

Family-Based Mental Health Education for Older Adults in Ho Chi Minh City: A Situational Analysis

Vu Thi Minh Phuong^{1*}, Nguyễn Thanh Bình²

¹Department of Social Work, University of Labour and Social Affairs, Branch 2 in Ho Chi Minh City (ULSA2).

² Head of the Faculty of Social Work, Hanoi National University of Education

DOI: <https://doi.org/10.5281/zenodo.16601221>

Published Date: 30-July-2025

Abstract: Against the backdrop of Vietnam's rapidly aging population, this study investigates the role of informal, family-based mental health education for older adults in Ho Chi Minh City. Employing a quantitative cross-sectional survey with 255 participants in Districts 5 and 12, the research assessed the frequency and perceived effectiveness of specific mental health support activities provided by family members. The findings reveal that these activities occurred only "occasionally" and were considered "moderately" effective. A significant paradox emerged: the act of "listening and sharing," despite being highly frequent, was rated as the least effective, highlighting a considerable gap between supportive intentions and the actual capacity to help. Comparative analysis indicated that residential area, living arrangements, and gender were statistically significant factors in the provision of mental health education, whereas age and educational attainment were not. The study concludes that the family serves as a vital yet constrained channel for mental health education. Future interventions should therefore focus on enhancing the capacity and skills of family members—not just target the older adults directly—to empower them as more effective educators.

Keywords: Mental health education, older adults, family support, urban Vietnam.

1. INTRODUCTION

The global demographic landscape is witnessing a historic shift, with Vietnam emerging as one of the world's most rapidly aging nations. According to projections from the United Nations Population Fund (UNFPA, 2025), the population segment aged 60 and over, which constituted 11.9% of the total population in 2019, is set to soar to over 25% by 2050. Remarkably, it will take Vietnam only about 25 years to transition from an "aging" to an "aged" society. This pace is significantly faster than that of developed countries like France (115 years) or the United States (69 years), placing immense pressure on social security and healthcare systems that have had insufficient time to adapt (Communist Review, 2023).

Within this national picture, Ho Chi Minh City (HCMC) stands as the epicenter of change, currently holding the fastest rate and highest index of population aging in the country (Tuoi Tre Online, 2024). By the end of 2023, the city was home to over 1.3 million people aged 60 and above, accounting for 12.05% of its population, with an aging index of 65.36 - considerably higher than the national average (Tuoi Tre Online, 2024). This rapid increase in the number of older adults in a major urban center, combined with the lagging development of formal care systems (Vo et al., 2025), has cultivated a challenging environment. Here, a large and increasingly vulnerable population faces escalating healthcare needs amidst underdeveloped support infrastructure, fostering conditions ripe for the emergence and spread of mental health issues.

Parallel to this demographic shift runs a silent public health crisis. Nationwide, an estimated 14 million people are living with mental disorders (Ministry of Health, 2023). For older adults, significant physical and social changes, coupled with feelings of loneliness, render them a high-risk group (Suc khoe Viet, 2024). Studies in Vietnam reveal that depression rates among the elderly fluctuate at alarming levels, ranging from 17% to over 34% across different survey samples (Vu et al., 2024; Vietnam Medical Journal, 2022). Anxiety disorders are also prevalent, with one hospital-based study indicating a

combined depression and anxiety rate of up to 40% among older inpatients (Pharmacity, n.d.). In HCMC, dementia and depression are among the most common mental conditions in the over-65 age group (Tuoi Tre Online, 2023).

The problem is compounded by the existence of an enormous treatment gap. It is estimated that over 90% of individuals with mental disorders in Vietnam do not access formal treatment services (Ministry of Health, 2023). This gap not only reflects the shortcomings of the healthcare system but also reveals a reality where the vast majority of patients and their families are left to fend for themselves, relying predominantly on non-professional sources of support. This leads to a central paradox within the Vietnamese cultural context, where the family is simultaneously the foundational pillar of support and potentially the greatest barrier.

