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Finding One’s Way to "a Place Where I Am Respected": the Experiences of First-Generation Vietnamese Americans with Depression and/or Post-traumatic Stress Disorder

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Finding One’s Way to “a Place Where I Am Respected”: the Experiences of First-Generation Vietnamese Americans with Depression and/or Post-traumatic Stress Disorder

A dissertation submitted in partial satisfaction of the requirements for the degree Doctor of Philosophy in Social Welfare

by

Hannah Thuy Thi Nguyen

2013
ABSTRACT OF THE DISSERTATION

Finding One’s Way to “a Place Where I Am Respected”: the Experiences of First-Generation Vietnamese Americans with Depression and/or Post-traumatic Stress Disorder

by

Hannah Thuy Thi Nguyen

Doctor of Philosophy in Social Welfare

University of California, Los Angeles, 2013

Professor Rosina Becerra, Co-chair

Professor Marjorie Kagawa-Singer, Co-chair

Despite the high prevalence of depression and post-traumatic stress disorder among first-generation Vietnamese Americans, their underutilization of mental health services continues to persist. The question of how culturally sensitive mental health services can be delivered to engage this population effectively in treatment has been a key issue for disparities research for the past several decades. Ample literature has identified individual, sociocultural and structural factors that influence mental health service use among this population, but very few studies have explored the perceptions of the clients themselves about mental illness or their pathways to care.

Twenty-one individual, inductive, and qualitative one-on-one interviews were conducted to address three aims: 1) to explore the conceptualizations of health among first-generation Vietnamese Americans living with depression and/or PTSD, 2) to illustrate the pathways through
which this population obtained outpatient mental health services, and 3) to describe their expectations and perceptions of outpatient mental health treatment. Constructivist grounded theory (GT) guided all aspects of this study.

The participants were mostly female and ranged in age from 42 to 74 years. Two major themes, “bounded within these four walls” and finding one’s way to “a place where I am respected,” emerged as overarching processes through which the participants described their experiences. Their rich stories portrayed journeys through losing, finding and reclaiming their self worth -- journeys marked with losses, sacrifices, disruptions, stigma, resilience, coming to terms with their conditions, and managing their illnesses. These men and women remained optimistic on the road to reclaiming their sense of self worth, despite being crippled by their legacies of war, trauma, and migration to the United States. Their stories offer a culturally nuanced understanding of how participants explained their emotional discomforts, how they found their various ways to agencies that could help ease these discomforts, and the unexpected resources and relationships they gained from outpatient mental health care. This study’s findings provide strong implications for social work research, practice, and policy that can help empower these individuals to find purpose and hope in their lives.
The dissertation of Hannah Thuy Thi Nguyen is approved.

Laura Abrams

Alfreda Iglehart

Ailee Moon

Rosina Becerra, Co-chair

Marjorie Kagawa-Singer, Co-chair

University of California, Los Angeles

2013
DEDICATION

This dissertation is dedicated to the aunts, uncles, and sisters who have gifted me with their stories and life experiences to make this project possible; and to all the individuals whose lives were touched by the Vietnam War.

Hằng xin cảm ơn các cô, chú, và các chị đã tặng cho Hằng một món quà thật quý. Đó là những tâm sự và câu chuyện về cuộc sống của mình và cũng là những bài học thật quý báo mà đã giúp Hằng viết ra luận án này. Hằng viết bài luận án này để ghi lại sự hy sinh cao cả của những người Việt đã bị ảnh hưởng bởi chiến tranh Việt Nam.
# TABLE OF CONTENTS

Abstract ii  
Committee Page iv  
Dedication v  
List of Figures viii  
List of Tables viii  
Acknowledgments ix  
Vita x

## Chapter 1 – Introduction
- Problem Statement 1  
- Background of Asian American Populations in the U.S. 2  
- Context of Mental Health Service Use 3  
- Research Goal and Objectives 5  
- Design and Methodology Overview 6  
- Significance & Implications 7

## Chapter 2 – Literature Review
- Vietnamese Americans in the United States 10  
- Mental Health Needs of First-Generation Vietnamese Americans 12  
- Mental Health Service Use among Vietnamese Americans 16  
- Conclusion 27

## Chapter 3 – Theoretical Review
- Introduction 29  
- The Anderson Behavioral Model 30  
- Network Episodic Model 32  
- Conclusion 37

## Chapter 4 – Design and Methodology
- Rationale for Inductive Research Design and Qualitative Inquiry 39  
- Guiding Conceptual Framework: Symbolic Interactionism (SI) 42  
- Sampling & Recruitment 43  
- Data Collection 49  
- Sample Description 54  
- Data Management 61
LIST OF FIGURES

Figure 1. An Overarching Framework of Study Aims and Corresponding Findings: A Process of Losing, Finding, and Reclaiming Self worth 75

Figure 2: Conceptualizations of Health among First-Generation Vietnamese Americans with Depression and/or PTSD 80

Figure 3. First-Generation Vietnamese Americans’ Pathways into Outpatient Mental Health Care for Depression and/or PTSD 109

Figure 4. Linking Outpatient Mental Health Treatment to the Reclaim of Self Worth 142

LIST OF TABLES

Table 1: Sample Demographics 57

Table 2: Participants’ Characteristics: Health Status before Coming To the U.S. and Treatment Status 58

Table 3: Categories and Dimensions on the Experiences of First-Generation Vietnamese Americans Living with Depression and/or PTSD 73

Table 4: Research Aim 1: Themes, Dimensions, and Properties 77

Table 5: Research Aim 2: Themes, Dimensions, and Properties 107

Table 6: Research Aim 3: Themes, Dimensions, and Properties 141
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VITA

2010-2013  Project Coordinator/Research Assistant
University of California, Los Angeles – Department of Psychology
Los Angeles, California

2011-2012  Teaching Assistant
University of California, Los Angeles – Department of Social Welfare
Los Angeles, California

2008-2010  Research Assistant
University of Southern California - School of Social Work
Los Angeles, California

2007-2009  Vietnamese Community Coordinator
Special Service for Groups (SSG), Older Adults Program
Los Angeles, California
Project: Racial and Ethnic Approaches to Community Health (REACH)
U.S. Health Access for Pacific Asian Seniors (HAPAS)/2010

2007  M.S.W., Social Welfare
University of California, Los Angeles
Los Angeles, California

2001  B.A., Sociology, Public & Community Services
University of California, Irvine
Irvine, California

PUBLICATIONS AND PRESENTATIONS


Chapter 1 – Introduction

Problem Statement

In 2001, the Surgeon General issued a first-of-its-kind report Mental Health: Culture, Race, and Ethnicity that highlighted disparities in access to and quality of mental health care for ethnic minorities (U.S. Department of Health and Human Services [USDHHS], 2001). A focus of this report was the provision of culturally relevant mental health services for ethnic minority populations. It is this same issue that Asian American mental health researchers have pondered since the 1960s. Several decades later, this challenge remains at the heart of the social work profession and the mental health professions at large. We are still trying to understand what culturally sensitive mental health service means and how it can be delivered effectively. Little progress has been made to address this question.

