functions as a powerful mechanism of social control that suppresses help-seeking behavior across generations (Do et al., 2020). This social dynamic is further reinforced by the relative scarcity of mental health professionals in Vietnam, where approximately 143 psychologists serve a population of over 14 million people living with mental disorders, making the structural barriers to care as formidable as the cultural ones (Nguyen & Bui, 2021). The combination of cultural stigma, structural inadequacy, and collectivist social pressure creates conditions in which silent suffering becomes not merely

common but culturally normalized a circumstance with profound consequences for individual, family, and community well-being.

A significant dimension of the mental health access crisis in Vietnamese communities is the pronounced generational gap in attitudes, beliefs, and behaviors related to psychological distress and its treatment. Older generations who came of age during periods of significant historical trauma including wartime displacement, economic hardship, and the radical social disruptions associated with Vietnam's political and economic transformations frequently developed coping orientations centered on stoic endurance, collective responsibility, and the subordination of individual psychological needs to family and community survival imperatives (Nguyen-Luu, 2024). Within this experiential framework, the expectation that young people should similarly endure psychological distress without professional intervention is not experienced as unreasonable but as the transmission of hard-won cultural wisdom about resilience and self-reliance. Younger generations, by contrast, have been shaped by dramatically different educational, digital, and social environments that have exposed them to global mental health discourse, normalized discussions of emotional well-being, and cultivated a language for psychological experience that their elders frequently lack (Le, 2026). This generational divergence does not merely create misunderstanding; it generates active intergenerational conflict in which the younger person's attempt to acknowledge and address their psychological suffering is experienced by older family members as a rejection of cultural values, an expression of weakness, or an embarrassing public disclosure that threatens family honor.

The resolution of these deeply layered cultural and generational barriers requires approaches that operate simultaneously at multiple levels individual, familial, community, and structural and that draw upon frameworks capable of bridging traditional cultural values with contemporary psychological knowledge. Buddhist psychology, with its rich contemplative tradition of cultivating loving-kindness (Metta), compassion (Karuna), and mindful awareness (sati) as foundational practices for the alleviation of suffering, offers precisely such a bridging framework (Bodhi, 1994; Harvey, 2013). Because Buddhist teachings are already deeply embedded in the cultural identity, ritual life, and ethical vocabulary of Vietnamese society, interventions grounded in Buddhist psychological principles are uniquely positioned to destigmatize mental health care by recasting it not as a clinical admission of pathology but as a culturally honored form of psychological cultivation and spiritual development (Le, 2026). The present article therefore examines the mechanisms through which cultural prejudice and generational gaps function as barriers to psychological treatment, explores the specific

contributions of loving-kindness and compassion as therapeutic and community-building resources, and proposes a Buddhist-informed model of culturally competent mental health practice capable of transforming individual healing and social cohesion in Vietnamese communities.

CULTURAL PREJUDICES, STIGMA, AND THE MISCHARACTERIZATION OF MENTAL ILLNESS THROUGH THE LENS OF LOVING-KINDNESS

1. The Karmic and Moral Mis-framing of Psychological Distress

The mischaracterization of mental illness within Vietnamese cultural contexts operates through a distinctive and historically deep set of interpretive frameworks that fundamentally differ from biomedical understandings of psychological disorder. Mental illness is frequently attributed to karmic retribution for past moral transgressions actions taken in this or previous lifetimes that are believed to manifest as psychological suffering in the present or to supernatural causes including demonic possession, ancestral displeasure, or the malevolent influence of hostile spiritual forces (Do et al., 2020). These explanatory frameworks are not limited to marginal belief systems only by the least educated segments of the population; they represent culturally authoritative interpretations of suffering that carry the weight of centuries-old religious and philosophical tradition and that are reinforced through community practice, family transmission, and lived experience (Nguyen-Luu, 2024). Within this interpretive system, psychological distress is experienced not as a health condition warranting compassionate medical attention but as a moral signal demanding ethical self-examination and spiritual remediation a framing that positions the sufferer as fundamentally responsible for their own condition and that renders professional psychological treatment not merely unnecessary but potentially subversive of the moral work that the condition is understood to demand.

