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# Family social networks and mental health service use among Vietnamese-Americans in multigenerational families

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BOSTON UNIVERSITY  
GRADUATE SCHOOL OF ARTS AND SCIENCES

Dissertation

**FAMILY SOCIAL NETWORKS AND MENTAL HEALTH SERVICE USE  
AMONG VIETNAMESE-AMERICANS IN MULTIGENERATIONAL FAMILIES**

by

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requirements for the degree of  
Doctor of Philosophy

2015

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## **DEDICATION**

I would like to dedicate this work to my grandma Yung Kwai Lee, who I wish could be here with us to share in the celebration of my graduation; to my parents Alan and Carol Lee for their unwavering support; and to my lovely wife Sarah for her constant support and encouragement to finish.

## ACKNOWLEDGMENTS

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Finally, I want to thank all of the Vietnamese respondents who volunteered their time and without them this dissertation would not have been possible. I hope that this study will contribute to creating more opportunities to provide mental health services to this Vietnamese-Americans with serious mental illness.

**FAMILY SOCIAL NETWORKS AND MENTAL HEALTH SERVICE USE  
AMONG VIETNAMESE-AMERICANS IN MULTIGENERATIONAL FAMILIES**

(Order No.        )

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**ABSTRACT**

While there is a large body of research demonstrating that Asian-Americans underutilize mental health services compared to other ethnic groups, little is known about how Vietnamese-Americans use formal mental health services. The traumatic war, post-war and refugee journey contributed to incidences of PTSD and other mental disorders. This mixed-method study aims to understand how multigenerational Vietnamese-Americans view their serious mental illness and how past experiences, family structure, and social networks influence mental health and use of mental health services. The theories that guided the research were the Network-Episode Model and Social Network Orientation Theory.

Quantitative analyses using data from the National Latino and Asian-American Study (NLAAS) examined the relationship of variables assessing acculturation, social support, cultural identity, and health/mental health status with formal mental health service use for the Vietnamese-American subsample (N=520). The qualitative study explored how Vietnamese-Americans in multigenerational households experience severe mental illness and the reasons that influenced their mental health help-seeking and

service use. Semi-structured interviews with 17 members of six multigenerational Vietnamese families from the greater Boston and Los Angeles area were conducted in English, transcribed, and analyzed using thematic analysis.

Findings from the study highlight the differences between 1<sup>st</sup> and 2<sup>nd</sup> generation Vietnamese respondents and provide insight into how generational culture – the prevailing attitudes, values, and beliefs of each generation – influences the social network support of Vietnamese-Americans and affects their mental health help-seeking behavior. The forced migration severed social networks, restricting 1<sup>st</sup> generation respondents to rely on small family networks for information and support. The traditional matriarchal hierarchy limited access to treatment as younger 2<sup>nd</sup> generation Vietnamese-Americans were unable to convince their parents to seek help for serious mental health problems or to get their approval to seek treatment. Cultural values such as belief in spiritual healers and self-reliance also insulated families from seeking professional help. The study found that the types of interactions respondents had with their social networks—whether positive or negative in orientation—shaped their beliefs about who and where they could go to for help with serious mental health problems and was instrumental in creating pathways to mental health service use.

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## CHAPTER 1: INTRODUCTION

The literature documenting how Vietnamese-Americans access and use mental health services is noticeably scant. There is a large body of research demonstrating that Asian-Americans underutilize mental health services compared to whites, African-Americans and Hispanics (Snowden & Cheung, 1990; Abe-Kim, et al, 2007; Chow, Jaffee, Snowden, 2003; Matsuoka, Breaux, Ryujin, 1997). Among the few studies of Vietnamese-American's use of formal mental health services, several studies found that Vietnamese-Americans were more likely to use conventional mental health treatment than other Asian-Americans (Choi & Kim, 2010; Nguyen, 2011) and that long-term immigrants that have been in the United States 11 years or more were less likely than American born Asian-Americans to use mental health services (Choi & Kim, 2010). Moreover, there is evidence that indicate generational differences in service utilization rates among Asian-Americans (Abe-Kim, et al., 2007), however, the results were aggregated among Asians and prevents any assessment of whether this is true across all Asian-American subgroups.

Among the Asian-American subgroups, the Vietnamese-American population is of great interest as they rank among the lowest in overall health (Barnes, Adams & Powell-Griner 2008; Frisbie, Cho, & Hummer, 2001), suffer from high rates of war trauma and PTSD (Steel, Silove, Phan, & Bauman, 2002; Uba, 1992), and have experienced adaptation problems as refugees (Lin, Tazuma, & Masuda, 1979). Since Vietnamese-Americans are exposed to these physical and mental health risk factors, there

is a need to better understand the reasons why different generations of Vietnamese-Americans use or not use formal mental health services and this study employed a mixed-method design to explore Vietnamese-Americans' use of formal mental health services using the National Latino and Asian-American Study (NLAAS) (Alegria & Takeuchi, 2002-2003) and qualitative interviews with 17 respondents from multigenerational Vietnamese-American families. The primary research aim is to explore Vietnamese-Americans' views and beliefs about mental illness and mental health services and examine their use of formal mental health services for serious mental health problems.

The theories employed to guide the research are Pescosolido's (1991;1992) Network-Episode Model (NEM) and Tolsdorf's (1976) Social Network Orientation Theory. The NEM is used as an overarching framework to help explain the interactions within social networks that influence formal mental health service utilization (Pescosolido, 1991; 1992). Tolsdorf's (1976) Social Network Orientation Theory is used to examine how a person's past experiences shape and reinforce their current values and beliefs about their relationship with their social network. Since social support has been associated with use of mental health services (Thoits, 2011; Pescosolido & Boyer, 1999), buffering acculturative stress (Lee, Koeske, & Sales, 2004), and promoting improved health (Berkman, 1995; Cohen & Willis, 1985), the theory addresses how past experiences impact social support and where to go to draw on resources for support during a mental health crisis.

Based on the available literature, I formulated two primary hypotheses to explore in the study:

Hypothesis 1: Acculturation is positively associated with any use of mental health services among Vietnamese-Americans.

From this hypothesis, I also generated several sub-hypotheses:

- First generation Vietnamese-Americans will experience more acculturative stress than second or third generation Vietnamese-Americans.
- Length of time in the United States will be associated with more mental health service use for second and third generation Vietnamese-Americans, but will be associated with less mental health service use by first generation Vietnamese-Americans.
- English proficiency will be associated with greater mental health service use among all Vietnamese-Americans.
- High acculturative stress will be associated with less formal mental health services use among all Vietnamese-Americans.

Hypothesis 2: Within first generation Vietnamese-Americans, there is an inverse relationship between the amount of social support received and formal mental health service use; while in second and third-generation Vietnamese-Americans, there is a positive relationship between the amount of social support received and formal mental health service use.

The findings in this dissertation are organized to presents the results of the study. Chapter five provides descriptive information on the 520 Vietnamese-American respondents in the NLAAS data set. In Chapter six I present the findings from bivariate analyses to explore the relationship between independent variables and respondents'

formal mental health service use. I then present the results from a logistic regression analysis to assess the use of formal mental health services. Findings from the qualitative study are presented in Chapters 7 through 9. In Chapter seven I present a description of the qualitative sample as well as their refugee experiences, which strongly shaped their experience of mental illness in the United States. Chapter 8 summarizes findings from two central themes that emerged from the interviews: how respondents viewed and defined mental illness, and how mental illness affected their families. In Chapter nine I present the respondents' explanations for the use or non-use of formal mental health services. Finally, Chapter 10 summarizes both the quantitative and qualitative findings and provides study limitations, implications for social work, and for future research.

## **CHAPTER 2: LITERATURE REVIEW**

### **Vietnamese-American Population At Risk**

The U.S. Census reports that Asian-Americans were the fastest growing ethnic group in the U.S. in 2012, with 2.3 percent growth in the past year of which 60 percent of the increase was due to international migration (U.S. Census, 2012). The U.S. Census also reported that in 2010, 1,625,365 Vietnamese were living in the U.S (U.S. Census, 2010). As a subgroup within Asian-Americans, Vietnamese-Americans are vulnerable and at risk for health and mental health problems. Vietnamese-Americans rank among the lowest in overall health (Barnes, Adams & Powell-Griner 2008; Frisbie, Cho, & Hummer, 2001), suffer from high rates of war trauma and PTSD (Steel, Silove, Phan, & Bauman, 2002; Uba, 1992), and have experienced adaptation problems as refugees (Lin, Tazuma, & Masuda, 1979). The Center for Disease Control (CDC) reports that 19 percent of Vietnamese-American adults indicated they were in “fair or poor” health, a far higher rate than every other Asian-American subgroup (Barnes, Adams & Powell-Griner 2008; Frisbie, Youngtae, & Hummer, 2001). Moreover, Vietnamese-Americans rank among the highest in uninsured rates (Alegria et al., 2006). Low English proficiency, a known barrier to health and mental health services (Kim, Loi, Chiriboga, Jang, Parmelee, & Allen, 2011; Leong & Lau, 2001; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Flores, 2006), is more common in Vietnamese-Americans more so than other Asian-American subgroups. One recent study found that only 27 percent of Vietnamese-Americans

reported good/excellent English proficiency compared to 82 percent among Filipinos and 52 percent among Chinese (Zhang & Ta, 2009).

### **Mental Health Service Use Among Vietnamese-Americans**

The literature documenting how Vietnamese-Americans access and use mental health services is noticeably scant and reveal how little is understood of this vulnerable population. Several studies show that Asian-Americans underutilize mental health services compared to African-Americans, Hispanics, and whites (Barreto & Segal, 2005; Bui & Takeuchi, 1992; Xu, et al., 2011), but do not specifically identify or separately analyze Vietnamese-Americans in their samples. For example, Bui & Takeuchi (1992) compared Los Angeles County census estimates of mental health service utilization patterns within a 5-year period and found that Asian-Americans had the lowest rates with 2.7 percent utilizing mental health services, compared to African-Americans (22.2 percent), Whites (35.1 percent), and Hispanics (35.6 percent). While these and other similar studies of Asian-Americans are important and indeed are suggestive of Vietnamese-American mental health service use, the absence of research specifically on Vietnamese-Americans is glaring. Failure to recognize the heterogeneity between Asian and Pacific Island groups is recognized as one of the major limitations in this area of research (Barreto & Segal, 2005; Su, 1998; Sue, Sue, Sue & Takeuchi, 1995).

Several few recent studies have assessed Vietnamese mental health using findings from the National Latino and Asian-American Study (NLAAS) (Alegria & Takeuchi, 2003), a nationally representative survey of Asian-Americans (N=2,095). For example, Abe-Kim, et al. (2007) compared in service utilization with other Asian subgroups (), Choi & Kim

(2010) examined the association between living in the United States and service use, Nguyen & Lee (2012) assessed age differences in service use among Vietnamese-Americans, and Sorkin et al. (2008) explored the high rates of perception of mental health need yet low service utilization.

The study by Abe-Kim and colleagues (2007) is particularly relevant to the current study. Utilizing the NLAAS data, the researchers examined Asian-American immigrant related factors on general medical and specialty mental health services. The immigrant related factors included among others nativity status, years in the United States, age at time of immigration, and generational status. Their objective was to examine the rates of mental health related service use between immigrant and U.S. born Asian Americans within a 12-month period. The authors compared several Asian-American subgroups, including Vietnamese-Americans and assessed health service use in three ways: 1) specialty mental health care, 2) general medical care, and 3) any services.

The findings confirm that service use is low among Asian-Americans. Only 8.6% of respondents sought help from any service, 4.3% sought help from general medical providers, and 3.1% sought help from mental health providers within the previous 12 months. The authors did find that service use was higher for individuals who had a probable diagnosis (34.1%) than without a diagnosis (6.0%). Moreover, the authors also indicate that U.S. born Asian-Americans utilized specialty mental health services at significantly higher rates than foreign born Asian-Americans (6.2% to 2.2% respectively). Among the three different generations of Asian-Americans, 3<sup>rd</sup> generation respondents

utilized the most health and specialty mental services compared to 2<sup>nd</sup> and 1<sup>st</sup> generation Asian-Americans (19.3%, 8.1%, and 7.6% respectively).

Abe-Kim and colleagues (2007) also found that U.S. born Vietnamese-Americans used mental health services at higher rates than immigrant born while foreign born reported significant low rates of perceived helpfulness in using mental health services when compared to US born. The authors identified that Vietnamese-Americans had the highest percentage of using any services compared to other Asian-American subgroups. Moreover, they also identified that 3<sup>rd</sup> generation Asian-Americans had higher service use rates than 1<sup>st</sup> or 2<sup>nd</sup> generation. The findings suggest ethnic differences in service use as well as generational differences. What the authors do not assess is the generational differences within each distinct Asian-American subgroup as the generational status findings they presented aggregated the data from all of the Asian-American groups.

One study that did examine the association between Asian-American generational status and mental health service use, Ta and colleagues (2010) found that Asian-Americans that generational status was significantly associated with greater mental health service use for 3<sup>rd</sup> or later generation Asian-Americans when compared to 1<sup>st</sup> Gen. The authors found no difference between 1<sup>st</sup> and 2<sup>nd</sup> generation in terms of service use. The overall findings suggest that generational status affected both likelihood of Asian-Americans seeking mental health services. What the findings do not identify is whether there are generational differences between ethnic groups as their generational status findings also aggregated Asian-American data.

In addition to generational status, the length of time living in the United States and service utilization was also assessed in several studies (Choi & Kim, 2010; Nguyen, 2011; Nguyen & Lee, 2012; Sorkin, et al., 2008) as length of stay and English language proficiency have been used as proxies for acculturation in many studies (Tata & Leong, 1994; Cabrera, Shannon, West, & Brooks-Gunn, 2006; Lee, Nguyen, & Tsui, 2011; Sentell, Shumway, & Snowden, 2007). In their study, Choi & Kim (2010) specifically focused on Vietnamese-Americans and reported that Vietnamese-Americans were more likely than other Asian subgroups to use conventional mental health services.

Conventional mental health services is defined as services that involve treating for “emotions, nerves, or use of alcohol or drugs in the past 12 months: psychiatrists, general practitioners/ medical doctors; psychologists, social workers; counselors; other mental health and health professionals (e.g., psychotherapists, mental health nurses, occupational therapists, mental health nurses, occupational therapists, and other non-MD professionals); spiritual advisors, and hotline” (Choi & Kim, 2010, p.572).

Their findings suggest that the level of acculturation may influence mental health awareness and service use since acculturation is defined as the process of adopting the values, attitudes, and beliefs of the dominant culture (Rogler, Cortes, & Malgady, 1991; Kim, 2007; Redfield, Linton, & Herskovits, 1936). In the Choi and Kim study, those who have been in the United States the longest, as well as their children, were more likely to use any conventional mental health services as previously defined above. Moreover, the researchers found that poor English language proficiency was associated with greater perception of mental health need. Although the authors identified a relationship between

the length of stay and service use among Vietnamese respondents and as well as differences between foreign born and U.S. born respondents, the findings do not specifically examine generational differences.

In a more recent study by Nguyen and Lee (2012) found that Vietnamese and Chinese respondents utilized mental health service less as they aged. The inverse relationship between age and service use would support Choi and Kim's (2010) findings that long-term immigrants living in the United States 11 years or longer were less likely to utilize mental health services. These findings would seem counter intuitive as one would expect greater acculturation the longer one resides in the country, however, there is evidence to support that Vietnamese-Americans have a high rate of perceived need of mental health services among younger Vietnamese-Americans and low rates of perceived need for mental health services among older Vietnamese-Americans (Nguyen 2011; Sorkin, et al., 2008).

Using the California Health Interview Survey with 980 respondents, Nguyen (2011) examined the association between acculturation and perceived mental health need among older Asian immigrants and found that 19 percent of Vietnamese-Americans indicated they had a mental health need. The Vietnamese percentage was the highest compared to Chinese and Filipino-Americans (5 percent for both Chinese and Filipinos). Despite the perceived need, older Vietnamese-Americans were reluctant to discuss their problems with doctors (Sorkin, et al., 2008). Overall, the two studies (Choi & Kim, 2010; Nguyen, 2011) provide evidence of age differences in perceived need and service use

behavior may reflect differences in acculturation among various generations of Vietnamese-Americans.

In sum, although there have been several studies that have identified generational differences among Asian-Americans, there is no known literature that address service utilization among different generations of an ethnic group. In particular, little is known about the differences in service use between different generations among Vietnamese-Americans. The studies previously mentioned have examined the relationship between ethnicity and service use (Abe-Kim et al., 2007), age differences and service use (Choi & Kim, 2010; Nguyen, 2011; Sorkin et al., 2008), and as well as generational status and service use (Abe-Kim et al., 2007) yet there is no assessment of generational status and service use among specific ethnic groups. My study aims to contribute to the understanding of how multi-generational Vietnamese-Americans use mental health services.

### **Cultural Factors**

Cultural factors relating to distrust of mental health providers by Asian-Americans also have been found by several researchers. Compared to whites, Asian-Americans rely on fewer referrals from family and friends for mental health services and researchers have hypothesized that Asian-Americans are more isolated and have limited access to the mental health service system, possibly due to stigma and shame about mental illness (Chow, Jaffee, & Snowden, 2003). Stigma is well known for deterring mental health service use (Anglin, Link, & Phelan, 2006; Corrigan, 1998; Corrigan & Miller, 2004) and there is evidence that those who can tolerate or ignore stigma are more

likely to engage in help-seeking behavior towards mental health treatment (Atkinson & Gim, 1989; Ting & Hwang, 2009). Researchers have found that Asian-Americans with low English proficiency and who experienced discrimination were more reluctant to talk about and seek treatments of any type for mental health problems (Zhang, Snowden, & Sue, 1998); other researchers have found that Asian-Americans who experienced discrimination increased informal service use but did not decrease formal use (Spencer, Chen, Gee, Fabian, & Takeuchi, 2010).

That cultural factors such as poor English proficiency, resilience to stigma, play a prominent role in how Vietnamese-American and other Asian-American access and use mental health services is not surprising. Culture has long been known to influence mental health help-seeking behavior since it is culture that shapes values and beliefs` that ultimately define how symptoms are described (Guarnaccia & Rogler, 1999; Kleinman, Eisenberg, & Good, 1978) and what types of treatment are viewed as appropriate (Olafsdottir & Pescosolido, 2009; Tata & Leong, 1994; Horwitz, 1977). In this view, culture has the power to categorize knowledge and direct attitudes towards help-seeking behavior. For example, Olafsdottir and Pescosolido (2009) found that individuals with mental illnesses were directed to specific types of services based on cultural influences or “cultural maps.” These cultural influences in turn help individuals discriminate between mental health providers and help establish patterns of use, whether formal or informal (Olafsdottir & Pescosolido, 2009).

For Vietnamese-Americans, the preference of prioritizing physical health over mental health (Nguyen & Anderson, 2005) is a prime example of cultural influences at

play. The influence of Confucianism, Buddhism, and Taoist thought has long shaped Vietnamese culture (Gian & Nguyen, 1992). The holistic view of health and the human body in these religions is at odds with the approach taken in Western medicine of separating mind and body (Phan & Silove, 1999). As such, this conflict has been found to result in the somatic manifestation of psychological symptoms in Asian-Americans, including Vietnamese-Americans (Lin & Cheung, 1999; Sue, 2010). For example, Nguyen and Anderson (2005) report that Vietnamese-Americans have a stronger interest in maintaining their physical health, view their mental health as secondary, and were mistrustful of mental health providers' ability to treat mental health problems. These differences may be perpetuated by the cultural dissonance, defined as a clash between parents and their children over cultural values (Choi, He, & Harachi, 2008), amongst the different Vietnamese generations. Hierarchical family structures have been documented among Asian-American households (Chow, 1987; Braun & Browne, 1998; Ho, 1990); in particular, Vietnamese families are strongly matriarchal (Young, 1998; Teerawichitchainan, Knodel, Loi, & Huy, 2010), with diverse worldviews about therapy between different generations (Lee & Mjelde-Mossey, 2004). Understanding what these differences are and why they exist may be important to understanding intergenerational differences in Vietnamese-American mental health service use.

### **The Vietnamese Refugee Experience**

The harsh experiences of first-generation Vietnamese-Americans is also noteworthy, as their forced dislocation may have led to a distinct pattern of mental health service use compared to other generations. For example, the forced exodus from Vietnam

as refugees was a struggle as many came to the United States experiencing war trauma and suffered from post-traumatic stress disorder (PTSD) (Shapiro, et al., 1999; Silove et al., 2007; Steel, et al., 2002; Watters, 2001). In addition to suffering high levels of physical and mental health problems (Lin, Tazuma, & Masuda, 1979), many were relocated to refugee communities that were often isolating (Sinnerbrink, et al., 1997). This isolation in the U.S. may have allowed first generation Vietnamese-Americans to connect themselves with other Vietnamese based on propinquity, while limiting the extent of social integration. Moreover, war trauma and the refugee experience may have increased homophily – the connection based on similarity and shared experiences (Kadushin, 2012) – and resulted in more insular social networks. The insular networks would not only limit the diversity of viewpoints on help-seeking behavior but also limit the level of acculturation for everyone associated with the network.

### **Vietnamese Social Support**

Leaving Vietnam during the War forced many to leave family and friends behind and as consequence severed ties with their support networks that were sources of social support. Social support has been associated with encouraging and restricting service utilization (Maulik, Eaton, & Bradshaw, 2009; Pescosolido, Wright, Alegria, & Vera, 1998; Thoits, 2011) and also as a buffer against the negative effects of mental illness (Berkman, 1995; Clark, 2001; Cohen & Wills, 1985; Corrigan & Phelan, 2004). Among the limited literature on Vietnamese social support, some have found that social support differed within groups (Chung, Bemak, & Wong, 2000), was negatively correlated with depression (Gellis, 2003; Lin & Hung, 2007; Stuchbery, Matthey, & Barnett, 1998), and

that it both encourages and inhibits mental health service use (Nicdao, Hong, & Takeuchi, 2008). Specifically, Nicdao and colleagues (2008) found that family support and friend harmony was associated with using specialist services while family harmony decreased the likelihood of using specialty mental health services. Although the findings suggest a relationship between social support and mental health service use, the aggregated results shed little light on how social support affected the different ethnic groups. As such, the authors did not assess how social support affects different Vietnamese generations and their mental health service use behaviors.

### **Summary**

To summarize, in spite of a growing body of literature that examines how Asian-Americans access and use mental health services, little is known about the factors that influence multigenerational Vietnamese-American's use of mental health services as Vietnamese samples tend to be aggregated with other Asian subgroups (Barreto & Segal, 2005; Cheung & Sowden, 1990; Yeh, et al, 2005). There are also few qualitative studies that examine how Vietnamese-Americans of different ages and generations experience serious mental illness and explain their use or avoidance of any type of mental health services. Given the few studies and the different factors associated with mental health service use involving Vietnamese-Americans to date, such as being foreign born or U.S. born (Abe-Kim, et al., 2007), length of stay in the U.S. (Choi & Kim, 2010), or social support (Nicdao, Hong, & Takeuchi, 2008), more research is needed to understand how generational differences among this group accesses and uses any mental health services. In sum, my study explores the views and beliefs of multigenerational Vietnamese-

Americans about mental illness and mental health services and examines their use of any mental health services for serious mental health problems.

### CHAPTER 3: CONCEPTUAL FRAMEWORK

For this study, I have relied on two conceptual frameworks to understand mental health service use among a multigenerational sample of Vietnamese-Americans: Pescosolido's Network-Episode Model (NEM) (Pescosolido, 1991; 1992), and Tolsdorf's Social Network Orientation Theory (Tolsdorf, 1976). The NEM provides a broad lens to understand how multigenerational Vietnamese-Americans use mental health services, and provides examples of relevant variables related to explaining how networks, social support, and institutions influences an individual's perception about mental illness, mental health, and mental health service utilization. Tolsdorf's (1976) Social Network Orientation Theory provides a useful micro level explanatory framework to explore how interpersonal interactions influence an individual's social perception of mental illness and social support in time of need.

These theories appealed to me because their focus on the role of social supports in influencing pathways to mental health service use. There is ample evidence that indicates the importance of social supports to mental health service utilization, both to inhibit service utilization (Lam & Rosenheck, 1999; Maulik, Eaton, & Bradshaw, 2009; Pescosolido, Wright, Alegria, & Vera, 1998; Thoits, 2011) and also as a buffer against the effects of mental disorders (Aneshensel & Stone, 1982; Berkman, 1995; Clark, 2001; Cohen & Wills, 1985; Corrigan & Phelan, 2004), stress (Lee, Koeske, & Sales, 2004; Wethington & Kessler, 1986). Numerous studies have found social support to be a critical component of health and mental health outcomes (Cohen, 2004; Kawachi &

Berkman, 2001; Pescosolido & Boyer, 1999; Berkman, 1995). Consequently, the NEM (Pescosolido, 1991; 1992) and Social Network Orientation Theory (Tolsdorf, 1976) are frameworks that help illustrate the association between social network interactions, where information and social support are exchanged, and help-seeking behaviors. Further descriptions of how they are utilized are described further below.

### **The Network-Episode Model (NEM)**

The NEM (Pescosolido, 1991; 1992) highlights various pathways through which social networks can influence the illness career of an individual. The illness career is defined as the path and development of an illness within an individual. The model illustrates how the individual interacts with social forces at the molecular, personal, community, and institutional levels to make health choices (Pescosolido, 1991; Pescosolido, 1992; Perry & Pescosolido, 2012). Specifically, the NEM emphasizes how social networks become the conduit that enables a person to identify, assess, and respond to mental illness, including seeking mental health treatment (Perry & Pescosolido, 2012). Moreover, social networks also provide structure and content that has influence on decision-making, and can either give comfort and social support, or can be coercive (Pescosolido, Wright, Alegria, & Ver, 1998). The NEM provided a major lens for focusing my inquiry in this dissertation. For the analysis of the Vietnamese-American sample in the NLAAS data set, NEM provides a theoretical framework to help guide and interpret the analysis. For the qualitative study, my qualitative interview guides were developed in part to reveal the “socially constructed patterns of decisions” (Pescosolido, 1992) that result in the different pathways to mental health service use. The specific use

of the NEM for the quantitative and qualitative components of the study is described below.

#### *Use of NEM in NLAAS Analysis*

The relevance of the NEM for my analysis of the Vietnamese-American sample in the NLAAS data set is that it provided a framework to understand the relationship between variables such as generational status, social support, and acculturative stress and mental health services. Through the lens of the NEM, generational status and social support variables operate as proxies for an individual's social network. In my study I examine how variables related to acculturation, social support and other independent variables are associated with the use of mental health services by Vietnamese-Americans. For example, Vietnamese-American war refugees and their standards of what constitutes as mental illness may differ from other more acculturated American-born Vietnamese-Americans, as refugee trauma has been linked to suppression of the past to mediate mental illnesses (Watters, 2001; Beiser & Hyman, 1997; Armstrong, Hill, & Secker, 2000). The implications of these generational differences may influence rates of service utilization across generations of Vietnamese-Americans.

#### *Use of NEM in Qualitative Study*

The NEM has four basic premises that form the foundation of the model, the first of which is based on the idea that all societies have a large reserve of people who are consulted with during an episode of an illness. For 1<sup>st</sup> generation Vietnamese, the forced migration caused by the Vietnam War severed network ties as many refugees had

difficulties maintaining contact with family members abroad. Using the first basic premise of the NEM, the interviews were analyzed to determine whether or not the Vietnamese respondents had large reserves of people to consult with during their struggles with mental illness in the United States.

The second premise of “bounded rationality” is drawn from Simon’s (1979) work, which stipulates that decisions are based on the limits of what you know (“satisfying”) rather than making the best utilitarian decision (“maximizing”). Simon (1979, p. 507) further adds that making any choice is not only based on “...objective characteristics of the problem situation” but also involves a heuristic process or an experience in making the decision that is necessary. The second premise of the NEM was used to understand how respondents’ decisions to use or not to use mental health services were affected by “bounded rationality.”

Third, the decision to use or not use mental health services is a dynamic process. Individuals combine a series of decisions over a long period of time that forms “patterns” and “pathways” when utilizing services. The third premise of the NEM will be used to understand how the respondents’ “bounded rationality” contributes to the patterns and pathways in their decisions to seek mental health services.

Finally, the fourth and last premise stipulates that people make decisions about health care based on information received from the interactions with their social networks. It is generally understood that the first and second wave of Vietnamese refugees had limited network structures when they arrived in the United States. The fourth assumption

of the NEM was used to understand how the respondents' decisions to seek mental health services were affected by their interactions with their limited network content.

### **Social Network Orientation Theory**

Specific to the qualitative study only, Tolsdorf's Social Network Orientation Theory (1976) is useful in understanding at a micro-level the interpersonal influences that affect a person's perception of social support during episodes of mental illness. Social Network Orientation Theory is concerned with the orientation of an individual to his or her social network. Tolsdorf (1976) posits that past experiences shape and reinforce values and beliefs of an individual that reflects the relationship between the individual and his or her social network. According to Tolsdorf (1976), *a positive network orientation* is defined as having an individual trust in the relationships within her social network as a source of support, empathy, and understanding in time of need. A *negative network orientation* views the social network as an impossible, useless, or inadvisable source to draw on for support when in crisis. As such, having a negative network orientation has been associated with an inverse relationship with social support (Clapp & Beck, 2009). Moreover, an individual's interpersonal experiences with other network members over time shape the individual's perception of his or her social networks as a reliable and trustworthy resource or as unreliable and dangerous. Having positive or negative social network orientations influences the types of resources the individual may solicit or receive from the social network in which she is embedded, such as seeking help (Larose, Bernier, Soucy, & Duchesne, 1999) or determine attachment style to sources of support (Wallace, & Vaux, 1993).

In the qualitative study, Tolsdorf's (1976) social network orientation theory was utilized to examine respondents' views that were important to social behavior. Specifically, how respondents' past interactions with their support structure influenced their perception of whether or not the network in question is a reliable source or an unreliable source of support. This theory provided a framework to focus the qualitative interview questions and probes to tease out how interpersonal interactions within Vietnamese households, such as family dynamics and hierarchies, orient an individual's perception about mental illness and service utilization in the family network. Social Network Orientation Theory also provides a framework to better understand how past experiences and interpersonal interactions influence negative and positive perceptions of social support within network structures. Specifically, Tolsdorf's theory provides a heuristic lens to understand how past experiences such as trauma and the refugee experience shaped the relationship between respondents and their network structure. From these experiences and interactions with their networks, the study aimed to reveal how values and beliefs about mental illness and service use was reinforced and how it impacted the different types of mental health service utilization.

### **Conceptual Framework**

Figure 1 shows the conceptual framework for the study. The model focuses on how a person's interactions with his or her social network, and the values and beliefs of network members, affect mental health service utilization. Social network is a construct that has been associated with health service use (Pescosolido, 1991; 1992; Pescosolido, Wright, Alegria, & Vera, 1998) and is defined as, "the web of identified social

relationships that surround an individual and include the characteristics of those relationships (Kumar & Browne, 2008, p.440). Social networks can be a source of information (McPherson, Smith-Lovin & Cook, 2001; Ozgen & Baron, 2007; Podolny & Baron, 1997) such as resources about service use (Birkel & Reppucci, 1983; Fu & VanLandingham, 2012; Yeung, Irvine, Ng, & Tsang, 2013) and are also sources of social support from the relationships within the network (Corrigan & Phelan, 2004; Perl & Trickett, 1988; Tolsdorf, 1976). The additional support networks of American born Vietnamese (e.g. 2<sup>nd</sup> generation) provide additional information about mental health and mental health services that are distinct from family values and beliefs about mental health treatment. The additional information provided by non-family members is a result of the interactions within social networks that confirms existing views and beliefs or provides new and diverse information that may inform the help-seeking process.

Social networks, and the social interactions within them, have been shown to promote health (Berkman, 1995) and impact pathways to psychiatric treatment (Perry & Pescosolido, 2012). Social network support in both of these senses can be positive as some have reported that support has been linked to promoting psychological well-being while buffering stress (Cohen & Wills, 1985; Taylor & Roberts, 1995; Thoits, 2011), dampen acculturative stress (Crockett, et al., 2007; Lee, Koeske, Sales, 2004), and reduce the effects of mental disorders such as depression (Noh & Kaspar, 2003; Crockett, et al., 2007). In contrast, having a negative social network orientation or lack of reliable support has been found to be linked to the severity of PTSD (Clapp & Beck, 2009) while the negative effects of providing social support have been linked to relationship strain (Bass,

McClendon, Deimling, & Mukherjee, 1994). As a result, these positive and negative effects of social network orientation may reflect the social capital embedded within their respective networks (Cramm, Hanna, Dijk, & Nieboer, 2013; Putnam, 1996) and affect how an individual views her/his support network as being a trustworthy or unreliable source of support in a time of need (Tolsdorf, 1976). Since benefits of social ties do not affect individuals uniformly across ethnic groups (Berkman & Kawachi, 2001), it is imperative to understand how their social networks and social support affect Vietnamese-American's mental health.