Research studies to date provide evidence for the prevalence of mental illness and the underutilization of mental health services (Abe-Kim et al., 2007; Harris, Edlund, & Larson, 2005; Zhang, Snowden, & Sue, 1998), as well as identify factors that predict service utilization (Leong & Lau, 2001) and treatment outcomes among Asian Americans (Takeuchi, Sue, & Yeh, 1995; Zane, Enomoto, & Chun, 1994). However, this body of research, largely informed by quantitative methodologies, is limited in its understanding of what the contexts are for Asian Americans with mental illness and how sociocultural factors could be integrated to improve mental health service use and quality of care for Asian American subgroups.

Little is known about the experiences of first-generation Vietnamese Americans, among whom there is a high prevalence of depression and post-traumatic stress disorder (PTSD) (Chung & Kagawa-Singer, 1993; W. L. Hinton et al., 1993; Tran, 1993). However, very few studies have explored the perceptions of first-generation Vietnamese Americans toward mental illness
and help seeking, how, why, and under what context they enter mental health treatment, and their perceptions of the care they receive once in treatment. Such knowledge could improve the utilization of mental health services and treatment outcomes for first-generation Vietnamese Americans. Thus, more research is needed to identify culturally relevant approaches to engage Asian American subgroups in treatment and to make mental health services more acceptable and effective for this population (Sue & Sue, 1999). This study seeks to address this gap.

**Background of Asian American Populations in the U.S.**

Asian Americans are the fastest-growing ethnic group in the United States, with approximately 14.7 million people comprising five percent of the total U.S. population (U.S. Census Bureau, 2011). Asian American is a heterogeneous category comprised of over fifty nationalities and over a hundred ethnic groups with diverse languages, cultures, socioeconomic statuses, length of time in the U.S., and pre- and post-migration experiences (USDHHS, 2001). Among the Asian American subgroups, Southeast Asians (particularly Vietnamese, Cambodian, Laotian) are at higher risk for mental illness given their refugee history driven by war and forced migration to the United States (Chung & Bemak, 2002; Marshall, Schell, Elliott, Berthold, & Chun, 2005; Meyer, Dhindsa, Gabriel, & Sue, 2009; Ngo, Tran, Gibbons, & Oliver, 2001). Upon arrival in the United States, most encountered a multitude of stressors associated with changes in family structure, way of life, and culture (Chung, Bemak, & Kagawa-Singer, 1998; Meyer, Dhindsa, et al., 2009; Moon & Rhee, 2006). For example, one study found that 70% of the Southeast Asian respondents met criteria for PTSD (Kinzie, Boehnlein, Leung, Moore, & et al., 1990). Another study found that Southeast Asians had the highest prevalence of depression among all Asian groups (Barreto & Segal, 2005). Experiences with trauma and post-settlement
adaptations continue to affect the mental health of Southeast Asians many years after their resettlement in the United States (Chung & Bemak, 2002; Marshall, et al., 2005).

Vietnamese Americans are the fourth largest and one of the fastest-growing Asian American subgroups with 1.5 million people in the United States (T. A. Nguyen, 2011). First-generation Vietnamese Americans came to this country as political refugees and immigrants who endured a multitude of stressors associated with war, trauma, and losses. Upon arrival in the United States, these individuals had few resources and little support to prepare for post-migration adjustments (Chung, et al., 1998; Kibria, 1993). Changes in family roles, gender expectations, and way of life exacerbated the psychological distress of Vietnamese immigrant families (Chung & Bemak, 2002; Meyer, Dhindsa, et al., 2009; Moon & Rhee, 2006). As such, depression and PTSD are particularly common among first-generation Vietnamese Americans (Buchwald et al., 1995; W. L. Hinton, et al., 1993; R. F. Mollica, Wyshak, & Lavelle, 1987; Tran, 1993). Despite research evidence indicating high rates of depression and PTSD for this group, first-generation Vietnamese Americans continue to underutilize mental health services (Barreto & Segal, 2005). Very few speak about their mental illness or seek mental health treatment.

**Context of Mental Health Service Use**

Studies that investigate the variation in incidence, prevalence, and outcome of mental illnesses among Asian Americans point to a variety of individual, sociocultural and structural factors that influence mental health service use for this population, such as stigma, incongruence in worldviews of providers and consumers pertaining to illness, language differences, and ability to pay for treatment (Herrick & Brown, 1998; Leong & Lau, 2001; Zhang, et al., 1998). Mental illness and help seeking remain highly stigmatized and poorly understood in the Vietnamese American community. Individuals with mental illness are generally referred to as *dien, khung* or
crazy, psychotic, and are marginalized. The attribution of mental illness to factors internal rather than external to the individual further exacerbates these stigmatized attitudes and beliefs. For example, mental illness may be viewed as caused by an imbalance in bodily am (negative) and duong (positive) forces and in the harmony between the individual and cosmological forces (Phan & Silcove, 1999). Other attributions include personal or family transgressions (Q. C. X. Nguyen & Anderson, 2005), poor moral character, spiritual weakness, faulty family upbringing, casting of a spell, or spiritual possession (Lien, 1993).

Cultural-specific attributions of the causes of mental illness thus shape Vietnamese Americans’ perceptions towards mental illness, and furthermore, when, how, and from whom they seek help (Kleinman, Eisenberg, & Good, 2006). The emphasis on saving face hinders an individual’s’ disclosure of, acceptance of, and treatment for a mental illness as it can bring shame and disgrace upon the entire family (Ng, 1997; Sue & Sue, 1999). Those with mental illness are hidden at home and suffer silently until the condition becomes unmanageable. When help is sought, Vietnamese Americans may seek out indigenous healers (e.g. herbalists, shamans, religious leaders) to cast away the bad luck and/or to restore wellness, depending on what these individuals believe is the cause of their illness (Phan & Silcove, 1999). The concept of talk therapy is non-existent in the Vietnamese culture; thus, many first-generation Vietnamese Americans are likely unfamiliar with the curative value of psychotherapy in treating their mental illness (Brower, 1980; Uba, 1994).