The consequences of this mis-framing for affected individuals are severe and multidimensional. When mental illness is understood as a karmic or moral failing, the appropriate cultural response is not empathy and support but judgment and social distancing, as proximity to the afflicted person risks both spiritual contamination and reputational association with moral failure (Do et al., 2020). This response dynamic creates a profound paradox for suffering individuals: the cultural system that most deeply shapes their identity and sense of belonging simultaneously renders them unable to seek comfort or support within that system without exposing themselves to further harm. Buddhist psychology offers a direct

and philosophically grounded counter-narrative to this mis-framing through the principle of loving-kindness (Metta) the systematic cultivation of unconditional goodwill toward all beings without exception, including those who are suffering, morally imperfect, or socially stigmatized (Salzberg, 1995). When the Buddhist doctrine of Metta is applied to the understanding of mental illness, it transforms the interpretive framework from one of moral judgment to one of compassionate recognition: suffering is understood not as evidence of karmic failure but as a universal human experience arising from conditions that can be understood and transformed through wise and compassionate engagement (Bodhi, 1994). This reframing, grounded in culturally authoritative Buddhist teaching, has the potential to shift community attitudes toward mental illness in ways that externally derived clinical models cannot achieve, because it speaks the moral language of the culture itself.

1.2 Family Honor, Collective Shame, and the Suppression of Help-Seeking Behavior

The collectivist social structure of Vietnamese society ensures that mental health stigma is never merely an individual experience but always a family and community phenomenon whose dynamics are shaped by the imperative to preserve collective honor and avoid the social consequences of public shame. The Vietnamese concept of face an intricate social currency encompassing personal dignity, family reputation, and community standing functions as a powerful regulatory mechanism that constrains behavior across multiple domains of social life, but its influence is particularly pronounced in the domain of mental health disclosure (Nguyen-Luu, 2024). To acknowledge that a family member is experiencing psychological distress and requires professional mental health treatment is, within this cultural framework, to invite community scrutiny and potential judgment of the entire family's moral character, parenting quality, and spiritual standing consequences so threatening to the family's social position that many families prefer to endure considerable private suffering rather than risk the public exposure that help-seeking entails (Do et al., 2020).

This dynamics of collective shame and honor-preservation creates what might be described as a conspiracy of silence around mental illness within Vietnamese families a shared, often unspoken agreement to maintain the appearance of psychological wellness in public contexts regardless of the private reality of suffering. While this conspiracy is maintained through cultural loyalty and protective familial motivation, its effects upon affected individuals are profoundly harmful, depriving them of the social support, professional intervention, and compassionate recognition that are essential for recovery (Pham, 2022). The Buddhist principle

of loving-kindness provides a therapeutically and culturally powerful resource for disrupting this conspiracy by redirecting the motivational framework of collective care from honor-preservation toward compassionate response to suffering. When families are supported to understand Metta as a foundational Buddhist virtue one that calls practitioners to extend unconditional goodwill to all beings, including family members who are suffering the cultural weight of Buddhist authority can be enlisted in service of mental health support rather than against it (Harvey, 2013). Community-level interventions that explicitly frame mental health care as an expression of loving-kindness toward those who suffer, delivered through culturally authoritative channels including Buddhist monasteries, community elders, and respected religious teachers, can gradually erode the honor-preservation logic that currently suppresses help-seeking, replacing it with a compassion-centered ethic more consistent with the deepest values of the Buddhist tradition itself.

THE GENERATIONAL GAP: DIVERGENT MENTAL HEALTH FRAMEWORKS, EMPATHIC UNDERSTANDING, AND THE ROLE OF COMPASSIONATE COMMUNICATION

1. Older Generations, Stoic Endurance, and the Absence of Empathic Attunement

The generational gap in attitudes toward mental health within Vietnamese communities reflects not merely a difference in information or education but a fundamental divergence in the experiential frameworks through which suffering is understood, evaluated, and responded to. Older generations who survived significant historical traumas wartime violence, forced displacement, economic deprivation, and the radical social disruptions of post-reunification Vietnam frequently developed psychological orientations centered on stoic endurance, collective responsibility, and the prioritization of survival over individual emotional processing (Nguyen-Luu, 2024). Within this experiential framework, the expectation that psychological distress should be endured silently, managed through community solidarity and spiritual practice rather than professional intervention, and never disclosed in ways that might compromise family reputation represents not cultural rigidity but hard-won adaptive wisdom accumulated through extraordinarily difficult collective experience.