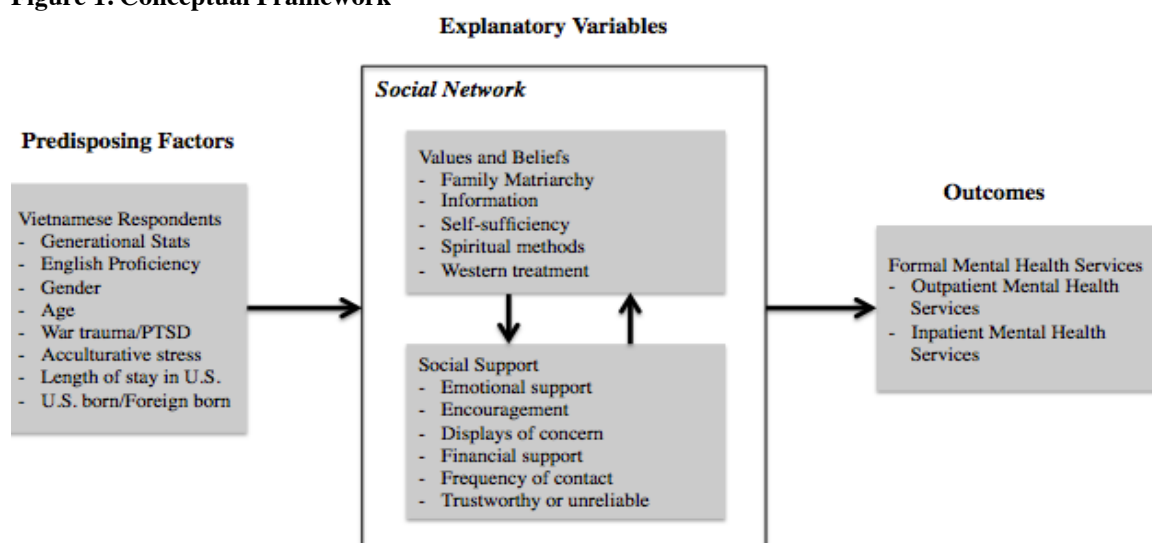
The conceptual framework incorporates both theoretical frameworks that I am drawing on in this study. Since the NEM stipulates that health care decisions are influenced by an individuals' interaction with her social network (Pescosolido, 1991; 1992), there is an expectation that the interactions that 1<sup>st</sup> generation Vietnamese have with their networks are limited to mostly family members as older people are more likely to rely on family alone (Pescosolido, 1992). In contrast, the younger 2<sup>nd</sup> and 3<sup>rd</sup> generation Vietnamese-Americans may have additional network support from sources external to their family network because of their upbringing in the United States. It is through these additional networks where interactions take place and new information is received that may affirm values and beliefs that encourage using mental health services. In comparison, the limited networks of 1<sup>st</sup> generation Vietnamese restricts the flow of new information about mental health or service utilization while drawing on familiar values and beliefs that may not encourage the use of mental health services.

As depicted in Figure 1, social interactions for older 1<sup>st</sup> generation Vietnamese-Americans are limited to family interactions thereby limiting the type and amount of information that would affirm or challenge their existing values and beliefs about mental health and service utilization. The differences in social network size and density between the different generations of Vietnamese-Americans may also affect how an individual interprets the support received within their respective networks as being acceptable or unacceptable. Drawing on the Social Network Orientation Theory, Tolsdorf's (1976) theory of positive and negative social network orientations may be a reflection of these differences in social support, as perceived network interactions as being supportive or unhelpful lead to different experiences of support types such as emotional or problem focused support (Chen, Kim, Mojaverian, & Morling, 2012). As such, the framework in my study attempts highlight the differences in social network orientation when network members from different generations interpret social support based on their interactions with their respective networks.

Overall, the network interactions that result in negative social network orientation would redirect individuals to seek support from connections that have a positive social network orientation. Since U.S. born Vietnamese have both family networks and networks external to the family, they have a larger network size and additional sources of support that may provide diverse information about mental health services when compared to older non-U.S. born Vietnamese-Americans. Drawing on Granovetter's (1973) notion of strength of weak ties, the external networks of younger Vietnamese-Americans adds an additional source of "weak ties" that provides access to diverse

information and opportunities, such as referrals to therapists and treatment options. In contrast, the older generations of Vietnamese are limited to strong dense family ties as most of their “weak ties” were severed during their forced relocation to the United States. As a result, older generation Vietnamese-Americans are limited to the homogenous information they receive within their insulated family ties and networks.

**Figure 1. Conceptual Framework**



## CHAPTER 4: METHODS

The aim of this mixed-methods study was to explore how Vietnamese-Americans use mental health service use across multiple generations. First, using data from the NLAAS survey (Alegria et al., 2004), I examined the association of Vietnamese-American mental health service utilization with several variables, informed by the NEM, in a nationally representative sample of Vietnamese-Americans. The variables included: generational status, English and Asian language proficiency, social support, length of time in the United States, acculturative stress, age, gender, citizenship, work status, household income and size, cultural identity, immigration age, and health and mental health status. Any mental health service is the primary dependent variable.

Second, semi-structured interviews were conducted in person to understand how social perceptions of each generation encourage or discourage mental health service use. The interviews consisted of 17 members of six multigenerational families Vietnamese-American living in the Greater Boston or Los Angeles area. Participants either have one of three serious mental disorders (bipolar disorder, schizophrenia, or severe depression) or have a family member who is suffering from one of these mental disorders with a diagnosis from a mental health professional or is presumed to have them. Serious mental illness is defined as:

“adults with a serious mental illness are persons: (1) age 18 and over, (2) who currently or at any time during the past year, (3) have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria

specified within the Diagnostic and Statistical Manual of Mental Disorders (*DSM-III-R*, (4) that has resulted in functional impairment which substantially interferes with or limits one or more major life activities...All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects” (Definition of Adults With Serious Mental Illness, C.F.R. (§) 1912, (1993).

I used thematic analysis for the semi-structured interviews to gain insight into: 1) how Vietnamese-Americans from varying age groups and generations in the U.S. understand mental illness and view mental health service use; and 2) how Vietnamese-Americans are socialized by their respective generations to use or not use mental health services.

### **National Latino and Asian-American Study (NLAAS) Survey**

The National Latino and Asian-American Study (NLAAS) is a nationally representative data set that provides information on service utilization patterns of Latinos and Asian-Americans. The NLAAS survey data was based on a multistage (four-step process) area probability sample from 252 geographic areas within the United States that was designed to be nationally representative of all U.S. populations. The study included Latino and Asian-American adults and ethnic groups were stratified by eligibility and national ethnicity of origin. The categories of ethnicity consisted of: Mexican, Puerto Rican, Cuban, all other Latinos, Chinese, Filipino, Vietnamese, and all other Asians. The study utilized self-reports of household members belonging to more than one Latino or Asian-American target population. The sample selection procedures were selected using the University of Michigan Survey National Sample design.

The dissertation sample is derived from the Vietnamese-American subsample of the public release version of the NLAAS survey that describes 12-month service utilization and mental illness rates among Asian-Americans and Latinos within the United States (Alegria et al., 2004). There was no substantive difference between the restricted data and the public release version other than sensitive census data and direct identifiers in the restricted version. The NLAAS data set is comprised of a sample of 2,095 Asian-Americans and 2,554 Latino respondents 18 years of age and older and was administered in six languages: English, Vietnamese, Spanish, Mandarin, Cantonese, or Tagalog. Among the Asian-American sample, 520 respondents were Vietnamese-American. In addition to demographic information, the NLAAS includes data on social position, environmental context, such as migration history, and psychosocial factors related to psychiatric disorders and use of mental health services.

The role of acculturation in shaping help-seeking behaviors of Asian-Americans has been repeatedly found by researchers (e.g., see Spencer, Chen, Gee, Fabian, & Takeuchi, 2010; Ta, Holck, & Gee, 2010; Miller, Yang, Hui, Choi, & Lim, 2011; Tata & Leong, 1994), and may play a role for Vietnamese-Americans as well (Choi & Kim, 2010; Nguyen, 2011). Abe-Kim and colleagues (2007) found that of the Asian-American and Pacific Islanders who had a probable mental illness diagnosis, only 34 percent sought any mental health services. Moreover, the authors found 51 percent of foreign-born Asian-Americans indicated that mental health treatment was helpful compared to 73 percent of U.S. born Asian-Americans, supporting the view that there are differences by generational status in use and efficacy of mental health services among Asian-American

minorities. The results support findings by Ta and colleagues (2010) who found different rates of mental health utilization among three different generations of Asian-Americans with 2<sup>nd</sup> - and 3<sup>rd</sup> - generations more likely to receive mental health services than first generation Asian-Americans (1.70 and 2.67 times greater odds respectively).

### *Hypotheses*

I generated two primary hypotheses that I planned to test in the secondary data analysis of the NLAAS dataset.

Hypothesis 1: Acculturation is positively associated with any use of mental health services among Vietnamese-Americans.

I also posited the following sub-hypotheses:

- First generation Vietnamese-Americans will experience more acculturative stress than second or third generation Vietnamese-Americans.
- Length of time in the United States will be associated with more mental health service use for second and third generation Vietnamese-Americans, but will be associated with less mental health service use by first generation Vietnamese-Americans.
- English proficiency will be associated with greater mental health service use among all Vietnamese-Americans.
- High acculturative stress will be associated with less mental health services use among all Vietnamese-Americans.

Hypothesis 2: Within first generation Vietnamese-Americans, there is an inverse relationship between the amount of social support received and mental health service use; while in second and third-generation Vietnamese-Americans, there is a positive relationship between the amount of social support received and mental health service use.

The definition of key independent and outcome variables and their justification for inclusion in the analysis are defined and listed below:

### *Variables*

The variables listed below were drawn from existing questionnaire sections from the NLAAS data set that were adapted into culturally relevant measures (Alegria, et al., 2004). Variables such as age, gender, household size and income, employment, citizenship, English proficiency, Asian language proficiency, and physical and mental health were analyzed without recoding. Several variables, however, were recoded to better illustrate relationships between these variables and the dependent variable, including length of time in the United States, age of immigration, and acculturative stress. Further detail about modifications to the original coding of variables is provided below.

#### A. Independent Variables

1. *Age*. The numerical number of years from the time of the respondents' birth.
2. *Gender*. The genders specified in the data only included females and males and is defined as:

- "Gender" (2 = Female; 1 = Male)

3. *Household Size*. The number of persons living in the respondent's household. The variable was recoded into a dichotomous variable with two categories that consist of 0 = "One to Four" family members and 1 = "Five or More" family members.

The variable is defined as:

- "Household Size" (0 = One to Four; 1 = Five or More)

4. *Household Income*. Total income earned within the defined household. The variable was defined as:

- "Household Income" (\$0 to \$200,000 or more)

5. *Employment*. Employment was included in the analysis as a result of its association with financial independence and poverty. Employment status variable was defined and reverse coded as:

- "Employment" (3 = Employed, 2 = Unemployed, 1 = Not in Labor Force).

6. *Citizenship*. Citizenship was utilized to help determine generational status. Two citizenship variables were used: a) Citizen of the United States (yes/no); and b) Origin of citizenship (Born a U.S. citizen, Became a U.S. citizen through naturalization). The two variables were defined as:

- "Citizen of the United States" (5 = No, 1 = Yes)
- "Born U.S. citizen or naturalized" (2 = Became a citizen through naturalization, 1 = Were born a citizen)

7. *Generational Status*. This variable was created following the approach taken by Ta, Holck, and Gee (2010). This variable is defined by what respondents indicate as their generation status in relation to their family immigration history. The variable is created by using Ta and colleague's (2010) definition of generation. Three

generations are defined in the data: (First-Generation): those born overseas or immigrated to the US; (Second-Generation): those born in the U.S. and having at least one foreign born parent; and (Third-Generation): those born in the U.S. and having both parents born in the US. Since the number count of Third-generation respondents was low, the generation status variable was recoded into a dichotomous variable:

- “Generational Status” (2 = 2<sup>nd</sup> & 3<sup>rd</sup> Gen, 1 = 1<sup>st</sup> Gen)

8. *Length of time living in the United States.* The length of time living in the United States was included in the quantitative analysis since it was used as a proxy for acculturation, an approach used by others (Suinn, Rickard-Figueroa, Lew, & Vigil, 1987). The length of time living in the United States was measured from the date of first arrival, or birth. The variable Years in U.S. was recoded to reflect three items and excluded subjects who were U.S. Born:

- “Length of time in U.S.” (0-10 years, 11-20years, and 20+ years).

9. *Age of Immigration.* The age of respondent at immigration was recoded into four categories:

- “Age immigrated to the U.S.” (4 = 35+ years, 3 = 18-34 years, 2 = 13-17 years, 1 = Less than 12 years)

10. *English Proficiency.* English Proficiency was defined using the Cultural Identity Scales for Latino Adolescents (Felix-Ortiz, Newcomb, & Meyers, 1994), following methods used by others (Bauer, Chen, & Alegria, 2010; Kim et al., 2011;). English proficiency was assessed with the following question:

- How well do you speak English” (1-Poor, 2-Fair, 3-Good, 4-Excellent)

11. *Asian Language Proficiency*. Asian language proficiency was also based off of The Cultural Identity Scales for Latino Adolescents (Felix-Ortiz, Newcomb, & Meyers, 1994) and was assessed by this question:

- “How well do you speak the Asian language” (1-Poor, 2-Fair, 3-Good, 4-Excellent)

12. *Acculturative Stress*. The *Acculturative Stress* variable is an nine items of a larger Acculturative Distress scale derived from the Mexican American Prevalence and Service Survey (MAPSS) (Vega et al., 1998) that measures the stress of culture change resulting from immigrating to the United States (Cervantes, Padilla, & Snyder, 1991). The MAPSS was also derived from the Hispanic Stress Inventory (HIS) (Cervantes, Padilla et al., 1991) that has been proven for Hispanic culture through psychometric testing (Cervantes et al., 1991). Moreover, since the NLAAS data was collected using a multistage area probability sample design, weights are necessary to provide results that are unbiased (Heeringa et al., 2004). Two acculturative stress variables used were based on the existing NLAAS acculturative stress measure that was comprised of nine separate items that asks respondents to answer “yes/no” to questions about acculturative stress listed below. Following Lueck and Wilson’s (2010), the same weighted scored were applied to the *Acculturative Stress Score* and was created using the mean weighted score of the 'yes' and 'no' counts from the nine variables. In addition to the *Mean Acculturative Stress* variable, a binary acculturative stress variable was created to explore relationships between respondents who answered “yes” to any of the variables.

- “Do you feel guilty for leaving family or friends in your country of origin?” (0 = No, 1= Yes)
- “Do you feel that in the United States you have the respect you had in your country of origin?” (0 = No, 1= Yes)
- “Do you feel that living out of your country of origin has limited your contact with family or friends?” (0 = No, 1= Yes)
- “Do you find it hard interacting with others because of difficulties you have with the English language?” (0 = No, 1= Yes)
- “Do people treat you badly because they think you do not speak English well or speak with an accent?” (0 = No, 1= Yes)
- “Do you find it difficult to find the work you want because you are of Latino/Asian descent?” (0 = No, 1= Yes)
- “Have you been questioned about your legal status?” (0 = No, 1= Yes)
- “Think might be deported if go to social/gov't agency” (0 = No, 1 = Yes)
- “Do you avoid seeking health services due to fear of immigration officials?” (0 = No, 1= Yes)

13. *Cultural Identity Variables.* Cultural identity is a category of variables in the NLAAS data set that assess ethnic group affiliation. The variables below were not combined into a composite variable but were analyzed individually. Several variables were included that identify level of closeness to the respondent’s ethnic group of origin. The variables were all reverse coded and are as follows:

- “Identifies with others of the same racial/ethnic decent” was assessed by: (3 = Very closely, 2 = Somewhat closely, 1 = Not very closely)
- “Respondent feels close in ideas/feelings with people of same racial decent” was assessed by: (2 = Very close or Somewhat close, 1 = Not close or not at all)

- “Amount of time the respondent would like to spend with people of the same ethnic/racial group” was assessed by: (3 = Very closely, 2 = Somewhat closely, 1 = Not very closely or not at all)

14. *Social Support Variables.* The prevalence of social support was assessed by analyzing two scales the first a 4-item subscale of the Family Cohesion Scale, as developed by Olson and colleagues (1986) that focused on family closeness and communication (Alegria, et al., 2004), and the second a 6-item subscale of the Social Network category from the NLAAS measures. The variables were analyzed separately and were included in the *social support* category to assess how supported respondent were and how much they could open up to family and friends. Consequently, the inclusion of the variables that revealed the level of social support was necessary in my analysis. The variable is defined as the positive support received from friends and family. Negative support variables were not included in the composite variable so as to control for the positive direction of social support. The following social support variables were recoded into dichotomous variables: FC4BinaryLG, FC7BinaryLG, FC9BinaryLG, FC10BinaryLG, SN1\_transf, SN2\_transfLG, SN6\_transf). The variables were analyzed individually to create the *social support* category.

- “Family trusts and confides in each other” was assessed by: (0 = Disagree, 1 = Agree)
- “Express feelings with family” was assessed by: (0 = Disagree, 1 = Agree)
- “Family feels close to each other” was assessed by: (0 = Disagree, 1 = Agree)
- “Family togetherness is important” was assessed by: (0 = Disagree, 1 = Agree)

- “Frequency talks with relatives” was assessed by: (0 = Once a month—Less than once a month, 1 = Most every day—Few times a month)
- “Frequency you rely on relatives who do not live with you for help if you have a serious problem” (0 = Some, to A lot, 1 = A little to Not at all)
- “Frequency you rely on relatives who don't live with you to discuss worries” (1 = A Lot, 2 = Some, 3 = A little, 4 = Not at all)
- “How often talk on phone or get together with friends” (0 = Once a month—Less than once a month, 1=Most every day—A few times a month)
- How much can you rely on friends when you have a serious problem” (1-A Lot, 2-Some, 3-A little, 4-Not at all)
- How much can you open up to friends and talk about your worries” (1-A Lot, 2-Some, 3-A little, 4-Not at all)

*15. Health and Mental Health Status Variables.* Several variables were included that assess self-rated physical and mental health and other mental health status variables. Both physical and mental health variables were reverse coded and are as follows:

- “Self-Rated Physical Health” was assessed by: (1 = Poor, 2 = Fair, 3 = Good, 4 = Very good, 5= Excellent)
- “Self-Rated Mental Health” was assessed by: (1 = Poor, 2 = Fair, 3 = Good, 4 = Very good, 5= Excellent)
- “Respondent has an emotional/mental health problem” was assessed by: (0 = No, 1 = Yes)
- “Respondent thinks she/he should talk to mental health professional” (0 = No, 1 = Yes)
- “Others think respondent should talk to mental health professional” (0 = No, 1 = Yes)

B. Major Outcome Variable.

1. *Any Mental Health Service Use*. The primary dependent variable, *Any Mental Health Service Use*, is a dichotomous (yes/no) variable comprised of inpatient services and any mental health service use. Following Abe-Kim and colleagues (2007), this variable is created using mental health support services categorized as “Services” or “Service Use” in the NLAAS data set. A dichotomous variable was used because of the low frequencies for any individual mental health service. The construction of the variable is consistent with what others have done in defining service use (Chang, Natsuaki, & Chen, 2013; Lee & Matejkowski, 2012). The *following* mental health treatments are captured in the variable:

- “Did you ever use an Internet support group or chat room to get help for problems with your emotions or nerves?” (1-Yes, 0-No)
- “Did you ever in your life go to a self-help group for help with your emotions or nerves?” (1-Yes, 0-No)
- “Did you ever in your life have a session of psychological counseling or therapy that lasted 30 minutes or longer with any type of professional?” (1-Yes, 0-No)
- “Did you ever get a prescription or medicine for your emotions, nerves or mental health from any type of professional?” (1-Yes, 0-No)
- “Psychiatrist for mental health/drug/alc/nerves/emotion” (1=Yes, 5 = No)
- “Gen practice or doc for mental health/drug/alc/nerves/emotion” (1=Yes, 0 = No)
- “Other med doc for mental health/drug/alc/nerves/emotion” (1=Yes, 0 = No)
- “Psychologist for mental health/drug/alc/nerves/emotion” (1=Yes, 0 = No)
- “Social worker for mental health/drug/alc/nerves/emotion” (1=Yes, 0 = No)
- “Counselor for mental health/drug/alc/nerves/emotion” (1=Yes, 0 = No)

- “Other mental health prof for mental health/drug/alc/nerve/emotion” (1=Yes, 0 = No)
- Nurse/OT/other health pro for mental health/drg/alc/nerve/emotion” (1=Yes, 0 = No)
- “Psych counseling with professional for 30+ min” (1=Yes, 0 = No)
- “Medicine for mental health/drug/alc/nerves/emotion” from prof (1=Yes, 0 = No)
- “Saw professional about sadness” (1=Yes, 0 = No)
- “Professional treatment for sadness in past 12 months” (1=Yes, 0 = No)
- “Talked to professional about irritability” (1=Yes, 0 = No)
- “Ever talked to professional about panic attacks” (1=Yes, 0 = No)
- “Talk to medical doc or professional about social fear months” (1=Yes, 0 = No)
- “Ever talked to Medical professional about fear” (1=Yes, 0 = No)
- “Saw medical doc or professional for worry/anxious/nervous (1=Yes, 0 = No)
- “Talked to medical doc or professional about anger attacks (1=Yes, 0 = No)
- “Professional psych counsel or therapy for 30 min +” (1=Yes, 0 = No)
- “Received meds for emotions/mental health from professional” (1=Yes, 5 = No)
- “Seen professional for emotions/nerves/sub use in lifetime” (1=Yes, 5 = No)
- “Received helpful/effective treatment for reactions” (1=Yes, 5 = No)
- “Ever talked to professional about tiredness” (1=Yes, 5 = No)
- “Talked to med doctor or other prof about problems w/ eat/weight” (1=Yes, 5 = No)
- “Talked to doctor about nervous attacks” (1=Yes, 5 = No)
- “Talked to professional about dealing w/ psychotic experiences” (1=Yes, 5 = No)
- “Took listed medication(s) for psychosis (1=Yes, 5 = No)
- “Night in hospital/facility for mental health/drug/alc/nerves/emotions” (1=Yes, 0 = No)
- “Hospitalized overnight for sadness” (1=Yes, 0 = No)

- “Hospitalized overnight for irritability” (1=Yes, 0 = No)
- “Hospitalized overnight for attacks irritability” (1=Yes, 0 = No)
- “Hospitalized overnight for social fear” (1=Yes, 0 = No)
- “Ever hospitalized overnight for fear?” (1=Yes, 0 = No)
- “Hospitalized overnight for worry/anxious/nervous” (1=Yes, 0 = No)
- “Hospitalized overnight for anger” (1=Yes, 0 = No)
- “Hospitalized overnight for tiredness (1=Yes, 0 = No)
- “Overnight stay in hospital/facility for mental health/drug-alc use” (1=Yes, 0 = No)

### *Data Analysis*

The analysis of the NLAAS data set was conducted using IBM’s Macintosh version 20.0.02 SPSS statistic software. The analysis of the NLAAS survey data consisted of basic descriptive statistics of the Vietnamese-American sample. I also used bivariate and multivariate logistic regression analyses to explore relationships between the key independent variables listed above and the primary dependent variable of any mental health service use. Missing data were not addressed in the analysis.

### **Qualitative Study of Vietnamese-Americans’ Use of Any Mental Health Services**

#### *Purpose and Rationale*

In order to gain insight into Vietnamese-American’s use of any mental health services for serious mental health problems, a qualitative study of the views of a multigenerational sample of Vietnamese-Americans was conducted. The purpose of this component of the study was to learn about the lived experiences of Vietnamese-

Americans with serious mental illness. Specifically, I was interested to learn about their beliefs and perceptions about mental illness, about their support networks and the role these support networks played in helping them address serious mental illness within the family, particularly the various pathways they used in dealing with serious mental health problems. Building on the Social Network Orientation Theory framework that shows how past experiences affect current levels of social support and service utilization, I also wanted to understand how different generations of Vietnamese-Americans are influenced by their past social interactions and how it has affected their families, their understanding of mental health issues, and any help-seeking behavior.

#### *Subjects and Selection Criteria*

A total of 17 participants from six multigenerational Vietnamese-American families were selected from the greater Boston, Massachusetts area, and Los Angeles and Orange County, California, specifically: Quincy, MA; Dorchester, MA; Los Angeles, CA; Costa Mesa, CA; Irvine, CA; Fountain Valley, CA; and Westminster, CA. Participants were solicited online, in person through flyers, and via various media outlets for the study. Due to the limitations of resources of the study (Kvale, 1999; Seidman, 2006), snowball sampling (Patton, 2002) was used to seek out qualified Vietnamese-American respondents. If a population is heterogeneous, researchers generally require more respondents in the study (Guest, Bunce, & Johnson, 2006). Since the Vietnamese-American sample is relatively homogenous in its sociodemographic and cultural factors, the study focused on a limited selection of cases. All participants were required to be self-identified as 1st or 2<sup>nd</sup> generation Vietnamese-Americans. An additional selection criterion

was that each participant was required to acknowledge that they, or at least one family member, have a serious mental disorder diagnosed by a mental health professional, or presumed to have one. Three serious mental health issues were targeted: bipolar disorder, schizophrenia, and severe depression.

### *Compensation*

Participation was voluntary and participants were compensated for the interviews, with funding for the interviews paid for from a Boston University School of Social Work dissertation grant. The respondents were interviewed for one to one and a half hours and were compensated \$40 per hour. An earlier effort to pay participants \$20 per hour was not successful in obtaining enough participants who met study criteria. I had more success in recruiting subjects in the Los Angeles and Orange County area as a result of the significant concentration of Vietnamese population in California.

### *Theory-Informed Construction of Interview Questions and Probes*

The questions and probes used in the qualitative study explored social factors that affected mental health service utilization and were developed in part from questions from the NLAAS survey as well as questions informed by the Network-Episode Model (NEM) and the Social Network Orientation Theory. Selected questions from the NLAAS survey focused on key social factors that the NEM has emphasized that impact care seeking behavior and pathways to treatment. Measures pertaining to social support, acculturative stress, English and Asian language proficiency, physical and mental health ratings, and any service use were selected. I used Social Network Orientation Theory to develop

questions and probes to elicit how respondents were influenced by their past social interactions and how it has affected their families, their understanding of mental health issues, and any help-seeking behavior.

### *Conduct of Interviews*

Each participating member within a family unit was at least 18 years of age or older at the time of the interview and at least suffered from one of three serious mental disorders (depression, schizophrenia, and bipolar disorder). The respondents were subsequently asked questions using a mix of open-ended questions and probes and closed-choice questions based on the Network-Episode Model (Pescosolido, 1991; 1992) and the Social Network Orientation Theory (Tolsdorf, 1976). I conducted all of the qualitative interviews to ensure interview consistency, privacy, and authenticity. Participants were encouraged to speak to me in private -- as family dynamics may influence content of responses. Only one participant out of the 17 in the sample preferred to speak in the presence of other family members. An interpreter was also employed to assist in translating interviews, but this proved unnecessary as all respondents spoke English or provided their own translator. (See Appendix A for the major questions that were asked in the interview).

### *Thematic Analysis of Interviews and Software*

I used the Macintosh NVivo version 10.0.4 and Thematic Analysis (TA) to explore the history of serious mental illness in a small sample of Vietnamese-Americans, and how they understood and responded to the family member or members with mental

illness and their knowledge and utilization of mental health services. Thematic analysis has been widely used to analyze the spoken, unscripted responses of participants to open-ended or semi-structured interview questions (Aronson, 1994; Butcher, Holkup, Park, & Maas, 2001; Tuckett, 2005; Braun & Clark, 2006; Patton, 2002; Fereday & Muir-Cochrane, 2006). Boyatzis (1998) lists the functions of thematic analysis as a way of seeing, making sense of unrelated material, analyzing qualitative information, systematically observing: an individual, an interaction, a group, an organization, or a culture; and to convert qualitative information into a quantifiable data. Qualitative information from the analysis of interview transcripts may yield themes or concepts that can be identified, condensed, and formulated into broader themes that shed light on research questions of interest.

The interviews were conducted face to face at a location of the respondent's choice and were audio-recorded and transcribed verbatim. The thematic content analysis of the interviews was conducted using NVivo software for Macs. The analysis process consisted of the following steps. First, I read the transcripts multiple times and utilized Pescosolido's (1991;1992) Network-Episode Model and Tolsdorf's (1976) Social Network Orientation Theory to help identify recurring codes and substantive categories related to concepts specific to the study's purpose (Maxwell, 2012) through open coding (Glasser, 1998). Second, I began to condense similar codes together to unify reoccurring codes each with operational definitions into substantive categories (Maxwell, 2012) using axial coding (Glasser & Strauss, 1967) and NVivo software. Transcripts, memos (Glasser, 1998), and initial codes were reviewed. Third, I summarized and organized the codes

from the entire data set and began to identify themes that were consistent across cases and aligned with the conceptual framework and core variables relevant to the study by using selective coding (Glasser & Strauss, 1967). Fourth, I verified the themes by comparing them to the literature and also the original quotes to ensure that the identified themes represented a complete thematic map of the interviewee responses. In the analysis, I refined the codes constantly in order to define them more clearly. Finally, I compiled the codes in my findings and highlighted examples in the text that illustrate all of the important codes identified. After condensing similar codes together, relevant themes were established. To strengthen the reliability of the coding, the data was checked by my dissertation advisor and recoded by a research assistant who was trained by the researcher to use the codebook protocol I developed for the study.

### **Human Subjects**

Protection of human subjects was a priority in this study. Strict guidelines for participant confidentiality were followed. Both components of the study were reviewed by the Boston University CRC IRB. For the analysis of the NLAAS data set, I applied for and received exempt status from IRB review #3311E. Access to the NLAAS data is restricted: I do not allow others access to the dataset. For the semi-structured interview, I applied for a separate expedited status through the Boston University CRC IRB. Respondents were treated fairly and ethically as described by Boston University IRB guidelines. Respondents were also required to sign a consent form prior to their interview. All of the questions and procedures were reviewed by the Boston University Charles River Campus Institutional Review Board (CRC IRB). Due to the sensitive nature of the

subject of mental health, I anticipated that there would be topics and questions that could evoke strong emotions. I employed clinical interviewing techniques to reduce discomfort to respondents. The respondents were also informed that they could choose not to answer any question, and could terminate the interview at any time. I had prepared a list of local mental health agencies to provide participants if any had asked for resources, but no participant requested assistance with resources. All data has been coded to prevent any identifying information from being revealed and all survey responses are kept confidential, stored in a locked cabinet, and only accessible to myself. Confidential electronic information collected during the interviews is kept in a password-protected laptop only accessible to the primary investigator. All participants were at least 18 years of age at the time of the interviews.

## CHAPTER 5: FINDINGS FROM THE NLAAS SURVEY

The NLAAS data set consisted of responses from Latino and Asian-Americans in the United States. The focus of my inquiry primarily involved Vietnamese-Americans among the 2,095 Asian-American participant responses in the data set. In this chapter, I will first describe the demographic characteristics of the Vietnamese-American sample and then present a descriptive analysis of the major independent variables (generational status, English proficiency, social support, length of stay in the U.S., and acculturative stress) and the major dependent variable – any mental health service utilization. I subsequently conducted analyses of the independent variables that consist of: age, gender, household size and income, employment, citizenship, length of time in the U.S., age of immigration, English and Asian language proficiency, acculturative stress, cultural identity, and social support variables with the primary dependent variable of any mental health service use.

Due to low utilization of any mental health services, the primary dependent variable is a dichotomous (yes/no) variable that measures any mental health service use, where service use both mental health support services and inpatient mental health services. The mental health support services mental health service use variables include the individual's use of any mental health treatment not requiring overnight stay within a specific timeframe of 12 months. The inpatient mental health service use variables include the frequency and duration of stay in mental health service facilities both voluntarily and involuntarily.

### **Demographic Characteristics of the Vietnamese Sample**

The Vietnamese sample is comprised of 520 respondents, approximately one-fourth of the entire Asian-American sample (n = 2,095). As shown in Table 1 below, the mean age of Vietnamese in the sample is 43 years of age. Overall, 243 (46.7%) of the Vietnamese sample are male and 277 (53.3%) are female. The modal household size is one to three people with the highest percentage (52%) indicating a household size of one to three people. The mean household income is \$53,100; in other data (not shown), 36 (6.9%) of the sample reported \$0 annual income while 2.9% reported earning \$200,000+ the highest income category. In the entire Vietnamese sample, 326(62.7%) were employed while 194(37.3%) were either unemployed or not in the labor market. The large majority of Vietnamese (74.4%) indicated that they were citizens of the United States. Most (95%) became citizens through naturalization while 19(4.9%) were born U.S. citizens.

The data show greater workforce participation and education achievement rates of the Vietnamese men in the sample. In other data (not shown), the mean household income for the Vietnamese men in the sample was \$57,072 compared to a mean household income of \$49,616 for the women. Men were more likely to be employed compared to women, 172(70.8%) to 154(55.6%) respectively. Among all Vietnamese females in the sample, the largest category (36.5%) had 0-11 years of education, while for men the largest education category was greater than 16 years (30.5%).

**Table 1. Demographic Characteristics of Vietnamese Sample**

Variables*	Descriptive Statistics	
	Mean	SD
<b>Demographic Variables</b>		
Age in Years	43.0	14.7
Gender <sup>1</sup>	0.5	0.5
Household Size	3.4	1.6
Mean Annual Income	\$53,100	51,323.6
Employment <sup>4</sup>	1.7	0.9
Citizen of the United States <sup>2</sup>	0.7	0.4
Citizenship Status <sup>3</sup>	0.1	0.2

\* N=520 unless otherwise noted.

<sup>1</sup> 1 = Female and 0 = Male.

<sup>2</sup> 1 = U.S. citizen and 0 = not U.S. citizen.

<sup>3</sup> 1 = U.S. born citizen and 0 = Naturalized citizen

<sup>4</sup> 1 = Employed, 2 = Unemployed, and 3 = Not in labor force.

### Measures of Acculturation and Cultural Identity

The NLAAS data set includes a number of variables that pertain to acculturation, acculturative stress, and cultural identity. Acculturation can be defined in two ways: 1) a unidimensional process where an individual abandons her or his ethnic culture of origin and adopts the new culture in a linear progression or 2) a bidimensional process of adopting the new culture while maintaining the ethnic culture of origin (Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005). Failure to adapt to the new dominant culture may lead to acculturative stress.

In Table 2, the first variable associated with acculturation is generational status and the variable was defined based on geographical birth location. The criteria for '3<sup>rd</sup> generation' is that in addition to the respondent being born in the United States, at least one grandparent and one parent is also born in the United States. For '2<sup>nd</sup> generation' at least one parent to be born in the U.S. and the respondent needs to be born in the U.S.