Traditionally, the family is the primary source of support for older adults, a role reinforced by deep-seated values of filial piety (Nguyen & Le, 2021; Tran et al., 2006). Children are duty-bound to care for their aging parents, providing them with both material and emotional assistance (Vietnam-France Psychology, n.d.). However, this very support system is often the source of stigma and misinformation regarding mental health. The fear of “losing face” or damaging the family's honor (Tran et al., 2006), the perception of mental illness as karmic retribution or a weakness of will (Nguyen, 2003), and the tendency to normalize symptoms as an inevitable part of aging (Nguyen et al., 2021) create a vicious cycle. This loop prevents proper problem recognition and the pursuit of professional help, inadvertently turning the closest caregivers into barriers to effective treatment.

Given this reality, the knowledge, beliefs, and communication patterns regarding mental health within the family - that is, their role as informal educators - emerge as a pivotal yet under-researched factor. Therefore, this study moves beyond merely acknowledging the family's supportive role to focus specifically on their educational function. The primary aims of this research are to assess the Mental Health Literacy (MHL) of urban older adults in HCMC, describe the characteristics of the informal mental health education they receive from their families, and analyze the relationship between this form of education, their MHL, and their attitudes toward seeking professional help.

2. LITERATURE REVIEW

To analyze the family's educational role, this study employs the theoretical framework of Mental Health Literacy (MHL). Defined by Jorm et al., MHL is the “knowledge and beliefs about mental disorders which aid in their recognition, management or prevention” (Jorm, 2019, p. 53). This concept extends beyond abstract knowledge to encompass a form of functional literacy applicable to real-world actions that benefit one's own mental health or that of others. Its core components include the ability to recognize developing disorders, knowledge of risk factors and causes, understanding of help-seeking options and available treatments, knowledge of effective self-help strategies, and attitudes that promote appropriate help-seeking (Jorm, 2019). The MHL framework enables a structured assessment of the knowledge and beliefs that older adults receive from their families, thereby identifying knowledge gaps that require intervention.

In the Vietnamese cultural context, the role of the family in the lives of older adults is characterized by considerable complexity. On one hand, the family is the primary source of emotional and material support, providing a sense of love and connection, which are potent protective factors against mental health issues like depression and anxiety (Vietnam-France Psychology, n.d.). Under the influence of Confucian values, filial piety (*hiếu*) dictates that adult children have a social obligation to care for their aging parents (Nguyen & Le, 2021). This makes family support the main source of well-being, particularly as the formal social security system remains limited and many older adults are economically dependent on their children and grandchildren (Lu et al., 2025).

On the other hand, however, the family is often the very place where the most significant cultural barriers to mental healthcare are generated and perpetuated. Mental illness is frequently perceived as a source of shame, a stain not only on the individual but on the entire family's honor (Tran et al., 2006). The fear of community judgment, or “losing face”, leads families to conceal the problem, thereby delaying or completely avoiding the pursuit of external help (Tran et al., 2006). Furthermore, mental health issues are often interpreted through the lens of folk beliefs, such as being caused by “karmic retribution” or ancestral punishment (Nguyen, 2003). Another common interpretation is to view symptoms like memory loss or sadness as normal manifestations of old age - something inevitable and not in need of medical intervention (Nguyen et al., 2021). These misinterpretations obscure its identity as a treatable medical condition.

This study proposes that the connecting link between the family's multifaceted role and the mental health outcomes of older adults is the concept of “informal education”. Through conversations, advice, and even silence, family members continuously act as “informal educators”, shaping the attitudes and knowledge of older adults regarding mental health

(Mandalia et al., 2018). The quality of this educational process may be a mediating factor that determines help-seeking behavior. Recent studies show that higher MHL is positively correlated with favorable attitudes and professional help-seeking behavior, and this relationship is strongly moderated by perceived social support and stigma levels (Li et al., 2024). Therefore, the content and quality of informal education within the family become an indirect yet powerful driver determining whether an older adult accesses formal care.

This reliance on the informal family support system is intensified by a formal care system beset by numerous barriers. These include cultural stigma, financial constraints and high out-of-pocket costs, geographical distance to specialized facilities, and a severe shortage of mental health professionals and integrated primary care services (Vo et al., 2025; Nguyen et al., 2021). This wall of barriers has left older adults and their families with little recourse but to rely on one another. Consequently, investigating and intervening to improve the quality of “education” within the family system is not merely a logical direction for inquiry but also an urgent public health priority.