Indeed, Vietnamese Americans’ conceptions about mental illness tend to differ from the monocultural, Western biomedical paradigm that dominates knowledge about and treatment for mental illness in the United States (Kagawa-Singer & Chung, 2002; Sue & Sue, 1999). Modern psychiatry assumes the universality of behavioral expression and manifestation of psychiatric
disorders (Fabrega, 2001). In the United States, mental illness is viewed and treated as a disease with a physiological, genetic, or chemical base (Aneshensel & Phelan, 1999). The appendix of Cultural Bound Syndromes in the Diagnostic and Statistical Manual of Mental Disorders (DSM) is reductionistic and inadequate for understanding and assessing the complex nature of idioms of distress across cultures (Kleinman, 1988). Western psychotherapy’s emphasis on individual autonomy, verbal communication, and exploration of intra-psychic conflict (Leong & Lau, 2001) may create discomfort for Asian Americans who are not accustomed to verbalizing and reflecting about their own needs and view themselves as interdependent with the larger group (Kagawa-Singer & Chung, 2002). As such, the lack of bilingual and bicultural providers can deter their willingness to utilize mental health services, and can further result in low quality of care for those already in treatment (e.g. fewer sessions, lower GAF scores, and shorter stays) (Takeuchi, et al., 1995; Zane, et al., 1994). The few ethnic-sensitive services are often concentrated in ethnic enclaves, making it difficult for those who live outside these regions to access them (Kang et al., 2010). Recent cuts in government funding have resulted in fewer staffs and longer waits at these ethnic-specific outpatient centers. Other factors such as limited English proficiency (Bauer, Chen, & Alegria, 2010; Sentell, Shumway, & Snowden, 2007), lack of insurance coverage (Kung, 2003), limited financial means to pay for treatment, and lack of transportation (Wong et al., 2006) can further deter Vietnamese Americans’ use of mental health services.

**Research Goal and Objectives**

Despite ample literature on mental health prevalence rates and factors that influence mental health service use among first-generation Vietnamese Americans, few studies have explored the experiences and perceptions of those suffering from mental illness and receiving
outpatient care. Outpatient treatment refers to that offered by mental health professionals such as psychiatrists, psychologists, psychiatric nurses, social workers, and care manager (B. A. Pescosolido & Boyer, 2010), usually in an appointment-based non-hospital setting. The most prevalent disorders among this group appear to be depression and PTSD (Kinzie, et al., 1990; R. F. Mollica, et al., 1987). Thus, the primary goal of this research study was to explore and describe the experiences of first-generation Vietnamese Americans receiving outpatient treatment for a diagnosis of depression and/or PTSD. In seeking to understand this phenomenon, the study proposed the following three aims:

1. explore the conceptualizations of health among first-generation Vietnamese Americans living with depression and/or PTSD,
2. illustrate the pathways through which first-generation Vietnamese Americans with depression and/or PTSD obtain outpatient mental health services, and,
3. describe their expectations and perceptions of outpatient mental health treatment.

**Design and Methodology Overview**

Given the research question, the unique sample, and the lack of prior targeted findings, this study utilized an inductive approach with qualitative methods to answer the research objectives. Specifically, constructivist grounded theory (GT) guided all aspects of this study (Charmaz, 2006). Constructivist GT is a qualitative research methodology that allows for the exploration of the processes and complexities of a phenomenon grounded in the words and lived experiences the participants.

Using purposive sampling, participants were recruited from outpatient mental health agencies and consumer support groups that serve Vietnamese Americans in Southern California. Individual in-depth, one-on-one interviews were conducted with 21 first-generation Vietnamese
Americans who were diagnosed with depression and/or PTSD and who were receiving outpatient treatment. Data were analyzed using the identified steps in constructivist GT analysis (Charmaz, 2006).

**Significance & Implications**

Mental illness is the number one cause for disability in the U.S. (World Health Organization, 2004). The underutilization of mental health treatment among first-generation Vietnamese Americans may have dire consequences for the well-being of individuals living with mental illness but not receiving help. The disabling effects of untreated mental illness can limit the quality of life and productivity of individuals (USDHHS, 2001). Untreated mental illness can lead to more persistent and severe mental health problems over time (National Institute of Mental Health, 2005), cause additional negative health consequences (Henshaw & Freedman-Doan, 2009), and pose a burden for families and others who provide care to the individual with the mental illness (Loukissa, 1995).

Mental health treatment has been found to be effective in treating some cases of mental illness (USDHHS, 2001). While studies on the effectiveness of mental health treatment for first-generation Vietnamese Americans remain limited, some research suggests an improvement among Asian Americans who utilize mental health services. For example, Mollica and colleagues (1990) found a decrease in depressive symptoms among Cambodians six months after they entered treatment. Flaskerud and Hu (1994) found that participation in mental health treatment was associated with higher Global Assessment Scale (GAS) scores at discharge among Chinese, Japanese, and Koreans with major depression. Thus, mental health treatment seems warranted for the Vietnamese Americans with mental health disorders. Notably, the detection and treatment of mental illness in its early stages may help to mitigate the symptoms and severity
of the disorder (Goldberg & Steury, 2001), so access to quality treatment would appear to be warranted.

It was the goal of this study to yield findings that could inform research and practice in order to improve mental health service use and quality of care for first-generation Vietnamese Americans. In terms of research, this study contributed to the larger body of mental health disparities research by aiming to better understand factors and processes associated with mental health service use among diverse ethnic populations, and first-generation immigrants more specifically. It would make meaningful contributions to the literature about the unique experiences and perspectives of first-generation Vietnamese Americans living with and receiving treatment for depression and/or PTSD – those whose voices have received very little attention in the literature. Findings might also be applied to research with other groups with similar characteristics, particularly for refugee communities where trauma is a community-wide issue that affects all the members. Further, research could shed light on the relevance of existing help-seeking theories and their application to the context of first-generation Vietnamese Americans.

Findings from this study could also have implications for policy and practice. First, findings could inform California’s Mental Health Services Act (Proposition 63) and the Affordable Care Act by integrating the worldviews of first-generation Vietnamese Americans into the design of culturally-relevant policies and programs to improve mental health service use and quality of care for this population. Second, findings could shape culturally-appropriate treatments that respond to the worldviews and needs of first-generation Vietnamese Americans, thereby improving the quality of care for this group. Finally, for social work theory and practice, findings could contribute to knowledge about health, mental health, and help-seeking beliefs and practices of first-generation Vietnamese Americans and inform social work practice by
suggesting strategies for mental health social workers to engage this group in more productive and effective treatment.
Chapter 2: Literature Review

This review begins with a historical overview of Vietnamese Americans in the United States, followed by evidence on the prevalence of depression and PTSD among first-generation refugees and immigrants. Then, factors that influence mental health service use are discussed, including barriers, promoting factors, and cross cultural variations in the expressions of and responses to mental illness.

Vietnamese Americans in the United States

The 2010 Census reported that approximately 1.5 million Vietnamese Americans live in the United States, making them the fourth largest and one of the fastest-growing Asian American subgroups (T. A. Nguyen, 2011). Individuals between the ages of 35 and 64 comprise 42% of the Vietnamese American population, followed by those aged 18 or younger (26%), 18 to 34 years old (23%), and 65 years or older (9%) (U.S. Census Bureau, 2009). Two-thirds, or one million of Vietnamese Americans are foreign-born. Among the Asian subgroups, Vietnamese Americans have the highest proportion of people who speak a language other than English at home (89%) and who speak English less than very well (55%). This group is among the Asian subgroups with the highest poverty rates (16%), and one in five has no health insurance coverage.