The difficulty arises when this orientation is transmitted to younger generations who face categorically different stressors academic competition, digital social comparison, identity fragmentation under globalization for which stoic endurance is neither adequate nor appropriate as a coping strategy (Do et al., 2020)The empathic gap that results from this

divergence in experiential frameworks is not merely cognitive a matter of different information or beliefs but affective and relational: older family members may have difficulty recognizing the suffering of younger people as real or significant because it does not correspond to their own experience of what constitutes genuine hardship worthy of acknowledgment and support. This failure of empathic attunement, rooted in the collision of profoundly different experiential worlds, prevents the family from functioning as the protective emotional resource it is culturally intended to be and instead transforms family interactions into additional sources of invalidation and isolation for struggling young people (Le, 2026).

Buddhist psychology's emphasis on *karuna* compassion defined precisely as the capacity to recognize and respond to suffering in others regardless of whether that suffering conforms to one's own experiential categories offers a direct therapeutic response to this empathic gap (Salzberg, 1995). Compassion, as understood in the Buddhist tradition, requires not that the observer has personally experienced the same form of suffering as the one who suffers, but that they have cultivated the attentional openness and emotional responsiveness to genuinely see and be moved by suffering in whatever form it presents. Training older family members in the practice of compassion meditation the systematic cultivation of the wish that others be free from suffering can therefore build the affective bridge across generational experience that informational psychoeducation alone cannot construct.

2. Youth Mental Health Literacy, Familial Constraint, and the Need for Compassionate Intergenerational Dialogue

Younger generations of Vietnamese people, both in Vietnam and within diaspora communities, have developed relatively higher levels of mental health literacy and openness toward psychological help-seeking than their elders a shift driven by increased access to global mental health discourse through digital media, greater exposure to Western psychological frameworks through education, and the lived experience of seeking to understand and address psychological difficulties that traditional cultural frameworks inadequately explain or support (Nguyen-Luu, 2024). This greater openness, however, does not straightforwardly translate into improved mental health outcomes, because the cultural and familial environments within which young people live their daily lives continue to be shaped predominantly by the attitudes, beliefs, and expectations of older generations whose frameworks remain resistant to the mental health discourse that younger people are attempting to engage (Le, 2026). The consequence is that many young Vietnamese people

find themselves navigating a painful double bind: mentally oriented toward seeking professional help for genuine psychological distress, yet socially and relationally constrained by family environments in which such help-seeking would be experienced as a betrayal of family values, a public admission of weakness, or a rejection of the cultural resilience that defines family identity.

Resolving this double bind requires not merely the further education of young people about mental health resources but the development of new communicative capacities and relational practices within families that enable genuine intergenerational dialogue about psychological experience. The Buddhist principle of Right Speech compassionate, truthful, timely, and non-harmful communication provides a practical framework for cultivating such dialogue within the Vietnamese cultural context, because it draws upon an already culturally authoritative ethical tradition to reframe the quality of family communication as a matter of spiritual practice rather than merely interpersonal preference (Harvey, 2013). When young people are supported to communicate their psychological distress through language that resonates with Buddhist values framing their suffering in terms of conditioned arising, impermanence, and the universal human experience of dukkha rather than through clinical diagnostic categories that carry stigmatizing connotations they are more likely to be heard and understood by older family members whose interpretive frameworks remain Buddhist rather than psychiatric (Bodhi, 1994). Simultaneously, when older family members are supported to cultivate the practice of compassionate listening the Metta informed capacity to receive another's expression of suffering with warmth, patience, and genuine openness rather than evaluative judgment the conditions for authentic intergenerational understanding become possible, and the family's capacity to function as a healing resource rather than a stigmatizing constraint can begin to be restored.