3. RESEARCH METHODOLOGY

Research Design

This study employed a quantitative research design, utilizing a cross-sectional survey method. This approach allows for the collection of data at a single point in time to assess the frequency and perceived effectiveness of family-based mental health education activities received by older adults. The study was conducted in two urban districts of Ho Chi Minh City, District 5 and District 12. These areas were selected for their diverse demographic characteristics and significant elderly populations, aligning with the research objectives.

Sample

The target population for this study comprised community-dwelling individuals aged 60 and over, residing in Districts 5 and 12, who were not in institutional care facilities. A convenience sampling method was utilized to recruit participants. A total of 255 valid surveys were collected. Inclusion criteria required that participants provide voluntary informed consent and possess the cognitive capacity to understand and respond to the questionnaire.

Measurement Instruments

The data collection instrument was a structured questionnaire consisting of two sections. The first section gathered socio-demographic information (age, gender, educational attainment, living situation, etc.). The second section featured the family-based mental health education scale, a custom-developed instrument designed to assess five specific activities. Participants rated each activity on two dimensions: Frequency (from 1 = very infrequently to 5 = very frequently) and Effectiveness (from 1 = very ineffective to 5 = very effective), using a 5-point Likert scale for each dimension.

Data collection procedure

Data were collected through face-to-face interviews. Trained enumerators approached eligible individuals in the research locales. Prior to the survey, the purpose of the research was clearly explained to each individual. Voluntary informed consent was obtained from each participant before commencement. All collected information was kept confidential and used solely for research purposes.

Data analysis

The collected data were analyzed using SPSS software, version 26.0. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were employed to summarize the sample's characteristics and describe the main variables. Inferential statistics, specifically the Independent Samples T-test and One-way Analysis of Variance (ANOVA), were used to compare mean score differences across various demographic groups.

4. RESULTS

4.1. Sample characteristics

This study utilizes data from a survey whose sample characteristics have been detailed in a separate publication (Vu & Tran, 2025). Table 1 summarizes the key demographic variables pertinent to the present analysis.

Within the study sample, female participants constituted the majority at 54.1% (n=138), compared to male participants at 45.9% (n=117). Regarding age, participants were distributed across three main groups: 43.1% (n=110) were aged 60-69, 41.2% (n=105) belonged to the 70-79 age bracket, and the remaining 15.7% (n=40) were 80 years or older.

Educational attainment within the sample was diverse. The largest cohort had completed lower secondary education (36.9%, n=94), followed by those who had completed primary education (30.6%, n=78). A smaller portion of the sample had completed upper secondary education (20.0%, n=51) or held a college/university degree (9.4%, n=24). A small percentage (3.1%, n=8) reported being illiterate.

In terms of living arrangements, a notable finding was that the vast majority of older adults (63.9%, n=163) resided in multigenerational households with their children and grandchildren. Those living with a spouse accounted for 29.0% (n=74), while only a small minority (5.9%, n=15) lived alone. Regarding geographical distribution, the sample was almost evenly split between residents of inner-city districts (49.8%, n=127) and suburban districts (50.2%, n=128).

Table 1. Sample Characteristics (N=255)

Variable	N	Percentage (%)
Gender		
Male	117	45.9
Female	138	54.1
Age group		
60–69 years	110	43.1
70–79 years	105	41.2
80 years and older	40	15.7
Educational attainment		
Illiterate	8	3.1
Primary school	78	30.6
Lower secondary school	94	36.9
Upper secondary school	51	20.0
College/University	24	9.4
Living arrangement		
Living alone	15	5.9
Living with spouse	74	29.0
Living with children/grandchildren	163	63.9
Other	3	1.2
Residential area		
Urban district	127	49.8
Peri-urban district	128	50.2

Source: Field survey data (2025).

4.2. The state of family-based mental health education activities

To assess the current state of family-based mental health education activities, a descriptive statistical analysis of the frequency and effectiveness of five specific activities was conducted. Prior to this analysis, the reliability of the measurement scales was examined. The results indicated excellent reliability for both scales, with a Cronbach's Alpha coefficient of 0.894 for the Frequency scale and 0.856 for the Effectiveness scale. This demonstrates high internal consistency among the items, confirming that they reliably measure the intended constructs and are suitable for aggregation into composite scores for further analysis.