Vietnamese Americans have a unique migration history to the United States: one triggered by decades of turmoil and unrest in their war-torn home country. First-generation Vietnamese Americans are those who were born outside the United States and who arrived after the age of 12 (Zhou & Bankston III, 1998). Many came to the United States from the mid-1970s to the early 1990s as refugees, and others came from the late 1980s to the present as immigrants. A refugee is an individual who “owing to a well-founded fear of being persecuted for reasons of
race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country…” (United Nations Higher Commissioner for Refugees, 2010). An immigrant is an individual who “voluntarily and for personal reasons, moves from his or her place of origin to a particular destination with the intention to establish residence without being compelled to do so…” (International Organization for Migration, 2010).

The earliest waves of Vietnamese Americans to arrive in the United States consisted of refugees, beginning with the United States’ evacuation of South Vietnamese at the end of the Vietnam War in 1975 (Birman & Tran, 2008). This group was wealthy and educated and consisted of military personnel, professionals, South Vietnam elite, government officials, wealthy business owners, and members of the Catholic church (Zhou & Bankston III, 1998). The second wave consisted of the lower middle class and rural poor (Zhou & Bankston III, 1998) who escaped Vietnam by foot and boat to refugee camps in Thailand, Indonesia, Malaysia, Hong Kong, and the Philippines (Birman & Tran, 2008; Shapiro et al., 1999). The second wave began in 1978 and continued through the early 1990s. These refugees remained at the camps for several months to several years before receiving approval to resettle in the United States or other receiving countries. In response to the rising number of Southeast Asian refugees, 70 countries adopted the Comprehensive Plan of Action in 1989 (Robinson, 2004). This plan, which implemented the screening and repatriation of refugees around the world, eventually ended the flow of asylum seekers from Vietnam.

During the late 1980s and early 1990s, a third wave of Amerasians and South Vietnam servicemen and their families came to the United States through the family reunification program known as the Orderly Departure Program (Birman & Tran, 2008) and the Humanitarian
Operations (HO) program for former South Vietnam political prisoners (Zhou & Bankston, 1993). According to the definition of the International Organization for Migration, these were the first Vietnamese immigrants to arrive in the United States. Today, there is a continuing flow of small numbers of Vietnamese immigrants to this country mainly through the sponsorships of families who came in earlier waves.

**Mental Health Needs of First-Generation Vietnamese Americans**

*Context of mental health needs.* The Vietnam War began in 1955 and lasted until 1975. During these two decades of war, bombing, death and dying, and uncertainties about the future became the daily reality for Vietnamese families. As the Vietnam War with the United States came to an end in 1975, Vietnamese servicemen who served in the South Vietnam army were rounded up and sentenced to years in re-education camps, where they were tortured, starved, and physically and psychologically abused (Zhou & Bankston III, 1998). Their families were left to live in poverty and under strict political, social, and religious control. Hundreds of thousands of these Vietnamese and others fled the country in search of freedom and life with a promise elsewhere.

Many Vietnamese endured dangerous escapes by sea and harsh living conditions in the international refugee camps in order to seek refuge in the United States and other receiving countries. Over 600,000 Vietnamese were admitted to the United States between 1975 and 1995, most of whom were refugees (Zhou & Bankston III, 1998). The loss of status, risk of poverty, and culture shock were sources of distress for Vietnamese immigrants, particularly among those who were educated, wealthy and of high military rank before the war ended. Long work hours, shifting family roles and intergenerational conflict weakened the cohesion and well-being of the Vietnamese family (Tran, 1993). Further, many left Vietnam without family or had lost family
members during the war or in transit to host countries. In the new country, it was common for single parents to raise their young children alone or for siblings to care for one another without their parents (Kibria, 1993). Economic, linguistic, and sociocultural marginality isolated early Vietnamese immigrants from opportunities in the mainstream community. For many, the skills and education that they had in Vietnam, if any, were not transferable to their new life in the United States (Zhou & Bankston III, 1998). Nonetheless, newly arrived immigrants all had to support themselves and their family members, so they picked up any job that was available to them, often low-wage, low-skilled, and with little to no health and long-term benefits (Kibria, 1993). Adjustment to life in the United States was particularly difficult for older immigrants who had to compete in a competitive labor market with limited job skills and English language proficiency. The loss of social and economic status was common for Vietnamese American immigrants.

The climate in which Vietnamese Americans arrived was an unwelcoming one. After the Vietnam War ended, the American public held ambivalent and resentful attitudes about the waves of refugees coming into the United States (Zhou & Bankston III, 1998). Vietnamese Americans were viewed as aliens, competitors, and dependents who were using the American tax dollars through government-funded social programs. The U.S. resettlement program purposefully scattered these families throughout urban or suburban neighborhoods across the country in small groups to reduce the burden on receiving communities, but the groups were too small to provide support to each other, and the families had little preparation for their new lives (Zhou & Bankston III, 1998). These families experienced social isolation in a community where they did not speak the language nor had a social support system from other Vietnamese Americans. Those who arrived under the status of refugees received help from the voluntary
social service agencies (VOLAGS) that linked them to English classes, job counseling, and governmental programs such as the Refugee Cash Assistance and Refugee Medical Assistance programs, Aid to Families with Dependent Children, Supplemental Security Income, Medicaid, and food stamps (Kibria, 1993). Those who came under the immigrant status, however, did not have access to these resources to the extent that the Vietnamese American refugees had. Nonetheless, these forms of assistance provided minimal subsistence and were short-term. The reality many Vietnamese Americans faced was that they transitioned into unstable jobs or occupations with low pay and limited benefits that hindered their economic advancements (Kibria, 1993; Zhou & Bankston III, 1998).

Thus, both the traumatic pre-migration experiences and challenges in post-migration adjustments of first-generation Vietnamese Americans increased their risk for mental health problems such as depression, adjustment disorders, PTSD, somatization, as well as physical disorders (Chung & Bemak, 2006; Hsu, Davies, & Hansen, 2004; Shapiro, et al., 1999; Ying, 2001). Even after several decades of living in the United States, many first-generation Vietnamese Americans continue to suffer silently from mental illness.