3. Compassionate Communication as a Bridge across Generational Divides

The practical cultivation of compassionate communication across generational lines requires both individual practice and structural support that creates regular, facilitated opportunities for families to develop new ways of engaging with psychological experience together. Research on family-based mental health interventions in Asian contexts consistently demonstrates that approaches which engage the entire family system rather than focusing exclusively on the identified patient or the younger generation produce significantly better outcomes in terms of symptom reduction, family cohesion, and sustained

help-seeking behavior (Bernal & Domenech Rodriguez, 2012). In the Vietnamese context, the integration of Buddhist psychological principles into family intervention creates a distinctive opportunity to reframe the entire enterprise of family mental health support as a collective spiritual practice rather than a clinical exercise one in which all family members, regardless of generation, are understood as practitioners engaged in the shared work of cultivating wisdom, compassion, and skillful response to suffering (Le, 2026). This reframing reduces the defensiveness and shame that can make family mental health conversations acutely difficult by positioning all participants as learners engaged in a shared cultural and spiritual endeavor rather than as patients and caregivers in a medicalized relationship that carries its own stigmatizing connotations.

Community-based programs that bring multigenerational family groups together for structured dialogue facilitated by trained Buddhist psychology practitioners combining psychoeducation about mental health with guided practice in loving-kindness meditation, compassionate listening, and Right Speech communication represent a practically achievable and culturally resonant model for building compassionate intergenerational communication in Vietnamese communities (Duc, 2025). Such programs, delivered through the existing infrastructure of Buddhist temples and community organizations that already command cultural legitimacy and intergenerational attendance, can reach families that would never engage with clinically framed mental health services, creating pathways for change that operate through the cultural channels that community members already trust and value.

CULTURALLY COMPETENT CARE: THE SYNERGISTIC POWER OF LOVING-KINDNESS, MINDFULNESS, AND FORGIVENESS FOR INDIVIDUAL HEALING AND SOCIAL COHESION

1. Buddhist Psychology as a Culturally Competent Bridge to Mental Health Care

The concept of cultural competence in mental health practice the capacity of practitioners and services to deliver effective care in ways that are congruent with clients' cultural values, beliefs, and practices has been increasingly recognized as essential for addressing the persistent disparities in mental health access and outcomes that affect culturally marginalized communities (Sue, Zane, Hall, & Berger, 2009). For Vietnamese clients whose cultural identity is deeply shaped by Buddhist philosophical and contemplative traditions, cultural competence in mental health practice requires not merely surface-level accommodation of cultural preferences but genuine engagement with the psychological insights, contemplative methods, and ethical frameworks that Buddhist teaching offers as

resources for understanding and transforming suffering (Le, 2026). Framing psychological intervention within Buddhist conceptual language speaking of suffering as dukkha arising from craving and ignorance, of healing as the cultivation of wisdom and compassion, and of therapeutic progress as the gradual development of the Noble Eightfold Path does not dilute clinical effectiveness but rather embeds it within a culturally authoritative meaning system that makes the work of psychological healing feel familiar, meaningful, and spiritually resonant rather than foreign, pathologizing, and shameful (Harvey, 2013).

The practice of loving-kindness meditation (Metta Bhavana) deserves particular attention as a clinically significant and culturally resonant intervention for Vietnamese clients struggling with the shame, self-criticism, and social isolation that typically accompany both depression and mental health stigma. Contemporary research on loving-kindness meditation demonstrates consistent and meaningful improvements in positive affect, self-compassion, social connectedness, and empathic capacity across diverse clinical and community populations, with effect sizes comparable to those achieved by established cognitive-behavioral interventions for depression and anxiety (Zeng, Chiu, Wang, Oei, & Leung, 2015).

For Vietnamese clients whose depressive experience is organized around shame-based self-criticism, conditional self-worth, and the painful experience of feeling unlovable when failing to meet family expectations, the systematic cultivation of unconditional goodwill toward oneself and others through Metta practice directly targets the core psychological dynamics maintaining depression in a way that is simultaneously clinically effective and culturally meaningful (Salzberg, 1995). When loving-kindness practice is delivered within a Buddhist psychological framework that explicitly connects it to the broader contemplative tradition already embedded in clients' cultural identity, the therapeutic benefit is amplified by the additional dimension of cultural belonging and spiritual continuity that the practice provides.