Table 2 presents the detailed results of the descriptive analysis. Overall, the family-based mental health education activities were perceived by older adults to occur at an "occasional" frequency (mean scores ranging from 3.02 to 3.27) and to have "moderate" effectiveness (mean scores ranging from 2.95 to 3.18). This suggests that while family concern for the mental health of older adults exists, it is neither consistently practiced nor markedly effective.

Table 2. Frequency and effectiveness of family-based mental health education activities (N=255)

Family-based mental health education activities	Frequency		Effectiveness	
	M	SD	M	SD
Learning about mental health and sharing knowledge with older adults.	3.27	0.949	3.18	1.046
Reading books/articles, watching videos, or attending talks about mental health together with older adults.	3.02	0.996	3.02	1.035
Encouraging older adults to participate in activities that raise mental health awareness.	3.22	0.891	3.10	1.082
Creating opportunities for older adults to practice mental self-care methods.	3.03	1.108	2.96	1.141
Listening to and sharing with older adults about mental health-related issues.	3.20	0.960	2.95	1.137

Note: M = Mean; SD = Std. Deviation. The scale ranges from 1 (lowest) to 5 (highest).

Source: Field survey data (2025).

Delving into the specific activities reveals several noteworthy findings. The activity “learning about mental health and sharing knowledge with older adults” was rated highest in terms of both frequency (M = 3.27) and effectiveness (M = 3.18). This is an encouraging indication that families are proactively seeking information to support their relatives. However, activities that require joint participation and more structure, such as “reading books/articles or watching videos together” (M = 3.02) and “creating opportunities for older adults to practice mental self-care” (M = 3.03), had the lowest frequencies. This may imply that informal education within the family tends to occur spontaneously through conversation rather than through specifically planned activities.

A significant paradox is highlighted by the activity “listening to and sharing with older adults about mental health-related issues”. Although this activity occurred with relatively high frequency (M = 3.20) - second only to information-seeking - it was rated as the least effective of all activities (M = 2.95). This finding suggests that while families listen often, the quality of that listening and sharing may not be meeting the needs of the older adults. It is possible that these conversations are superficial, lack deep empathy, or that family members do not have the necessary skills to provide constructive feedback, leading to low perceived effectiveness.

4.3. Comparison of family-based mental health education across demographic groups

To identify demographic factors associated with the state of family-based mental health education, a series of mean comparison analyses were conducted. The Independent Samples T-test was used for two-group comparisons (gender, district), while One-way Analysis of Variance (ANOVA) was used for comparisons across three or more groups (age group, educational attainment, living arrangement). The results revealed that survey district, living arrangement, and gender were statistically significantly associated with older adults' perceptions of family-based mental health education. Key findings are summarized in Table 3.

Table 3. Comparison of the frequency and effectiveness of mental health education by demographic groups

Variable	Analysis	Frequency	Effectiveness
Gender (Male vs. Female)	T-test	$t(253) = -2.403, p = .017^*$ (Female > Male)	$t(253) = -2.301, p = .022^*$ (Female > Male)
Survey district (District 12 vs. District 5)	T-test	$t(217.076) = 5.615, p < .001^{***}$ (District 12 > District 5)	$t(206.459) = 5.982, p < .001^{***}$ (District 12 > District 5)
Age group	ANOVA	$F(2, 252) = 1.320, p = .269$	$F(2, 252) = 0.816, p = .443$
Educational attainment	ANOVA	$F(4, 250) = 1.234, p = .297$	$F(4, 250) = 1.900, p = .111$
Living arrangement	ANOVA	$F(3, 251) = 11.536, p < .001^{***}$	$F(3, 251) = 7.378, p < .001^{***}$

Note: * $p < .05$, ** $p < .01$, *** $p < .001$

Source: Field survey data (2025).