**Prevalence of depression and PTSD.** The burden of mental illness is pronounced among first-generation immigrants and refugees who were born in Vietnam and had first-hand experience with war, forced migration, and adjustment to a new country. A number of studies have documented the prevalence of depression and PTSD for this group (Buchwald, et al., 1995; W. L. Hinton, et al., 1993; R. F. Mollica, et al., 1987; Tran, 1993). While these early studies were limited to small clinical and community samples, they shed light on the dire mental health needs of first-generation Vietnamese Americans that otherwise would remain unknown. One study revealed that as many as 54% of the 127 Vietnamese refugees at a psychiatric clinic met
the DSM-III criteria for PTSD (Kinzie, et al., 1990). In another study of DSM-III disorders among 201 newly arrived Vietnamese, 24.1% had one or more current disorders, 8.4% had adjustment disorder, 7.2% had major depression, and 7.2% had PTSD (W. L. Hinton, et al., 1993). Similarly, Buchwald and colleagues (1995) examined the prevalence of depressive symptoms among 1,998 adult Vietnamese refugees within two months of their arrival in the United States and found that 6% met the criteria for probable depression. Nearly one-third reported psychological symptoms of sadness and concentration difficulties. Common physical symptoms included headaches, loss of appetite, fatigue, and anxiety about having these symptoms. In another study of 100 Vietnamese refugees attending a psychiatric clinic, as many as 34% of participants reported having orthostatic panic attacks, meeting criteria for the DSM-IV diagnosis of PTSD (D. E. Hinton et al., 2007).

Some studies examined factors associated with pre-migratory trauma and post-migration adjustments that contribute to the prevalence of mental disorders among first-generation Vietnamese Americans. For example, Mollica and colleagues (1987) found more depression and PTSD among ex-political detainees who were exposed to more trauma events (witnessing killing, deprivation, physical injury or torture, lack of food or water) than among the comparison group (depression = 49% vs. 15%; PTSD = 90% vs. 79%). In a study that included a non-clinical sample of 847 Vietnamese refugees, significant pre-migration predictors for depression included more trauma events, and anxiety predictors included more family member deaths (Chung & Kagawa-Singer, 1993). Significant post-migration predictors for depression included lower family income, and anxiety predictors included lower family income and larger family size in the United States (Chung & Kagawa-Singer, 1993).
Moreover, research has identified gender, English language proficiency, age, and education as significant predictors of mental distress among Vietnamese Americans. One study found that Vietnamese women were more likely to experience depression and anxiety than men, that the likelihood of self-reported depression and anxiety increased with age, and that those with higher education in Vietnam were less likely to report depression and anxiety (Chung & Kagawa-Singer, 1993). Based on 184 recent Vietnamese immigrants, one study compared the psychosocial adaptation differences and predictors of mental distress across three generations (elderly, middle-aged, or young adults) and found that the two older groups appeared to have greater difficulty adapting to life in the U.S. (Shapiro, et al., 1999). Young adults were the most acculturated and most bicultural and were significantly less depressed than the oldest group. However, young adults also reported the most dissatisfaction with their current lives and with family conflict. In another study, Hinton and colleagues (1997) found that two factors - being older and having limited English language proficiency - predicted depression among Vietnamese refugee respondents 18 to 24 months after their arrival in the United States. Overall, these findings highlight the immense difficulties first-generation Vietnamese Americans faced when adjusting to their new lives in the United States, such as intergenerational conflict, limited English language proficiency, role reversal, downward social mobility, and financial problems (Hsu, et al., 2004). Thus, post-migration stressors can exacerbate the mental health problems of this group.

**Mental health service use among Vietnamese Americans**

While research on mental health service use specific to first-generation Vietnamese Americans remains limited, the few studies on Vietnamese Americans indicate they are less likely than their White counterparts to see a mental health professional for their mental health
problems (Abe-Kim, et al., 2007; Sorkin, Tan, Hays, Mangione, & Ngo-Metzger, 2008). For example, compared with the general population, fewer Vietnamese Americans sought any mental health-related service (9.96% vs. 17.9%) and specialty mental health service (3.92% vs. 8.8%) (Abe-Kim, et al., 2007; Wang et al., 2005). Indeed, service underutilization can put Vietnamese Americans at risk for severe and persistent mental illness. This risk is likely greater for first-generation Vietnamese Americans who have had mental illness for many years but have not and are not receiving appropriate professional help.

Factors that influence mental health service use

Given the lack of published research on help seeking among Vietnamese Americans, factors influencing use of mental health services are drawn from the larger Asian American literature. The discussion that follows is based on Leong and Lau’s (2001) categorization of four types of barriers that Asian Americans face when initiating mental health treatment: cognitive, affective, value orientation, and physical, which examine factors at the individual level and then moves to sociocultural and structural levels. It is important also to examine factors that promote mental health service use, thereby prompting those with mental illness to enter treatment. Finally, the influence of immigration-related factors on help-seeking behaviors will be discussed.

Barriers

Cognitive barriers. Cognitive barriers pertain to beliefs about the nature, causes, and cures of mental illness (Leong & Lau, 2001). Within the Vietnamese culture, illnesses are explained in terms of mind/body interconnectedness, cosmology, and supernatural or animistic beliefs (Phan & Silcove, 1999). The individual is viewed as a holistic entity whose wellness is maintained through a balance within oneself and harmony with one’s environment (Wing, 1998). As such, many believe that a disturbance in bodily am (negative charge) and duong (positive
charge) forces or in one’s harmony with cosmological elements (earth, air, fire, water, metal) can negatively impact one’s well-being (Phan & Silcove, 1999). Vietnamese beliefs also view the mind and body as interconnected, holistic entities, and a disruption in one’s bodily wellness will also influence one’s psychological state and vice versa. Therefore, psychological distress may be experienced and manifested in somatic forms (Kawanishi, 1992), such as headaches, dizziness, and fatigue.

Illnesses may be caused by retribution for personal or family transgressions, faulty family upbringing, poor moral character, and spiritual weakness (Lien, 1993). Some may also attribute illness to spiritual possession or casting of a spell (Lien, 1993; Luu, Leung, & Nash, 2009). Fatalism, or the acceptance of one’s situation, is another prominent belief among some Vietnamese Americans (Hsu, et al., 2004). Fatalism is rooted in the Buddhist belief that life experiences are due to fate and karma, which are consequences of past deeds of the self or even ancestors (Abeug & Chun, 1996). For some, fatalism may mean accepting one’s fate in this life that one cannot change, including having a mental illness. As such, mental illness may be highly stigmatized in the community due to the belief that it is caused by the individual’s or their family’s bad deeds.

Thus, the meanings individuals ascribe to mental illness influence their perceptions about these problems, the need for help-seeking (Koroukian, 2008), and whether professional help is an appropriate means to alleviate the problems (Akutsu & Chu, 2006). In the United States, one acceptable course of action for those with mental illness is to obtain treatment from mental health professionals (Uba, 1994). However, this may not be the case among Vietnamese Americans, who hold a different set of beliefs about the causes of mental illness and appropriate help-seeking behaviors. For example, people who believe mental illness is due to a disruption in
balance and harmony would seek help from traditional healers and herbalists to restore balance and wellness (Phan & Silcove, 1999). If they view mental illness as spiritual-related, then they would obtain blessings from religious leaders to remove the bad spirit or to pray for good things to come. Shamans and sorcerers may be sought out to remove bad curses and misfortunes and to provide advice for healing (Phan & Silcove, 1999). Vietnamese commonly practice rituals such as offering prayers and articles to the spirits or ancestors to expel bad luck and to bring good health. Individuals who experience somatic symptoms may turn to medical doctors to treat what they believe are physical problems. The degree of consonance between the beliefs and assumptions of first-generation Vietnamese Americans and the Western mental health systems are likely to influence whether and how Vietnamese Americans choose to enter outpatient care (Sue & Sue, 1999). Thus, Vietnamese Americans’ perceptions of the causes of mental illness can deter decisions to enter outpatient care when they believe that indigenous healing methods are more appropriate treatment choices.