2. The Synergistic Effects of Mindfulness and Forgiveness on Social Cohesion and Intercultural Harmony

Beyond their contributions to individual psychological healing, mindfulness and forgiveness practices derived from the Buddhist contemplative tradition suggest potential synergistic effects on social cohesion, intercultural understanding, and community well-being effects that are particularly significant in the multicultural, rapidly urbanizing environments that characterize contemporary Vietnam. Research conducted in Binh Duong province a major industrial hub that serves as home to a highly diverse population of local residents,

internal migrant workers from across Vietnam, and international students and workers from multiple countries demonstrates that the combined practice of mindfulness and forgiveness produces measurable improvements in emotional regulation, interpersonal empathy, reduction of intercultural conflict, and overall sense of community belonging (Duc, 2025). These findings are theoretically significant because they demonstrate that the benefits of Buddhist contemplative practice are not confined to the individual psychological domain but extend into the relational and social dimensions of human experience in ways that address the collective dimensions of the mental health crisis that individual-focused interventions cannot reach.

The mechanism through which mindfulness and forgiveness produce these social benefits can be understood through the Buddhist psychological framework of the *Brahmavihara* the four divine abodes of loving-kindness (*Metta*), compassion (*Karuna*), empathic joy (*Mudita*), and equanimity (*Upekkha*) which constitute the contemplative foundation of prosocial emotion and ethical social engagement in Buddhist psychology (Bodhi, 1993). Mindfulness practice cultivates the attentional stability and present-moment awareness that enables practitioners to observe interpersonal dynamics with clarity rather than reactivity, creating the psychological space within which compassionate response becomes possible rather than automatic defensive reaction (Segal, Williams, & Teasdale, 2013).

Forgiveness practice, grounded in the Buddhist understanding of karma and interdependence, enables practitioners to release the resentment and grievance that sustain interpersonal conflict by cultivating a more expansive understanding of the conditions that give rise to harmful behavior understanding that, without excusing harmful actions, transforms the experience of being wronged from an occasion for enduring anger into an opportunity for compassionate insight (Enright & Fitzgibbons, 2015). Together, these practices create a contemplative foundation for social cohesion that is simultaneously culturally resonant for Vietnamese communities and empirically grounded in contemporary psychological research a combination that makes them uniquely valuable as tools for addressing both the individual and collective dimensions of the mental health crisis in Vietnamese contexts.

3. Implementation of Loving-Kindness and Compassion Training in Community Settings

The practical implementation of Buddhist psychological principles in community mental health settings requires thoughtful attention to both the content of intervention and the channels through which it is delivered, in order to maximize cultural resonance, minimize stigma, and reach populations that would not engage with conventionally framed clinical services. Buddhist temples and community organizations represent the most strategically significant delivery channels for culturally competent mental health intervention in Vietnamese communities, because they already command widespread trust and legitimacy across generational lines, provide existing infrastructure for regular community gathering, and offer the contemplative and ethical frameworks within which Buddhist psychological principles can be authentically embedded rather than superficially borrowed (Le, 2026). Programs delivered through these channels that combine structured loving-kindness and mindfulness practice with psychoeducational content about mental health framed explicitly within Buddhist philosophical language and facilitated by practitioners who hold both contemplative credibility and basic psychological training can reach community members across the generational spectrum in ways that clinic-based services fundamentally cannot.

The training of Buddhist monastics and community religious leaders as mental health first responders and mindfulness-based intervention facilitators represents a particularly promising and cost-effective strategy for extending the reach of culturally competent mental health support in Vietnamese communities (Duc, 2025). Monastics who receive structured training in basic psychological first aid, mental health literacy, compassionate listening, and the facilitation of loving-kindness and mindfulness practices are uniquely positioned to serve as bridges between the cultural and spiritual world their communities trust and the mental health knowledge and skills that their communities need functioning in precisely the "task-shifting" role that resource-limited mental health systems require in order to achieve meaningful population-level impact (Le, 2026). The integration of Metta practice into regular temple programming, the establishment of facilitated intergenerational dialogue groups within community religious organizations, and the development of family-oriented Buddhist psychological wellness programs constitute the practical infrastructure through which the transformative potential of Buddhist psychological principles can be made genuinely accessible to Vietnamese communities navigating the intersection of cultural stigma, generational conflict, and psychological distress.