The designation of '1st generation' is when both the respondent and their parents are born outside of the U.S. Of the entire Vietnamese sample in the NLAAS data set, 492 (96.5%) qualify as 1<sup>st</sup> generation while only 14 Vietnamese respondents (2.69%) indicated they were 2<sup>nd</sup> generation. Only four respondents met the criteria of being 3<sup>rd</sup> generation (0.77%). As a result of the low counts, 2<sup>nd</sup> and 3<sup>rd</sup> generation were combined into a single category of '2<sup>nd</sup>/3<sup>rd</sup> generation.' I had anticipated that there would be greater variation in generational status in the Vietnamese sample. The implication of the low counts of 3<sup>rd</sup> generation Vietnamese in the sample and so few 2<sup>nd</sup> generation respondents means that several of the hypotheses I developed could be addressed by this analysis. As a result, I will use the qualitative study to explore the role of generational status on any mental health service use among Vietnamese-Americans.

With the intervals set by the NLAAS data set, most of the Vietnamese in the sample (41.8%) had lived in United States between 0 to 10 years, while 30% indicated they had lived in the United States between 11 and 20 years, and another 28% indicated they had lived in the United States for more than 20 years. Close to a majority of those who immigrated to the United States (45%) were between the ages of 18 and 34 years of age while the second largest group (33.3%) were 35 years of age and older. In spite of how long most of the sample respondents had lived in the United States, English proficiency was low, with almost 70% of Vietnamese in the sample indicating they were 'poor' or 'fair' when speaking, reading, and writing English. Not surprisingly, proficiency in speaking, reading, and writing an Asian language was high, with at least 70% indicating they were 'good' or 'excellent' when speaking, reading, and writing an

Asian language. Despite the poor English proficiency, a Mann-Whitney test was conducted and determined that there was no statistical significance between English proficiency and any mental health service utilization. As a result, the sub-hypothesis that English proficiency will be associated with greater mental health service use could not be confirmed.

As described earlier in Chapter 4, acculturative stress is due to the socialization process between two cultures. Psychocultural stress due to cultural differences found between a host culture and an incoming culture has been shown to lead to a reduction in the physical and mental health status of individuals or groups undergoing acculturation (Nwadiora & McAdoo, 1996). Hence, two acculturative stress variables were created to better capture how much acculturation the Vietnamese-Americans experienced in the sample. The first is a binary variable created by summing the scores of all 'yes' counts to any of nine acculturative stress measures in the NLAAS data set (see Chapter 4 for a complete description of the variable). The acculturative stress variables included the following: 'Do you feel guilty for leaving family or friends in your country of origin?' 'Do you feel that in the United States you have the respect you had in your country of origin?' and 'Do you feel that living out of your country of origin has limited your contact with family or friends?' In data not shown, 78.4% of Vietnamese-Americans experienced at least one type of acculturative stress.

The acculturative stress variable is a mean acculturative stress score created by applying weights to the nine acculturative stress variables. I followed the approach of Lueck and Wilson (2010), who applied weights to each acculturative stress variable

based on the perceived qualitative and quantitative value for each question. Their justification for applying greater weights was to give more value to the questions that contributed to the ‘...overall construct of acculturative stress’ (Lueck & Wilson, 2010, p.49). In this measure, the lowest acculturative stress score possible is 0; the highest possible score is 217 (see Chapter 4 for full description). Among the Vietnamese in the sample, the mean acculturative stress score was 18.9 with a standard deviation of 31.7, an indication that many of the Vietnamese in the sample had experienced relatively low levels of acculturative stress as the range of values was 0 to 217.8.

In the related area of cultural identity or affiliation, several variables included in the NLAAS data support the strong cultural ties of the Vietnamese respondents. As shown in Table 2, 77.9% of the Vietnamese respondents ‘very closely’ identify ‘with others who are of the same racial/ethnic decent’; 68.6% percent of the Vietnamese sample stated they ‘feels close in ideas/feelings with people of same racial descent’, and 85.5% of the sample report that they would like to spend ‘some’ or ‘a lot’ of time with people of their same racial/ethnic group.

**Table 2. . Acculturation, Acculturative Stress and Cultural Identify Variables**

Variables	Descriptive Statistics	
	Mean	SD
<b>Demographic Variables</b>		
Generation Status <sup>1</sup>	1.0	0.2
Years In U.S.	2.7	1.1
Age at Immigration	2.9	1.1
English Proficiency <sup>2</sup>	2.0	0.9
Asian Language Proficiency <sup>3</sup>	3.2	0.9
Acculturative Stress <sup>4</sup>	18.9	31.7
Identify with others of same racial/ethnic descent	1.3	0.6
Feel close in your ideas/feelings w/ people of same racial descent	1.4	0.6

Amount time would like to spend w/ people of same racial/ethnic group	1.6	0.7
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<sup>1</sup> 1 = 1st generation, 2 = 2nd generation, and 3 = 3rd generation. The full definition of this variable is provided in Chapter 4.

<sup>2</sup> English proficiency (LP5D) is specified as “speaking” English only and more detailed description can be found in Chapter 4.

<sup>3</sup> Asian language proficiency (LP5A) is specified as “speaking” Asian language only and a more detailed description can be found in Chapter 4.

<sup>4</sup> Acculturative Stress Score is a composite variable that represents a weighted score based on the number and type of acculturative stresses. The range of the scores are from 0 to 217.8. The full definition of this variable is provided in Chapter 4.

### **Social Support and Other Independent Variables**

Social support has been associated with encouraging mental health service utilization when support is high (Bonin, Fournier, & Blais, 2007) and internalizing disorders when support is low (Briggs-Gowan, et al., 2000). Moreover, social support has been found to lead to improved health and mental health outcomes (Cohen, 2004; Kawachi & Berkman, 2001; Pescosolido & Boyer, 1999; Berkman, 1995).

As shown in Table 3 below, the Vietnamese in the NLAAS survey have strong social support through family ties. Among the Vietnamese respondents, 96.7% report agreeing strongly with the statement that that family members should trust and confide in one another; 95.9% agree strongly that they can express feelings with family; 96.1% agree strongly with the statement that the family should feel close to each other, and 98.3% agree strongly that family togetherness is important. In addition to their strong immediate family ties, most of the Vietnamese respondents were in frequent contact with relatives and friends in their broader social networks. For example, 61.3% of the Vietnamese respondents spoke with relatives a few times a month or more; and 52.8% spoke to their friends on the phone or got together with them a few times a month or

more. Among the Vietnamese in the NLAAS data set, 21.7% reported relying on relatives not living with them ‘a lot’ for help with serious problems, 15.7% reported relying on relatives not living with them ‘a lot’ to discuss worries, 10.5% also reported ‘a lot’ when asked how much can they rely on friends when they have a serious problems. Finally, 15.5% said they would be able to open up to friends and talk about worries.

The majority of Vietnamese in the sample rated their physical health as ‘good’ (31.2%) to ‘very good’ (28.8%) while only 9.6% indicated poor physical health. Self-rated mental health was also clustered around ‘good,’ ‘very good,’ and ‘excellent’ with each category indicating 32.5%, 26.7%, and 27.9% respectively while the ‘poor’ mental health rating was at 5.4%. Of the entire Vietnamese sample in the data set, only 16 (3.1%) indicated that they have an emotional or mental health problem. Moreover, 41 (7.9%) respondents from the sample indicated that they should talk to a mental health professional while 25 (4.8%) have been told by others that they should talk to a mental health professional. Overall, these findings indicate that the Vietnamese in the data set had higher rates of poor physical and mental health than good or excellent physical and mental health. Furthermore, the Vietnamese were more likely to trust, confide, express feelings, and feel close to family members while maintaining contact with relatives and friends frequently than to feel distant or have feelings of distrust.

**Table 3. Social Support, Self-Reported Health and Mental Health, and Informal Support Variables**

Variables	Descriptive Statistics	
	Mean	SD
<b>Social Support Variables</b>		
Family trusts and confides in each other <sup>1,2</sup>	1.0	0.2
Can express feelings with family <sup>1,2</sup>	1.0	0.2
Family feels close to each other <sup>1,2</sup>	1.0	0.1
Family togetherness is important <sup>1,2</sup>	1.0	0.1
Frequently talks to relatives <sup>1,3</sup>	0.3	0.9
How often talks on phone or gets together with friends <sup>1,3</sup>	0.4	0.9
Frequently rely on relatives not living with R for help with serious problems <sup>5</sup>	0.5	0.9
Frequently can rely on relatives not living with R to discuss worries <sup>4</sup>	2.6	1.0
How much can rely on friends when have serious problem <sup>4</sup>	2.9	1.0
How much R can open up to friends and talk about worries <sup>4</sup>	2.7	1.0
<sup>1</sup> This variable has been recoded into a dichotomous variable.		
<sup>2</sup> Coded as 0 = disagree, 1 = agree.		
<sup>3</sup> Coded as 0 = once a month—less than once a month, 1 = most every day—few times a month.		
<sup>4</sup> Coded as 1 = a lot, 2 = some, 3 = a little, 4 = not at all.		
<sup>5</sup> Coded as 0 = some to a lot, 1 = a little to not at all		
R = respondent		

### **Mental Health Service Use among Vietnamese in the NLAAS Dataset**

Understanding the use of any mental health services by Vietnamese-Americans who have a serious mental illness is the leading focus of this inquiry. As such, and as described in the previous chapter, the primary dependent variable in this analysis is a dichotomous (yes/no) variable of any mental health service use. As shown in Table 4 below, the analysis of the NLAAS data set indicates that any mental health service use among the Vietnamese sample was relatively low. Of the 520 Vietnamese in the data set, only 70 (13.5%) indicated they had sought or used any type of any mental health service such as seeing a psychiatrist, a psychologist, or a mental health counselor, or had been admitted to an inpatient psychiatric facility. Overall, only 4.4% of the Vietnamese sample used inpatient mental health services. Also among the entire Vietnamese sample, 6.2% of

respondents indicated severe emotional distress during sad episode while 1% indicated severe worrying and 0.8% had severe social fear (these data are not shown)

The analysis of individual mental health service use variables illustrates the low incidence of any service use among the Vietnamese-American sample in the NLAAS data set. For example, only seven respondents (1.3%) indicated they had seen a ‘psychiatrist for emotional problems/substance abuse’; three respondents (0.6%) indicated they ‘sought a psychologist for emotional problems/substance use’; one individual (0.2%) ‘sought a social worker for mental health/substance use’ and five respondents (1%) ‘sought counselor for mental health/substance abuse.’ Among the Vietnamese respondents, 1.7% used inpatient services while 13.5% used mental health support services (data not shown). Overall, only 26 (6.4%) respondents indicated they had used medication for mental health problems.

**Table 4. Health, Mental Health, and Mental Health Service Use**

Variables	Descriptive Statistics	
	Mean	SD
<b>Mental Health Variables</b>		
Self-rated physical health <sup>1</sup>	2.7	1.2
Self-rated mental health <sup>1</sup>	2.4	1.1
R has emotional/mental health problem <sup>5</sup>	0.0	0.2
R thinks he/she should talk to mental health professional <sup>5</sup>	0.1	0.3
Others think R should talk to mental health professional <sup>5</sup>	0.1	0.2
Any Mental Health Service Use <sup>2,4</sup>	0.1	0.3

<sup>1</sup> Coded as 1 = poor, 2 = fair, 3 = good, 4 = very good, 5 = excellent.

<sup>2</sup> .0 = No mental health service use, 1 = Used mental health services.

<sup>3</sup> Any Mental Health Service Use is a composite variable comprised of both inpatient and mental health support services mental health service use. The full definition of the variable is provided in Chapter 4

<sup>4</sup> This variable has been coded into a dichotomous variable.

<sup>5</sup> Coded as 0 = no, 1 = yes.

R = respondent

## **Conclusion**

This chapter describes the Vietnamese sample in the NLAAS data set. In sum, the Vietnamese-Americans in the NLAAS data set that utilized mental health services were more likely to be female, naturalized citizens, who had been living in the United States for less than 20 years. The Vietnamese sample as a whole achieved low levels of education and were mostly unemployed, reported having poor physical and mental health. In addition to physical and mental health, 78.4% (mean 18.9) of the Vietnamese in the data set said “yes” to having acculturative stress variables and utilized the least amount of any mental health services (13.5%) among the three Asian subgroups (25.7% for Filipinos and 18% for Chinese). In the next chapter I explore the relationship of demographic, acculturation, social support, and other independent variables with any mental health service use among the Vietnamese sample in the NLAAS data set utilizing bivariate analysis and logistic regression.

## **CHAPTER 6: EXPLORING THE RELATIONSHIP OF INDEPENDENT VARIABLES WITH MENTAL HEALTH SERVICE USE**

This chapter shows the results of bivariate analyses and multivariate logistic regression analyses to explore relationships between the independent variables: age, gender, household size and income, employment, citizenship, length of time in the U.S., age of immigration, English and Asian language proficiency, acculturative stress, cultural identity, and social support variables and the study's primary dependent variable – any mental health service use. In the bivariate analyses, chi-square ( $\chi^2$ ) and one-way analysis of variance (ANOVA) were used to assess the relationship between demographic, acculturation, social support, and other independent variables previously mentioned with any mental health service use. A multivariate logistic regression was then conducted to assess the relationship between any mental health service use and statistically significant independent variables identified in the bivariate analysis.

### **The Relationship of Demographic Variables and Mental Health Service Use**

Table 5 below displays the relationship of demographic variables and any mental health service use for the Vietnamese respondents in the NLAAS data set. Gender differences in any mental health service use was significant as females were more likely to use any mental health services than men, with 16.2% of females reporting they used any mental health services compared to 10.3% of males ( $\chi^2(1, N = 520) = 3.94, p = .047$ ). Household size was also significantly related to any mental health service use as smaller

Vietnamese households with ‘One-Four’ household members were more likely to use any mental health services than larger households with ‘Five or More’ ( $\chi^2(1, N = 520) = 5.83$ ,  $p = .016$ ) living at home. Vietnamese in the data set who were unemployed or not in the labor force were also more likely to use any mental health services (21.5% and 18% respectively) than those who were working (9.2%;  $\chi^2(2, N = 520) = 14.00$ ,  $p = .001$ ). There were no significant associations between age, annual income, or either measure of citizenship status and any mental health service use for the Vietnamese sample in the NLAAS data set.

**Table 5. Bivariate Analysis of Demographic Variables and Any Mental Health Service Use**

Variables	Any Mental Health Services
Demographic Variables	Test Statistic
Age <sup>1,4</sup>	-1.8
Gender <sup>3</sup>	3.9*
Household Size <sup>1</sup>	5.8*
Household Income <sup>2</sup>	1.0
Employment <sup>3</sup>	14**
Citizen of the United States <sup>3</sup>	0.3
Citizenship Status <sup>3</sup>	2.5

(\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$ )

<sup>1</sup> t statistic

<sup>2</sup> F statistic

<sup>3</sup>  $\chi^2$

<sup>4</sup> Age rates from 18 to 77 years of age.

All values are measured at the 2-tailed level.

## **The Relationship of Acculturation, Acculturative Stress and Cultural Identify Variables and Mental Health Service Use**

Table 6 below shows the relationship between a number of measures of acculturation from the NLAAS data set – generation status, years in the U.S., age at immigration, English proficiency (speaking), English proficiency (reading), English proficiency (writing), Asian language proficiency (speaking), and Asian language proficiency (writing) – and any mental health service use. The association of these variables with mental health service use has been well documented in the literature (e.g., see Koneru, Mamani, & Betancourt, 2007; Hu, Snowden, Jerrell, & Kang, 1993, Nguyen, 2010). I hypothesized there would be a significant relationship between generation status and mental health service use among the Vietnamese Americans in the NLAAS survey. The findings from the bivariate analysis indicate that of the 67 Vietnamese respondents who used any services, 12.8% of 1<sup>st</sup> generation Vietnamese-Americans used any mental health services compared to 22.2% of 2<sup>nd</sup> and 3<sup>rd</sup> generation Vietnamese-Americans. This is in the hypothesized direction but the relationship between generation status and any mental health use was not significant. As indicated in the previous chapter, few respondents met the criteria of being 3<sup>rd</sup> generation: only 4(0.77%) respondents overall. Despite combining the 2<sup>nd</sup> and 3<sup>rd</sup> generation categories into a single category, the low numbers of 2<sup>nd</sup> and 3<sup>rd</sup> generation Vietnamese respondents in the sample prevents a complete exploration of the relationship of generational status and mental health service use.

I also hypothesized that the length of time in the United States would be associated with more mental health service use among 2<sup>nd</sup> and 3<sup>rd</sup> generation Vietnamese-Americans and less service use among 1<sup>st</sup> generation Vietnamese-Americans. The length of time in the United States was not significantly associated with any mental health service use among the Vietnamese sample, almost all of whom are 1<sup>st</sup> generation. I also hypothesized that English proficiency would be associated with mental health service use. However, as shown in Table 6 below, there was no significant association between three assessments of English proficiency and any mental health service use. In addition, there was also no significant relation between age of immigration to the U.S. and any service use. As with generation status, the low count of 2<sup>nd</sup> and 3<sup>rd</sup> generational Vietnamese-Americans in the sample prevents a thorough analysis of the relationship between length of time in the United States and English proficiency with any mental health service use.

Data in Table 6 also shows there was no significant association between two measures of acculturative stress and any mental health use among the Vietnamese respondents in the NLAAS data set. I hypothesized that first generation Vietnamese-Americans will experience more acculturative stress than 2<sup>nd</sup> or 3<sup>rd</sup> generation Vietnamese-Americans, and that acculturative stress will be associated with less any type of mental health services use among all Vietnamese-Americans. Contrary to expectations, there was no significant association. However, any mental health service use was significantly associated with one measure of cultural identity. The variable that asks if the respondent ‘feels close in ideas/feelings with people of same decent’ was significantly related to any mental health service use ( $\chi^2(2, N = 508) = 7.28, p = .026$ ). Among those who felt ‘very

close' in ideas and feelings, 13.3% of the Vietnamese respondents indicated using any mental health services while among respondents who indicated they were 'not very close or not at all close' 29% indicated they had used any mental health services. Mental health service use was not significantly associated with two other variables that assess cultural identity.

**Table 6. Bivariate Analysis of Acculturation Variables and Any Mental Health Service Use**

Variables	Any Mental Health Services
Acculturation Variables	Test Statistic
Generation Status <sup>1,8</sup>	1.35
Years In the United States <sup>2,8</sup>	0.591
Age at Immigration <sup>3,8</sup>	5.89
English Proficiency <sup>8</sup>	3.7
Asian Language Proficiency <sup>8</sup>	3.6.
<b>Acculturative Stress Variables</b>	
Acculturative Stress <sup>4,8</sup>	1.17
Acculturative Stress Score <sup>5,7</sup>	1.28
<b>Cultural Identity Variables</b>	
Respondent identifies with others of same racial/ethnic descent <sup>6,8</sup>	1.77
Respondent feels close in ideas/feelings with people of same racial descent <sup>6,8</sup>	7.28*
Amount of time Respondent would like to spend with people of same racial/ethnic group <sup>6,8</sup>	4.67

(\*p<.05,\*\*p<.01,\*\*\*p<.001)

<sup>1</sup> 1 = 1st generation, 2 = 2nd generation, and 3 = 3rd generation (see Chapter 4).

<sup>2</sup> 1 = "0-10 years," 2 = "11-20 years," 3 = "20+ years."

<sup>3</sup> 1 = "0-12 years," 2 = "13-17 years," 3 = "18-34 years," 4 = "35+ years."

<sup>4</sup> 0 = "No acculturative stress," 1 = "Have acculturative stress." The full definition of the variable is provided in Chapter 4.

<sup>5</sup> Acculturative Stress Score is a composite variable that represents a weighted score based on the number and type of acculturative stresses. The full definition of this variable is provided in the Chap 4.

<sup>6</sup> 1 = "Very close," 2 = "Somewhat closely," 3 = "Not very closely or Not at all."

<sup>7</sup> F statistic

<sup>8</sup>  $\chi^2$

All p-values are measured at the 2-tailed level.

A variety of variables assessing social support among the Vietnamese in the NLAAS survey were found to be significantly associated with any mental health service use. As illustrated in Table 7 below, those Vietnamese respondents who agree with the statement that they could trust and confide in family used any services less than those who disagreed with the statement (12.6% versus 41.2% respectively;  $\chi^2(1, N = 517) = 11.47$ ,  $p = .001$ ). Expressing feelings with family also was significantly related to mental health service use among the Vietnamese sample. Respondents who agreed with the statement that they can express feelings with family were less likely to use any services than those who disagreed with the statement (12.7% versus 33.3% respectively;  $\chi^2(1, N = 517) = 7.33$ ,  $p = .007$ ). Similarly, respondents who agreed that their ‘family feels close’ used any mental health services less than respondents who disagreed with this statement (12.7% versus 35% respectively;  $\chi^2(1, N = 517) = 8.19$ ,  $p = .004$ ). Valuing the importance of family togetherness was also significantly associated with mental health service use: those who agreed with this statement were less likely to use any mental health services than those who disagreed with the statement (13% versus 44.4%;  $\chi^2(1, N = 518) = 7.50$ ,  $p = .006$ ).

However, there was no significant association between the following social support variables that address frequency of contact with friends and relatives and how important friends and relatives are as sources of support and any mental health service use: “how frequently talks to relatives”, “how often talks on phone or gets together with friends,” “how frequently rely on relatives for help with serious problem,” “how frequently can rely on relatives not living with respondent to discuss worries,” “how much

can rely on friends when having a serious problem,” and “how much can the respondent open up to friends and talk about worries.”

Table 7 also shows the relation between variables that assess the respondents' health and mental health status and any mental health use among the Vietnamese in the NLAAS data set. The respondents who rated their physical health as 'poor' used any mental health services significantly more than respondents who rated their health as 'excellent' (42% versus 5.6% respectively;  $\chi^2(4, N = 520) = 43.58, p < .0001$ ). The association between any mental health service use and self-rated mental health was also significant. Vietnamese-Americans in the sample who reported 'poor' mental health utilized significantly more services than respondents who self-rated their mental health as 'excellent' (64.3% versus 5% respectively;  $\chi^2(4, N = 520) = 91.75, p < .0001$ ).

Other variables associated with physical health and mental health were also significantly associated with any mental health service use. Almost 70% (68.8%) of respondents who indicated they “had an emotional/mental health problem” had used any mental health services compared to 31.2% usage for respondents who said they did not have an emotional/mental health problem ( $\chi^2(1, N = 519) = 43.21, p < .0001$ ). Respondents who indicated they thought they ‘should talk to a mental health professional,’ utilized significantly more services than respondents who did not think they needed to talk to a mental health professional (78% versus 22% respectively;  $\chi^2(1, N = 520) = 159.38, p < .0001$ ). Finally, respondents who answered ‘yes’ to the item ‘others suggest that they should seek out a mental health professional’ used significantly more any mental health

services than respondents who answered 'no' to this item (84% versus 16% respectively;

$\chi^2(1, N = 520) = 112.17, p < .0001$ ).

**Table 7. Bivariate Analysis of Social Support and Other Independent Variables and Any Mental Health Service Use**

Variables	Any Mental Health Services
Acculturation Variables	Test Statistic
Family trusts and confides in each other <sup>1,3</sup>	11.5***
Can express feelings with family <sup>1,3</sup>	7.3**
Family feels close to each other <sup>1,3</sup>	8.2**
Family togetherness is important <sup>1,3</sup>	7.5**
Frequently talks to relatives <sup>1,3</sup>	6.1
How often talks on phone or gets together with friends <sup>2,3</sup>	1.2
Frequently rely on relatives not living with R for help with serious problems <sup>2</sup>	5.0
Frequently can rely on relatives not living with R to discuss worries <sup>3</sup>	5.2
How much can rely on friends when have serious problem <sup>3</sup>	2.9
How much R can open up to friends and talk about worries <sup>3</sup>	6.0

(\*p<.05, \*\*p<.01, \*\*\*p<.001)

<sup>1</sup> 0 = "Disagree," 1 = "Agree."

<sup>2</sup> 0 = "Once a month/Less than once a month," 1 = "Most every day/few times a month."

<sup>3</sup>  $\chi^2$

All values are measured at the 2-tailed level unless noted.

### **Logistic Regression Analysis of Mental Health Service Use**

A multivariate logistic regression was conducted to understand further the relationship between relevant independent variables and the primary dependent variable of any mental health service use. All independent variables found to have a significant association with any mental health service use were included in the model. In the final model, seven independent variables were significantly associated with any mental health services. These are shown in Table 8 below. All were significant with at least p-values

of .05 and at least one category in each variable was significant. These were identified using Wald backward variable selection (Kleinbaum, Kupper, Muller, & Nizam, & Rosenberg, 2013). Since the mental health service utilization rate was 13.5% of the Vietnamese sample, the cutoff probability value beyond which cases are predicted to fall in the positive category (i.e. “yes” to using any mental health services) was set to .135, which is the sample proportion of subjects who used such services or the event rate where the predicted probabilities will cluster around. All analyses were conducted using SPSS version 20.0.0.2.

The first significant predictor is the variable that asks respondents how close they are in ideas and feelings with people of the same racial/ethnic group. The analysis shows that Vietnamese-Americans who felt ‘somewhat close’ in ideas and feelings to people of the same racial/ethnic decent were 80% less likely to use any mental health services ( $B = -1.59$ ,  $p = .09$ ,  $\text{Exp}(B) = .20$ ) when compared to individuals who were ‘not very close’ or ‘not close at all’ in ideas and feelings with others of the same racial/ethnic decent. Vietnamese respondents who identified as feeling ‘very close’ were three and a half times more likely to use any mental health services ( $B = -1.27$ ,  $p = .02$ ,  $\text{Exp}(B) = 3.56$ ) compared to those who felt ‘not very close or not at all.’

The second significant predictor variable is the respondent’s assessment of how close the members of the respondent’s family are to each other. Respondents who agreed with the statement that their family felt close ( $B = -1.64$ ,  $p = .01$ ,  $\text{Exp}(B) = .19$ ) were 80% less likely to use any mental health services compared to those who disagreed with

the statement. The values for the reference category, 'disagree', were not displayed by the model.

Self-rated mental health was also a significant predictor of any mental health service use. Respondents who self-rated their mental health as 'fair' were 72% less likely to use mental health services ( $B = -1.26$ ,  $p = .08$ ,  $\text{Exp}(B) = .28$ ) while those who reported 'good' ( $B = -1.81$ ,  $p = .003$ ,  $\text{Exp}(B) = .16$ ) in the logistic regression were 84% less likely to use any mental health services when compared to Vietnamese who indicated 'poor' mental health. Having 'very good' ( $B = -2.69$ ,  $p = .000$ ,  $\text{Exp}(B) = .07$ ) and 'excellent' ( $B = -3.09$ ,  $p = .000$ ,  $\text{Exp}(B) = .046$ ) self-rated mental health led Vietnamese respondents to use any mental health services 93% and 95% (respectively) less than individuals who self-reported 'poor' mental health.

Two other variables that address the respondent's mental health status were also significantly related to any mental health service use. In the first variable, Vietnamese-Americans in the sample who said 'yes' to having an emotional/mental health problem were four and a half times more likely to use mental health services when compared to individuals who said 'no' to the same statement ( $B = 1.54$ ,  $p = .72$ ,  $\text{Exp}(B) = 4.66$ ). In the second variable, when Vietnamese in the NLAAS survey agreed that 'others thought they should talk to mental health professional,' respondents were 39 times more likely to use any services compared to those who disagreed ( $B = 3.66$ ,  $p = .000$ ,  $\text{Exp}(B) = 38.89$ ).

Two demographic variables were significant predictors in the logistic regression. First, my analysis found that gender was a significant predictor of any mental health service use. When respondents reported being a female they were more than twice as

likely to use any mental health services compared to their male counterparts ( $B = .87$ ,  $p = .021$ ,  $\text{Exp}(B) = 2.04$ ). Larger family households of ‘five or more’ were 49% less likely to use mental health services compared to smaller household sizes ( $B = -.67$ ,  $p = .049$ ,  $\text{Exp}(B) = .510$ ).

**Table 8. Logistic Regression of Significant Independent Variables**

Variables	Logistic Regression	
	<i>B</i>	S.E.
Feels somewhat close or very close in ideas/feelings with people of same decent <sup>1</sup>	-1.4**	(0.5)
Agree that Family Feels Close to Each Other <sup>2</sup>	-1.6**	(0.6)
Self-rated mental health <sup>3</sup>	-1.4**	(0.5)
Has emotional/mental health problem	1.5	(0.9)
R thinks he/she should talk to mental health professional	3.7***	(0.7)
Others think R should talk to mental health professional	3.7***	(0.7)
Gender (Female) <sup>4</sup>	0.7*	(0.4)
Household Size (Five or More)	-0.7*	(0.3)

(\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$ )

<sup>1</sup> 1 = "Not very close or Not at all," 2 = "Somewhat close," 3 = "Very close."

<sup>2</sup> 0 = "Disagree," 1 = "Agree."

<sup>3</sup> 0 = "Fair or poor," 1 = "Good, very good, excellent."

<sup>4</sup> 0 = Male, 1 = Female.

note: standard errors are indicated in parentheses

Two assessments of the original seven variables model were conducted to evaluate the adequacy of the model. The Hosmer-Lemeshow test is a common test of the goodness-of-fit of a logistic regression model and is similar to a Chi-Square test (Lemeshow & Hosmer, 1982; Hosmer & Lemeshow, 1980; Hosmer, Lemeshow, & Klar, 1988). The Hosmer-Lemeshow procedure ‘...involves grouping of the observations based on the expected probabilities and then testing the hypothesis that the difference between observed and expected events is simultaneously zero for all the groups’ (Shah, Barnwell, 2003, p. 3778). Since the Hosmer-Lemeshow test was not significant, this provides some

support for the overall adequacy of the model ( $\chi^2 = 6.72$ ,  $df = 8$ ,  $p = .567$ ), i.e. at least one of the included independent variables can be used for differentiating between the two outcome classes.

A second assessment of the fit of the model is to examine the extent to which the model adequately explains the variability of the any mental health services variable, or, in other words, how well the model is able to predict the odds that a Vietnamese American is likely to use any mental health services. Two common ‘pseudo’ R-squared statistics were conducted: the Cox & Snell  $R^2$  (Cox & Snell, 1989) and the Nagelkerke  $R^2$  (Nagelkerke, 1991). The results for these two tests show that the model was able to explain 24% and 43% respectively of the variability of the outcome using the variables in the table below. Based on these results and the final regression model, 82.1% of the sample cases were correctly classified (see Table 9 below). Overall, the model was able to achieve an accuracy of 83.9% for individuals who did not use any mental health services, and 71% for those who did. Because logistic regression does not provide a true R squared, these statistics should be interpreted cautiously as they may be weak predictors as they only identify the general fit of the model but not necessarily to what extent (“Goodness of Fit Measures”).

**Table 9. Logistic Regression Classification**

<b>Dependent Variable</b>	<b>Predicted Service Use</b>		
	<b>No</b>	<b>Yes</b>	<b>% Correct</b>
Total Any Mental Health Service Use			
No	365	70	83.9
Yes	20	49	71
Overall Percentage			82.1

## Conclusion

In sum, the results presented in this chapter and previous chapter shed light on the possible factors associated with why Vietnamese in the NLAAS survey used any mental health services. The limitation of the sample to primarily 1<sup>st</sup> generation Vietnamese Americans restricted my ability to fully assess the relationship between acculturation and any mental health service use. None of the acculturation or acculturative stress variables were significantly related to the any mental health services variable. Other findings from the bivariate analyses, however, provide support for some of my hypotheses. Among the significant findings, Vietnamese respondents who relied on family support used less any mental health services compared to those who did not. Drawing on Tolsdorf's (1976) Social Network Orientation Theory, this finding suggests that the Vietnamese sample had positive social network orientation within their respective families through which they were able to obtain and receive reliable sources of support. The results support my hypothesis that within 1<sup>st</sup> generation Vietnamese-Americans, there is an inverse relationship between the amount of social support received and mental health service use.

Results from the logistic regression for social support variables were mixed. Vietnamese respondents who agreed that their family feels close were less likely to use services compared to those who felt family was not close. The respondents in the data that 'felt close to family' reflected a positive social network orientation and may be exhibiting the patterns of service use consistent with their family network and the content of their "bounded rationality" (Pescosolido, 1991; 1992). Among the factors that increased service use, several variables were associated with increasing the odds of using

any mental health services. In addition to Vietnamese respondents who were ‘very close’ to ideas and feelings of people of the same racial/ethnic group, individuals who ‘agree’ with others who recommended that they talk to a professional about mental health/emotional problems,’ acknowledged that they have a mental health problem, were female, and lived in small households were more likely to use any mental health services. The results suggest that health care choices are socially constructed patterns of decisions (Pescosolido, 1992) about utilizing any mental health services and point to the influence of social networks in decision-making.

The limitations in the data prevent a complete analysis of why Vietnamese-Americans utilizes services at the rate that they do. Based on the limited knowledge that they possess, Vietnamese-Americans suffering from serious mental health problem make decisions to seek or not to seek any mental health services. It is unclear what types of information or the extent of their “bounded rationality” Vietnamese-Americans are using to help them make their decisions about utilizing mental health services (Pescosolido, Wright, Alegria, & Vera, 1998; Simon, 1979). In the following chapters I present results from the qualitative study that present the lived experience of Vietnamese-Americans with severe mental illness, and will provide additional insight into how their traumatic past impact current patterns of behaviors, their current understanding of the origins of mental illness, and the pathways to treatment they pursued.

## **CHAPTER 7: REFUGEE EXPERIENCE OF VIETNAMESE-AMERICANS**

The results from the quantitative analysis revealed limitations of the NLAAS data set as the Vietnamese sample was predominantly 1<sup>st</sup> generation (94.6%) and lacked 2<sup>nd</sup> generation respondents (5.6%). As a result, the analysis of any mental health services by Vietnamese-Americans with serious mental health problems was limited. To better understand multi-generational mental health service use patterns in the Vietnamese-American community, I conducted a qualitative study with 17 Vietnamese-American respondents, eight self-identifying as 1<sup>st</sup> generation and nine self-identifying as 2<sup>nd</sup> generation.