One of the most prominent findings is the significant difference related to the survey district. Older adults in District 12 reported markedly higher levels of family-based mental health education than those in District 5, in terms of both frequency ($t(217.076) = 5.615, p < .001$) and effectiveness ($t(206.459) = 5.982, p < .001$). This disparity may reflect differences in socioeconomic characteristics and family structures between a developing suburban district (District 12) and a historic inner-city district (District 5). It is possible that families in suburban areas have more spacious living arrangements, fostering more intergenerational interactions, or possess distinct community characteristics that promote greater concern for members' health.

Similarly, living arrangement was a strongly influential factor. The ANOVA revealed highly statistically significant differences among living arrangement groups for both frequency ($F(3, 251) = 11.536, p < .001$) and effectiveness ($F(3, 251) = 7.378, p < .001$). This finding reinforces the importance of the multigenerational family structure in Vietnamese culture. Living with children and grandchildren creates a natural and frequent interactive environment, through which older adults have more opportunities to receive attention and health-related education compared to those living alone or only with a spouse.

Regarding gender, the results indicate that female older adults tended to rate family-based mental health education activities more positively than their male counterparts, with statistically significant differences in both frequency ($t(253) = -2.403, p = .017$) and effectiveness ($t(253) = -2.301, p = .022$). This may reflect traditional gender roles within Vietnamese families, where women are often more proactive in conversations about health and in caregiving for family members. Consequently, they may be more aware of or more involved in these activities.

Interestingly, factors such as age group and educational attainment did not show statistically significant differences ($p > .05$). The similar perceptions across different age groups suggest that the need for and expectation of emotional support from family may be a constant throughout the later stages of life. Likewise, the lack of difference based on educational attainment may imply that family-based mental health education is currently rooted more in cultural and emotional values than in academic knowledge, thus exerting a uniform influence on older adults regardless of their educational background.

5. DISCUSSION

5.1. Overview of key findings

This study provides a quantitative snapshot of the state of informal, family-based mental health education for older adults in a major Vietnamese metropolis. The key results reveal a complex picture: while such educational activities are present, they occur only “occasionally” and are perceived as “moderately” effective. The most significant, and perhaps most profound, finding of this research is the discrepancy between the frequency and effectiveness of “listening and sharing”. That this activity is highly frequent indicates that the Vietnamese family continues to serve as a space for older adults to confide in, which aligns with cultural values of family cohesion (Vietnam-France Psychology, n.d.). However, the fact that it was rated as the least effective activity is an alarming signal. This implies that the presence and listening of family members may be merely perfunctory or lacking in necessary skills. Conversations might be governed by misconceptions, such as normalizing psychological symptoms as an inevitable part of aging (Nguyen et al., 2021), or may offer generic advice in place of deep empathy. In other words, families may be “hearing” but not truly “understanding”, revealing a significant competency gap - or more specifically, a deficit in “Mental health Literacy” (Jorm, 2019) among the closest caregivers themselves.

Demographic factors further illuminate this context. The pronounced difference between the survey districts (District 12 and District 5) suggests that socioeconomic characteristics and the degree of urbanization can influence how families access information and interact regarding mental health. Similarly, the finding that older adults in multigenerational households receive greater support reaffirms the central role of the family in Vietnamese culture, where filial piety and the responsibility to care for aging parents remain important social norms (Nguyen & Le, 2021; Tran et al., 2006). At the same time, it sounds a warning about the vulnerability of older adults who live alone, a group at high risk of facing loneliness and a lack of support (Nguyen et al., 2021). The gender difference, with women reporting higher levels of support, can be explained through traditional gender roles, where women often assume the “caregiver” role within the family. Interestingly, the fact that educational attainment and age group did not yield statistically significant differences suggests that family-based mental health education is perhaps currently rooted more in affection and cultural values than in academic knowledge, thus exerting a uniform influence on older adults regardless of their background.

5.2. Limitations of the study

However, this study has several limitations that should be acknowledged. First, the cross-sectional research design only allows for the identification of correlations at a single point in time and cannot establish causal relationships between variables. Second, the use of a convenience sampling method may limit the generalizability of the findings to the entire older adult population of Ho Chi Minh City. Finally, the data were collected based on participants' self-reports and may therefore be subject to recall bias or social desirability bias.