CONCLUSION

The intersection of cultural prejudice and generational gaps constitutes a profound and multidimensional barrier to mental health care access in Vietnamese communities, one that may be difficult to address effectively through the simple provision of more clinical services or the straightforward dissemination of mental health information. The mischaracterization of mental illness as karmic failure or moral weakness, the collectivist imperative to preserve family honor at the cost of individual psychological well-being, and the empathic gap between generations shaped by radically different historical experiences all combine to create an environment in which silent suffering is normalized and help-seeking is actively suppressed.

Addressing this crisis requires a fundamental paradigm shift grounded in the Buddhist principle of loving-kindness the systematic cultivation of unconditional compassionate regard for those who suffer, regardless of the form their suffering takes or the cultural judgments that surround it. In practical terms, the application of Buddhist psychological principles to this crisis begins with the training of community religious leaders and Buddhist monastics in compassionate listening, mental health first aid, and the facilitation of loving-kindness and mindfulness practice within existing community and temple settings.

It continues through the development of multigenerational family dialogue programs that use Right Speech and Metta practice to build the communicative bridges that currently do not exist between generations holding incompatible mental health frameworks. It extends into school and community mental health programs that frame psychological wellness explicitly within Buddhist contemplative traditions, destigmatizing care by positioning it as spiritual cultivation rather than clinical pathology. And it culminates in the systemic integration of Buddhist psychological wisdom with evidence-based psychotherapy to create intervention models that are simultaneously scientifically rigorous and culturally resonant models capable of reaching the populations most in need precisely because they speak the language, honor the values, and draw upon the wisdom traditions that those populations already hold. When loving-kindness becomes not merely a meditative practice but a community organizing principle for mental health promotion, the barriers of prejudice and generational division can gradually give way to the compassionate, informed, and culturally grounded care that Vietnamese communities urgently deserve.