All 1<sup>st</sup> generation respondents arrived in the United States when they were young children and grew up in the United States. All respondents were part of multi-generational households in which at least one family member had a serious mental health problem. Interviews were conducted with a combination of semi-structured questions and open-ended questions and probes.

The thematic analysis of the transcripts from the qualitative study will be presented in the following three chapters. This chapter presents a description of the sample and presents respondents' views about the refugee experience, highlighting the profound and lingering effects of the refugee experience on all aspects of their lives including physical health, mental health, and social network structures. Chapter 8 presents themes that capture how respondents understood and made sense of mental illness and how mental illness impacted their families. Chapter 9 presents the respondents'

views about using mental health services and their pathways to care, and applies to the Network-Episode Model (Pescosolido, 1991; 1992) and Social Network Orientation Theory (Tolsdorf, 1976) frameworks to help understand their decision to use or not use any mental health services.

### **Demographic Characteristics of Respondents**

Table 10 below summarizes the demographic characteristics of the participants in the study. The average age of the 17 respondents was 30.8 years old. The youngest of the respondents was 24 years while the oldest respondent was 42 years. Nine of the 17 interview subjects (58.8%) were female. All of the participants indicated that they were United States citizens and in all, seven of the 17 respondents (41.1%) indicated that they had a mental illness. Including family members, 15 households had at least one person in the family suffering from one of three major mental disorders: schizophrenia, severe depression, or bi-polar disorder. Due to the nature of comorbidity of mental disorders, some of the frequencies and percentages reflect a higher count than the 17 respondents in the study.

**Table 10. Demographic Characteristics of Qualitative Study Participants**

Variables	Descriptive Statistics	
Demographic Variables	Mean/Percentage	SD
Age <sup>1</sup>		
Average:	30.8 years	6.0
Gender		
Female	10	58.80%
Male	7	41.10%
Citizenship Status		
U.S.	17	100%
Non-U.S.	0	0%
Generational Status		
1st Gen	8	47%
2nd Gen	9	53%
Nativity Status		
U.S. Born	9	53%
Non-U.S.	8	47%
Who has Mental Disorder in Family*		
Respondent	7	
Siblings	5	41.10%
Parents	5	23.40%
Relatives	3	23.40%
Mental Disorder Type**		
Bi-Polar	8	47%
Schizophrenia	4	23.50%
Depression	9	53%
Anxiety	4	23.50%
Suicidal	2	11.80%

<sup>1</sup> Age ranges from 18 years of age to 42 years of age.

\* Some may be co-occurring in the family

\*\* Percentages reflect all individuals in the respondent's family

Table 11 below indicates the types of self-reported and diagnosed mental disorders among the respondents and their family members. Two households had multiple family members suffering from mental disorders including bipolar disorder, schizophrenia, severe depression, and anxiety. In all but two cases (John, #4; Page, #6), doctors had formally diagnosed the mental illnesses reported.

**Table 11. Types of Self-Reported and Diagnosed Mental Disorders in Respondent Families\***

Name of Respondents	Family Member with Mental Illness			
	Self	Parent	Sibling	Other Relative
Alfred (#1)				Bipolar (uncle)
Gloria (#2)		Bipolar (mother)		
Esther (#3)	Depression		Suicide Attempt (sister)	
John (#4)		Dementia (father)		
Miwa (#5)				Depression (uncle)
Page (#6)			Down syndrome (sister)	
Jackie (#7)		Bipolar (mother)		
Huy (#8)	Depression and Anxiety			
Sarah (#9)	Anxiety	Depression and Anxiety (mother)	Bipolar (brother)	
Tony (#10)	Depression			
Tim (#11)			Schizophrenia and Bipolar (sister)	
Jennifer (#12)		Depression and Bipolar (mother)		
Sammy (#13)	Depression		Depression (brother)	
Qui (#14)	Depression and Anxiety			
Truc (#15)	Schizophrenia			
Lisa (#16)				Schizophrenia (cousin)
Fong (#17)	Bipolar	Schizophrenia (mother)		

\* All names have been changed

### **Enduring Effects of Respondents' Refugee Experiences**

A century of almost constant war and conflict provides a context for understanding the refugee experiences of the Vietnamese-Americans. Vietnam was embroiled in almost constant conflict with France, the United States, and China (Thee, 1976; Burton, 1979; Herschman, Preston, & Loi, 1995). The French ruled Vietnam in stages from 1858-1945, and Vietnam fought for independence from colonial rule during the French Indochina War between 1946 to 1954 (Herschman, Preston, & Loi, 1995). Approximately half a million Vietnamese died in this war (Harrison, 1989). The Vietnam War followed the Indochina War. From 1955-1975, as many as two million Vietnamese civilians were killed and 200,000 to 250,000 South Vietnamese soldiers allied with the United States against the communist North were killed. The quest for unification by the North led to the fall of Saigon in 1975 and created a mass exodus of Vietnamese. The constant conflict of the Indochina and Vietnam Wars over a period of almost 30 years significantly disrupted lives and displaced many families and individuals in the process. Between 1975 and 1995, an estimated 424,590 Vietnamese refugees resettled in the U.S. (United Nations High Commissioner Report, 2000). By 2007, approximately 1.5 million Vietnamese were in the United States (U.S. Census, 2010).

Fleeing war torn Vietnam exposed many Vietnamese to trauma and hardship, and for those who were fortunate to leave Vietnam, many faced uncertainty and endured difficult passages. The refugee experience and resulting hardships due to the Vietnam War represents a major theme that will be discussed in this chapter. Without being prompted by interview questions, five of 17 respondents described the impact of the

Vietnam War on their lives during the refugee migration to the United States. An additional three respondents described the difficulties of life in the United States as refugees, and four (Sammy (#13), Miwa (#5), Esther (#3), and Huy (#8)) others said their parents' refugee experiences were so difficult that they were never discussed.

Leaving Vietnam drastically changed the refugees' network structure when they lost ties with family and friends who remained in Vietnam. The forced migration of the Vietnamese refugees reduced their social networks because family and friendship ties in Vietnam were eliminated, and many families were socially isolated after their emigration to the United States. Under these conditions, the severed network ties undermines one of the first basic premises of the NEM, that all societies have large groups of people to consult with during an episode of illness. The Vietnamese respondents were cut off from their extended family and friends because communicating with family members back in Vietnam was difficult, if not impossible. As a result, respondents had to rely on denser and less diverse network ties, typically immediate family members, for support as they were the only support networks they had in the United States. These smaller networks provide less information about and knowledge of resources content for respondents to make health care decisions. This is supported by research on immigrant kinship networks, which found that Vietnamese refugees relied mostly on family support (Gellis, 2003; Menjivar, 1997), and less on community organizations during their first wave of migration (Menjivar, 1997).

*War's Aftermath: Fear, Exploitation, and Poverty*

Citing the Vietnam War, many respondents reported traumatic experiences and hardship in their stories. The extreme hardships included fear, exploitation, and poverty – all of which exacerbated and masked the mental disorders within the families. Two respondents described the impact of the Vietnam War on their lives during the refugee migration to the United States and an additional three respondents described the difficulties of life in the United States as refugees. Several other respondents stated their parents did not verbalize their refugee experiences because the events were too traumatic to describe. All respondent names have been changed using pseudonyms.

Two 1<sup>st</sup> generation respondents, Gloria (#2) and Jackie (#7), who are sisters, fled Vietnam as young children after the fall of Saigon. They reported first-hand accounts of their emigration experiences. Gloria (#2) and Jackie (#7) have a Vietnamese mother and an American father (U.S. marine):

*"After my dad left and after the fall of Saigon and our country was going crazy. Like, everybody was so scared for their lives and it's a lot of stress and then there was no money. It's like survival you know like my mom was like 'Oh, my God the government is going to come and kill us'..my dad actually is a GI. He is Caucasian. He is American...and so he met my mom in Vietnam. They got married. Had three kids, three girls...and then my dad left before the fall of 1975 and after that we lost all communication with him and so that was hard. That started a very hard time with my mom...it was*

*extremely difficult for my mom and a lot of people you know like my mom was married to an American soldier and so it's the enemy."*

(Gloria, #2)

The forced withdrawal of the troops left Gloria (#2) without a father to support the family. Gloria (#2) describes the fear and chaos of her life, including how their lives changed:

*"1975 was when the big crazy chaos you know took over the south and everybody was so scared and panic...so she had to sell all the things that we have, you know the material things that my dad left for us. And then you know she has to, like her lifestyle just change completely. And then she has to find a way to support us by becoming a vendor before she was like a Beverly Hill housewife, you know."* (Gloria, #2)

Vietnamese allies that were left behind faced severe consequences as aiding and abetting enemies of the communist North forced many into labor and reeducation camps, imprisonment, or execution (Hauff & Vaglum, 1993; Richard, et al., 1998). Life was especially difficult for families who had close connections to the United States military.

The following is Gloria's (#2) account of labor exploitation in camps:

*"...it was extremely difficult for my mom and a lot of people you know like my mom was married to an American soldier and so it's the enemy... and so she was sent to like a day camp where she has to work all day, and that's like a punishment. And then she was no longer able to work you know. Basically, she is like on a black list. So, my mom has to wait five weeks to survive by becoming a*

*vendor selling you know whatever, you know vegetables, some food or to support us...now she has to go out and struggle, fighting, you know to make money."* (Gloria, #2)

Miwa (#5), a 2<sup>nd</sup> generation respondent, describes the stress her parents endured fleeing their home country:

*"So I, I mean, I'm sure my mom has post-traumatic stress disorder from coming, you know, from Vietnam on a boat with two younger children and...she escaped on a boat and was pregnant."*(Miwa, #5)

Jackie (#7) describes life in the refugee camps, where water and food were scarce and space was cramped:

*"It was a little strange staying in the refugee camps in the Philippines. Imagine 15 people staying in a cramped space and sharing a small little kitchen. We were like sardines in cans. Food was distributed a couple times a week which were barely enough to eat. We had to line up for water supply. (Jackie, #7)*

In all, the respondents that shared about their families' refugee experiences described stories of fear, exploitation, and poverty. Other respondents and their families did not directly share details about their refugee experiences. Below, several respondents talk about their parents' unwillingness to describe the past.

*“Don’t Want to Talk About It”--Refugee Experiences Getting to the United States*

It is striking that among the respondents who did not disclose any details about their refugee experiences, many explicitly and repeatedly mentioned that they or their parents “would not talk about the Vietnam War.” Respondents reported that their 1<sup>st</sup> generation parents do not see any benefit in talking about old wounds. Sammy (#13), Miwa (#5), Esther (#3), and Huy (#8), all children of 1<sup>st</sup> generation parents, describe their parents’ resistance to talk about the past:

*"But no one, yeah, yeah. I was going to say no one in my, no one in the older generation has gone through counseling even though they've probably gone through more severe, like, trauma than we have, but yeah. And then some differences, though, I think, I think, like, my mom and my family, they're all, like my older generation family, they don't believe in talking to others about difficult things."*

(Sammy, #13)

*"My mom is like that with herself too. She doesn't talk about her journey to the States and you know other things that happened. We just don't talk about things."* (Miwa, #5)

Esther (#3), a 1<sup>st</sup> generation respondent who arrived in the United States when she was two years old, reported that her parents suffered from Post Traumatic Stress Disorder (PTSD) from the war and that the trauma was painful to recall and relive. The presence of PTSD has been shown to be a barrier to seeking proper mental health care (Silove, Steel,

Bauman, Chey, & Mcfarlene, 2007) and Esther's (#3) parents' avoidance of the past may also inhibit seeking mental health services. Esther (#3) recalls how her parents reacted when asked about their past:

*"There's definitely a lot of PTSD from post-war stuff, 'cause once in a while, she'll talk to me about things. And then I myself did research a while back and I asked my parents about their experience as refugees. And, like, they would talk a little bit about it and they would stop because they don't want to talk about it anymore. And they're, like, you know, 'It's nothing good to mention or worth talking about it anymore.' My dad doesn't show it as much. He went through the war, like, on both sides. And my mom, actually, you can tell there are lots of things that she still (keeps inside) and she still is, like, hurt by it. And she won't talk about it often. When she does, she'll break down. And so there's that piece of it with my mom. We have a lot of siblings too. And so when one of us goes through something dramatic, it's either she totally goes on the end of not being able...she falls apart or she doesn't know how to cope with it to show that she cares. And so I don't really know what to make of that."* (Esther, #3)

Respondent Huy (#8), a 1<sup>st</sup> generation respondent, immigrated to the United States at an early age; in fact, he considers himself to be a 2<sup>nd</sup> generation Vietnamese-American. Huy suffers from severe depression. He describes his family's reluctance to

talk to each other about current or past issues, especially mental health issues, as part of traditional Vietnamese culture. This cultural reticence to discuss painful experiences will come into play in later chapters when respondents address the issue of whether and how they have addressed the mental health problems of their family members. In Huy's words:

*"But I think my family, my, including my sisters who were raised here but have really held on to traditional values, have really, they don't, they don't understand how it can help to talk about or to medicate for mental health issues. I think we have a hard enough time talking to each other let alone talking to someone who is outside the family..I think that's part of it because, you know, you don't air your dirty laundry, in such a deep way even if your counselor isn't part of the community, but I think it's also, you know, kind of if I don't acknowledge it it's not there...so this is, we don't even talk about issues that are current or in the past let alone mental health issues. Like, that's just a stretch." (Huy, #8)*

The description of 1<sup>st</sup> generation Vietnamese by their 2<sup>nd</sup> generation children paint a picture of reluctance and avoidance when talking about painful memories. The excerpts above also describe the parents' belief that talking about the past is not useful or productive. These cultural and trauma-related inhibitions to discussing painful events also colors respondents' later discussions about how they cope with mental health issues, seek help, and use mental health services. These themes are the focus of Chapter 8 and 9.

*Difficulties of Life in the United States: Severed Ties, Poverty, and Language Barriers*

In addition to war trauma and hardship, general daily living was difficult for respondents when they first arrived in the United States. The refugees often dealt with multiple complex problems, which were compounded by poverty, language barriers, stress, mental illness, and reduced family networks.

Severed Family Ties

For the first and second waves of Vietnamese refugees, many left Vietnam thinking they would never see their family and relatives again. Respondents Jackie (#7) and Gloria (#2), recall leaving Vietnam without expecting to ever see their relatives again. The experience of losing family ties after their emigration to the United States was a stark reminder of the political situation in Vietnam. The following transcripts illustrate the difficulty of maintaining contact:

*"Back then because we weren't able to telephone, only letters, and back then it's very, very hard to send letter too because sometime they think that we might put something, like money, in there. They would rip up your letters and mail and read it. Yep. And see it was also back then it was very hard, we don't, we thought we never see them again, that we were unable to communicate with them through a phone call...the moment that we step on the airplane to leave Vietnam that was like, seems like to us that's the last time that we ever see them or hear from them again." (Jackie, #7)*

*"In the beginning, yeah. It was much harder to...you know when we left we didn't think we can go back and visit, but now you can go as many times as you want."* (Gloria, #2)

Gloria (#2) then describes how her family sought support from a Buddhist temple in the United States because they had no other support structures to rely on. She recalls:

*"Yeah, so we were teenagers when we go to the Buddhist youth program. I think that's also one of the biggest support systems for my family...because we didn't have anyone. We didn't have any other relatives...We would mostly seek guidance from the temple, you know from other adults, our neighbors."* (Gloria, #2)

The forced migration severed ties to family and relatives in Vietnam and also limited contact with them. When Jackie (#7) and Gloria (#2) needed help with their mother, the isolation from family limited whom they could go to for help. Subsequently, the lack of family network forced Jackie (#7) and Gloria (#2) to seek help from their neighbors, friends, and spiritual community in the United States.

### Poverty

For some families, the constraining factors of poverty made life difficult. In the excerpt below, Jackie (#7) describes the multiple and inter-related hardships her family faced during her mother's hospitalization in the psychiatric ward:

*"I mean you, you know, as an immigrant coming to this, you know, a foreign country and surviving, then being successful and to be where you are given all the struggles and, and trials and obstacles*

*that you had to jump over and, you know, plow through, I think... I remember one time, I don't know if this is important, but when, when I was in high school, still in high school, we dropped food to my mom and I don't have any, I have only fifty cents to go for the train, at that time. And we, I supposed to meet with Gloria at (inaudible) Station but then somehow Gloria misheard me, she wait for me at UMass, at the JFK. So I wait for like half an hour, almost an hour. I didn't see her so I went back home and I wait for her phone call. And somehow she call and she say, where were you? And then I say, I waited for you for so long so I left, I went home. She said, okay, let's meet up again but I don't have any money to go on the train again. Somehow I found a one dollar food stamp in my pocket..I was 16, 17. I was really embarrassed because I couldn't find any penny in the house, so I don't know what to do, so I went to one of the Vietnamese supermarket. I say in order to get change I have to buy something with one dollar, so I was, I bought a lollipop and I say, you know, and then the cashier asked me, is this all you buying? I say, yeah, I'm only buying lollipop for my younger, for my younger sister, just made it up. So she able to give me like, I think it was seventy five cents back, so I have some change to go on the train. It was very embarrassed. It was very shame, and I had no choice. But looking back, I was, you*

*know, I was a teen. (inaudible) for me is something very shameful because we low income family. We poor. But you have to do what you have to do when you have no choice. But now looking back I say, you know, nothing to be ashamed about. I had to survive, you know. And I met up with Gloria eventually, and we brought food to our mom.” (Jackie, #7)*

Jackie (#7) also describes the tremendous financial burden her family experienced during her mother’s psychiatric hospitalization. She recalls the desperation of the family at the time and what her older sister had to do to keep the family together. Jackie (#7) said:

*"It was, it was very tough and rough and a hard time for us, especially we have no money. She, she, we were on assistance and because she was sick and she was in this hospital, all of the case got closed, her case got closed and so we had zero penny in the house, no food. (My older sister) where she has to commute because she went to Regis but then she has to come back home to stay with us because I couldn't handle it by myself. I was only 17. So has to go to court and get legal guardianship for the girls and also as for myself too. And that's how we, and then after that we got all the documentation and we went back to a life on public assistance. That's how we could get a little bit of money and food stamps to support the girls. Yeah, it was really tough, but you know,*

*you have to do what you have to do at that point. You don't think a lot outside of the box. You know why it's happening to us? And, you know, sit there and cry or cry to God or cry to (inaudible), you know, why has this happened to our family? You do what you need to do, that's all. Yeah. I don't think we think much back then. We just, we just did. Just do it. We don't think much. I think if you think too much about, you just sit there and think and not, you won't accomplish anything. Somehow we learn and somehow we have to try and find ways for us to survive." (Jackie, #7)*

The poverty that Jackie (#7) and her family experienced was obviously difficult for them and severely affected individual family members and the family unit as a whole. In many instances, Jackie's (#7) mother's mental illness developed after the fall of Saigon and the poverty and hardship endured may have exacerbated her mother's mental illness. Experiencing impoverished conditions in the United States may have contributed to her mental health problems poverty has long been associated with mental health problems, especially among women (Belle, 1990), and creating barriers to the use of mental health services (Alegria, et al., 2001; Chow, Jaffee, & Snowden, 2003).

### Language Barriers

Poor language proficiency in English was a struggle for most Vietnamese refugees as they arrived in the United States, and despite efforts to teach English to the refugees in the refugee camps, the lack of English proficiency made adjusting to life in the United States more difficult. Below, Jackie (#7), and Gloria (#2), talks about how

their interactions with others at school made them acutely aware of their English language limitations. The language barriers contributed to social isolation and limited opportunities to make friends at school for Jackie (#7) and Gloria (#2) growing up. They cite their struggles below:

*“When we first came, you know, English was a barrier for us, but somehow people didn't make fun of us. I mean I, I speak with other kids in the class, but we don't, we not friends outside of the school because of the language and because of the living style...I think it's, limit myself to just step up and meet other people because of the language barrier. So, because maybe it's because of myself more than them because I feel intimidating and I feel, you know, I'm isolated a little bit because of the language. I don't feel confident stepping up to meet other friends because of the language...”*  
(Jackie, #7)

*"Because we, I think I wasn't able to communicate with other kids in the school. It was hard you know. A lot of times it just it's hard to, you want to say something and you can't because you know you don't know how to speak English."(Gloria, #2)*

The language barrier not only impeded respondents' relationships with others in the United States but also affected their family relationships and ties. Another respondent,

Esther (#3), describes the isolation during her early years in school because her parents were not able to take part in her life due to their inability to speak English:

*"I came in with no English. Even at home, my parents spoke Vietnamese so even when I started kindergarten, I didn't have English...But it was actually really hard to articulate and really hard for my parents to be a part of my life because they did speak Vietnamese. And so they were never part of my education. They were never part of my conferences. They were never part of elementary school."* (Esther, #3)

Language barriers affected respondents at varying life stages. Respondents described that as children, they felt isolated and could not make friends easily because they did not speak English. Parents who could not speak English had a harder time getting involved with their children's schooling and educational development.

### *2<sup>nd</sup> Generation Respondents' Views about Identity and Cultural Conflict*

Second generation Vietnamese who are American born often experience a clash between their adopted American values and traditional Vietnamese culture (Kim, Atkinson, & Umemoto, 2001). In the case of three 2<sup>nd</sup> generation respondents in the qualitative study, Sarah (#9), Miwa (#5), and Jennifer (#12), their struggle to balance the treatment approach of both cultures is clear in their excerpts.

Sarah (#9), born in the United States, is faced with being 'the perpetual foreigner'. She does not feel like she belongs to her ethnic culture of origin nor fit in with American culture. Below, Sarah (#9) describes a trip to Vietnam to visit family:

*"I think it was the other things, kind of more related to being a Vietnamese. They call it Nogi Gai foreigner. So people who've left versus those who stayed behind. But my family members, like get their experience kind of limited access. Or self-limited because of their fear of (their affiliation) to the Communist Party in Vietnam or something. I sometimes feel not as unaccepted and not at home here as I did in Vietnam. I thought it would be a homecoming when I went to Vietnam and it wasn't like that at all. I realized it was a country I really didn't have any experience and knowledge of."*(Sarah, #9)

Miwa (#5) describes how it is difficult and confusing to be both American and Vietnamese. Depending on the situation, she struggles with balancing dual identities:

*"I certainly feel, I think there have certainly been times where I feel more Vietnamese than I do American and there are times when I feel more American. I think it depends on the group. When I'm with my family, I feel more American and when I'm with a lot of white people, I feel more Vietnamese. Well, it's and it's always it'll come back to your American, you know you're too American, you're too American, you know we're Vietnamese we don't do that and so it's always, you know that. I think a lot of times I feel confused whether or not what they're saying is true, like maybe I am too American or maybe I should have been more understanding*

*because I think that's, that's part of my personality is to kind of look at both sides" (Miwa, #5)*

Jennifer (#12) is caught between exercising her own independence in moving away and her duty to live at home and take care of her family. The urgency of her family wanting her to remain at home is heightened by the fact that there was no one else to rely on for support other than family. For Jennifer (#12) to live independently was viewed as a rejection of loyalty to the family. In the excerpt below, Jennifer (#12) recalls her decision to move out and forgo her cultural duties:

*"I don't want to live with crazy. I'm not, not calling anyone crazy but like crazy atmosphere, but when I decided to leave I think my entire family felt that I was forgoing part of my familial responsibility to take care of each other." (Jennifer, #12)*

She continues to describe how living in the United States has isolated her from her ethnic heritage and limited her from accessing Vietnamese culture:

*"It feels sort of isolating. I mean, living in this town for so long, I realize now that I have such a limited understanding of the Vietnamese community. It's very limited. I don't know much about our traditions and I don't know much about the history, 'cause I feel like while I'm here, I can only go back so far. It stops at a certain point. And it only exists here in Westminster and Garden Grove. And then beyond that, it's changing. So now, I feel very*

*isolated. I feel like I know all I can know about this area and I feel very isolated."* (Jennifer, #12)

In addition to the culture clashes respondents faced, the relationships between respondents and parents were often strained. The atrocities and trauma respondents' parents experienced as refugees was very different from the social problems their children, mostly 2<sup>nd</sup> generation Vietnamese-Americans, faced on a daily basis living in the United States. Parents would often minimize their children's experiences or misrecognize the severity of a mental health problem because there is no cultural context for mental health in Vietnamese culture. Below, Jennifer (#12), a 2<sup>nd</sup> generation respondent, describes how her mother minimizes her experiences and does not show her empathy:

*"And the way she views me and herself is completely different. She doesn't think that what she's feeling could possibly be the same as something I've experienced. So there's no bridging. Or if something hard has happened to me and I come home, like, 'Mom, I had a terrible day.' She's, like, 'Well, what you've been through doesn't compare to everything I've been through as a child. Let me tell you.' And she'll tell me all these really bad stories. Like, 'Oh, God. That is really bad. I guess what happened to me wasn't really bad. But why are you minimizing my experience? You know, it's so hard.' So everything I say to her, she perceives as really petty. So I couldn't possibly bridge the gap with her because I can't reach*

*out and say, 'I understand how it feels to feel this way' because everything I've been through in her eyes doesn't even come close to anything she's experienced or felt."* (Jennifer, #12)

### **Conclusion**

The refugee experience has had a profound impact on the Vietnamese community in the U.S. The forced relocation of respondents severed family ties and reduced social networks, and mental health issues were exacerbated by War trauma, poverty, language barriers, and cultural isolation. The refugee experience drastically changed the lives of Vietnamese-Americans. The severed ties to family and friends in Vietnam subsequently reduced the size and density of their networks when they arrived in the United States. Drawing on the ideas of the NEM (Pescosolido, 1991; 1992), the dissemination of values and beliefs -- defined as being aligned in the direction of endorsement for or against mental health service use (Edmonds, Hruschka, Bernard, & Sibley, 2012; Pescosolido, Wright, Alegria, & Vera, 1998) -- within Vietnamese families rested on the few members that immigrated to the United States. Since network content is disseminated within network structures, having smaller networks would limit knowledge and beliefs about mental illness and mental health service use. In the next chapter, I show how respondents' beliefs and values shape their understanding of mental illness and exacerbate the impact of the illness on the family.

## **CHAPTER 8: RESPONDENTS' UNDERSTANDINGS OF MENTAL ILLNESS AND THE IMPACT OF MENTAL ILLNESS ON THE FAMILY**

This chapter highlights respondents' views and beliefs about mental illness. Tolsdorf 's (1976) Social Network Orientation Theory will be particularly relevant. This theory posits that past experiences shape and reinforce values and beliefs of an individual. In this perspective, the refugee experience that shaped the views and beliefs of 1<sup>st</sup> generation Vietnamese and may have contributed to the pattern of avoiding past trauma described in the previous chapter, and is likely to influence their awareness and use of any mental health resources.

Several themes emerged from the respondent interviews that focused on Vietnamese-American views of mental health and mental illness. First, respondents described the impact of mental illness on themselves and their families. A second theme concerned the general lack of understanding about serious mental illness, and this is related to the final theme: respondents understanding about the causes of mental illness. We begin with the impact mental illness has had on respondents and their families.

### **Impact of Mental Illness on Respondents and Their Families**

This section highlights respondents' discussion of the impact of mental illness on respondents and their families. The personal experiences of individuals who struggle with mental disorders are seldom heard, however, friends and family members are at times able to relay these experiences. The respondents reported lifelong effects that included embarrassment from their parents' outburst during an illness episode, feeling heartbreak

as they left their parent in the psychiatric ward while they begged to be taken home, and the breakdown of family relationships. The respondents also had feelings of being ashamed, isolated, being left alone, and being unable to function in the school environment.

Below, respondents describe how mental illness first affected themselves and/or their families. Four respondents, Gloria (#2), Jackie (#7), Qui (#14), and Sarah (#9) describe their own experiences with mental disorders and the mental illness symptoms they observed in their family members. Below, Gloria (#2) recalls how her mother, who suffers from bi-polar disorder, developed delusions of grandeur and embarrassed the family with her actions:

*"...I think you know we were kind of like older in high school like we know it, like we know she's not herself. And she would put a ton of makeup on her face because she know it doesn't and speak English and say that she could fly airplane. She can be a pilot. She can do a lot of things. She would talk in nonstop. Stay up late at night talking to people and like she would go out at night, in the middle of the night and then come back in the morning. She would be walking. She would be getting very friendly to people. It was up to the point that we embarrassed." (Gloria, #2)*

Jackie (#7) grew up not understanding her mother's odd behaviors. During some of her mother's episodes of mental illness, she describes being left alone by her mother. Below, Jackie (#7) talks about her experiences with her mother's bipolar disorder:

*"So we (were) kind of left alone (by our mother). We didn't know what to do, and she became out of control, and she left, she would leave the house in the middle of the night and wander on the street. We don't even know where she went, and a few hours later she would turn home and then she talked to herself. She talked to herself in different language. I don't know what she was saying. Something like French or something, but she never knew that part of the language herself. And she did weird stuff...She go out. She'll talk to people. She, one time she sing to people and she go to the market and she talk to people and it just, she's not herself. She's usually very content but when she gets sick, she's opposite. All the time (my mother) call me constantly every five minutes. Every five minutes. Oh and sometimes she will say, oh you know what, your husband is not nice to me. She tend to repeat herself more and more of that and we know. She can be very outspoken and be very aggressive. Doesn't sleep. When she's manic, she doesn't sleep. And then she will call my family in Vietnam, my aunts in Vietnam and yell at them. And then after she got well, you know, after she got discharged from the hospital she received the phone bill. She, oh my god, what happened to my (phone). I say, yeah, you called Vietnam a lot."(Jackie, #7)*

Qui (#14) who, along with his father and sister suffers from depression, describes his own experiences with his mental illness and observations of his father's symptoms:

*"I noticed them first because when I would be depressed I would go, I would exclude myself from, like, events, and I would, you know, live more solitary confinement, you know, just kind of lock myself in a room, spend time by myself... He (his father), yeah, he was, he was withdrawn from everybody. He, not very social at all, negative talk. I don't know what other symptoms there would be other than just being kind of solitary."(Qui, #14)*

Another participant, Sarah (#9), a 2<sup>nd</sup> generation Vietnamese-American, tells a story about her brother who was diagnosed with bi-polar disorder in high school shortly after an incident at school. The interaction between the brother and his friends at school brought attention to his mental illness and allowed his family to also become aware that his behaviors were not normal. Sarah (#9) describes the time her brother acted out for the first time:

*"But he did that then and I remember recently he told me he realized, like, when he was in the fifth or sixth grade and he was in the middle of class. He said it kind of feels like a lot of bees buzzing in his head. The teacher was giving a lecture and he knew he shouldn't, but he wanted to shout out a word; I don't know what the word was. And he really shouldn't have, but he did it anyway, so he got in trouble for it. He didn't realize when he was younger*

*that sometimes it affected his learning, until that incident in high school. But that kind of out seeks random outbursts (inaudible) something, that was a behavior that happened which I remember distinctly around that time. But I also remember that happening before then, so it's just something he's always done."*(Sarah, #9)

### *Living with Mental Illness*

Living with a mental disorder is not only disruptive for an individual, but also for all involved in the caretaking process, as they often experience burnout (Etzion, 1984; Felton, 1998; Rosenberg & Pace, 2006). An individual suffering from a mental disorder can tax family resources and exacerbate interpersonal relationships. Respondents Gloria (#2), Jackie (#7), and Miwa (#5) reported significant burden experienced at a young age due to mentally ill parents.