**Affective barriers.** Affective barriers consist of attitudes and perceptions toward mental illness and help seeking (Leong & Lau, 2001). In the Vietnamese culture, individuals with mental illness are labeled as *dien khung* (crazy, mad, psychotic) and are avoided at all cost due to the belief that they are violent and dangerous. The term mental illness is most often equated with the most severe and disruptive behaviors. Individuals have little to no knowledge about the distinction between the types and severity of mental illness used in Western biomedicine. A limited understanding of the causes and nature of mental illness further reinforces the stigma and blaming of those with mental illness (Lien, 1993; Ng, 1997). As such, mental illness is viewed as an individual deficiency and a shameful condition that brings disgrace upon the individual and the name of the family.
The stigma toward and misconceptions about mental illness in the Vietnamese community can result in the marginalization of individuals with mental illness (Kramer, Ton, & Lu, 2006; U.S. Department of Health and Human Services, 2001). The labeling of individuals with mental illness as *dien khung* often leads to the treatment of them as deficient and as marginal members of society. On the personal level, Vietnamese Americans with mental illness may see themselves as outcasts. These individuals may further face rejection within their own families, simply because of the families’ lack of understanding about mental illness and the expectations that individuals with mental illness are incapable of living “normal” lives and have little hope for recovery. The pervasiveness of stigma and misconceptions about mental illness further result in the marginalization of individuals with mental illness from their own communities (Kramer, et al., 2006). Some Vietnamese Americans may be hesitant to disclose their mental illness and seek mental health treatment due to the fear of being viewed as crazy and being shunned by others in the community, or suffering from loss of face. “Face” is the idea of preserving the honor and image of one’s family and influences Asian Americans’ decisions to seek professional help (Kramer, et al., 2006). This means that individuals within a family are responsible for upholding the family reputation through their actions (Wynaden et al., 2005). For individuals with mental illness, seeking help outside of the family may result in the loss of face for several reasons. Such public disclosure of one’s illness may bring shame upon one’s family (Q. C. X. Nguyen & Anderson, 2005), as the entire family is now associated with having a member who is crazy. The family also may be judged negatively due to the belief that their family member’s mental illness is caused by the family’s bad morals and poor relationships. Such a label could result in the distancing of neighbors and others in the community from the individual known to have the mental illness and his/her family.
Moreover, within the Asian culture, there is an emphasis on internal control such that individuals withhold and resolve problems on their own. Help seeking may be perceived as a sign of personal weakness (B. S. K. Kim & Omizo, 2003) and the inability of an individual and his/her family to resolve their own problems (Q. C. X. Nguyen & Anderson, 2005). One’s problems are to remain strictly within the family and not to be told to outsiders. It is therefore common for individuals with mental illness to hide the illness or to be taken care of at home (Weine & Siddiqui, 2009) until the condition becomes unmanageable (Lien, 1993). If help is sought outside of the family, immediate/informal sources of support such as community resources and indigenous healers are often the first line of support (Sue & Sue, 1999), and professional mental health treatment is the last resort (Zhang, et al., 1998). Thus, the stigma and shame associated with mental illness and help seeking continue to hinder decisions to enter outpatient care among first-generation Vietnamese Americans.

Value orientation barriers. Another barrier to mental health service use is the conflict between Asian American values and those of the mental health system (Leong & Lau, 2001; Zhang, et al., 1998). Talk therapy is non-existent in Southeast Asia (Ying, 2001). Thus, it can be expected that first-generation Vietnamese Americans are not familiar with what therapy really entails (Brower, 1980; Q. C. X. Nguyen & Anderson, 2005), as well as the curative value of talk psychotherapy and the roles of multiple sessions, reflecting on one’s problems, and psychotropic medication (Uba, 1994). When individuals are in treatment, differences in treatment expectations between clients and providers are probable due to the lack of familiarity with therapy among Asian Americans. Western psychotherapy’s emphasis on the individual, verbal communication, and exploration of intra-psychic conflict may be incongruent with the collectivistic and non-verbal communication Asian values (B. S. K. Kim & Omizo, 2003; Sue &
Insight-oriented therapy that requires talking through one’s feelings, experiences, and cognition can create discomfort for Vietnamese Americans who are not accustomed to verbalizing and reflecting about their own needs. Further, these therapeutic strategies may be incongruent with Asian American clients’ expectations for pragmatic, immediate solutions to their problems. Psychotherapy’s emphasis on autonomy and happiness of the individual can conflict with Asian Americans’ conceptualization of the self in relation to and interdependent with the larger group and community (Kagawa-Singer & Chung, 2002; Markus & Kitayama, 1991). Thus, incompatibilities in the values and expectations between mental health services and Asian American clients can further deter help seeking in this population (Zhang, et al., 1998).

Literature in anthropology, sociology, and cross-cultural psychology has well established the influence of culture on how mental disorders are understood, experienced, manifested, and managed (Fabrega, 2001; Kagawa-Singer & Chung, 2002; Kleinman, 1988). Indeed, Vietnamese Americans’ conceptions about mental illness tend to differ from the monocultural, Western biomedical paradigm that dominates knowledge about and treatment of mental illness in the United States. Modern psychiatry views and treats mental illness as a disorder or disease with a physiological, genetic, or chemical base (Aneshensel & Phelan, 1999) and less a character flaw or a family’s responsibility. The tradition further assumes the universality of behavioral expression and manifestation of psychiatric disorders (Fabrega, 2001; Sue & Sue, 1999). As such, the diagnostic categories in the DSM are culturally biased toward Western conceptualizations of mental illness. For example, the criteria of mental disorders focus on spheres of thought and emotion (Fabrega, 1989), which can discount somatic forms and idioms of distress (Kleinman, 1988) that are prevalent across Asian groups. The differentiation of mental illness from physical illness can negate or seem incompatible with and incomprehensible
to Asian Americans’ beliefs in the interconnectedness of mind and body. As such, research has pointed out the ethnocentricities in modern psychiatry that ascribe taken-for-granted diagnostic criteria and classifications to individuals with mental illness without consideration of the sociocultural, spiritual, and existential contexts of their experiences and expressions of mental distress (Fabrega, 2001; Kleinman, 1988; Stein, 1993). The application of a Western biomedical model to engage and treat ethnic minority populations in therapy may impose certain assumptions about mental illness and treatment rather than integrate the belief systems and practices that are relevant for these populations (Sue & Sue, 1999).