6. CONCLUSION

This study has provided important quantitative evidence on the state of informal, family-based mental health education for older adults in a rapidly aging urban context like Ho Chi Minh City. The primary finding reveals a profound paradox: while older adults rely heavily on their families for emotional support, this very network often lacks the knowledge and skills to provide effective help. Notably, the most common activity, “listening and sharing”, is perceived as the least effective, indicating a significant gap between supportive intent and actual capacity. Factors such as residential district and multigenerational family structure emerge as important, while the lack of significant differences based on educational attainment implies that current support patterns are rooted more in emotion and culture than in specialized knowledge.

The study's main contribution is its shift in analytical focus from the family's general supportive role to their specific function as “informal educators”, thereby identifying this as a strategic point for intervention. Based on these findings, several recommendations are proposed. First, intervention programs should focus on “training the trainers” - that is, providing knowledge and skills to the children and relatives of older adults. The content must extend beyond mere information provision to build practical skills such as empathetic listening and non-judgmental communication. Second, these programs should be integrated into the primary healthcare system and the activities of elderly associations, and they must be sensitive to the local context. Finally, targeted support policies are needed for the most vulnerable groups, particularly older men and those who live alone.

In conclusion, in the context of rapid population aging, equipping families with the necessary tools and skills to become effective mental health educators is not only a humane solution but also a prudent public health strategy. Investing in the capacity of the family is an investment in a society where older adults can live lives that are healthy and fulfilling, both physically and mentally.

REFERENCES

- [1] Ministry of Health. (2023, August 4). *Việt Nam có khoảng 14 triệu người rối loạn tâm thần* [Vietnam has about 14 million people with mental disorders]. Ministry of Health Information Portal.
- [2] Jorm, A. F. (2019). The concept of mental health literacy. In *International Handbook of Health Literacy* (pp. 53-66).
- [3] Li, Y., Wang, Y., Zhang, Y., & Zhang, J. (2024). The relationship between mental health literacy and professional psychological help-seeking behavior among Chinese college students: Mediating roles of perceived social support and psychological help-seeking stigma. *Frontiers in Psychology, 15*, 1356435. <https://doi.org/10.3389/fpsyg.2024.1356435>
- [4] Lu, Y., Zhang, J., Zhou, Z., He, R., Zhu, B., & Mao, Y. (2025). Age-specific associations between intergenerational support from children and depression in middle-aged and elderly Chinese: Results from the China health and retirement longitudinal study. *Frontiers in Psychology, 16*, 1621444.
- [5] Mandalia, H. V., Mutalib, M. A., & Nasrudin, N. F. (2018). Exploring informal education for promoting mental health literacy: A study to youth in Malaysia. *International Journal of Academic Research in Business and Social Sciences, 11*(12), 1936–1951.
- [6] Nguyen, T. (2003). *Mental illness in the Vietnamese American community*. The California Endowment.
- [7] Nguyen, T. H., & Le, Q. (2021). The care of older adults in the Vietnamese family and related issues. In T. H. Nguyen & R. T. T. Tran (Eds.), *Family and gender issues in Viet Nam in the context of social changes* (pp. 39–60). The Gioi Publishers.
- [8] Nguyen, T. H., Nguyen, T. L., Nguyen, T. T. M., & Le, T. H. (2021). Greater risk of negative health outcomes of older adults living alone in Vietnam: A community survey. *International Journal of Environmental Research and Public Health, 18*(21), 11115. <https://doi.org/10.3390/ijerph18211115>