Gloria (#2), a 1<sup>st</sup> generation respondent, came to United States when she was young and she describes how she and her older sister took on the burden of guardianship of their younger siblings while their mother was institutionalized in a psychiatric ward:

*"(My sister) where she has to commute because she went to Regis but then she has to come back home to stay with us because I couldn't handle it by myself. I was only 17. So (my sister) has to go to court and get legal guardianship for the girls and also as for myself too. And that's how we, and then after that we got all the documentation and we went back to a life on public assistance. That's how we could get a little bit of money and food stamps to*

*support the girls. Yeah, it was really tough, but you know, you have to do what you have to do at that point. You don't think a lot outside of the box. You know why it's happening to us? And, you know, sit there and cry or cry to God or cry to Buddha, you know, why has this happened to our family? You do what you need to do, that's all. Yeah."*(Gloria, #2)

Gloria (#2) recalls her mother's extended hospitalization and how it forced her to move home from college to take on the burden of caring for her younger siblings. Additionally, Gloria (#2) cooked ethnic foods daily to bring to her mother because she didn't eat hospital food:

*"No, and also when she was in the hospital from when I was in college, I was living in a dorm. So, I had to move home. I forgot to mention that part. Had to move home and take care of my two little sisters, me and my younger sister. I was 19. She was 17. She was a senior in high school. My first semester in college. My two siblings were like 3 and 4 years old. Then, my mom doesn't eat American food at the psychiatric wards. So, almost every day we have to cook. We don't drive...(we)take the bus. Take a train or get a taxi. Ask an older family friend to drive us and bring her the food and come home, do our homework, take care of younger siblings and go to school the next day."*(Gloria, #2)

Similarly, Jackie (#7), a 1<sup>st</sup> generation immigrant, describes her mother's absenteeism from regular household duties, family events, and personal milestones because of severe bi-polar disorder. As a result, Jackie (#7) and her siblings took on the burden of household duties. She recalls her family's early years in the United States and their struggle during her mother's hospitalization:

*"Of course. It took a lot because we, we were, she took care of us. You know, we don't know how to cook. I mean we, we do our house chores and all that, but we have no ideas of how to write a check to pay for utilities, how to do grocery. We just very naive in some ways, and we just kids. (We were) very young, and we really never really took care of anybody except ourselves. Sometime, you even took care of yourself at that age, but we took, we took over a mother's role to take care of our siblings, and I think we did a pretty good job. And the hardest part is we have to go and visit her every single day and seeing her the way she's acting and we don't know how long it's going to, how long she going to be discharged, how long she going to be in the hospital for...And your high school at that point is really tough, and I have to really, you know, I was a senior. I have to prepare for college and all that and somehow we get through everything. I think it's just someone above just helping us to get through a tough time at that time."*(Jackie, #7)

The hospitalization was extremely disruptive to the rest of the family members, and as a result of her physical proximity to her siblings Jackie (#7) has been one of the few family members that has provided support for them. The amount of energy Jackie (#7) has utilized has been overwhelming. Below, Jackie (#7) describes how she still takes care of her mother, and it is physically and emotionally taxing:

*"So I have to, really at some point I have to come to the house every single day to medicate her, and it's burning out because I have family, I have kids, I have work...I'm tired. I don't want to take it anymore. 'Just let me die.' She always say she's going to die. I say, mom, it's not about dying...It's, you know how tough it is for us every time you end up in the hospital? There are 10 situations. My youngest (brother) needs to come and live with us and I have, it's not, I don't mind. I love my, he's like my son, but it's just turning his life upside down. I burn out. I said, mom, you know what? I come to the house every day. I medicate. You, you take it. I have to stand in front of her, see her swallow the pills and then go to work...after a while I said I'm tired. I said, mom, why do I have to do this? This is something you can do...I say, 'you know what mom? If you get sick, you get sick, you know. We've been living with this for 20 years. You've been in and out of the hospital so many times it's not a problem to us anymore. So you want to take it, you take it. You don't, don't. It's your health, it's not mine. I'm*

*tired.' So, but now I say, do you want to end up in the hospital again, go ahead, don't take the medication. And it's tiresome. And then, you know, I bring her to a doctor's appointment, so all her appointments, I keep track of it. I take her to the appointment. Sometime I have to beg her to go. I'm taking her and bring her home and still begging her to go, and sometimes she refuse. And then I said, mom, please just go, okay? I said, but then sometime I keep her, I say, mom, forget it. If you don't want to go, don't go. I'm tired. It burns me out." (Jackie, #7)*

Jackie's (#7) mother was constantly hospitalized over the past 20 years and this caused strain in their relationship because of a reversal of roles between parent and child. In order to address her mother's mental health problems, Jackie (#7) sought out the only sister she trusted to confide in. Through the process of conferring with her sister, Jackie's (#7) decisions about mental health care for her mother changed from being a choice to being a socially constructed pattern. Moreover, Jackie's (#7) fear that her mother is incapable of providing support and develops a negative social network orientation. Below, Jackie (#7) describes turning to other family members for support:

*"I feel a little sad, knowing I have a mom, I call her mom and I appreciate all the things that she did for us or still do, but I feel like I don't have a mom to run to and she has stuff or (inaudible) my problem or pretty much anything. I don't even tell my mom about sister's problem because I don't think she can handle it, and*

*it going to make her, I think she gonna make her more sick and because she's the person who always take things and make it to a worse part instead of making to a, she's very negative. She doesn't have a good, she's not optimistic, so we cannot go to her for anything or anything. I don't think we come to her for anything...Pretty much when, when she got sick, I have to call (my sister) or (my sister) has to call me, and she say, okay, what, what should we do? I say (my sister), what you want to do, we say, what you want to do? I say okay, let's meet. So we come and meet and we sit down with mom and talk...We try to do as much as possible to help her but sometimes, you know, as her kids you can only do so much. You want to act, act like adult but you don't want to, I don't want to act like my mother. And (inaudible) I feel like I'm more a mother than a daughter to her and it's, it's sad and it's very sad."(Jackie, #7)*

### *The Burden on Family Caretakers*

Respondents frequently described the heavy toll of care-taking responsibilities. Stress experienced within the family structure had a significant impact on many within their respective households. Jackie (#7) describes the birth of her youngest brother, which occurred during her mother's first hospitalization. He had to be moved between different homes whenever the mother was hospitalized:

*"Actually she gave birth to my brother during the sick time, and we brought him home and she stayed there another, like a couple months or so, and then after she had him she got better and she got home. She went home with us. But she was very angry and every time we came in to see her, she got angry with us. It's not, every time we visit her it wasn't, it wasn't a good visit. It's heartbroken. It's very painful. It's, we, sometime we just wanted to bring food and go home. We just don't want to stay there to see that kind of scene, you know, the way she's acting and she's just not herself at all...And it's, it was a very struggling time. She was mad, she was mad at us, very mad for brought her into the hospital, but we didn't have any choice what to do...Back then I don't think because they know a lot about Vietnamese culture and there's no, we, they don't have Vietnamese social worker back then, not too many to my understanding...Sometime, I love to talk about this because it's, just make me look back see how strong we were and up to now too that we, we still have a lot of things and we stay stronger in life, but I think my sibling, my siblings, they don't have the understanding..I mean she's, she's come in and out of the hospital for the last 20 years in and out more than ten times. Seems like she's in the hospital every year. For the last couple years she's been good...I think it much be really hard for my youngest one, my youngest*

*brother because every time she got sick he had to stay with us, and he turned out a pretty good kid...He's 20 now. She's been sick for 21, 22 years, and he been living with (inaudible) 20 years, with a disease for 20 years, with an illness for 20 years...It has a lot of disruption because first of all, like I said earlier, she, we have to bring food, we have to visit her very often, and finding a good hospital for her to stay."(#7)*

Two other respondents, Sarah (#9) and Jennifer (#12) also experienced stress at home when dealing with family members, both coincidentally suffering from bi-polar disorder. Based on frequent interactions with her brother's mental illness, Sarah (#9) has grown adept in identifying symptoms of his mental disorder. Sarah (#9) recalls the uncertainty and stress of living with her brother:

*"Well, it was hard. Sometimes it's hard now. It kind of always felt like walking on egg shells. I can tell when he's having a hard time or when he might be dipping into depression or a kind of manic rage. I've developed an acute sense of observation for the tone and the types of comments he would make when things aren't going well or when he's starting to feel upset. So that was stressful growing up. And also you can see that it affects my parents. And because they really think that it's something that they can control or something, a failing on their own part in raising him, it was stressful. Just, I can see when things change and try to manage and*

*try to shift it. And in some episodes when we were younger, he would just go through these deep paralyzing depressions. And I also think looking back there where past traumas or experiences and current."*(Sarah, #9)

Sarah (#9) also describes the strained interactions in her family between her parents and her siblings' spouses because of her brother's bi-polar disorder. The spouses do not understand the brother's mental illness and the parents, on one hand, feel the need to protect and stand up for him, and on the other hand, do not want to offend the spouses. Below, she recalls how her brother's mental disorder weakened his family network structure:

*"Their (my parent's) relationships with my other siblings' spouses, their partners, is sometimes strained. Because (my parents) feel like they have to be very protective of my brother in general but feel they always have to defend him. But also maintain the balance between defending him and not offending my siblings' partners so it's a difficult balancing act. And I find them constantly doing that."*(Sarah, #9)

Jennifer (#12) further describes how family was almost paralyzed by her mother's illness, including her father, who is also limited in power and authority when attempting to persuade the mother to listen to advice from her children:

*"I was so scared. There were weeks they were telling me, "Just go." And I was, like, "No, I can't." I was so scared. So when I see my*

*mom, like, man, she has that same fear and I don't know how to tell her that it's okay. She doesn't trust me because I am her youngest daughter. How could she possibly even listen to me. But even as her daughter, as her own blood, she doesn't even trust me. So it's really hard. And my dad can't help me, 'cause he's got no power either...My dad's view of my mom is, 'Don't say anything. She does what she does. She's her own person.' I mean, they definitely don't stick to...there's no patriarchy or anything. He's very, 'Whatever she says goes. She's the boss. We all listen to her.' He just sits back. And if she yells, he's just very quiet, doesn't say anything. And then he'll go out and have a smoke afterwards. That's my dad's view. I mean, sometimes he can't take anymore, like, once in a blue moon, he'll talk back or say something, but he'll immediately regret it. He'll immediately just say, 'I think I'm gonna get my own place. I think I'm gonna move out.' And I'm, like, 'Oh, no. Why? This is so bad.' And that's happened a lot where he's just come to my room and he's, like, 'Can we eat dinner in your room tonight?' And I'm, like, 'Oh my God. It's that bad, we're gonna eat burgers on the floor of my room.' There's so many times we've done that.'(Jennifer, #12)*

Language barriers also exacerbated how respondents and their families experienced the mental disorders they were suffering. A lack of Vietnamese translators

also contributed to confusion and lack of knowledge about treatment plans. When dealing with mental health issues, not being proficient in English can have negative consequences such as limiting communication for support and for understanding mental health treatment. For the older 1<sup>st</sup> generation respondents, the concept of mental health was foreign to them, especially if there were no Vietnamese translations available. Gloria (#2) describes her mother's level of understanding during an initial diagnosis:

*"...She didn't understand why she was acting like that..I think a lot of the things we had to figure it out by ourselves."* (Gloria, #2)

Miwa (#5) describes that with no Vietnamese translators, the family's experience of mental illness was made even more difficult. In this example, Miwa describes how difficult it was to understand her uncle's behavior when he was hospitalized the first time. She says:

*"I mean I physically remember him (my uncle) and what he looked like there because it was so strange, and I think part of that was alarming to my mom because she could physically see a difference in him, and I think she didn't really understand what was happening either because they didn't have Vietnamese translators so they didn't and I was too young to translate for them and I don't think, you know, I was a legal age to look through documents, you know."*(Miwa, #5)

### **Lack of Understanding about Mental Health and Mental Illness**

One of the major theme identified from the interviews was the respondents' limited awareness in recognizing symptoms of mental illness. The lack of understanding about mental health issues among the respondents also limited the values and beliefs within the family and resulted in confusion. Below, three participants, Gloria (#2), Sarah (#9), and Miwa (#5) describe their limited understanding about their family members' mental illness symptoms, attributing symptoms to personality traits and physical sickness. Gloria (#2) describes confusion about her mother's symptoms:

*“Like I just want somebody to come and fix her, like you know for her to be normal and be my mom again. And so at the time I don't know what's really going on with her. I was really confused, yeah. We all feel the same way that she's changed...something is wrong...and they tried to make sense, you know like I have a mentor and like older friends who would try to help us figure out what's going on with my mom...but I think it came to the point where we were afraid that she was harming herself because she would walk out in the middle of the night. We tried to figure it out, you know what is the solution to you know why my mom's acting the way she's actin...something was wrong, but we didn't know she had an illness.” (Gloria, #2)*

Initially, Sarah (#9) attributed her brother's bi-polar disorder to his personality. However, after seeing other family members struggle with mental health symptoms, and

through interactions with them over time, Sarah (#9) developed a better understanding of the needs of her family. She recalls:

*"I thought this was just his personality. He does it now and sometimes he's come, he's had different understandings about what is his illness and what is his personality. And I think he has a hard time differentiating between the two sometimes. But he often is, well, just talking to himself or he makes up words..I really recognized and I had to grapple with it for a while, but recognized that it's also kind of hormonal or inexplicable in some cases how it develops. But that it's something that needs consistent treatment and support, something that she might live with for the rest of her life. And I think around five years ago just seeing her on a daily basis and seeing the changes in the patterns of her behavior as the episodes happened helped me to understand that, come to a new understanding of what living with mental illness is."(Sarah, #9)*

The symptoms of mental illness can be confusing to those who are unaware of its origins. For some, the mental illness behaviors are explained by existing knowledge of physical health. Miwa (#5) believes in the idea that psychological disorders can be treated just like a physical ailment much like pneumonia. Below, Miwa (#5) describes how she made sense of her uncle's disorder:

*"I mean I think of it as similar to any physical ailment. It's just an ailment to the brain, I guess, but I think that because I think of it as*

*similar to a physical ailment that it needs to be treated in a similar way as a disease or an ill, you know, a cancer or anything like that.”(Miwa, #5)*

When asked about how family members responded to the mental disorders, Fong (#17), a 1<sup>st</sup> generation respondent, describes having limited knowledge of treatment options. Fong (#17) stated his family did not know how to respond properly nor know where to seek help:

*“We didn’t know how to deal with it properly. We didn’t know how to treat it properly. We didn’t know how to identify it properly and where to seek help.” (Fong, #17)*

Additionally, respondents Miwa (#5) and Tim (#11) explain how there is no language in Vietnamese to describe mental illness. Were it not for Miwa’s (#5) education, the concept of mental disorder would have only been limited to a few words. She briefly talks about the differences in understanding between her parents and her own views. Similarly, Tim’s (#11) family generalized all disorders by using terms such as “mat” or “binh.” Miwa (#11) and Tim (#11) recall below:

*"I mean when I heard my mom talk about it, literally translated from Vietnamese it's sickness in the head, which is not a nice way of saying it but because it's not talked about in our culture, I don't really have other words that I heard from my parents or you know my siblings about it in Vietnamese...And I think because of being western education...I have other words that I, you know, like post-*

*traumatic stress disorder and all these other things that I could use and probably could better identify." (Miwa, #5)*

*"We, would say she's 'mat,' which is, like, 'crazy'...Yeah, generalize. They're, they're sick. You know, you see a homeless guy he's sick, he talking to himself, he's sick. Or any other, even if you're just almost handicapped you're called 'binh'..I think Vietnamese, they just generalize it more. Doesn't assume any problem, any mental issue, it's just they're sick in the head. I think they don't really go further than that. They don't really care what it is." (Tim, #11)*

Even with formal diagnosis by doctors, respondents reported that parents and family members still did not comprehend what they were suffering from. Sarah (#9), whose brother suffers from bi-polar disorder, describes the difficulty of explaining mental health concepts and side effects of medications to her parents:

*"And it's embarrassing for him too because he's trying to talk to them about communication or therapy sessions and they don't really seem to have a grasp of what that is. You know, they just see that some of the medication makes him a bit antisocial or just he, he said he feels like a zombie. So that scares them, I think. So for him it's also very stressful because he doesn't know how to relay his illness to them." (Sarah, #9)*

Similarly, Jackie (#7), who immigrated to the United States when she was 11 years old, reports that she and her mother did not understand the implications of her mother's diagnosis of bi-polar disorder, particularly because there were no Vietnamese-speaking doctors or translators available at that time. As a result of her mothers' silliness, Jackie (#7) entered into the health profession as a translator and was determined that her own children would have a better understanding of mental health issues. She provides additional testimony that many of her clinic's Vietnamese-American patients and their children continue to lack understanding of mental disorders:

*"And we don't know really have much understanding what bipolar is, what depression is, what brought her to this point or to that point at the time, and we just kind of go along whatever the doctors say. And we have very, don't have much understanding ...Up to now I don't think she, she truly understand what is her diagnoses at all...You know even now, when my kids were younger they, even four and five, they say mommy, I think it's time for 'ngoai', which is grandma, to go to the hospital. They can tell because they, even though they don't live with her, but they can tell when she got sick. They don't have, people don't have much understanding about different disorder, mental health disorder, what impact, how it happened. And I mean they do have some form of understanding but not a deep one and so I feel like they don't have support for family like us, (inaudible) up to now because I do medical*

*interpreting and I interpret for a lot of mental ill patients at the clinic. I can still tell they, the children of the patient don't even have much understanding why their parents acted this or why they're not talking or what making them, you know, doesn't want to do anything or what cause depression. It's very lack, there's a lack of understanding and lack support.” (Jackie, #7)*

Some respondents believed that nothing was wrong with their mental health.

Studies have shown that, depending on the level of insight, individuals may or may not have stigmatizing views of mental illness (Lysaker, Roe, & Yanos, 2006). Three respondents, Sarah (#9), Huy (#8) and Tony (#10) report that neither they or their parents felt that there was anything wrong with their mental health. Below, Sarah (#9) describes how her mother disagrees with her diagnosis of having a mental health problem. Her mother questions the authenticity of the diagnosis:

*"And, and when my mother was diagnosed with anxiety she always said, like, 'It feels like I'm just making it up. And there's this made up disease in my head. It's in my head like I'm making it up.' So I don't think it was denial, they just didn't really believe in this, culturally they didn't accept or believe the concept of mental illness." (Sarah, #9)*

Huy (#8), who is diagnosed with depression, also describes how he believes that there is nothing wrong with his mental health:

*"I'll be honest with you. To myself, you know, I didn't think there was anything wrong with me, you know?...Because I feel like, you know, my mental capacity, you know socializing with people was like way less than the people that were sitting next to me, you know. It was just like, they're like this high, I'm like this high, it's like, I don't know what to say... (Huy, #8)*

Tony (#10), who suffers from manic depression, did not recognize his mental disorder when he was going through school and, as a result of his belief that there was nothing wrong with him, left his mental health unchecked. Social Network Orientation Theory posits that beliefs are shaped by past experiences with an individual's network and Tony's (#10) interaction with his schoolmates reshaped his belief about his state of mental health and changed his values and beliefs about how he saw himself and being reliant on using psychotropic medication. Using language from the NEM, the mechanism at play in Tony's (#10) situation was his interactions with his social network that transformed his belief about his mental health and made him realize that something was wrong. Below, Tony (#10) discloses the time he realized that he had a mental health problem:

*"I didn't think there was anything wrong, but, I mean, I guess I was in denial...I knew something was wrong because the way I interact with people and the way I went to school, it just didn't feel right at all...I don't feel like myself at all because first of all, like, when I speak to someone or interact with someone, I really feel*

*like they get a sense that something is wrong with me mentally...you know, I felt depressed inside. I felt like I was cheating myself and I wasn't, like..I didn't need something to supplement how could I can possibly feel. And I think that's the biggest factor." (Tony, #10)*

The three respondents mentioned above described situations where mental health issues were not recognized even with formal diagnoses. The lack of insight into their mental health may explain their reluctance to seek treatment. In addition to a lack of insight, the differences in network interactions created several distinct outcomes. For Sarah's (#9) mother, her cultural values and beliefs influenced her belief that she did not have a mental illness. Originally, Huy (#8) was not aware of his depression but his interactions with his network led him to recognize his symptoms and that he was depressed. Similarly, Tony (#10) became aware of his mental health as a result of interactions with his social network. Overall, the social network interactions played a crucial role in creating self-awareness of mental disorders.

### **Views About and Causes of Mental Illness**

Another major theme that emerged from the analysis of the interviews concerned respondents' views and beliefs about the causes of mental illness. The respondents' views about the causes of mental illness can be categorized by two general explanations: a) attributing mental illness to traumatic events or influences outside of their control, and b) attributing the causes of mental illness to spiritual possession or other religious explanations.

*Attributing Mental Illness to Influences Outside of Their Control*

Often the network content, or the beliefs and attitudes of network members, can have a profound impact on how we understand social phenomena (Pescosolido, 1991). For the respondents, attributing mental illness to forces out of their control was a significant subtheme that emerged from the interviews. Mental disorders were believed to be caused by external influences, as three respondents Jackie (#7), Tim (#11), and Miwa (#5) describe.

Jackie (#7), a 1<sup>st</sup> generation Vietnamese-American, describes her belief that her older sister's mental health decline was caused by the pressures of taking care of the family. Jackie (#7) believes external stressors caused her sister's mental disorder. Here, Jackie (#7) explains the causes of her sister's mental illness:

*“With my sister, it's, you know, all the pressure of having to care for us in her younger years has made her this way or, you know, she has marital issues and so I need to be sensitive to that because whatever I say can create, you know, make them argue and make them fight and all these other things. So if there's ever an issue mental health or otherwise or it's always, it's the cause of something external, so it's never viewed as like an issue with one's self, it's something else, and I feel like part of that is a control thing because you can control, they feel they can control external issues but can't, less of control for, like, of course it's not you. You*

*are able to control yourself, it's all these other things that's making you this way, which I think is interesting."*(Jackie, #7)

Similarly, Tim (#11), a 1<sup>st</sup> generation respondent, describes how his family believes his sister's schizophrenia was caused by an event like assault or suffocation. The father believes the schizophrenia is due to the mother yelling at the sister. The limitations of Tim's (#11) father's understanding of the underlying causes of mental illness can be seen below:

*"And it would be more of a cause. A mental issue caused by something. You know, for suffocation when she was much younger or the assault. Something caused it, or born with a genetic problem. Yeah, like, the father, or at least my father just it's that he doesn't want confrontation. Oh, my father thinks that part of my sister's problem is because my mother keep on yelling at her. (Tim, #11)*

Miwa (#5) describes her mother attributing her uncle's behavior to the event of a death in the family. Miwa's (#5) parents believed that the uncle's emotional grief, in addition to drug use and poor affiliations (or network ties), led to the onset on his mental disorder. Miwa (#5) recalls her uncle's situation:

*"..I think she didn't really understand what was happening either because they didn't have Vietnamese translators so they didn't and I was too young to translate for them and I don't think, you know, I was a legal age to look through documents, you know, I, so it was...It seemed like it was after my grandfather passed or my mom*

*seems to believe that that was what started it...I think also when my mom has talked about my uncle or about my sister it's always someone else or something else that has created that. Like it's never an individual's issue. It's like my grandfather's death was what caused my uncle to go the way he went. Or my father and the drugs he introduced to my uncle or kind of being around that bad influence is what caused my uncle to be sick in addition to kind of how kind and vulnerable he is in personality." (Miwa, #5)*

#### *Spiritual Possession and Religious Reasons*

Throughout history, people with symptoms of mental disorders have been described in different ways (Yeh, et al., 2005; Yeh, Hough, McCabe, Lau, & Garland, 2004; Lam, Salkovskis, & Warwick, 2005; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999) and many cultures use spiritualism and religion to make sense of the odd behaviors of individuals who suffer from severe mental disorders (Neblett, Hammond, Seaton, & Townsend, 2010; Choi & Kim, 2010). Five respondents interviewed, Tim (#11), Jackie (#7), Gloria (#2), Sarah (#9), and Truc (#15), used religious and spiritual reasons to describe causes for odd behaviors associated with mental disorders. The first two excerpts below highlight how spiritual factors and luck explain the occurrence of emotional instability. Respondent Tim (#11) describes his mother's explanation for his sister's schizophrenia and respondent Jackie (#7) describes her family practice of visiting a fortune-teller:

*"I think my mom believes that my sister's, my older sister, the 33-year-old one was kind of dealt a bad hand in this lifetime and has thus had to suffer by being the oldest sister and you know, have a bad relationship with her in-laws or you know is emotionally unstable sometimes or doesn't have the best marital relationship. So she thinks that my sister is just not very lucky...I think they were desperate. They couldn't control her through verbal education, through teaching. So they thought it was more of a spiritual problem. Like someone's possessing her. You know, they will believe that more before accepting it was more of a psychological/mental issue." (Tim, #11)*

*"My family, my mom will often see a fortune teller who will say, you know, and she'll share this with us, fortune teller says that [my younger sister sister's] really lucky and blah, blah, blah, blah. Fortune teller says that my oldest sister, was dealt a bad card and so we need to be more sympathetic to her needs, so there's no, I don't think they believe that they are masters of their destiny or my mom, my mom, I don't know about my sisters. I know my mom doesn't feel like she's the master of her destiny, but she certainly tries to make the best of situations."(Jackie, #7)*

The lack of mental health knowledge for Jackie's (#7) family led to the belief that her mother's behavior was the result of spiritual possession. Since spiritual possession was not associated with mental illness, Jackie's (#7) family sought a cure through a spiritual healer. The network content or values and beliefs of the family viewed spiritual possession as the only plausible explanation for their mother's odd behavior:

*"Well, I would say possessed by spirit. Back then, when I don't have any understanding of mental health, if, crazy, possessed by spirit is some form of, is not defined as the mental health behavior. But back then, because we have no knowledge what is mental health, so that's what we thought it was. Just from a personal experience from my mom because she was possessed by (spirits), we thought she was possessed by a spirit and so that's when she got sick...because we were influenced by what we, influenced because when we stayed in Vietnam, we were back in Vietnam, it happened once to our mom, and we, our family invited a, like, what do you call it? Like one of those spirit... spiritual healer into the home to treat her for quite some time, over a month period of time and that's what we thought." (Jackie, #7)*

Below, Gloria (#2) remembers how her family tried to make sense of her mother's behaviors by attributing the mental illness to spiritual possession. She describes her mother's diagnosed bipolar disorder:

*"Yeah, back in Vietnam when my mom was working and then she got sick like this, really sick in bed. She was locked in her room and she would be acting crazy and then...so, you know it did and mental illness is total ignorant...but we had this story where...so we tried to make sense while she was like possessed. And then my mom after she was herself again, she told us that you know because she is a vendor she has to go real early in the morning to buy the good stuff. So, she got up too early more than usually and then she walked through alleys Vietnam, you know like...tight alleys and then she saw this person standing smoking and blow smoke in her face and she asked him why you do this, like stand here and she looked down and the guy was lift like...floating. If you are spoken to by a spirit and you respond that's when they possess you. So everybody think that's why she was acting like crazy. Because we go to the temple on Sunday for activities...they would suggest that I bring our mom to the temple to be cured. See if they can cure her."(Gloria, #2)*

In a different interview, a brief exchange between the respondent, Truc (#15), a respondent with schizophrenia, and her brother, who is translating her responses into English, illustrates the belief that Truc (#15) was spiritually possessed and highlights how influential parents can be in changing Truc's mind about her mental health. They discuss how their father previously thought that an evil spirit possessed Truc (#15):

*“Brother: When dad thought you were (possessed) (inaudible)*

*[speaking Vietnamese].*

*Truc (#15): Yeah.*

*Brother: [Speaking Vietnamese] Do you believe that or no?*

*Truc (#15): No.*

*Brother: You (didn't) believe that.*

*Truc (#15): No, nobody inside of me...Yeah. But (not) no more.*

*[Background conversation]:*

*Brother: Did you think you were or no?*

*Truc (#15): Maybe." (Truc, #15)*

In addition to spiritual possession, some respondents used other aspects of religion to explain and to understand the misfortunes that befell family members. As such, respondent Sarah's (#9) mother attributes her son's bi-polar disorder to a byproduct of “misdeeds” and bad karma that resulted in a build-up of “negative energy”:

*"Now, I won't speak for my father, but my mother thinks that in this life he hasn't kind of compensated for misdeeds or things he's done in his past life. And so because of that there are other negative energies or other negative beings that inhabit him when he has his episodes. They think that because he might be in a negative space and because of his negative energy or low energy vibrations he's attracting these other negative energy vibrations or, you know, spiritual beings. And that more or less that he's possessed, that it's*

*not him when he has episodes. Yeah, she thinks they're different ones. She thinks there are ones that have stayed in him and haven't left yet because he hasn't meditated enough, he hasn't extracted them. And she thinks there are other ones that kind of pass through when he's at certain points in his life."* (Sarah, #9)

From the excerpts above, respondents attributed external influences and spiritual explanations to make sense of the strange behaviors their family members were displaying. For some respondents, they believed that the onset of the behaviors exhibited by their loved ones were caused by external events that negatively affected the family member. Using spiritual possession and external influences to define their family member highlights the prevailing belief systems that they have and actively use. Furthermore, the descriptions also reveal the respondents' use of spirituality and religion as a familiar lens to explain human behavior and points to the limitations of their understandings about mental illness.

### **Conclusion**

In this chapter, the Vietnamese respondents revealed their ways of thinking and shared their beliefs about mental health and mental illness. The transcripts of the Vietnamese-American respondents in the qualitative study provided greater insight into how 1<sup>st</sup> and 2<sup>nd</sup> generation Vietnamese-Americans viewed mental health, their views on the causes or origin of mental illness, and the impact of mental illness on respondents and respondents' families. Consistent with the Social Network Orientation Theory (Tolsdorf, 1976), respondents who have had past experiences in dealing with mental health issues in

Vietnam also informed how they viewed and dealt with mental illness in the United States. In general, the respondents, especially 1<sup>st</sup> generation respondents, indicated a limited understanding of mental illness or the causes of the mental disorders in their families. Respondents frequently attributed mental illness to situations that were out of their control or to spiritual possession or other religious explanations. For older 1<sup>st</sup> generation Vietnamese, the respondents' views on mental health and mental illness emphasized a general lack of knowledge and utilized their own understanding to explain mental health issues. In contrast, 2<sup>nd</sup> generation Vietnamese were more aware of Western definitions but were also influenced by the traditional views of their parents. Overall, differences the views of 1<sup>st</sup> and 2<sup>nd</sup> generation Vietnamese-Americans highlighted in this chapter illustrate the difficulty faced by Vietnamese-Americans in accessing and using any mental health services. This topic is the focus of the next chapter.

## **CHAPTER 9: VIETNAMESE-AMERICANS' USE OF ANY MENTAL HEALTH SERVICES**

As Chapter 7 and 8 illustrate, the effects of mental disorders on Vietnamese Americans was debilitating and often placed a tremendous burden on family and friends. The experiences of the Vietnamese-Americans in this study highlight the complex challenges in caring for loved ones suffering from mental disorders. The Network-Episode Model and Social Network Orientation Theory support hypotheses that health care decisions towards or away from any service providers are at least partly the result of an individual's values and beliefs interacting with his/her social network structure (Pescosolido, 1991; 1992) and from past experiences that shape these beliefs (Tolsdorf, 1976). This chapter examines possible explanations for Vietnamese-Americans' decision to use or not use any mental health services. Specifically, this chapter presents five themes findings stemming from the qualitative interviews: 1) the traditional hierarchical structure of Vietnamese-American families limits utilization of mental health services; 2) belief in traditional spiritual solutions to mental illness limits access and use of any mental health services; 3) strong cultural beliefs in self-sufficiency limits Vietnamese-Americans from seeking any mental health services; 4) limited social support among Vietnamese-Americans negatively influenced knowledge or and access to any mental health services; and 5) any mental health service use by Vietnamese-Americans was influenced by positive or negative orientations to social networks. A summary review of

all respondents' pathways or help-seeking behavior in response to serious mental illness in themselves or their families is also presented.

### **Impact of Family Structure on Mental Health Service Use**

Family members are usually the first line of social support for those with serious mental illness, and play key roles in their help-seeking process (Clark, 2001; Lu & Argyle, 1992; Thoits, 2011). However, there may be limitations to family support as Vietnamese respondents have reported that parents were reluctant to receive support provided by their children. The presence of a hierarchical family structure where children are expected to obey and take care of parents (Gilbert, Gilbert, & Sanghera, 2004), compounded by having ideological differences between different generations (Sonuga-Barke & Mistry, 2000) complicates the family's help-seeking process in using mental health services. For the respondents, the family hierarchy structure restricts the flow of influence directionally from the oldest to the youngest and seldom allows the youngest to influence the oldest. Consequently, younger Vietnamese-American respondents who have older family members suffering from mental disorders encounter resistance when suggesting that their elders seek mental health services. Below, respondents describe the hierarchical family structures that impact service utilization and the burnout and burden they faced while dealing with the mental health needs of their family members.

#### *Family Hierarchy and Treatment*

Three 2<sup>nd</sup> generation respondents, Jennifer (#12), Esther (#3), and Huy (#8) reported difficulties utilizing mental health services due to family dynamics and

hierarchical family structures. For these respondents, the traditional matriarchal family structure and the cultural beliefs that children should obey their parents meant that decision-making authority resides with the matriarch and is progressively reduced to the youngest in the family. The youngest child often lacks influence and power as he/she is expected to obey the elders. Moreover, families in which the parents have betrayed the trust of younger family members, such as by being abusive, often created an obstacle to treatment as is seen in Huy (#8). These hierarchal family dynamics in Vietnamese households create a pattern that “pulls” away from any treatment pathways, particularly for families with elders who suffers from a mental disorder and for individuals with dysfunctional families.