Cultural variations in conceptual, semantic and contextual expressions of mental distress may contribute to diagnostic inaccuracy and miscommunication when Western clinicians assess Vietnamese patients (Phan & Silcove, 1999). For example, many mental illness-related descriptions in the English language do not translate directly to or have meaning in the Vietnamese language. It may take several phrases to translate one English term into Vietnamese. While a range of expressions relating to thoughts, feelings, and behaviors exists in the Vietnamese language, some terminologies cannot be directly translated into English (Kinzie et al., 1982). Some mental health terminologies may not exist in the Vietnamese language.

Moreover, research studies have found that factors such as ethnic- and language-match (Takeuchi, et al., 1995), experiential similarities between clients and clinicians (Meyer et al., 2011), and cognitive match (e.g. problem conceptualization, means for coping with or solving the problem, and goals for treatment) (Zane et al., 2005) could improve the quality of care for diverse ethnic clients. Thus, the lack of culturally and linguistically sensitive mental health services could make mental health treatment appear to be of little value and unfriendly to first-generation Vietnamese Americans and may hinder their use of service.
Structural/physical barriers. Research indicates that structural factors (e.g. socioeconomic status, insurance coverage, English language proficiency, and geographic location in proximity to services) pose significant barriers to Asian Americans’ use of mental health services (Leong & Lau, 2001). These barriers may be more pronounced for first-generation Vietnamese Americans who are older, lack the resources and skills to navigate services, and are more culturally and linguistically isolated compared with those born in the United States (Rhee, 2009). Some studies have found that Asian Americans without health insurance coverage were less likely to use mental health services compared with their insured counterparts (Kung, 2003; Marshall et al., 2006). In another study, 80% of the Cambodian respondents reported high cost of services as a reason for not seeking Western mental health care (Wong, et al., 2006). Thus, both cost and time required for psychotherapy may deter willingness to initiate treatment (Bemak, Chung, & Bornemann, 1996). For Vietnamese American immigrant families, the priority is to meet the basic necessities of daily living (e.g. food, housing, monthly bills). Working to contribute to the family income has highest priority, and does not allow for taking time off work to attend multiple treatment sessions and then paying for these sessions.

The limited capacity of the mental health system to respond to the cultural and linguistic needs of Asian Americans poses additional barriers to service use. In one report, the Surgeon General raised concerns about the lack of an Asian American mental health workforce proportionate to the number of Asian Americans who need mental health services (U.S. Department of Health and Human Services, 2001). First-generation immigrants who lack knowledge and language to navigate mental health services will be less likely to seek help from providers who neither speak their native language nor understand their culture. The few
culturally and linguistically tailored mental health services are often concentrated in ethnic enclaves (Kang, et al., 2010). Even so, these agencies are limited in the number of providers who are fluent in the clients’ native Asian language. Agencies are overtaxed resulting in high caseloads, limited session times, and long waitlists. Asian Americans who live outside the ethnic communities must travel long distances to reach these providers, which can take up to several hours to and from the service site (Kang, et al., 2010). Distance and transportation barriers may be worse for older immigrants who are unable to drive (Palinkas et al., 2007). Others may not have a car or may be unable to utilize the public transportation system due to limited English language proficiency and unfamiliarity with public transportation. In one study of factors that influence Cambodians’ decisions to seek mental health treatment, nearly one in four reported transportation issues as a barrier to service (Wong, et al., 2006). In some cases, many are not aware of the availability of mental health services in or near their place of residence (G. Kim et al., 2011).

Factors that prompt mental health service use

Severity of condition. In addition to the examination of factors that can hinder mental health service use for Asian Americans, other studies have identified factors that promote entry to care. The presence and severity of identifiable mental health problems are likely to be related to mental health service use for Asian Americans. Research has found that mental health-related service use was higher among individuals with probable DSM-IV diagnosis compared with those without one (34.1% vs. 6%) (Abe-Kim, et al., 2007), and among respondents who reported worse self-rated mental health status compared with those who reported better mental health (Kang, et al., 2010). Moreover, Asian Americans are more likely to enter treatment when the conditions are most severe (Chu & Sue, 2011; Wynaden, et al., 2005), lives are disrupted (Kung, 2003), or
somatic symptoms increase (Kung & Lu, 2008; Zhang, et al., 1998). An assumption of these studies, however, is that Asian Americans are able to and do recognize their problems as mental health-related, but this may not be the case for those who lack knowledge about mental illness.

*Family.* Findings have been mixed regarding the role of family in mental health service use for Asian Americans. Some research indicates that families can serve as support systems and resources for individuals with mental illness (Weine & Siddiqui, 2009) and can direct family members with mental illness to professional help (Snowden, 1998). However, other research shows that some families do not bring their relatives with mental illness to treatment even when help is needed (Lin, Inui, Kleinman, & Womack, 1982). This may be related to the family’s perceptions about mental illness and help seeking. For example, one study found that delays in mental health service use among Asian Americans were positively related to their relatives’ higher levels of stigma about the mental illness (Okazaki, 2000). Thus, a sense of stigma towards mental illness and mental health services appears to be a key influence on whether they would encourage treatment for family members.

*Immigration-related factors.* Immigration-related factors (e.g. English language proficiency, generational status, and nativity or place of birth) also influence mental health service use for Asian Americans (Abe-Kim, et al., 2007; G. Kim, et al., 2011; Meyer, Zane, Cho, & Takeuchi, 2009; Takeuchi et al., 2007). For example, Asian Americans with limited English language proficiency were less likely to use mental health services than those with better proficiency (Kang, et al., 2010; Sentell, et al., 2007). Other research found that among those with probable DSM-IV diagnoses, U.S.-born Asian Americans were more likely to use specialty mental health services than Asian Americans born outside the United States (40% vs. 23%) (Meyer, Dhindsa, et al., 2009), and third generation Asian Americans were more likely to use
them than their first and second generation counterparts (Abe-Kim, et al., 2007). Age of migration is another factor that influences decisions to enter treatment, such that Asian Americans who arrived in the United States after the age of 18 were less likely to use mental health services than those arriving at a younger age (Kang, et al., 2010). In another study, Kung (2003) examined the relationship between acculturation (as measured by language, years in the U.S., social contact, cultural activities, generational status) and receipt of mental health-related services among Chinese Americans. Kung found that acculturation was a positive significant predictor of mental health service use in the overall sample.