Here's the English translation of the body of knowledge summary

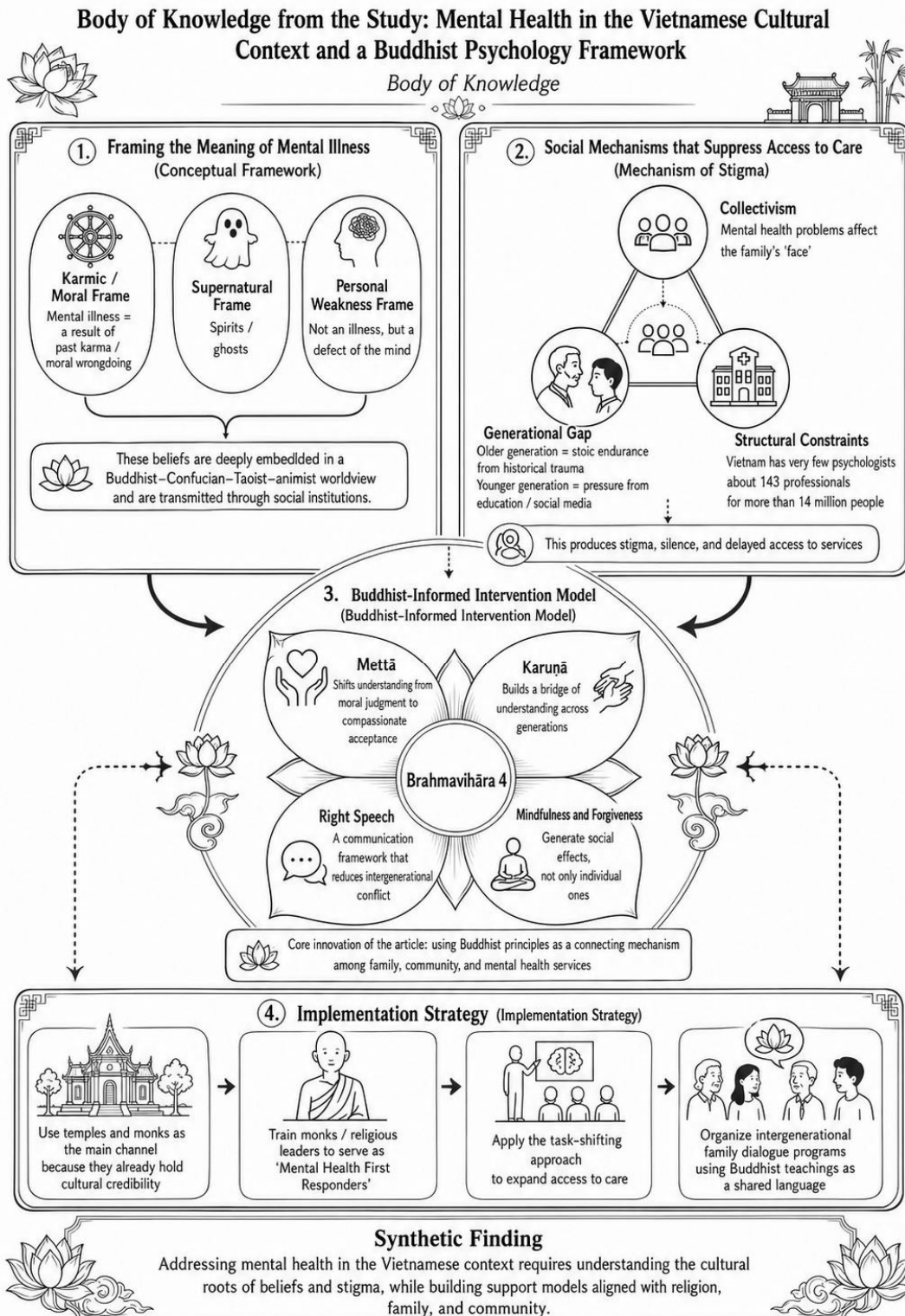


Figure 1. body of knowledge

1. Conceptual Framework: Reframing the Meaning of Mental Illness

The article proposes that mental illness in the Vietnamese cultural context is interpreted through three main belief frameworks that conflict with modern medical perspectives

- 1) Karmic/Moral framework (mental illness as a result of past karma/moral wrongdoing)
- 2) Supernatural framework (spirits/malevolent forces)
- 3) Personal weakness framework (not viewed as a disease, but as a personal psychological inadequacy)

The key insight is that these frameworks are not marginal superstitions, but deeply embedded beliefs within a syncretic philosophical-religious system blending Buddhism, Confucianism, Taoism, and animism, transmitted through social institutions.

2. The Mechanism of Stigma Suppressing Access to Care

The article identifies three interacting factors that create barriers to mental health access

- 1) Collectivist social structure makes mental health disclosure not a private matter, but one that affects the family's "face"
- 2) Generational/Empathic Gap older generations, having endured historical trauma (war, displacement), developed a "stoic endurance" orientation that doesn't align with the suffering of younger generations (driven by academic and social media pressures)
- 3) Structural limitations Vietnam has a severe shortage of mental health professionals (approximately 143 psychologists for over 14 million people with mental disorders)

3. The Buddhist-Informed Intervention Model

This is the core innovative contribution of the article proposing the Four Brahmaviharas as a bridging mechanism

- 1) Metta (loving-kindness) reframes understanding from "moral judgment" to "compassionate acceptance"
- 2) Karuna (compassion) builds an empathic bridge across generations (addressing the empathic gap)
- 3) Right Speech provides a communication framework that reduces intergenerational conflict

4) Mindfulness and forgiveness produce social, not merely individual, effects (supported by evidence from the Binh Duong study)

4. Implementation Strategy

The article proposes concrete delivery channels:

1) Using Buddhist temples and monastics as the primary channel, since they already hold cultural legitimacy

2) Training monks/religious leaders as "mental health first responders" through a task-shifting approach

3) Organizing intergenerational dialogue programs within families using Buddhist principles as a common language

Summary of the Key Contribution

This article generates new knowledge by integrating three disciplines: cultural anthropology, clinical psychology, and Buddhist psychology — proposing that using an existing cultural language (Buddhism) as a destigmatizing tool is more effective than directly applying Western psychiatric frameworks, because it avoids creating a sense of "alienation" from cultural identity.

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