Jennifer’s (#12) mother, who suffers from bi-polar disorder and is severely depressed, is the matriarch of the family. In the excerpt below, Jennifer (#12) describes the family hierarchy and her lack of power as the youngest in the family:

*"..I think there's also a family hierarchy, and I'm on the very bottom of that totem pole being the youngest, so it's very much like who am I as the youngest to say this about my older siblings and my family. So there's a cultural, there's cultural expectations of what is appropriate and what, in terms of behavior that's, you know, coming from the youngest of the youngest." (Jennifer, #12)*

Jennifer (#12) describes how her mother will not take advice from the children to seek professional mental help. Jennifer (#12) also describes how difficult it is to

encourage her mother to seek mental health services. The resistance and tension caused by the family hierarchy is described:

*"But she doesn't even take it from my sister. I mean, she'll listen to my sister at least, but she won't accept the fact. And I've even said it to her, like, 'Mom, have you considered maybe you're depressed and maybe you're bipolar?' And she'll explode. She'll say, 'No, I don't need to go to the doctor. You need to go to the doctor. You need to see somebody. It's not me, it's you.'...I think even as adults now, we all still fear her a lot. I mean, I don't fear her at all, obviously, 'cause I fight with her all the time. But my brothers and sisters definitely fear her...It's always a blowout and that's why I'm considered the black sheep in my family because my brothers and sisters, they shut their mouths. They don't say anything. They don't talk back. But me on the other hand, I'll say it to her, like, 'No, you can't do this. It's not okay.' And I'll tell her and I always get in a fight. And my mom calls me 'hong' a lot. It means you're bad or disrespectful, like, rude. She calls me that a lot. She says I have a smart mouth. I am her punishment for anything she's done bad in life. She says a lot of messed up stuff like that, which I have to learn to laugh at now. It's definitely just a total disrespect. My dad is kind of that way too. If you're to challenge their views, you're definitely seen as a disrespectful person. Even if you try to approach it in the*

*kindest way, it's still a no-go, My sister would say, 'this is why mom is always so mad at you because you don't know when to shut up.' But I can't help myself. It's so weird...She's like the head honcho. If something's wrong with her, everybody disperses."* (Jennifer, #12)

Because of the family hierarchy, it is difficult for the children to assist their mother and get her the help that she needs. The rigid structure of the family creates a restrictive pathway to service utilization. Jennifer (#12) describes asking her older siblings for assistance in getting her mother to seek therapy because she has no voice as the youngest:

*"I mean, my oldest sister tries to help me sometimes. She tries to mention it because she knows my mom will at least listen and hear her out. But that's as far as it goes. Like, "Mom, maybe you should go see a doctor. I think maybe you should schedule an appointment with the therapist. She'll say stuff like that and my mom will say, 'Yeah, I thought about it.' But she won't do anything about it. I feel like someone needs to grab her by the wrist, put her in the car, click the seat belt and then take her. And the only person who can do that is me because I'm the only one who's here. My dad is definitely not doing it. But I don't have that power. I can't do that by myself. So other people have mentioned it to her. I mean, just my older sister and me, but my other brother and sister, they just say, 'Oh, mom is that way.' And I've even fought with them saying,*

*like, 'How could you say that? How can you just accept this? How are you just gonna live with this?' And they (her siblings) just say they can't. They just basically say, 'We can't make her. We can't handcuff her and throw her into a car.' I don't know what would happen, but they make it seem like it would be the worst thing. There's no way we could just have an intervention and be, like, 'Mom, get in the car. We're taking you to see someone now.' There's no way. We would be disowned. I mean, I've been disowned a lot. I know she doesn't mean it, but I think that would be...there's no way.'*(Jennifer, #12)

Having differences in opinions and a lack of consensus about how to get help for her mother, Jennifer (#12) describes feelings of frustration and powerlessness as she is unable to garner family support to get her mother the help she needs. Moreover, the lack of power within the family hierarchy further marginalizes her and what she has to say about her mother's mental illness. The network structure of the family limits all of Jennifer's (#12) siblings, much like a gatekeeper, to the extent that they are incapable of addressing their mom's mental health need. Jennifer (#12) elaborates:

*"We're just all mini punching bags and we just take it and they just say, 'This is how mom is. This is how we deal with it. This is how she's been dealing with it.' You can't teach an old dog new tricks. That's how I feel like it is. There's no recognizing. And, I mean, I wanna do something so bad, like, all these years. I've just*

wanted to say, 'Get in my car. We're going to the doctor now.' But it's just, like, I'm very powerless because in the hierarchy of family, I'm the last child and I don't really have a whole lot of power of say. And so anything I would do would be seen as disrespectful. It would really be seen like the worst thing ever if it were me. But I can't really get my other brothers and sisters to be on my side because they live so far and they don't necessarily have the same views as me. I can't even mention it. I can't even think about how I would say, 'We're gonna do this.' I don't think I would get any of their support. And so when they see my mom, it's normal for them too. They're, like, 'Oh, this is just the way she is. This is the way we are.' So when something happens, my mom doesn't really tell them or I'm not allowed to tell them because I would be seen as disrespectful. I would really be seen as, 'How could you go behind my back and tell my sister that I did this? How dare you.' ...And so when I see my mom and I try to be that way, I realize in her eyes, I don't have any power." (Jennifer, #12)

Within this type of family hierarchy, the primary expectation of 1<sup>st</sup> generation Vietnamese parents is for the young to obey and take care of the old. However, 2<sup>nd</sup> generation children often do not hold the same beliefs about familial responsibility as their elders do. These differences in cultural expectations often precipitates interpersonal

conflict, which can undermine the family's ability to access needed support. For example, Esther (#3) describes her views and how these lead to conflict with her mother:

*"She's (the mother) the person that brings out the worst in me. And when I lose it, it's usually when I'm with her. Just the way she reacts to things or the way she talks to us or the way she asks for things. It's just very stressful. It's that mentality of, 'You're my kid. You need to support me. I've (grown you), I've nurtured you all my life. Now it's your time to repay. So when I want something, I want it now. It gets done now.' That's her mentality of things. Like, 'I want this. Go do it for me now. I need to get my meds. Go get them for me now.' It's just her and her agenda. I love my mom, but this is why there's so many problems because we all have an individualized...and it gets to the point where we try to be in their lives and support them as well. And it gets to the point where she doesn't consider other things that go on."(Esther, #3)*

Esther (#3)'s older sister was hospitalized for attempted suicide. The older sister, in contrast to Esther (#3), believed it was her duty to move back home in order to take care of her parents and fulfill her role within the family hierarchy, resulting in her prematurely leaving treatment. This example illustrates how family duty can shorten the length of mental health treatment as the respondent describes below:

*"All that, through that whole week, I don't think my family saw her until she went back home. And even when she returned home, it*

*was, like...I talked about different options for her so she wouldn't have to be home. And we were saying, like, maybe she should move out and live somewhere else for a while or come live with me and just be away from all the drama until she was stable enough to come home, because it was part of what triggered it. And so she said, 'No, no, no' So she actually went home. She's, like, 'I wanna make sure that somebody takes care of our parents. You know, like, somebody's there for them.' And she was, like, 'I don't want mom and dad to feel guilty or any of that.' So she actually returned home after that week."(Esther, #3)*

The structure of a family and the roles within its established hierarchy can complicate interpersonal relationships, especially when help-seeking decisions are involved. For the Vietnamese-American respondents above, their birth order and status within the family hierarchy prevented them from convincing their older family members to seek mental health treatment. Consequently, the family dynamics within Vietnamese households complicates the help-seeking process for older Vietnamese-Americans since the beliefs and opinions of younger members of the households are not respected. The adherence to hierarchies restricts the direction in which information and support flows within the family. Some younger respondents felt it was their duty to take care of their family despite struggling with their own mental health issues. Overall, family values and beliefs and the hierarchy embedded within these social networks 'pushed' and 'pulled' consumers towards and away from any mental health services and complicated the help-

seeking process for the respondents. It is the values and beliefs within the family's support network that influences the decisions whether to seek medical care (Pescosolido, Wright, Alegria, & Vera, 1998).

In contrast, Miwa (#5), a 2<sup>nd</sup> generation Vietnamese-American, describes how she avoided the burden of taking care of her sister who was suffering from post-partum depression. Miwa's family expectations and filial responsibilities required her to live at home take care of family. However, she did not want to adhere to those cultural restrictions and decided to leave. As a result of the disobedience, Miwa's (#5) family reacted with great disappointment and severed family ties. She recalls actively abandoning her familial duties:

*"When the first time that it happened she was living in her, she was living with her in-laws and so I didn't really have relationships or trust people there to watch her but now that she lives with my other sister and my mom, like they could help watch her, but I think that's a part of why my mom was really, my mom and sisters were really angry with me for leaving because I, that was an action of I don't want responsibility for what happens here, like I feel like they and I think part of it was myself, I'm not, I don't want to, I don't want to live with crazy. I'm not, not calling anyone crazy but like crazy atmosphere, but when I decided to leave I think my entire family felt that I was forgoing part of my familial responsibility to take care of each other, but I think now if she had postpartum she*

*lives with her husband, well, um, I wouldn't count on him. She lives with my sister and my mom who have and will take care of her."*

(Miwa, #5)

The level of commitment family members have for each other changes depending on what values and traditions individuals hold. In Gloria (#2), Jackie (#7), and Miwa's (#5) cases, the effects of mental illness reduced social support for the individual suffering from mental illness because of conflicting expectations in filial duties that exacerbated interpersonal family relationships. Even though mentally ill parents who used health services may have benefited from hospitalization treatment, their extended absence negatively affected the children by causing sustained burden on the family.

### **'Spiritual' Pathways to Treatment of Mental Illness**

Buddhism and the spiritual realm has been a strong part of Vietnamese culture, and respondents Jackie (#7), Sarah (#9), Tim (#11), Gloria (#2), and Sammy (#13) identify with its practices. The themes that emerged from their interviews reflect the heritage of spirituality in the lives of the Vietnamese-Americans. Although their spirituality 'pulls' the respondents and their families away from utilizing any health and mental health services, it does function as a solution that attempts to address the mental health need. In the following accounts below, respondents describe utilizing spiritual means to treat themselves and/or family members with mental disorders.

Jackie (#7), a 1<sup>st</sup> generation respondent, remembers how when still in Vietnam, her mother's mental health declined slowly unbeknownst to the immediate family. As children, the Jackie (#7) and her siblings paid little attention to their mother and it wasn't

until their mother was perceived to be a danger to her children that the extended family sought help from a spiritual medium in Vietnam for treatment. Jackie describes the situation below:

*"It was gradually, it was gradual. Actually, but because we so young, so, no, she's acting weird sometime. We don't really pay attention...And that's how, that's when we realized that she was really sick and then she was locked up in a different room in the house and then my aunts look for, you know, the exorcist to come home and help her...Yeah. Back, he wasn't a monk, but he had some kind of spiritual, like one of those, I don't know what you call this person who can really know how to get rid of the spirit into your body, (Like an exorcist) Something like that, similar... I think you could call him an exorcist. Yeah, because it's very similar. When she got sick in Vietnam she didn't know who we are, who we were at that time. At the time she doesn't even remember that she has three kids. She doesn't even, she didn't even knew that we exist. And then she was locked up in a private room where no one, like I told you earlier, no one can really enter the room except this, that person, exorcist or like my aunt (inaudible) deliver (inaudible). She, she seems dangerous at the time because she's, her mind wasn't really...So we invited, this time we invite monks and nuns, you know, Buddhists and monks and came over, tried to help or see*

*if they can, you know, talk to, cultivate the spirit so that they don't have, you know, whoever it is in her body don't have the control over her but then somehow it didn't help her at all. But I don't know, was, she was possessed by spirit back then or was it what, like a depression or bipolar as well, so, but then she got treated with herbals and medications and all that and custom spiritual. I don't know."*(Jackie, #7)

As many Asian cultures utilize spiritual means to treat mental disorders (Abe-Kim, et al., 2007; Choi & Kim, 2010), Jackie (#7) tells a harrowing story about when they were still living in Vietnam of how her mother chased her and her siblings around the house with a knife thinking that they were little pigs. The severity of the condition outweighed the resources of the network system to respond to it adequately (Pescosolido, Wright, Alegria, & Vera, 1998) and, faced with physical harm, forced the family to get help. Jackie (#7) recalls:

*"So my oldest (sister) is the pig (Chinese Zodiac sign). So she say, and she thought that three of us are three pigs. That's, I don't know how she, she saw it the way, I don't know what's in her mind, but that's. We weren't her kids at the time. She locks us in a room and chases us with a knife. She wanted to kill us. We were so scared. And then she, my sister, my oldest got caught. She got, she catch my sister and cut her hand with a knife and she was crying. She has a scar on her palm. And luckily my aunt somehow came home*

*and unlocked the door and we were released. And that's how, that's when we realized that she was really sick and then she was locked up in a different room in the house and then my aunts look for, you know, the exorcist to come home and help her."*(Jackie, #7)

Jackie (#7) continues to describe her family's reliance on spiritual means in order to improve the mother's well being. The viewed the mother's treatment as not just specifically for her as it is in Western medicine, but instead includes the whole family engaging in dietary restrictions. Family actions such as adhering to a specific diet for the whole family are believed to impact the mother's mental health. Below, Jackie (#7) describes improving the family karma by not eating meat:

*"I pray as well and you, you, what I did was you don't eat and you become a monk, become like a, like monks but you don't eat meat, become a vegan for a short period of time so you sometime, it's like it repays, you know. I pray that if I don't kill, I don't eat meat, and just that's when I pray to (inaudible), you know, my mom would get well."*(Jackie, #7)

The "bounded rationality" (Pescosolido, Wright, Alegria, & Vera, 1998) created by religious beliefs "pushed" the family's treatment pathway towards spiritual means. Jackie (#7) explains other spiritual treatments used to heal the mother's bi-polar disorder including burning spiritual talismans and incorporating it into a medicinal drink for her

mother to consume. This treatment pathway is attributed to Jackie's (#7) religious beliefs, understanding of Vietnamese culture, and influence of Vietnamese media:

*"We read and we, my god, it's, looking back now I don't know how, there's a cure but not, but we burn, it's not incense but when you burn one of those? I don't know what you call it. And they write some kind of...(talisman charm) Yeah, something like that...something and you burn it...you put it in water and you drink it... That's was we did to our mom. Cause we don't know anything else. We think, you know, that's what we, we, you know, we saw on TV and we heard about it and you saw the exorcist (monks) in Vietnam did it the same way. Did it work? No. She drink a lot of ashes."(Jackie, #7)*

Relocating to the United States did not change Jackie (#7) and her family's perception of what caused their mother's odd behavior, which was known to the family at the time as spiritual possession. They sought help from Buddhist monks and nuns based in the United States, but they were of little help. Jackie (#7) did not know what else to do, so she allowed her mother to continue in her state of illness. When Jackie (#7) could no longer control her mother's behaviors, she called the police to intervene:

*"...and again she (mom) got sick, and we didn't know why. We thought, oh my god, she got sick again with the same stuff. So we invited, this time we invite monks and nuns, you know, Buddhists and monks and came over, tried to help or see if they can, you*

*know, talk to, cultivate the spirit so that they don't have, you know, whoever it is in her body don't have the control over her but then somehow it didn't help her at all. So we kind of left alone. We didn't know what to do, and she became out of control, and she left, she would leave the house in the middle of the night and wander on the street. We don't even know where she went, and a few hours later she would turn home and then she talked to herself. She talked to herself in different language. I don't know what she was saying. Something like French or something, but she never knew that part of the language herself. And she did weird stuff. So at one point I, Gloria was away in college and I was a senior so I couldn't control her anymore and eventually I call Gloria to come home, and we end up calling the police. And they brought her to the hospital, and she was there for over a year, and then finally that's how we knew it wasn't, she wasn't possessed by this, a spirit at all, but she has some kind of form of disorder called bipolar and depression.” (Jackie, #7)*

Jackie (#7) recalls telling the doctor about spiritual possession. She also recalls how surprised she was to learn that Western medicine provides an alternative method of treatment:

*"You know when we came into the hospital, we told the doctor that, I think we think that she possessed by the spirit. They say 'no, no,*

*there's no such thing as possessed by spirit.' I said 'no, she, she, I think we did. I think she did got possessed because it happened in Vietnam too.' And you know as an American, a Western doctor they don't believe in those kind of stuff but to us, we think she, she was...We were, because we, at that time kind of relief because there's no medicine for spiritual possess but there's western medicine for this kind of thing but it gonna take time, and we know that she's going to be safe because she's been locked up in an institution."*(Jackie, #7)

The relocation to the United States and having accessed the mental health care system did not change much of the family's network content, or values and beliefs about the root causes of mental illness. Although the family was not skeptical of the any mental health system, they were mostly unaware of the resources available until the mental health needs of the mother became so severe that it overtaxed family resources (Pescosolido, Wright, Alegria, & Vera, 1998). Consequently, the family sought the help of the police to intervene and bring Jackie's (#7) mother to the hospital on many occasions. Jackie's (#7) mother who did not understand why she was being taken to the hospital was mostly resistant to the many attempts the family made. In the excerpt below, Jackie (#7) describes not being able to control her mother during subsequent episodes of her bipolar disorder and recalls how tough it was for her:

*"It's very tough every time she gets sick we have to make the decision of my brother come, here he comes again. We have to call*

*the police. We have to call the, we have to call the (inaudible) team to come down to evaluate her and usually you have to bring your, the sick person into the hospital, especially being seen for an evaluation. It's necessary with the best (inaudible) she located. And usually we ask them if they can come to the house and they would, and they do an evaluation and they assess her and then we call the ambulance and take her to the hospital. Sometimes it's during the daytime, sometimes it's in the middle of the night. And we ask the, you know, the ambulance company not to turn on the siren because that would, if she hear it, she knew, she know that she going to go to the hospital, so we ask them not to turn on the siren. Yeah. And the police would come and usually my sister work at the (inaudible) at the Boston Police so she would make a phone call or I would and then they knew who we were and they come and they kind of talk to her because she wouldn't believe and she hated us. When she got sick she really hated us for doing that, you know, calling the ambulance, they would bring her to the hospital. So that we take, we let the law enforcement, the police come and talk to her...One time, they had to sedate her because she wouldn't comply, she'd fight back. She fought back." (Jackie, #7)*

Another respondent, Sarah (#9), has a brother who has bi-polar disorder. Her parents believed his ailments were due to evil spirits possessing him, and she describes her family's need to expel the evil spirit:

*"When they think that it's within his control or speaks of these spiritual beings, they take it personally because they believe that they can do more to expel it, or he can do this meditation or whatever it is to expel it."*(Sarah, #9)

Sarah's (#9) family also believed in destiny and fate as a determining factor for her brother's mental health. The family's position about what caused the onset of the brother's illness is described below:

*"But before it was just, 'You ask the gods. It's out of your hands.'...It just aligns more closely with their (my parents') cultural beliefs...I spent a lot of time trying to figure out how much they believe in self-determination versus fate and destiny. And I think that they err on the side of destiny and nature, instead of nurture...I don't know why but that understanding of it being beyond their control is more despairing than it is, 'Well, this is just something in his wiring. And it's who he is so we'll just, you know, deal with him and be supportive.'"*(Sarah, #9)

As a last resort, Sarah (#9) talks about the types of spiritual treatments her parents sought for their son. She describes how her parents sought help from spiritual leaders to exercise the negative energies from her brother:

*"I remember for my mother they had some older friends who were considered spiritual mediums and, you know, she's gone to Vietnam for treatment too and gone to a spiritual medium to extract what she believes were these spiritual entities that caused her to have these periods or felt that way. And my mother's very religious so she would pray. But for my brother, they'd go to this meditation school and they practice meditation. And it's a mix of mediation and (Reiki) so they really believe in positive and negative energy, low and high vibrations and that when you are not well it means that your vibrational energy is really low...They have tried to take him to this school and he's been resistant, so they've tried to do treatment at home where they would have him sit for half an hour or 45 minutes and try to channel positive energy to push that negative energy..I think that was their last resort; seeking help from spiritual elders. Because they felt like that they really couldn't do anything more."(Sarah, #9)*

Overall, Sarah (#9) also indicate that her parents' tendency to rely on spiritual methods of dispelling negative energies. She said:

*"I visited a village in Vietnam and I visited some temples and a lot of people would go and ask spiritual elders and the Gods for help... I think that was always, yeah, a primary outlet. At least in my family that would be the case."(Sarah, #9)*

For another 1<sup>st</sup> generation respondent, Tim (#11) recalls how his family was reluctant to take his schizophrenic sister to see a medical professional. He remembers when his sister started to exhibit symptoms but his parents decided to seek a spiritual healer in place of a medical doctor. Tim (#11) recalls:

*"No. In the beginning they never wanted to, don't go to the doctor. And they even went to one of those spiritual people..A healer, trying to find out her problem and yeah, they went to that. But they didn't went to the doctor, no counseling...Yeah, she went to this lady who, this medium to channel some God in the other world and just tried that and they tried to sell amulets...yeah, they bought it, bought into that. They believe that more than mental health, more than even seeing a doctor..I think they were desperate. They couldn't control her through verbal education, through teaching. So they thought it was more of a spiritual problem."(Tim, #11)*

Seeking spiritual services was not only specific to the United States as spiritual services were sought even in Vietnam. Gloria (#2) remembers the time when her mother sought spiritual help in from a Buddhist temple in place of any mental health services as she describes below:

*"So, I think that it play a lot much stress because my mom is a very spiritual person. She would go to the temple. That's where we seek refuge, where we seek advice and support, in the temple, the female monks or man monks that would give us food and you know*

*we would go and we would pray and it's just like calling it therapy you know. It's just spiritual for my mom. She is close to very you could say like a spiritual person and into Buddhism.”(Gloria, #2)*

To help her mother, Gloria (#2) sought advice from neighbors and sought spiritual guidance from Buddhist monks. Gloria (#2) recalls where she gets the majority of her support:

*"We would mostly seek guidance from the temple, you know from other adults, our neighbors. Ask them like you know how we can...We tried to figure it out, you know what is the solution to you know why my mom's acting the way she's acting." (Gloria, #2)*

Sammy (#13), who struggles with depression, remembers how her family prayed to their ancestors and turned to religious help. Sammy describes the use of prayer, holy water, and changes in diet to treat her depression:

*“But the things that my family usually does is like every year they'll, like, pray to our ancestors, like from New Year and then, but it's it a little confusing because, like, when I was going through depression, I also, like, prayed. I think, okay, so like my mom's faith and, like, religious views, they're really ambiguous, is like I really don't know what to categorize her as. But, like, one of my aunts is a Catholic and so she encouraged my mom to like, pray, to like Mary and like, I don't know. But she did, and like gave me, like, certain fruits to eat so I would be healthy again, like, she even,*

*yeah. yeah...I don't even want to go into this, but she even made me, my mom and my aunt made me like this at church to like get like, what do you call it? Like holy water or something to like wash my hands with and my face with. I was just like, this is ridiculous. So, yeah, I guess that's all of it, but in general, like, they're praying to their ancestors and then occasionally my mom will like pray to God in general about whatever, for everything."(Sammy, #13)*

For Jackie (#7), Sarah (#9), Gloria (#2), and Sammy (#13), spiritual beliefs dominated pathways to treatment. Despite the treatment being religious and informal, it signifies the importance spirituality plays in the lives of the respondent and their families. The significance of seeking spiritual solutions to treat mental health issues highlights the heavy reliance on religion among the Vietnamese respondents and captures the ‘push’ towards spiritual pathways to treatment while it ‘pulls’ from formal health care pathways. In the next section, respondents describe pathways to any mental health service use.

### **Belief in Self-Sufficiency**

A third theme related to mental health utilization that emerged from the qualitative study is the respondents’ strong belief in taking care of personal problems, especially among 1<sup>st</sup> generation respondents. Three respondents, Sarah (#9), Tim (#11), and Tony (#10) described an almost unshakeable belief of self-sufficiency when dealing with mental illness or any problem. Sarah (#9) describes her parents’ belief that her brother can overcome his illness by “trying harder” and “meditating” more. These views differed from Sarah (#9) and her brother’s views. The failed attempts at communicating

with the parents about the benefits of psychotherapy resulted in the parents' disapproval of seeking help and the brother feeling unsupported. Sarah (#9) describes:

*"Whereas (my parents) are more fearful and certainly I think psychotherapy sessions have helped (my brother). But they don't share that understanding. (My parents) don't really believe in psychotherapy, particularly speaking to a stranger. They also believe that he can cure himself if he just tries hard enough and do an alternative therapy, like, meditation. And they have, I think, specific spiritual beliefs about (my brother's) illness that I don't share...And it's embarrassing for him too because he's trying to talk to them about communication or therapy sessions and they don't really seem to have a grasp of what that is.*

(Sarah, #9)

The brother's inability to communicate with his parents restricted network interactions within the family. Subsequently, the parents did not understand the purpose of seeking professional help and Sarah's (#9) brother experienced a lack of support. The parents' belief that their son could recover on his own efforts and the brother's inability to communicate with his parents about the necessity of mental health treatment prevented the brother from consulting with his parents. This is consistent with the NEM, which stipulates, health care decisions are made within the context of interpersonal interactions (Pescosolido, 1991; 1992). Sarah's (#9) brother was limited in the interactions with his parents that resulted in a restricted pathway to care. Sarah (#9) recalls:

*"Because they really, I think it makes him feel like they view his illness as something that he can control or something that he could expel but*

*he's just not willing to do it. So I think he feels like he doesn't have as much of a support. So he's constantly struggling between feeling included and feeling excluded...So for him it's also very stressful because he doesn't know how to relay his illness to them."* (Sarah, #9)

In addition to Sarah's (#9) brother, other respondents also had family members that expected greater effort on the part of the mentally ill to overcome their sickness. Continuing with the theme of self-sufficiency, respondent Tim (#11) explains how his family attributes his sister's schizophrenia to her lack of effort and laziness to change her situation ("kuhh" is translated in English to "lazy"):

*"Oh, we call her, 'She's sick.' You know, well, my mom always thought she was lazy or just 'Kuhh'"* (Tim, #11)

For another respondent, Tony (#10), his belief in having agency over his mental illness was very much in line with his parent's views. As past experiences shape and reinforce values and beliefs (Tolsdorf, 1976), Tony (#10) believes his current mental health was influenced by his experiences in high school. He recalls feeling personally responsible for his mental health, believing it was something he had full control over:

*"I mean, whatever came about as far as mental illness, I (wasn't) ready to accept because I felt I went through it all in high school. I was the one responsible for depression and I thought it had nothing to do with other people. I knew it was on me. I mean, I knew that I (could) change if I wanted to. I mean, this is something that I brought upon myself.* (Tony, #10)

Even though Tony (#10) believes his views about mental health are different from his parent's views, they are actually similar. Tony (#10) and his parents share the same belief that he is able to control the development of his mental illness. The family believed Tony (#10) created his mental illness and it was not a serious problem that needed to be addressed. When asked what were the differences in viewpoints between him and his parents he said:

*"I think it's a generation gap when it comes to understanding my parents' views compared to mine. I mean, their perspective on mental illness is nothing because the way that they grew up in their homeland, which is...the illnesses that they see over there is more tragic as, like, leprosy. Mental illness to them is more like something that isn't too extreme and it's kind of, like, the way I would describe my parents seeing my illness is sort of, like, just something that I have to be...I can take care of it on my own...But, I mean, I have to be responsible. It's not something that they think is terrible. I mean, they think I can live a normal life and everything."*(Tony, #10)

In addition to sharing similar perspectives on being in control of his mental health, Tony's (#10) parents also discouraged seeking mental health services as they thought it was unnecessary and costly. Below, Tony (#10) describes how his parents viewed seeking help:

*"They don't think there's anything quite to the extreme about it...they didn't agree that I should go to a psychiatrist because they thought, I mean, psychiatrists, all they do is just talk to you. So we were kind of,*

*like, low income so they thought that was just a waste of time and a waste of money to go to a psychiatrist. And I agreed too, because I thought the first time I met a psychiatrist and the way we were conversing, it just didn't seem like I got anything out of it. I mean, I (couldn't) speak to my friends the same way. And so we just backed out of it after the one or two meetings."* (Tony, #10)

The belief that an individual is able to recover on his or her own helped create a disconnection between parents and their 2<sup>nd</sup> generation children. Specifically, the 1<sup>st</sup> generation views about the lack of efficacy of any mental health services at times conflicted with 2<sup>nd</sup> generation respondents such as Sarah (#9) and her brother. In contrast, others such as Tony (#10) and Tim (#11) shared similar views with their parents. Overall, the perception that self-sufficiency or being able to personally address mental illness varied as it was dependent upon the respondents' relationship with their parents. In the following section the relationship between social support and its impact on help-seeking behaviors will be explored further.

### **The Influence of Limited Social Network Support**

Although normal family ties are typically close, and involve frequent contacts with family members at great distances (McPherson, Smith-Lovin, & Cook, 2001), the migration to the United States forced many Vietnamese refugees to leave family and friends behind without any hope of seeing them again. Gloria (#2), a 1<sup>st</sup> generation respondent, recalls when she left with her family during the first two waves of the Vietnamese migration. She said:

*"In the beginning, yea. It was much harder to...you know when we left we didn't think we can go back and visit...and see it was also back then it was very hard, we don't, we thought we never see them again, that we were unable to communicate with them through a phone call...very fortunate. I been thinking if we, if we didn't come here, I don't think we'd have a future..."(Gloria, #2)*

As a result of her limited family network, Gloria (#2) also recalls how her family utilized spiritual support and describes the primary reliance on Buddhist monks in dealing with her mother's undiagnosed mental disorder in Vietnam. The absence of relatives in the United States and family's religious beliefs guided Gloria (#2) and her family towards a U.S. based Buddhist temple and extended friends in order to find a solution for her mother's mental illness. Gloria (#2) recalls:

*"Yea, so we were teenagers when we go to the Buddhist youth program. I think that's also one of the biggest support systems for my family...but in like the Buddhist youth program we would consult with the Buddhas through the monk...because we didn't have anyone. We didn't have any other relatives...We would mostly seek guidance from the temple, you know from other adults, our neighbors. Ask them like you know how we can...We tried to figure it out, you know what is the solution to you know why my mom's acting the way she's acting."(Gloria, #2)*

Some respondents resorted to self care by attempting to solve their problems. Miwa (#5) explains how her uncle, who has an undiagnosed mental disorder, lacks understanding about his own illness. He attempts to address his problems by talking to Miwa's (#5) older sister who suffers from depression. Miwa (#5) describes the uncle's pathway to care below:

*"Well they turn to each other for help and it drives me crazy because they don't know any better. They just, they're so similar that they're just feeding each other's, they're just agreeing with each other so it's, it drives me crazy because they don't know what they're talking about because they don't know."(Miwa, #5)*

Miwa (#5), who also was not aware of available mental health services and could not consult with her parents because of their lack of understanding, sent her older sister to the emergency room when she tried to commit suicide. She recalls below:

*"I just didn't know what, how, like what type of help or how to get her that help, so I took her to the emergency room and that was where they had a bed, but I think I felt really guilty for doing that because it was probably an inappropriate response from me but I was young, I was 23 and didn't really know how to help her but I feel like since then I think she feels that people think that she's crazy because of that experience...I think I was scared for her, and I really believed that she needed help. I just did not know, like, who, I mean I think now I probably would have found a counselor for*

*her to call someone the next day...Yeah, but I, she, I mean her reaction was she was a bit hysterical and I just was, I did not know if she, if harm was going to happen to my, my niece or nephew and so I reacted strongly. And I think I still feel guilty for that."(Miwa, #5)*

In retrospect, Miwa (#5) felt her response to send her sister to the emergency room was an over-reaction but because her knowledge of the mental health system was limited, sending her sister to the hospital was the only course of action she could think of. Despite her feelings of overreacting, Miwa's (#5) lack of understanding about available mental health services ultimately 'pushed' her sister into a formal pathway of care. She indicates:

*"Then I was like, oh my gosh, she's not, she's not crazy. She's not, you know, I think, I mean there probably could have been a better place that they could have found for her but I don't know, I don't know how the system works when you go to an ER and like what happens where they filter people or how they, like, I just, I don't know, but I felt like I, I was responsible for bringing her there in this place that she did not belong."(Miwa, #5)*

For a different respondent, the relocation to the United States isolated Jackie's (#7) family from their main source of support, such as extended family and neighbors. Since there was no extended network to consult with during Jackie's mother's illness episode, the family had no other option but to resort to utilizing any mental health

services. Despite not having anyone to rely on for support, Jackie's (#7) family utilized social services and the health care network for support, which became the pathway to care. She recalls:

*"No choice. We had no choice. Just went along with them (doctors). And then at that time we were referred by, to the social service department for help. Back then I don't think because they know a lot about Vietnamese culture and there's no, we, they don't have Vietnamese social worker back then, not too many to my understanding...To be honest with you, even though the Vietnamese community is extending and there's more knowledge about mental health issue, but there's not much a support. I think they don't have groups...It's very lack, there's a lack of understanding and lack support...we rely on each other so much but if, if there is some form of like a family support or like a group for family member to just to talk about, you know, if you have a family member and mom, some kind of a form, a group talk then I think I would participate just to share, you know, some of the issue or share some of my experience so that among others can have a better understanding of the illness itself. But I don't think we have much of that. I mean there is, at (inaudible) I know they have like, they have a group for the patient of the clinic, but I don't think they have outside of that."*(Jackie, #7)

Jackie (#7) further adds how her immediate family, in particular her sister Gloria (#2), was her only source of family support in dealing with the mother's bi-polar disorder. She also recalls how some of her neighbors in the United States was helpful during that time:

*"...We don't have a lot of support because back then there's, we don't know any, like social services. We don't have any Vietnamese or like community, really none. It's just pretty much on our own. And we kind of deal with whatever doctors telling us back then...It was a very difficult time. When you don't have any support. We just have each other. It's just me and Gloria. We have much (inaudible). And the girls were really young. They were only four and five years old. We, but thank, you know, thank God that we had a good neighbor. She was our landlord as well, and her kids went to the same school as our siblings. So she helped us out in the morning to take the girls to school and then pick them up, and then after I get home from school I pretty much take care of the girls and cooking for them and bring food to my mom...Gloria and I are very close, We're like twins. We have almost the same thinking. And so I, Gloria go to me or I go to her and pretty much we have each other. Otherwise I don't go to anybody else...That's my support...that's my network..."(Jackie, #7)*

Despite the tremendous pressure and burden of taking care of her mother and siblings, Jackie (#7) also recalls how she was reluctant to seek out friends for support despite having an extended network. The NEM's first premise states that all individuals have access to a large group of people to consult with during an illness episode (Pescosolido, Wright, Alegria, & Vera, 1998), however, Jackie (#7) specifically limited herself from consulting with her friends in her network about what she was not "supposed to share." The act of not sharing may reflect the values and beliefs Jackie (#7) adheres to that could entail feelings of shame (Bradby, et al., 2007), or stigma (Anglin, Link, & Phelan, 2006; Corrigan, 1998). In the excerpt below, she recalls:

*I can talk to my friends, but I don't have, I don't share anything personal with my friend. We like, you know, there's a deep personal, there's a mild persona, it's just a, I very limit myself. I don't, I don't share a lot of stuff beyond what I'm not supposed to share. I'm very private. Yah, so, but Gloria is the one I could go to."(Jackie, #7)*

As a consequence of their refugee migration, Vietnamese were forced to sever ties to family and friends in Vietnam. For any major event, especially a traumatic event, the ties that hold a family together may dissolve weaker ties and limit new information shared within the group (Burt, 2002), such as receiving information about mental health treatments or whether Western treatments are useful. One respondent, Huy (#8), who was sexually assaulted as a child by a family member, suffers from severe depression and anxiety. Huy (#8) describe his negative views about his family and the lack of support he

received from them. In addition, after Huy's (#8) parents passed, his extended family showed him little care and support and fostered a lack of trust and confidence in the family support structure that diminished his family ties.