- [9] Nguyen, T. V., Nguyen, T. H. T., Nguyen, T. T. H., & Nguyen, T. H. (2021). 'He is just getting old, you know': The role of cultural and health beliefs in shaping the help-seeking process of family members caring for persons with dementia in Vietnam. *Aging & Mental Health*, 25(10), 1859-1867. <https://doi.org/10.1080/13607863.2020.1859556>
- [10] Pharmacy. (n.d.). *Rối loạn tâm lý ở người cao tuổi: Nguyên nhân, dấu hiệu và cách phòng ngừa* [Psychological disorders in the elderly: Causes, signs, and prevention]. Retrieved July 23, 2025, from <https://www.pharmacy.vn/roi-loan-tam-ly-o-nguoi-cao-tuoi.htm>
- [11] United Nations Population Fund (UNFPA). (2025). *Già hóa dân số* [Population aging]. UNFPA Vietnam. Retrieved July 23, 2025, from <https://vietnam.unfpa.org/vi/topics/gi%C3%A0-h%C3%B3a-d%C3%A2n-s%E1%BB%91>
- [12] Suc khoe Viet. (2024, July 2). *Chăm sóc sức khỏe tâm thần - Chìa khóa sống khỏe cho người cao tuổi* [Mental healthcare - The key to healthy living for the elderly]. Retrieved July 23, 2025, from <https://suckhoeviet.org.vn/cham-soc-suc-khoe-tam-than-chia-khoa-song-khoe-cho-nguoi-cao-tuoi-14771.html>
- [13] *Tap chi Cong san* [Communist Review]. (2023, November 20). *Vấn đề già hóa dân số ở Việt Nam* [The issue of population aging in Vietnam]. Retrieved July 23, 2025, from https://tapchicongsan.org.vn/web/guest/hoat-ong-cua-lanh-ao-ang-nha-nuoc/-/2018/1019302/view_content
- [14] *Tap chi Y hoc Viet Nam* [Vietnam Medical Journal]. (2022). *Lo âu ở người cao tuổi có bệnh nền tại Bệnh viện Y học cổ truyền Cần Thơ trong giai đoạn dịch Covid-19* [Anxiety in elderly people with underlying diseases at Can Tho Traditional Medicine Hospital during the Covid-19 pandemic period]. *Vietnam Medical Journal*, 518(1).
- [15] *Tam ly Viet Phap* [Vietnam-France Psychology]. (n.d.). *Tác động của gia đình và xã hội lên tâm lý người cao tuổi* [The impact of family and society on the psychology of the elderly]. Retrieved July 23, 2025, from <https://tamlyvietphap.vn/tac-dong-gia-dinh-tam-ly-nguoi-cao-tuoi>
- [16] Tran, J., Hinton, L., & Kagawa-Singer, M. (2006). *Cultural considerations in dementia care for Vietnamese-Americans*. Alzheimer's Association.
- [17] Tuoi Tre Online. (2023, June 28). *14,1% dân số cả nước rối loạn tâm thần, khoảng trống điều trị lớn* [14.1% of the national population has mental disorders, a large treatment gap exists]. <https://tuoitre.vn/14-1-dan-so-ca-nuoc-roi-loan-tam-than-khoang-trong-dieu-tri-lon-20230628120545628.htm>
- [18] Tuoi Tre Online. (2024, December 11). *TP.HCM có chỉ số già hóa dân số nhanh nhất cả nước* [HCMC has the fastest population aging index in the country]. <https://tuoitre.vn/tp-hcm-co-chi-so-gia-hoa-dan-so-nhanh-nhat-ca-nuoc-20241211121120651.htm>
- [19] Tuoi Tre Online. (2025, April 1). *Tốc độ già hóa dân số tại TP.HCM đang diễn ra rất nhanh, vượt qua các dự báo* [The speed of population aging in HCMC is occurring very rapidly, surpassing forecasts]. <https://tuoitre.vn/toc-do-gia-hoa-dan-so-tai-tp-hcm-dang-dien-ra-rat-nhanh-vuot-qua-cac-du-bao-20250401100458334.htm>
- [20] Vo, M. T. H., Nakamura, K., Tran, D. T. H., & Moncatar, T. J. R. T. (2025). Is equitable access to health and social care possible for Vietnamese older adults? Care providers' perspectives. *International Health*, ihaf066. <https://doi.org/10.1093/inthealth/ihaf066>
- [21] Vu, T. M., Nguyen, H. T., Nguyen, T. T., & et al. (2024). Depression and associated factors among older people in Vietnam: Findings from a National Aging Survey. *PLOS ONE*, 19(3), e0299791. <https://doi.org/10.1371/journal.pone.0299791>
- [22] Vu, T. M. P., & Tran, V. T. (2025). Self-care capacity: A protective factor for mental health among older adults in an urban context. In *7th Kuala Lumpur International Multidisciplinary Academic Conference 2025 (KLIMAC2025): Conference Proceedings & Program Book* (pp. 394–406). Asian Scholars Network.