*“you know what the thing is, I don't, the only thing is I don't think they care, so, honestly I don't think they care that my mom died or my dad died, they just care about the money. Honestly, (inaudible) because (inaudible) there, you know, and they haven't done anything to help me, so what does that mean? They don't care.”(Huy, #8)*

His family also encouraged the use of medication, however, the broken relationship with his family and the ridicule Huy (#8) experienced from his friends about taking psychotropic drugs made him shameful and fearful about being dependent on drugs. After a conversation with one friend, who encouraged him not to take medications, Huy (#8) decided to discontinue as he recalls:

*“The, you know, they (family) mostly just told me that, you know, you should take it (medication), you know, it's make you feel better. It will make you move faster and you know..I actually only spoke to one friend about it (taking medication). You know, I don't really talk about it, you know... She just told me, you know, I believe her, you know. I'm pretty sure she wasn't lying, you know...” (Huy, #8)*

The strength of the friend's advice over the advice of family and the psychiatrist illustrates Huy's (#8) lack of trust and support of his family's opinions. The weak family

ties interacting with Huy's (#8) feelings of betrayal and abandonment made him more distrustful of family advice. Huy (#8) trusted his friend's advice to not take medication, and decided to discontinue compliance with taking psychotropic drugs. Huy's (#8) interaction with his social network, and in this case his family and his friends, influenced his pathway to treatment. The result in this case for Huy (#8) was a pathway that 'pulled' away from any medical treatment.

When dealing with problems, many families resort to dealing with it on their own. Miwa (#5) describes how her family deals with family problems in general and that if it is a problem that involves family, the problem cycles

*"Well, honestly, problems within the family, I don't think any of us go elsewhere or if they go anywhere for help, honestly, if it's a family issue, it just stays there and it gets thrown into this big pot and just boils."(Miwa, #5)*

Miwa's (#5) further adds how the insular nature of her family pushed her to seek a therapist. She describes:

*"If I, if I adopted my family's view of mental health or just trauma in general, I would probably have not seen my therapist and I would probably be very easily triggered by events happening around me...Mm-hmm. I mean if I had, if I, if I had chosen to deal with it the way that my sisters and my family deal with things, I would still be living at home very miserable, very unhappy and they would be the ones who would be helping me through this. I*

*don't think I would be the same person that I am now... 'No. No. Why do I need therapy? I could just talk to you guys,' that's what they think. They're just going to tell me things I already know..."(Miwa, #5)*

For one respondent despite having access to outside help, Sammy's (#13) family encourages seeking help only from within the immediate family. In Sammy's (#13) case, her family expects her to limit the network in which she seeks help to only focus on her family. Below, Sammy (#13) describes the differences between her own viewpoints with her parents:

*"And then some differences, though, I think, I think, like, my mom and my family, they're all, like my older generation family, they don't believe in talking to others about difficult things. Like, my mom has this view that you can't rely on anyone but yourself and even though I, like, kind of see what she's saying, I don't think that's true and I don't think it's, like, exemplified by the way that we live... 'really only your family should know your struggles or your dirty laundry' as she puts it. You know, like, where as I think that if you don't talk about it with people and if you don't talk about family issues with people, outside of your family or relationship issues outside of your relationship, it can become very toxic internally and like, relationally. So that, I think that's a huge difference, like talking about stuff."(Sammy, #13)*

Tim (#11), a 1<sup>st</sup> generation respondent, describes the sequence of events that precipitated his sister's psychological evaluation. Initially, the family did not understand what was wrong with Tim's (#11) sister, but hallucinations prompted them to call the police that led her to a psychiatrist. From there, a diagnosis of schizophrenia was given. In this scenario, the sister's use of mental health services was a result of the interaction with her family network structure that did not understand what was wrong. Nonetheless, the family realized something needed to be done and called for help. Consequently, the progression of Tim's (#11) sister's mental illness pushed other family members away as Tim (#11) recalled below:

*"It wasn't until it got severe when she was in college went, went to college classes that she started stealing stuff first. And then, at the point when I was in college at Irvine...And later on she got worse and then we had to call the police because she was getting kind of, like, hallucinating a little bit...And then we went to the police and then they took her to the hospital and then they evaluated her and then she went to visit psychiatrist and then that's when we got the diagnosis that she was a schizophrenic. And so that caused conflict and then so my sister. And looking back, maybe kind of pushed, it pushed my brothers and sisters away because it made my mom, you know, the dynamic's kind of weird." (Tim, #11)*

In a study by Perry and Pescosolido (2012), researchers found that individuals suffering from severe mental illness had support networks that reduced over the course of

the development of the illness. Unlike the respondents in the Perry and Pescosolido's (2012) study that found that individuals with schizophrenia had significantly larger networks at the point of entry into treatment, the Vietnamese respondents in this study had drastically smaller networks as a result of their forced migration and severed network ties. As such, Tim's (#11) family has limited resources to provide the support his sister needs. Additionally, he describes how his siblings distanced themselves from his sister after her mental illness symptoms manifested. This is consistent with what Tolsdorf (1976) found in his report, that individuals with schizophrenia had less intimate relationships with family members.

The respondents highlighted above shared stories about how respondents and their families reacted to the limited networks of supports in the United States. For some, the severed network ties forced families to seek support and help outside of the family while others in contrast chose to isolate and deal with the problems amongst family members only. The 2<sup>nd</sup> generation respondents did view seeking support and help outside of the family as being an acceptable and identified differences in help-seeking preferences when compared to the views of their 1<sup>st</sup> generation parents that were more insular. These differences in accessing support within the context of a limited network support structure point to the various viewpoints within a household that may become sources of conflict. Moreover, the mental illness itself was also a catalyst that reduced and strengthened network ties. In the next section, the two types of social support, positive and negative, will be discussed further in their relationship to seeking mental health services.

## **The Role of Positive and Negative Network Orientations on Mental Health**

### **Service Use**

Tolsdorf's (1976) Social Network Orientation Theory classifies having a *negative social network orientation* when the individual views his/her social network as an impossible, useless, or inadvisable source to draw on for support when in crisis.

Tolsdorf's theory considers a person to have a *positive social network orientation* he or she is able to trust in the interpersonal relationships for support, empathy, and understanding in time of need. The levels of social support for respondents in this study varied case by case as some experienced negative social network orientations with their support network while others experienced positive ones. For the respondents in this study who developed negative social orientations, seeking help outside the family was their only source of social support and pathway to care. For the respondents who maintained positive social network orientations, the reliability of their social support encouraged pathways to service utilization that differ from those with negative social network orientations.

This section will describe the negative (weak) social network orientation and positive (strong) social network orientation reported by respondents and how these levels of social support impact mental illness and help-seeking behaviors. Of the 17 respondents in the study, eight interviews revealed varying levels of social support for dealing with mental health issues. Of those eight interviews, four Miwa (#5), and Jennifer (#12)) reported receiving little to no support, while four (Esther (#3), Sarah (#9), Gloria (#2), Jackie (#7), Tony (#10), and Sammy (#13)) reported having various types of social

support or having strong social support. The remaining nine respondents did not elaborate about their social support networks.

### *Negative Social Network Orientation*

Four respondents, Miwa (#5), Esther (#3), Sarah (#9), and Jennifer (#12), describe having weak and/or no family social support when dealing with their mental health issues. For Miwa (#5), who is 2<sup>nd</sup> generation and the youngest in the family, her limited insight about her depression was frustrating to her because she couldn't see it herself. Her family tried to point out her symptoms, but coupled with family tension caused additional strain on Miwa's (#5) relationship with her family. She describes the frustrations and confusion she faced when she coped with depression:

*"I think I couldn't see what was happening. Like, I couldn't see what was happening which is why my family was trying to show me, and I think part of it was this, it was challenging because they had helped me see it but also they were aggravating other issues as well, so it was like, I felt like I had owed them something but at the same time I felt very victimized all over again. So it was just very, that was additionally confusing to me which is kind of what forced me into therapy too I think...I don't think I knew, I don't think I knew that I was depressed. Like when she wrote me a receipt for whatever, the sessions, and she wrote for depression, I was like, oh, I guess I was depressed."(Miwa, #5)*

Miwa (#5) recalls when she was kicked out of the house because she expressed intentions to become independent from the family. Miwa (#5) mentioned the idea of living on her own, and the family was so outraged by her proposal that they kicked her out of the house before she could move out on her own. The forced separation from family severed intimacy and reduced the emotional intensity of family relationships. The resulting weak family social support led Miwa (#5) to seek help and support outside of her family, which precipitated her pathway to treatment:

*“I knew that I had to talk to someone. I just didn't know what it, like what someone professional would call it but it was just, it was, you know I felt, I felt very, I felt unwanted. I felt like worthless. I felt unloved, you know if my family are supposed to love me unconditionally and they kicked me out, what does that say about my other relationships and who could I depend on? I mean it was, I didn't know how to process, I mean I was kicked out of my mom's house...”(Miwa, #5)*

Miwa (#5) had no support from her family, which resulted in a negative social network orientation within the family that pushed Miwa (#5) to seek care outside of her family's support. Subsequently, Miwa (#5) developed a positive social network orientation outside of her family because she cultivated strong friendships and support systems from school, community organizations, and church. Similarly, respondent Esther (#3) lacked support at home. As a 2<sup>nd</sup> generation Vietnamese respondent, Esther (#3) describes how she and her sisters supported their younger sister when she made an

attempt on her on life as a result of a severe episode of depression. Although the parents were not supportive in their daughter's recovery, Esther (#3) and an older sibling took it upon themselves to ensure that their younger sister utilized services after she was discharged from the hospital. The social support from the siblings helped cultivate a positive network orientation for her sister and, more importantly, ensured that their little sister was directed towards a pathway to treatment. Esther (#3) recalls:

*"I can't say we think alike, but similarly, we support it because I suggested that for my sister to make sure that after she got out that she gets counseling and she gets help and she realizes that she needs it to make sure it's okay to see somebody 'cause I myself have that problem...And then my older sister, I know for sure that she supports it because when everything happened, she was away. But she wanted to make sure my sister was getting help. And she checks on her and makes sure, like, she asks if she's getting counseling or not. And her husband is a doctor too. And so she's also in support of that and she understands. She's older, but she's also more open-minded to that and she sees that perspective of it."(Esther, #3)*

Esther (#3) further describes the how her parents were not supportive during the hospitalization period of Esther's sister. Esther (#3) recalls:

*"I love my mom, but this is why there's so many problems because we all have an individualized...and it gets to the point where we try*

*to be in their (my parents) lives and support them as well...And so she (my sister) didn't see anybody else in the family for those first couple days. And then even until she was in rehab, it was me, my sister who took turns going to see her. My parents didn't see her and my brother brought his kid in once because his kid and my sister are really close."*(Esther, #3)

In all, Esther's (#3) parents' lack of support in caring for her sister's mental health issues led Esther (#3) to seek support from friends during her own struggles with depression. The lack of reciprocity in her parents supporting her sister also reduced the level of trust, empathy, and understanding in time of need. Despite not being able to rely on her parents for support for mental health issues, Esther (#3) reported that she would be able to rely on her friends to get the best support—creating a positive network orientation outside of her family network. She verbalizes the sentiment of relying on friends:

*"I feel like they're (her friends) much less judgmental. Like, if I were to screw up somewhere, like, if I were to tell my family and it would get back to my parents, I would hear it from my parents, versus if they were my friends, they would be more supportive in any way, even if it was a bad decision or something that I don't approve of or they don't...they'd be a friend and be supportive more than judgmental."*(Esther, #3)

Sarah (#9), a 2<sup>nd</sup> generation respondent, describes acting as a mediator between her parents and her brother who suffers from bi-polar disorder. This bridge between her

brother and her parents helped develop a better understanding of the mental health needs of her brother, and reduced the level of distress the parents experienced. As a result of having little support at home, Sarah (#9) decided to move back home to provide greater social support for her brother. Sarah (#9) cites her reasons for moving back home below:

*"I guess I moved back for that reason..I always thought that he (my brother) doesn't really share things with any of the other siblings as he did with me. Or this used to be the case, I don't know if it is now. So I always thought I was helpful as just a listener. And because I could mediate through what he was saying to my parents and I thought I could have more of a role as a mediator if I were present. And also so I can talk my parents down from their stress when they were stressing out or despairing. I can talk him out of his big misunderstandings that he kind of creates in his mind when he's having these episodes."(Sarah, #9)*

Sarah (#9) explains she is not sure if her brother's decision to refuse psychological help is a result of his own desires or a result of the lacking support at home.

She indicates:

*"Other people, friends I have whose siblings also have bipolar disorder, they are not very consistent with their medication. And I don't know if it has to do with family support because I seen a correlation between times when they're more supportive and his treatment being more successful versus. I just don't know how*

*much of it is himself and not wanting to take medication, not wanting to follow-up, versus how supportive my family's being."*(Sarah, #9)

When asked how much support Sarah (#9) receives, she recalls not being able to trust and rely on her family for support when she was younger, pointing to a negative network orientation. However, now that she is older, Sarah (#9) describes having a transformed social support because she has since developed closer and supportive relations with her family and friends. Sarah (#9) recalls the change in being able to rely on family and friends:

*" I think I have a very strong support system around me. Like when I was younger I was more reluctant to reach out for help. But now that I'm older I have my partner and I have a handful of close friends who I would speak to and you know, even my siblings now who if I thought before that they wouldn't have understood me, they seem, I think they are a bit more open minded about different ideas and different approaches...So depending on the problem I'm having in my life, I could go to different people."*(Sarah, #9)

Jennifer (#12), a 2<sup>nd</sup> generation Vietnamese-American suffering from depression, also describes an unsupportive parent whom she cannot trust or rely on in times of need:

*"I know if I were to come to my mom and say, like, 'I'm really depressed' she would judge me. I know she would say something, like, 'Well, that's your fault. You need to go do something about it.*

*You're so stupid for feeling that way.' I don't even bother. In high school, I've done that and I've failed so much that I just don't even bother anymore."* (Jennifer, #12)

In addition, Jennifer's (#12) mother taught her to only rely on the family and not discuss her depression with anyone outside of the family, not even friends. The mother's side of the family shares these attitudes and values. Jennifer (#12) does not talk to her father's side of the family, who lives in Vietnam:

*"She's even said to me growing up, like, 'Why do you bother having best friends? There's no such thing as a best friend. No one is gonna love you more than I love you. No one is gonna love you more than your brothers and sisters love you. Why do you bother having friends? My dad's side of the family, I don't really know anybody from my dad's side. They're still all in Vietnam. He doesn't talk to them for some reason. Some drama happened there. We don't talk to them anymore. I'm gonna find out soon but my mom's side of the family, they're all kind of this way too. They've all had the same sort of, like, abusive upbringing, their own immigration stories. And so when they see my mom, it's normal for them too. They're, like, 'Oh, this is just the way she is.'"* (Jennifer, #12)

Jennifer's (#12) mother was also reluctant to talk about the family's past and history, which caused Jennifer (#12) to turn outside of the family structure to seek answers and personal care. In order to address her mental health needs, Jennifer (#12)

participates in Native healing circles as a support structure. Furthermore, Jennifer (#12) sought professional help from a therapist in conjunction to her healing circles to address her depression. She also believes that utilizing both spiritual and any mental health care are important as she indicates below:

*“Yeah, I think there's a good in-between, because I feel like I'm sort of spiritual in a way. I like to meditate and I like to go to sacred healing circles. There's a sacred healing circle my friend takes me to that's with the Native American community. And it's just a medication, like, healing circle where people pray. You meditate together and it's a guided, spiritual medication. I mean, I do that because I know how calming it is. But in conjunction with that, you need to go to a therapist. You need to also see someone who's qualified to tell you what's going on in your life and how to process it. So I see both sides...I just think that going to the therapist satisfies the practical side of me. You need to make sure that someone who studies this and is qualified can tell you that you're okay. But for yourself, for your own satisfaction, you need to go pray, go meditate. Do those things for yourself.”* (Jennifer, #12)

The interactions within Jennifer's (#12) social network, specifically around the resistance and disapproval of her family, encouraged Jennifer (#12) towards a spiritual pathway to find answers to her identity. Overall, the interactions within Jennifer's (#12)

social network, such as her friends taking her to healing circles or suggest seeing a therapist, directed her towards a blend of informal and formal pathways to address her mental health needs.

### *Positive Social Network Orientation*

Strong social support has been associated with greater mental health service use (Lam & Rosenheck, 1999) and buffers stress (Lee, Koeske, & Sales, 2004) while its benefits to physical and mental health exceeds the costs (Thoits, 1995). Social support for the respondents in the study highlight some of these benefits as respondents with mental disorders who reported having less supportive families were equal in numbers to those who had strong social support. Four respondents, Gloria (#2), Jackie (#7), Tony (#10), and Sammy (#13) indicated having social support, with varied sources and levels of support for each respondent.

Gloria (#2), a 1<sup>st</sup> generation respondent, remembers how her extended social network in the United States supported her mother and the family during the mother's hospitalization. She emphasizes how vital the support was to her family. The impact was so great that she decided to pursue a career in the medical translation field as an attempt to pay it forward. She recalls:

*"Yea and you know like I have at the school I have a professor that you know I can share with them my struggle and they understand and supportive. They would you know spare me from certain assignments or ask me to, give me extra time to do my work And you know I went to a small women's college and so they were very*

*supportive...and my future mother-in-law who at the time lived in Florida, knows about my family's problems. She was you know, she asked my husband if we need help. We've been very blessed. We have like great help. We have the lady that I talked about from the Catholic charity, she would come and tell us don't divide them up; they'll take your kids away because they have older sibling. You know she worked with us. She would come to our house, talk to us, guide us and now when we see her she is like part of our family you know. It was...I mean social service is so important that you know why I'm doing medical translations."*(Gloria, #2)

For another 1<sup>st</sup> generation respondent, Jackie (#7), the amount of social support received was different in Vietnam compared to the United States. In Vietnam, Jackie's (#7) mother, who suffered from undiagnosed bi-polar disorder, had access to family and friends from the village for support. Jackie (#7) reports:

*"I mean the family, in terms of family, her, they treat her, treated her with caring and also ones who, you know, really wanted to bring into the medical treatment into the home so able to treat her so she can get better. It's not like they (ignored), tried to ignore her or ignored her in some way else or like not helping her at all. They were very helpful and supportive, especially with us kids. They, my aunts and uncles were during her sick time, during her sick time they took care of us."*(Jackie, #7)

Tony (#10), a 2<sup>nd</sup> generation respondent with manic depression discusses how his family displayed support by making less demands of him. The family conveyed encouragement in a loving way. Tony's (#10) description of his parents associating his depression with being pushed too hard reveals his parents' level of understanding about mental health. Below, Tony (#10) describes how his family embodies a positive network orientation that shows sensitivity to his mental health needs. He remembers how his parents treated him during the onset of his depression:

*"Actually, they're very loving and supportive of everything, but they just want me to be a little bit...they try to indirectly say, try to get me to speak more. That's all. They do it in a loving way...Yeah, being encouraging. A little more encouraging, a little bit more acceptance. Basically, they didn't do anything different at all. But basically, they didn't push me as hard as before. When I was growing up, they pushed me in school a lot. They found out I had depression. They were, like, 'You can go to work. You don't have to go to school.' That was the major change. That was the biggest and probably the most dramatic change, yeah. They didn't push me as hard as they would have wanted if I was a healthy, full functioning, going to school type of adult. I think they found out that it was tough on me and they love me as a son. They didn't want me to go through any pain 'cause they saw a lot of pain and*

*how I felt about my situation as far as a teenager. And they didn't want for me to continue to be sad."*(Tony, #10)

The addition of having strong influences from friends was also instrumental in molding Tony's (#10) own beliefs and values about using mental health services. Tony (#10) verbally affirms that his friends have become a reliable source of support and explicitly indicates that his friends have influenced his views on mental health services. This exchange in social network interaction as mentioned in the NEM describes the mechanism in which care decisions are made that either hinder or facilitate service use (Pescosolido, 1991). Tony (#10) recalls his positive social network orientation:

*"..Most of my friends are very positive and helpful and they themselves seek mental health. And so we listen to each other. We hear each other out. We support each other. So my friends are a very good influence and I actually have a lot of friends who seek mental health...between, like, still coping with traumatic stuff and just between, like, regular day-to-day stress and balance stuff..I think it's all personal choice. You know, you just surround yourself with certain types of people. And so my friends are educated too and a lot of them are teachers and a lot of them I met through college. So they're very educated people. I think that helps frame your thinking and your beliefs."*(Tony, #10)

Tony (#10) further adds how having a church social support structure helped keep him stable:

*"And then that was when everything just kinda...nothing went out of control because I had some type of support as far as going somewhere. I had a church group I was going to...So that kept my mind at ease. I wasn't by myself all the time. So the church group was my stability factor. So when I go to the church, and this would be a different church from what I grew up from so I would meet new people and that was exciting for me because I wasn't much of a social."*(Tony, #10)

Sammy (#13), a 2<sup>nd</sup> generation respondent with depression, describes how even though her parents have a limited understanding of mental health, they were still supportive. She says her parents believe psychological disorders are a cultural phenomenon specific to Western culture:

*"And I think the younger generation, like, it's nice to have name for it, where the older generation is like, this is just American culture, like, the culture of, like, the lack of (inaudible) or something like that. I don't know how to describe it. Like, it's this, like oh, this is just western phenomenon in American culture versus like an actual, like, thing that happens in your brain or like thing that happens in your, like, experience of the world, you know. Yeah...I think that she, like they definitely had to find their own tools to like be mentally, like, healthy after they left Vietnam and then just having to adjust to this culture was nothing. You know it's like that whole*

*narrative, I just don't think they had a name for what they were experiencing and that's why it sounds kind of like hokey when, like, you introduce, like, oh, like depression and like you can go to a doctor for that. It's just not, it's foreign to them."* (Sammy, #13)

Even though Sammy's (#13) family did not understand her depression nor have a cultural context to understand mental illness, her family was still overwhelmingly supportive. Sammy (#13) describes her struggles with severe depression despite having family support. She states:

*"And like, they were really supportive. I think once I did get counseling, I personally was pretty, like, I still didn't care at that point. At that point I also, like, I had been, like, harboring, like, suicidal thoughts and stuff like that, so it was kind of like, oh, I don't care, I'll just go and like the next chance I get, like, you know, I'll kill myself or something. It like scares me now to even say that because it's so not me."* (Sammy, #13)

Sammy (#13) was also fortunate to have friends in her support network that have experienced the same mental disorder. These friends reached out to Sammy (#13) when they noticed her symptoms. She recalls having tremendous support from her boyfriend at the time, friends, and her church community. The excerpt below reveals her sentiments about her differing types of social support:

*"Yeah. So actually, like, I feel like I have a really fortunate, like, set of people in my life because I know like it's stigma in a lot of*

*Christian communities, but actually, like, in my, like in my Christian community back in, at Yale, like, actually like my boyfriend at the time, he went through depression and then my best friend also had a history of depression, so like, they had already kind of, like, developed strategies to deal with it while in college. And so, like, they were among the people who, like my ex and then my best friend, reached out to me a lot and kind of also sent emails, I guess, to like a lot of my friends back east about, like, what they, what they assumed was happening to me. So a lot of people reached out and just kind of, like, gosh, like a lot of things. Everything from like texts, like every other day. They're like asking me, like, how's it going? And then like emails and then like letters or like books and like art that they would send, and I was just a terrible friend..."(Sammy, #13)*

Reflecting on how important her friends and family was to her during her bout with severe depression, Sammy (#13) describes in detail how her support network, particularly her family, meticulously kept an eye on her. The positive social network orientation Sammy (#13) had in amongst her friends and family fostered trust and provided a safe space to recognize that there was support she could access. She recalls:

*"I actually think it's a huge blessing that I was not living alone at the time because I think living with my mom, even though it was, I just don't like it with the (inaudible), like just have to, like, deal*

*with familial stuff, like, at the time. I think looking back it was like, it, like, partially saved me I think and then my friends also helped too because that made me, like, physically not alone, like I couldn't, it was very hard for me to be alone. Like even if I had to go grocery shopping for my family, like my mom would send my brother with me because she was afraid that I would do something, you know. So even though it's frustrating for me because I wanted to at the time, like be alone or like go off somewhere and like contemplate this, contemplate that, like it saved me that my family was always with me. So we would, my mom would, like, we would just like watch movies or watch TV and she would, like, ask me, can you please, like, sit here with, if you're going to sit, just like sit in our room, you know, so we would watch movies together, take walks, cook together, I went grocery shopping accompanied by my siblings, Shawn prayed for me, and then I wrote and did crafts with Brenda. Yeah, there was a lot. It was really intense."*(Sammy, #13)

Sammy (#13) was also asked how she sought help for her depression. Her response was that the overwhelming support she received from family and friends made her become aware of being loved. She recalls:

*"I think for a lot of, like in a lot of ways, like I, because my family showed that they loved me so much and like in such tangible ways, like to go through all that trouble, and like my younger siblings,*

*they were like in high school, you know, and it's like, gosh, like I can't even, it's crazy...But it was definitely like they were instrumental and then like I have a handful of friends who were also really instrumental."*(Sammy, #13)

As described earlier, Vietnamese-American family dynamics are often structured with hierarchal relationships where support and advice typically flow in a single direction—from oldest to youngest. As a result, respondents who have older mentally ill family members typically encountered stress, frustration, and resistance when suggesting that the older family member seek mental health services. For some respondents and their families, not using services was an active choice while others were encouraged or forced into utilizing services. Families that provided little support created negatively oriented networks. In this study, Huy (#8), Miwa (#5), Esther, (#3), Sarah (#9), and Jennifer (#12), felt neglected by their families and that their mental health needs were unmet. The little support resulted in seeking support outside of the family or through any mental health services in some cases.

### **Respondents' Experience with Any Mental Health Services**

Despite lacking knowledge and utilizing informal treatments, all of the 17 respondents and their family members eventually accessed and utilized mental health services in the United States. The pathways to formal service use, however, were not always direct. As described in the previous sections and Table 12 below on page 192, some individuals received any service use as a result of a family member calling the police due to lack of knowledge about what to do. For the respondents who did receive

any service use, not all of these experiences were positive ones. Respondents who received any mental health services expressed both positive and negative views of their experiences.

Miwa (#5) recalls that when dealing with her own depression, the influence of educational and community based organizations and positive experiences from mental health professions were most influential in normalizing seeking mental health services and viewing mental health treatment positively. The influence of Miwa's (#5) social network exemplifies Tolsdorf's Social Network Orientation Theory in that her values and beliefs about mental health services aligned with the views of people she trusted and interacted with in her past. The following excerpt depicts how past social interactions developed Miwa's (#5) willingness to seek and continue to seek help:

*"You know I took course on Asian American culture and history. I, I don't know. I somehow normalized it because, I think maybe it started in high school. I had a really great counselor who let me talk to her about issues and that normalized it for me, like it was okay to have issues and it was okay to talk about it. I think there were also community organizations that I worked with that, one is Summer Search, and they're very personal in the sense that they really want to know your history and I, and part of being in that program is really sharing your story and they really normalized it for me too and really encouraged me to share my story which includes, you know...so I think my therapist has really helped to*

*validate like, yeah, that's not healthy because, you know, everything I've known has been with my family, so talking with informal networks, talking with formal networks have really helped me understand what's 'normal' and healthy versus what's not okay, and I think in my family they think that what they're doing is okay when some things aren't, like it's not normal to talk to each other this way or it's not normal to, you know, externalize everything."*

(Miwa, #5)

In addition to her educational background, Miwa (#5) describes how her balance of dual identities affected her choice to seek therapy as a pathway to care:

*"And she's (the therapist) not Asian, but she's very understanding too, kind of the dynamics, which was one of my concerns, I was like, do I need to see someone who is, like how would that help or hurt if I saw someone that looked like me. I certainly feel, I think there have certainly been times where I feel more Vietnamese than I do American and there are times when I feel more American..I think that's, that's part of my personality is to kind of look at both sides."* (Miwa, #5)

Moreover, Miwa (#5) describes how at the beginning of the care process, she did not know what services she needed to access. Fortunately, the outer circle of friends in her network referred her to a trusted therapist:

*"I think my friends encouraged me, and I've always been very open to talk about family issues too, so at some point I was with two friends and one of them was the one that gave me, like eventually it was like, oh you know you're talking and like you're like, yeah, maybe you should talk to someone and then I think it was, I was ambivalent because I didn't know where to start and one of them was like I have someone and it worked out...during the time when my sister kicked me out and you know that was obviously a very difficult time, I spoke to a lot to girlfriends and kind of my outside network and one of them actually suggested like, gave me her therapist's number...I think I just wanted someone who was culturally competent and would understand kind of this type of dynamic and because my friend who is South Asian recommended it to me and kind of understood what I needed, I trusted her referral."(Miwa, #5)*

Other respondents had different responses to any mental health service use. Jackie (#7) describes a negative experience with any service care. She describes the hospital's inability to translate important information during her mother's psychiatric hospitalization, leading her to believe her mother received substandard care. The doctors never explained the treatment plan:

*"Back then I don't think because they (the doctors) know a lot about Vietnamese culture and there's no, we, they don't have*

*Vietnamese social worker back then, not too many to my understanding... And (my mother) was the only Asian there. The only Asian. Only Vietnamese there, and we don't have much communication with the doctors and every time we come in we don't have, we had a family meeting but they don't really have that kind of support or a clear understanding, explanation, you know, what kind of medication she's on. It's just very, seems like very vague and very like, it seems to me they just want to make money, like getting the money from the insurance but not treating her well. The symptoms, but she getting sicker and sicker at that place than at other places and eventually we, we almost went to court to have her like a voluntary withdrawal, like to take her out of that."(Jackie, #7)*

Jackie (#7) also describes how it is difficult to get her mother to comply with her any mental health treatment, whether a result of previous experiences with any use or her bi-polar disorder is unclear to Jackie (#7). She ended up calling the police to have her mother taken to the hospital:

*"...Often time she wouldn't want to go. She's like you know we were with mental illness, especially with bipolar, it's poles...a lot of times it's very hard and it's very emotional and stressful and sometime we have to call the police department intervene for her*

*to talk to them to help escort her to the emergency room and other times she called herself."(Jackie, #7)*

Esther (#3), a first generation respondent who suffers from depression, embraces the Western practice of talk therapy, but articulates why she disagrees with her therapist's solution, a Western model of treatment. The therapist suggests that Esther (#3) remove herself from the family situation that is negatively affecting her mental health. Yet Esther (#3) indicates that, despite the family being the problem, leaving her family is not a culturally acceptable solution. The excerpt below illustrates Esther's (#3) duality of adhering to cultural values and Western approaches:

*"She (the therapist) told me to leave the situation. Like, I feel like there's this community oriented thinking for Asian families versus Caucasians where it's very independent where you leave your house at 18, you have your own life. She said just leave it all behind. And I don't think she really understood the responsibilities that I felt like was an obligation or being part of a family or being able to deal with this, this, and this. Like, those were my duties. I can't leave it and go away. If I could, I would have. I wouldn't come see you. And so when we talked through these sessions, a lot of her advice was to drop it and not deal with it. And so I was, like, 'No, I can't drop my parents.' And, like, if there's a difference, you know, and then the whole gambling piece with my mom, like, I can't give her money, but then I can't let her starve, either...But it's*

*about how to deal with it, not how to escape it. So I was getting frustrated with her (the therapist). And I'm, like, I'm gonna say it's because you're white and you don't understand the ties I have that I'm obligated to do versus being 18 and fucking off. And even when you're away, there's still ties and responsibilities that we as Vietnamese who were raised a certain way still have to do...And I was, like, 'Lady, I'm just wasting my money and my time.' And that's just cultural, but it's also, like, that's non-negotiable. That's not something I can give up...I didn't mean I have to get a Vietnamese counselor. She just had to get past that point. I was open. I don't want a Vietnamese counselor at all. Why would I want that? I just want someone to understand that and be able to be empathetic enough to make suggestions that I can do. Like, yes, it's my life, I have to fix it, but you have to be able to, like, 'Okay. Talk me through it. What can I do?' You know, something that I can do. So it's not about being a counselor of culture. It's about being a counselor that can help you think things through in a sense that makes sense. That's all.'*(Esther, #3)

Truc (#15), a 1<sup>st</sup> generation respondent who experiences severe schizophrenia, briefly describes why she did not initially see a physician. When asked why she did not get help when she felt that something was wrong, Truc (#15) recalls how her parents

thought she was acting normally. In this situation, the parents became the gatekeepers to Truc's (#15) service use, which ultimately delayed her use of mental health services:

*No, I don't see a doctor (for many times) 'cause they (my parents) thought I'm okay, but I don't feel that I'm okay."*(Truc, #15)

The process of finding a physician to treat her schizophrenia was difficult as highlighted in an exchange between Truc (#15) and the interviewer:

*Truc (#15): Uh huh. I go to a doctor.*

*Interviewer: Oh, you agreed?*

*Truc (#15): Yeah.*

*Interviewer: So you wanted to go see a doctor?*

*Truc (#15): Yeah.*

*Interviewer: Okay. And was it easy to find a doctor?*

*Truc (#15): No.*

*Interviewer: Why was it not easy?*

*Truc (#15): (Inaudible) recommended (inaudible) not just (not easy), yeah.*

*Interviewer: It was not easy?*

*Truc (#15): No.*

*Interviewer: So you had to wait for a recommendation?*

*Truc (#15): Yeah, yeah.*

*Interviewer: Did it take a long time to find the recommendation?*

*Truc (#15): Yeah.*

*Interviewer: Why did it take a long time?*

*Truc (#15): Yeah, (inaudible) for long time. [Background conversation between respondent and her brother, who is translating:*

*Brother: Why?*

*Truc (#15): Yeah.*

*Brother: Why?*

*Truc (#15): (Not) for long time to see the doctor, you know?"*

*(Truc, #15)*

When asked further about the frequency, duration, and quality of mental health services she received once she started utilizing services, Truc (#15) reported the psychiatrist did not provide much assistance. Below is an exchange between Truc (#15) and her brother about her latest therapy session:

*Brother: (Inaudible). When was the last time you saw a psychiatrist? Truc (#15): I don't see him for long time...*

*Brother: (How long)?*

*Truc (#15): ...eight months already.*

*Brother: Nine months?*

*Truc (#15): Yeah. They didn't check up on me, but he thought I'm okay so he didn't check up on me..I saw him, but he (doesn't) say nothing.*

*Brother: When did you see him?*

*Truc (#15): Last week.*

*Brother: Last week?*

*Truc (#15): Yeah.*

*Brother: You saw him last week. You told me you saw (Vietnamese for therapist).*

*Truc (#15): I saw him, but he didn't say nothing. (The psychiatrist) don't say nothing.*

*Brother: So did you see him last week or you saw him eight months ago? Truc (#15): Last week, yeah.”(#15)*

### *Summary of Pathways to Treatment*

Table 12 summarizes the various pathways to treatment among the respondents in the qualitative study, and also summarizes the respondents' values and beliefs, and social network characteristics that were found to be associated with any mental health service use. Among the respondents that did use formal services, their paths towards utilization varied as different interpersonal factors precipitated the use of any mental health treatment. Four respondents, Gloria (#2), Jackie (#7), Tim (#11) and Miwa (#5) utilized external agencies such as the police and the emergency room as entry into psychiatric services for their family members. Other respondents' use of any mental health services, using NEM's fourth assumption, depended on their interactions and exchanges of information with family and friends. From these interactions, some positive and some negative, the respondents were able to make decisions about using mental health

treatments. Overall, it was difficult for Vietnamese respondents to use any mental health services and, among those who did, their experience of those services was often difficult.

**Table 12. Pathways to Treatment**

Respondent Comparison	Family Hierarchical Structure	Belief in Spiritual Solutions	Belief in Self-Reliance	Social Network Support	Network Orientation		Services/Treatment Outcomes
					Family	Non-Family	
<i>1st Generation</i>							
Gloria (#2)		✓	✓	✓	+	-	Called police; hospitalized involuntarily and chronically [for mother]
Esther (#3)	✓		✓	✓	+	+	Therapy; also encourages parents seek help [self and parents]
Jackie (#7)		✓	✓	✓	+	-	Called police; hospitalized involuntarily and chronically [for mother]
Huy (#8)	✓		✓	✓	-	+	Therapy; psychotropic drugs (non-compliant) [for respondent]
Tim (#11)		✓	✓	✓	+	-	Parents pray at temple; therapy for sister [for sister]
Truc (#15)		✓	✓	✓	+	-	Spiritual prayer; therapy; psychotropic drugs [for respondent]

Fong (#17)		✓	✓	✓	-	+	Spiritual prayer; therapy, hospitalization ; psychotropic drugs [for respondent]
<i>2nd Generation</i>							
John (#4)	na	na	na	na	na	na	na
Miwa (#5)	✓		✓	✓	-	+	Therapy; independent [for respondent]
Page (#6)			✓	✓	-	+	na
Sarah (#9)			✓	✓	-	+	Therapy; and for brother; chronic depression/bipolar; psychotropic drugs [for respondent and brother]
Tony (#10)			✓	✓	+		Therapy; felt therapy was ineffective; antidepressants [for respondent]
Jennifer (#12)	✓			✓	-	+	Therapy [for respondent]
Sammy (#13)				✓	+	+	Therapy; recovered from psychosis with antidepressants [for respondent]
Qui (#14)				✓	+	-	Therapy; antidepressants [for respondent]

## Conclusion

This chapter reviews and summarizes the Vietnamese-Americans respondents' lived experiences with serious mental illness and the various pathways of help-seeking behaviors each took in response. Several themes emerged from the analysis of the interviews. First, the traditional hierarchal structure of the Vietnamese families limited help-seeking behaviors for some respondents by controlling specific types of values and beliefs about mental illness and treatment solutions. This was particularly the case for 2<sup>nd</sup> generation respondents who often were open to using mental health services but were expected to obey parents and even if their wishes conflicted with their parents. As the NEM stipulates, it is the values and beliefs interacting with the social network (Pescosolido, 1991;1992; Pescosolido, Wright, Alegria, & Vera, 1998), and in this case the family's support network, that influenced the decisions of whether to seek mental health services.

Second, the study found that respondents' beliefs in traditional spiritual solutions to mental illness limited access and use of any mental health services for many of the respondents and their families. This was particularly true of 1<sup>st</sup> generation respondents, but, as in the case above, these strongly held parental views made it difficult for their children to help them, or to seek formal help for their own mental illness if they had one.

Third, strong cultural beliefs in self-sufficiency limited Vietnamese-Americans from seeking any mental health services. This strong cultural belief was held across generations – both 1<sup>st</sup> generation and 2<sup>nd</sup> generation respondents expressed the view that

they had the ability and responsibility to overcome their ailments. The reliance on self-sufficiency delayed respondents' entry into the treatment system.

Fourth, the respondents' interactions with their family support system influenced their values and beliefs about how to respond or cope with serious mental disorders. Drawing on the theoretical framework of the NEM (Pescosolido, 1991;1992) and Social Network Orientation Theory (Tolsdorf, 1976), any mental health service use by Vietnamese-Americans was influenced by knowledge, values and beliefs within their social networks. Because many of the Vietnamese-American respondents had limited social networks due to the harsh refugee experiences they endured, many of the respondents received limited assistance from their social networks, which in turn limited their ability to access and use any mental health services. The respondents' interaction with their support network systems influenced the values and beliefs about mental health, mental illness, and help seeking.

Finally, consistent with Social Network Orientation Theory, respondents with unsupportive families developed a negative social network orientation (Tolsdorf, 1976) and sought support outside of the family unit. This may have been the result of the family not being able to provide emotional and instrumental support (Halbesleben, 2006). In contrast, respondents with positive social network orientations had reliable sources of social support from both family and non-family members of their social networks. The result of the additional sources of support helped respondents in some cases to enter into the mental health treatment system. Through their networks, respondents developed positive or negative social network orientations developed based on how reliable,

supportive, and helpful the networks were in providing support for the respondent's or family member's mental health problem.

## CHAPTER 10: CONCLUSION

The arrival of Vietnamese refugees in the United States marked a period of relocation and transition for many individuals and families. The traumatic war, post-war and refugee journey that many Vietnamese-Americans experienced severely affected the population and contributed to incidences of PTSD, depression, and other mental disorders. The purpose of this study was to gain a better understanding of Vietnamese-American's mental health service use for serious mental illnesses. I was specifically interested in learning how Vietnamese-Americans of different generations view their mental illness, and how their past experiences, family structure, social networks influence their struggles with mental illness and use of any mental health services.

Based on the existing literature that documents generational differences in mental health service utilization between Asian-Americans (Abe-Kim et al., 2007) as well as age differences in service utilization among Vietnamese-Americans (Choi & Kim, 2010), I hypothesized that acculturation would be positively associated with mental health service use among Vietnamese-Americans. I anticipated that increased acculturative stress in the United States would direct Vietnamese respondents towards family supports and 'push' respondents away from any mental health service use. I also developed four sub-hypotheses related to acculturation: a) first generation Vietnamese-Americans will experience more acculturative stress than second generation Vietnamese-Americans; b) high acculturative stress will be associated with less use of any mental health services use among all Vietnamese-Americans; c) length of time in the United States will be

associated with more mental health service use for second and third generation Vietnamese-Americans, but will be associated with less mental health service use by first generation Vietnamese-Americans; and d) English proficiency will be associated with greater mental health service use among all Vietnamese-Americans.

In the NLAAS analysis I included several measures of acculturation – generational status, acculturative stress, English proficiency in speaking, and length of stay in the United States— to assess the overall relationship between acculturation and mental health service use. Overall, the analysis of the NLAAS data set did not allow an assessment of this hypothesis or sub hypotheses as the large majority of the Vietnamese-American sample was 1<sup>st</sup> generation. However, I did find strong support for this hypothesis and sub-hypotheses in the qualitative study. Although acculturative stress here was not assessed with an established scale, the respondents interviewed did exhibit clear elements that suggested acculturative stress such as intergenerational conflicts between parents and their adult children about how best to deal with their mental disorders. For example, Jackie (#7) recalls how her mother was distraught from being kept from leaving her hospital bed and recalls how her mother responded below:

*“But she was very angry and every time we came in to see her, she got angry with us. It's not, every time we visit her it wasn't, it wasn't a good visit. It's heartbroken. It's very painful. It's, we, sometime we just wanted to bring food and go home. We just don't want to stay there to see that kind of scene, you know, the way she's acting and she's just not herself at all...And it's, it was a very*

*struggling time. She was mad, she was mad at us, very mad for brought her into the hospital, but we didn't have any choice what to do... “ Jackie (#7)*

In another example of acculturative stress, Sarah (#9) attempts to reduce the amount of distress her parents encounter when dealing with mental health issues in the family and recalls:

*So I always thought I was helpful as just a listener. And because I could mediate through what he was saying to my parents and I thought I could have more of a role as a mediator if I were present. And also so I can talk my parents down from their stress when they were stressing out or despairing. I can talk him out of his big misunderstandings that he kind of creates in his mind when he's having these episodes.”(Sarah, #9)*

In the interviews, behaviors and thoughts reflecting acculturative stress among 1<sup>st</sup> generation Vietnamese appeared to inhibit mental health service utilization (Jackie, #7; Gloria, #2) while 2<sup>nd</sup> generation respondents who were more acculturated more likely to seek help even if they were discouraged by their parents (Jennifer, #12; Miwa, #5; Sammy, #13; Sarah, #9).

The second sub-hypothesis – that the length of time in the United States will be associated with more mental health service use for second and third generation Vietnamese-Americans, but will be associated with less mental health service use by first generation Vietnamese-Americans -- was partially supported. This is supported by 2<sup>nd</sup>

generation respondents expressing more openness to using mental health service than their parents as they become exposed to mental health concepts through school and through friends. In contrast, their older 1<sup>st</sup> generation parents adhered to different values and beliefs and were more reluctant to use services or get help outside of the family support network (Jennifer, #12; Miwa, #5; Sammy, #13; Sarah, #9).

The qualitative study also supported the hypothesis that English proficiency will be associated with greater mental health service use among all Vietnamese-Americans. Although all of the respondents spoke some English, several respondents indicate that the lack of English proficiency was an issue that affected the use of mental health services for their parents. In contrast, 2<sup>nd</sup> generation respondents with high English proficiency enabled them to understand the different types of mental disorders and the benefits of their respective treatments. For example, one respondent (Miwa (#5)) describes how her ability to engage in meaningful dialogue in English increased her awareness about her mental health. Miwa's (#5) ability to engage in mental health conversations not only helped develop a different perspective but also helped her to be proactive about her mental health. Other younger generation respondents had similar responses when discussing options for mental health services as well.

The last sub-hypothesis – that high acculturative stress would be associated with less any mental health services use among all Vietnamese-Americans -- was also partially supported. The acculturative stress was mostly described through intergenerational conflict about not seeking and using mental health services as well as having differences in values and beliefs than their children that led to strained relationships. Respondents

like Huy, #8; Jackie, #7; Gloria, #2; Sarah, #9; and Jennifer, #12, talked about their parents and their understanding of mental disorders indicated that their lack of understanding and personal values and beliefs reflected how they viewed the symptoms of mental illness and either delayed, deterred, or discouraged the use of mental health services.

The qualitative interviews highlighted the differences between several generations of Vietnamese-Americans about their values and beliefs about mental illness and mental health service use and identified two components of social network support that affected their use of any mental health services. The qualitative study provided more insight into how generational culture – the prevailing attitudes, values, and beliefs of each generation – influences the social network support of Vietnamese-Americans and affects the mental health help-seeking behavior for each generation. Three themes emerged in the analysis that shed light on respondents' reluctance to use any mental health services for serious mental health issues: 1) the traditional hierarchical structure of Vietnamese-American families; 2) belief in traditional spiritual solutions to mental illness; 3) strong cultural beliefs in self-sufficiency.

First, the obligations to family in the form of deferring to elders changed how social support was experienced by 1<sup>st</sup> generation parents as their children's attempts to encourage seeking help was viewed as disrespectful and unsupportive. The family hierarchy reinforced rigid flows of support as younger 2<sup>nd</sup> generation Vietnamese-Americans were unable to convince their older 1<sup>st</sup> generation parents to seek help when they needed mental health services. Several respondents described how parents were

resistant to their children's advice and any encouragement to seek help was viewed as being disrespectful. When a parent had a serious mental illness, younger family members were non-confrontational and lacked the capacity or willingness to go against their parent's wishes and force their parents to seek help. When the person with mental illness was the child of one of the 1<sup>st</sup> generation parents, the children frequently experienced less support at home and often sought help through friends or any mental health services.

Second, several respondents stated that family members in Vietnam sought out spiritual guides such as Buddhist monks to excise what family members believed to be demonic possession. At the time, the network structure in Vietnam was still dominated with network content that was religiously based and resulted in the family seeking spiritual solutions for their mental health needs. The arrival in the United States did not change their spiritual views, as several 1<sup>st</sup> generation respondents relied on religious practices to deal with mental disorders. Whether the family member with mental illness was the child or the parent, the parent's belief in seeking spiritual solutions created a barrier to mental health service use.

Third, self-sufficiency or the belief in one's own ability to overcome one's own mental disorder also constrained any mental health service use. Within the Vietnamese families that were interviewed, the perception that a person should be fully capable of controlling his or her own behavior was expressed frequently; similarly, failure to control one's behavior or to solve one's problems, whether as a result of a mental illness or any other problem, was considered a direct reflection on their efforts. The interviews showed that the traumatic respondents' experiences during the process of leaving Vietnam had a

profound effect on 1<sup>st</sup> generation Vietnamese-Americans, often leading them to avoid painful memories and traumatic experiences and refusing to talk about them. Other interviews revealed this was a more general cultural response to painful experiences of any kind, including, for example, serious mental illness. Moreover, 1<sup>st</sup> generation Vietnamese-Americans expected their children to implement the same coping strategies in dealing with problems. In some instances where families would seek spiritual guidance to address their children's mental illness, respondents suggested that their children "try harder" to overcome their mental illness, or ignore the issue completely. Indeed, several respondents from the study stated that mental disorders were a reflection of individual effort and work ethic. Respondents suffering from severe mental disorders would be labeled as being 'lazy' that often resulted in a delay in entering the treatment system as they struggled to deal with their illness on their own.

The qualitative study also highlighted two components of social network support that affected respondents' use of any mental health services. First, the forced migration for the 1<sup>st</sup> generation Vietnamese severed family ties and truncated social networks - many Vietnamese-Americans immigrants had to leave family and friends behind not knowing whether they will see them again. The limited network for Vietnamese refugees affected the number of people they could consult with for information about mental health issues, restricting 1<sup>st</sup> generation respondents to rely on small, primarily family networks. Coupled with limited networks, the values and beliefs of the network insulated families from seeking help outside of the family. Older 1<sup>st</sup> generation Vietnamese-Americans had a poor understanding at best of Western concepts of mental illness, health

practices, and treatment methods. As a result, most 1<sup>st</sup> generation Vietnamese respondents were reluctant to seek mental health services but instead relied on traditional religious or other spiritual services to deal with mental illness. These findings are consistent with the NEM, which stipulates people make health care decisions through the interaction of network ties and the values and beliefs of their network (Pescosolido, 1991; 1992; Pescosolido, Wright, Alegria, & Vera, 1998).

Another major focus of the study was to explore the influence of social support and mental health service use among Vietnamese-Americans with a serious mental illness. Since social support has been associated with using mental health services (Lam & Rosenheck, 1999; Thoits, 2011) and with buffers acculturative stress (Lee, Koeske, & Sales, 2004) that has been linked to poorer mental health outcomes (Dao, Lee, & Chang, 2007; Gonzales, Deardorff, Formoso, Barr, & Barrera, 2006; Koneru, Mamani, Flynn, & Betancourt, 2007), I hypothesized that: “Within first generation Vietnamese-Americans, there is an inverse relationship between the amount of social support received and any mental health service use; while in second and third-generation Vietnamese-Americans, there is a positive relationship between the amount of social support received and any mental health service use.” Both the quantitative analysis of the NLAAS data set and the qualitative study provided partial support for this hypothesis.

My initial bivariate analysis of the NLAAS data set suggest that variables associated with family support led to less use of any mental health services among the Vietnamese-American. This finding is consistent with research that has found that greater social support led to a perception of needing mental health services less and may suggest

that family support is a factor in delaying entry into the treatment system (Sherbourne, 1988; Thoits, 2011). Additional analysis from the logistic regression for social support variables was mixed as respondents who agreed that their ‘family feels close’ were less likely to use services than those who didn’t feel ‘family was close.’ Conversely, respondents who felt ‘very close in ideas and feelings with people of the same decent’ were more likely to use services compared to those who did not feel close in their ideas and feelings. This finding is consistent with what Nicdao and colleagues (2008) identified in their findings that as family support increased the use of specialist services also increased. The authors also did not find any association between relying on family and friend support and the use of generalist services but did find that family harmony, nativity, income and employment status were associated with using generalist and specialty services (Nicdao, Hong, & Takeuchi, 2008). The findings suggest that social support provides vital information about mental health services.

The analysis of respondents’ interviews also shows that the level of social support within their social networks was instrumental in creating pathways to mental health service use. Respondents developed negative or positive social network orientations based on the types of interactions they had with their social networks, and these interactions shaped their beliefs about who and where they could go to for help in time of need (Clapp & Beck, 2009; Larose, Bernier, Soucy, & Duchesne, 1999; Tolsdorf, 1976). For example, as the qualitative interviews demonstrated, 1<sup>st</sup> generation Vietnamese-Americans typically only tapped their immediate family social networks and did not seek to non-family support when seeking help with mental health problems. Consequently

more 1<sup>st</sup> generation respondents displayed a negative social network orientation towards non-family networks.

In contrast, 2<sup>nd</sup> generation respondents had mixed orientations to their social networks. For those whose parents blocked their attempts to seek help for mental health problems, some sought support elsewhere in the form of friends and religious institutions. The stress and burden of taking care of a family member with a serious mental illness pushed social support resources to its limits and forced some family members, especially those who suffered from mental disorders, to develop a mistrust of family support and cultivate a negative social network orientation at home. Other family members sought help from others, like hospitals or the police, who, in some cases, knew little about Vietnamese culture. In these instances, the need for resources from the social network was beyond what members were able to provide, leaving some Vietnamese-Americans to use the formal service system, even if the services were viewed as inappropriate (Pescosolido, Wright, Alegria, & Vera, 1998).

In response to parents who were resistant to their children using any mental health services and who were unsupportive, some 2<sup>nd</sup> generation respondents utilized the encouragement and support of non-family members that led to the use of mental health services. The additional external support 2<sup>nd</sup> generation respondents developed outside of their immediate family were instrumental to accessing new information and support in the form of encouragements and referrals. This support led 2<sup>nd</sup> generation respondents to develop a positive social network orientation that was separate from the family that provided a different outlet to address mental health needs. In all, the value of the strength

of having a positive social network orientation appeared to be instrumental to receiving vital support increased the likelihood of using any mental health services.

Overall, the results in this study support are consistent with what others researchers have found that social support is integral to the provision of care and information about mental health services (Nicdao, Hong, & Takeuchi, 2008). However, this study contributes to the literature in showing, based on findings from the qualitative study, how pathways to mental health service use at the micro treatment level are developed and are influenced by the source of social support. For example, the differences between generations of service use among Vietnamese-Americans in this study confirm what others have identified among the Asian-American community and service use (Abe-Kim et al., 200), between age differences and service use (Choi & Kim, 2010; Nguyen & Lee, 2012), and differences in awareness of mental health need (Sorkin et al., 2008; Nguyen, 2011). Findings from the qualitative study suggest that seeking help and support from different networks of people may influence help-seeking behaviors as a result of the values and beliefs about mental illness and what type of treatment is most appropriate. Having a negative social network orientation tends to “push” individuals away from information, values, and beliefs of that respective network and may force individuals to seek these resources elsewhere where it is more reliable. The reliable sources of support, or a positive social network orientation, provide greater opportunity to “pull” or access information that may affect what mental health choices individuals make. In general, the findings suggest that having diverse networks increases the heterogeneity

of information, values, and beliefs about mental illness and increases the likelihood that individuals will have gain information about what type of treatment is most appropriate.

### **Limitations of the Study**

There were several notable limitations to the study that restrict the generalizability of the findings. A major limitation of the NLAAS survey data is that the Vietnamese sample was predominantly 1<sup>st</sup> generation Vietnamese. As a result, I was not able to compare the generational differences in the use of formal mental health services. Despite being a nationally representative survey, the NLAAS sample of consisted mostly 1<sup>st</sup> generation Vietnamese-Americans. Another limitation of the study is that only the publicly released data, and not the restricted use data, was utilized in the analysis and may have affected associations between the independent variables and mental health service use. In addition to the quantitative data, there were important also limitations in my qualitative study. First, the limited size and SES diversity of the sample limited how much I could explore my key research questions. Most of the respondents were acquired as a result of snowball sampling via flyer postings, the Tet Festival (Vietnamese New Year celebration), the Internet such as email and social media outlets. Due to the small sample size and non-randomized sampling, the findings from the study are not generalizable to the larger Vietnamese population in the United States. The sample of respondents were mostly working class families and were relatively young in age that ranged from 21 to 43. Although flyers were posted at health clinics and corporate buildings, method of sampling may have contributed to the homogeneity of the sample.

The lack of 3<sup>rd</sup> and 4<sup>th</sup> generation participants in the sample also limited my ability to explore multi-generational differences in attitudes about and use of any mental health services. The general absence of research on 3<sup>rd</sup> and 4<sup>th</sup> generation Vietnamese-Americans points to the necessity of research that addresses the issues and concerns of the newer generations of Vietnamese-Americans. Since the Vietnamese population in the United States is still fairly young compared to other Asian subgroups, the mental health issues that 3<sup>rd</sup> and 4<sup>th</sup> generations is an important area of research.

Another limitation of my qualitative study is that the payment of \$40 to respondents may have influenced who participated and what was said. Payment is a possible source of bias and may have influenced respondents' participation in the study. I had originally offered \$20/hour for participation but had to increase the amount to \$40/hour due to the inability to attract enough recipients. During the screening process, most respondents indicated that their interest in the study was a result of their experiences in dealing with mental health issues and that they wanted to help.

Finally, the lack of testing for inter-rater reliability is another weakness of the study. Although themes were reviewed by myself and both Dr. Geron and a research assistant using a structured codebook, this is was not a sufficient substitute for assessing inter-rater reliability.

### **Implications for Social Work**

The results from this study, though limited, suggest several implications for the field of social work that are both clinical and macro in scope. Since the study shows the negative effects War and migration are long-lasting and as a result more attention is

needed to develop treatment approaches for treating trauma in ways that culturally acceptable and that the Vietnamese identify with. There is also a need for greater outreach for Vietnamese-Americans who tend to be more isolated than other Asian-American subgroups from their extended networks. Since older 1<sup>st</sup> generation Vietnamese-American respondents may have denser and less diverse social networks when compared to their U.S. born children who may have more diverse networks, accessing new information about mental health may be limited. The isolation may contribute to a lack of exposure to information relevant to mental health and promote reliance on traditional ways of coping and understanding in dealing with their mental health needs and inhibit mental health service utilization.

In addition to clinical social work, there are also implications for macro social work. In particular there is a need to train social workers on engaging language minority populations like Vietnamese-Americans who are isolated from the formal service system. More pressing now is the significant influx of refugees stemming from existing wars and conflicts in Iraq, Afghanistan, and Libya who may need mental health services as a result of the PTSD and war trauma they've experienced. In light of the needs of refugees, the list of macro issues that social workers need to address include: 1) need for greater use of translators for immigrants and refugees; 2) helping social workers and other health and social service professionals gain awareness of the cultural values and beliefs of recent immigrants and refugees; 3) evaluation of refugee's social history to determine social network orientation; and 4) working to help immigrant and refugees develop understanding of treatment options, benefits and terminology, and working with health

and mental health professionals to develop health literacy to engage with immigrant and refugee groups with serious mental health disorders. Ultimately, more attention is needed for change policies to make it easier for recent immigrant and refugee groups to navigate our complicated health care system for vulnerable immigrant and refugee families.

### **Future Research**

For additional future work, I would like to also continue to investigate the relationship between acculturation and mental health service use among Vietnamese-Americans. The significant association between feeling close to family and mental health service use requires additional research to understand how feeling close to social network members, regardless of size and density of network ties, may contribute to greater mental health service utilization. I am also interested in examining differences between mental health service use between Vietnamese-American and other Asian-American groups. Existing research suggests that mental health service use rates differ between age groups as identified by Choi and Kim (2010) and Nguyen (2010) and suggest there may be generational differences in service use (Abe-Kim et al, 2007). Further research will require a nationally representative survey of Vietnamese-Americans and other Asian-American subgroups that includes 2<sup>nd</sup> to 4<sup>th</sup> generation respondents. Finally, since the Vietnamese population is fairly young in comparison to other Asian-American subgroups in the United States, a longitudinal study of any mental health service use with a multigenerational sample of Vietnamese-Americans who have serious mental illness would greatly advance Vietnamese-American research.

## APPENDICES

### Appendix A

#### Selected Questions from Semi-structured Interview Guide

The following selection of questions will be used in the semi-structured interviews with 18 Vietnamese-Americans. The questions will explore the respondent's beliefs about mental illness and the use of mental health services, as well as explore their beliefs about mental illness influences their use of their social networks to address mental health problems and access mental health services. The complete questionnaire will include general background questions, including that the respondent or a member of his/her family has a serious mental health problem and questions on ethnicity, age, length of time in the United States, language spoken, English language proficiency.

1. Sometimes people have an imbalance in their mind and body. What are the words you use to describe people who have that kind of imbalance? (Probe for the words they use to describe mental health problems like depression and schizophrenia.)
2. Do you or a member of your family have a [name of mental health problem]? (Probe for who or whom in family. If YES, probe for how respondent describes/labels the mental health problem).
3. Can you please tell me about [your/his/her] [name of mental health problem]? (Probe for description of mental health problem in respondent's own words. Probe for history and trajectory of the problem: age at onset. Probe: Please tell me more about your views of mental health services?)
4. Do(oes) you have a diagnosis from a psychiatrist or doctor about the [name of mental health problem]? If YES, probe for formal source of diagnosis. If NO: probe for informal source who has identified the problem.

5. In your opinion, what do you think caused this [name of mental health problem]? (Probe to have them explain their beliefs e.g. ancestors, society, parents etc.).
6. When you [or name of family member] have problems with [name of mental health problem] do you get help from your family or friends? Probe for their experience when trying to get help. If NO, probe for reasons why not).
7. How do you heal [name of mental health problem] when it is not well? (Probe: What are some things you do?)
8. Does the Vietnamese community or your church help you deal with your (their) physical/mental/spiritual imbalance? (If YES, probe for source (temple, ancestor worship, attend church). Have these practices helped you deal (effective) with these problems? Why or why not?)  
  
Have [you/family member] gotten help for [name of mental health problem] from a doctor or other mental health provider like a psychiatrist or psychologist? (If Yes: please describe. Explore which are used, how often. How they feel about the services they use. If NO: What are some reasons why you won't use mental health services? What would have to be different or changed for you to use services?)
9. Do you think there are differences between traditional Vietnamese ways of treating [name of mental health problem] and Western medicine? Probes: Please explain. Which would you prefer and why? How did you come to believe in these practices?
10. What are some similarities and differences between how you think about [name of mental health problem] and how your [children/parent/grandparents] think about [name of mental health problem]?

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## CURRICULUM VITAE

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### EDUCATION

- |           |   |
|-----------|---|
| 2006-2015 | Ph.D. candidate, ABD at Boston University School of Social Work, Interdisciplinary degree in Sociology and Social Work. Thesis topic: Family Social Networks and Mental Health Service Use Among Vietnamese-Americans in Multigenerational Families. Degree expected September 2015 |
| 2004-2006 | M.S.W., University of Pennsylvania, School of Social Policy & Practice  |
| 1998-2003 | B.A., California State University, Long Beach, Department of Psychology   |

### RESEARCH INTEREST

My research focus has been primarily on mental health service utilization and social factors that contributes to under use in minority populations. Subsequent interests that stem from this focus are: AAPI youth and adolescent development, bullying, family violence, and the influence of social networks on human behavior. My overall interest in academia is to promote the duality of teaching and research and to engage students in a strengths based approach that engenders trust, mutual respect, and the equitable exchange of knowledge.

### RESEARCH EXPERIENCE

- |           |  |
|-----------|--|
| 2011-2012 | Graduate Research Assistant<br>Center for Addictions Research & Services<br>Boston University School of Social Work, Boston, MA<br>Professors Lena Lundgren; Melvin Delgado; and Maryann Amodeo <ul style="list-style-type: none"> <li>• Uploaded survey data using GPRA software</li> </ul> |
|-----------|--|

- 2007-2008 Graduate Research Assistant  
Boston University School of Social Work, Boston, MA  
Treatment and Psychopathology of Compulsive Hoarding Study  
Professor Gail Steketee
- Conducted interpersonal interviews using established psychological measures and hoarding instruments. Screened study subjects
  - Implemented field measures to determine severity of hoarding
  - Collaborated with team members to coordinate home visits
- 2006 Graduate Research Assistant  
Boston University School of Social Work, Boston, MA  
National Evaluation of Child Welfare Training Grants  
Professor Mary Collins
- Evaluated study questionnaires about program performance
  - Documented survey responses in Excel

### FIELD EXPERIENCE

- 2007 Independent Study on the Role of Social Development and its Impact on NGO Health Service Delivery in Mali, Boston University School of Social Work, Boston, MA
- Studied African culture and health delivery for 17 days in Mali
  - Visited key NGOs in Dogon Country to explore NGO response to female genital mutilation and HIV prevention
  - Interfaced with locals; ate with them and traveled with them
- 2005-2006 Financial Coordinator, Diversified Community Services, Dixon House, Philadelphia, PA
- Implemented financial management programs for the Center
  - Scheduled workshops with financial expert guest speakers
  - Lead weekly anti-predatory lending workshops with groups of 10-15 individuals who qualified for low income heating assistance
- 2004-2005 Social Work Intern, University City High, Philadelphia, PA

- Conducted 1:1 sessions and mentored international students on a weekly basis to address bullying, cultivate academic success, and develop coping strategies
  - Used a strengths based approach to facilitate group discussion of ethnicity and cultural heritage
  - Coordinated keynote speaker and special guests to address the prevalence of violence at an Anti-Violence Day event
- 2003-2004      Junior High Counselor (K-8<sup>th</sup>), Saint Catherine's Catholic Military School, Anaheim, CA
- Implemented play therapy, art therapy, and behavior modification with 24 children in grades 1-8.
  - Counseled ADD/ADHD and autistic students utilizing clinical interviewing and play therapy techniques
- 2002-2003      Gestalt and Client Centered Therapy Facilitator, Psychology Department at Cal State University, Long Beach, CA
- Proctored undergraduate students in Gestalt and Client Centered Therapy exercises
  - Conducted power lab scenarios and evaluated students' comprehension of theory and clinical skills
- 1999-2003      Junior High Counselor, The First Chinese Baptist Church, Fountain Valley, CA
- Provided spiritual and behavioral counseling to students ages 8 to 14 years
- 1999-2002      Mein/Hmong Camp Counselor, Mt. Hope Mein Camp, Forbestown, CA
- Served as summer camp counselor focused on behavioral and spiritual counseling ages 13 to 18 years
  - Provided spiritual and emotional support in dealing with problems relevant to each camper

### TEACHING EXPERIENCE

- 2009      MP781: Community Organizing, Boston University School of Social Work, MA
- Guest lectured about community organizing
  - Engaged students with reflexive questions about weekly required readings
  - Stimulated discussion during classroom exercises

- Coordinated with professor about classroom objectives
- Maintained a safe, positive, and open classroom environment

1999-2003

Hospitality Officer and Bible Study Leader, The First Chinese Baptist Church, Fountain Valley, CA

- Spearheaded outreach social events such as Bowling Nights, Potlucks, Beach Bonfires, and Hot-Pot Night, which had turnouts of 35-40 students
- Initiated interactions with newcomers, established relationships, and made newcomers feel welcomed
- Organized, prepared and taught weekly Bible study lectures and discussions about spirituality with college students

#### PUBLICATIONS AND PRESENTATIONS

Chu, J., Rubin, C.L., Lee, A.S., Ghosh, S., Sahgal, P., Kapoor, P., Sauma, D., Luk, C., & Freund, K.M. Defining the empowerment process: Perspectives of Asian domestic violence survivors and their advocates. Unpublished manuscript.

Hong, J.S., Cho, H., & Lee, A.S. (2010). Revisiting the Virginia Tech shooting: An ecological systems analysis. *Journal of Loss and Trauma*, 5(6), 561-575.

Lao, M., Lee, A.S., Roberts-Lewis, A.C., Hong, J.S., & Jiao, K. (2011). Child Maltreatment in China: An ecological review of the literature. *Children and Youth Services Review*, 33, 1709-1719.

Tsui, V., Lee, A.S., & Chui, E. (2013). Social Welfare in Hong Kong: Colonial Legacy and Challenges for the HKSAR. In S.B.C.L. Furuto (Ed.). New York: Columbia University Press.

2007

Poster: The Longitudinal Effects of Adolescent Co-Morbidity on HIV/Sexually Transmitted Infections

2005

Colloquium: Cultural Complexity in the age of Globalization: The Global and Local Dyad of the Therapeutic Model for Evidence Based Practices, Boston University

#### SERVICE EXPERIENCE

2009

Annual Program Meeting (APM) committee member, Council on Social Work Education Minority Fellows Program

2005-2006 Asian Social Work Council Chair, University of Pennsylvania  
 Field Placement Student Representative, University of Pennsylvania  
 Racism Sequence Student Representative, University of Pennsylvania

#### HONORS AND AWARDS

2013-2014 Boston University, School of Social Work Dissertation Grant Award for \$10,000  
 2008-2011 Council on Social Work Education Minority Fellowship Program Fellow  
 2003-2004 Counselor of the Year, Outreach Concern Inc. In appreciation for excellence in clinical judgment, dedication and commitment to counseling

#### SKILLS/CERTIFICATIONS

Languages spoken: Cantonese (fluent), Mandarin Chinese, (conversationalist), Spanish (beginner)

Software: Microsoft Office, SPSS, GPRA, NviVo Qualitative Analysis software, Papers pdf Management Software, Bookends Citation Software

Other: Grant writing, clinical interviewing