**Conclusion**

In summary, this literature review identified the prevalence of depression and PTSD among first-generation Vietnamese Americans and significant stressors associated with both the pre-migratory war trauma and post-migratory challenges in adjustments to the new life in the United States. As discussed, Vietnamese Americans’ decisions to use mental health services may be prompted by factors such as severity and disruptiveness of mental health problems, the increase in somatization of symptoms, and immigration-related factors such as age of migration, nativity, and English language proficiency. A multitude of cognitive, affective, value orientation, and structural factors, however, continue to pose barriers to the use of mental health services for this population. As such, decisions to enter outpatient treatment appear to be complex processes. In their seminal work, Sue and Sue (1999) advocated for the development of “appropriate help-giving practices, intervention strategies, and structures that take into account the historical, cultural, and environmental experiences/influences of the culturally different client” (Sue & Sue, 1999, p. 7). This movement toward identifying culturally-relevant solutions to disparities in mental health service access, quality of care, and treatment outcomes remains at
the core of Asian American mental health research (Abe-Kim, et al., 2007; Chu & Sue, 2011; Snowden, 1998; Takeuchi, et al., 1995; Zhang, et al., 1998). One approach to closing the disparities gap is to inform the mental health service system about the help-seeking contexts for Asian Americans with mental illness and how treatment can be inclusive of the diverse needs, worldviews, and practices of Asian American subgroups. This study contributed to an insider understanding of the beliefs and perceptions about mental illness, help seeking, and outpatient care among first-generation Vietnamese Americans with depression and/or PTSD. It also explored their pathways into outpatient care, a topic about which there is little research. The findings from this study could inform culturally-relevant practices to improve mental health service use and quality of care for first-generation Vietnamese Americans, thereby adding to the access and quality of care pieces of the larger Asian American mental health literature.
Chapter 3: Theoretical Review

Introduction

The following chapter provides a review of two theoretical frameworks on help-seeking behaviors: the Anderson Behavioral Model (ABM) and the Network Episode Model (NEM). Whereas the ABM and NEM have been widely used in the help-seeking literature, they have not been applied to first-generation Vietnamese Americans. Thus, their relevance to this population is unknown. This study seeks to explore the views, experiences, and processes of help seeking in the unique context of first generation Vietnamese Americans, and this review provides more background about what has been traditionally done to understand help-seeking behaviors, although the ABM and the NEM frameworks will not guide the study design or data analysis; rather, they will be used to compare the findings with the assumptions underlying the NEM and ABM and the factors identified as salient in the theoretical models.

Research on help-seeking behaviors is largely informed by utilization theories developed to understand health behaviors and use of medical care (B. A. Pescosolido, 2010). The ABM was developed initially to explain health care use and has undergone multiple revisions since. It has also been widely used to understand health behaviors across ethnically diverse populations, primarily with Whites and African Americans, and a few Latino and Asian American groups (Babitsch, Gohl, & Lengerke, 2012). The NEM focuses specifically on mental health service use and was developed using a sample of predominantly White and some Black respondents. However, no research has been conducted to examine whether the assumptions and constructs in the ABM and NEM are applicable to Vietnamese American immigrants and their use of outpatient mental health services. The following discussion will review the two models’ theoretical framework pertaining to health (ABM) and mental health service utilization (NEM),
as well as an assessment of their relevance to the processes whereby first-generation Vietnamese Americans with depression and/or PTSD enter outpatient mental health treatment.

**The Anderson Behavioral Model**

The ABM was developed in the 1960s to understand why families use health services and which issues are related to equitable access to health care (Anderson, 1995). Since then, the model has undergone a series of modifications. The current ABM proposes that a variety of factors at the contextual and individual levels influence access to health care (Anderson & Davidson, 2007). The *contextual domain* includes factors at the organizational, environmental, and macro level, whereas the *individual domain* includes factors at the individual and interpersonal level. The ABM categorizes these factors into three core constructs: predisposing, enabling, and need characteristics.

*Predisposing characteristics* are conditions that make it likely or unlikely for individuals to use health services (Anderson, 2005). Predisposing characteristics at the contextual level include the demographic composition of a community (e.g. age, gender, marital status), social characteristics of the community in which people live (e.g. education level, ethnic/racial composition, employment level, crime rate), and beliefs or community or organizational values and norms about the organization, financing, and accessibility of health services (Anderson & Davidson, 2007).

*Enabling characteristics* are conditions that make it possible for individuals to obtain care. These characteristics such as health policy, financing, and organization could provide individuals with the means to obtain care (Anderson, 1995; Anderson & Davidson, 2007). Health policies are decisions pertaining to health care regulations made by the state or federal government or by the private sector. Financing characteristics are the various resources and
affordability of care at the community level that could be used to pay for health services, including per capita income, wealth, cost of health care, and cost of insurance coverage. Organization refers to the amount, distribution, and structuring of health services facilities and personnel to deliver health services. For example, the ratios of physicians and hospital beds to number of people in the community, outreach and education programs, office hours, and location of services are all organizational factors that could impact service use (Anderson, 2005).

*Need characteristics* refer to the existence of an illness and the need for professional care, and at the contextual level consist of environmental and population health indices that reflect the health needs of the community (Anderson & Davidson, 2007). Environmental need factors include measures of the physical environment (e.g. housing, water, air), and injury and death rates as a function of health-related factors in the physical environment. Population health indices are general indicators of community health including general and condition-specific rates of mortality, morbidity, and disability. Thus, the contextual characteristics within the ABM emphasize the impact of the environment and structure on health needs and service use.

Similarly, the ABM highlights the influence of predisposing, enabling, and need characteristics within the individual domain on health service use (Anderson & Davidson, 2007). Individual *predisposing characteristics* include demographic factors (e.g. age, gender); social factors or the social status of a person (e.g. education, occupation) and one’s ability to use resources to cope with health problems (e.g. social network); and health beliefs or the attitudes, values, and knowledge about health and health services. Individual *enabling characteristics* are financing factors (e.g. income and wealth an individual has to pay for health services or price of health care as affected by insurance coverage and cost) and organization factors (e.g. regular access to a car, transportation, waiting time for care). Individual *need characteristics* are one’s
perceived and evaluated needs for health care. Such perceived needs include perceptions of one’s general health and functional state and one’s experiences with illness symptoms (Anderson & Davidson, 2007). According to this model, these perceptions and experiences are influenced by social characteristics (e.g. ethnicity, education) and health beliefs (e.g. attitude and knowledge about illness, health care). A second measure of need is evaluated needs, or a professional assessment and objective measurement of the individual’s health status and the need for care (e.g. blood pressure reading, blood results) (Anderson, 1995). Evaluated needs can heighten one’s perception of having an illness, thereby prompting a decision to seek care.

In its entirety, the ABM proposes an interaction of individual and contextual characteristics that determine actual use of health services, also referred to as realized access (Anderson & Davidson, 2007). Predisposing characteristics affect the likelihood of using health services, further influenced by enabling factors that make it possible to access the services and by the perceived need for health care.

Network Episode Model

The Network Episode Model (NEM) was developed in the early 1990s as a process model that describes mental health service use as multiple pathways and movements in and out of care throughout an individual’s illness career (B. A. Pescosolido, Gardner, & Lubell, 1998). Unlike previous help-seeking models, the NEM moves beyond the assumption that individuals are rational decision makers who engage in a linear decision-making process to enter treatment (B. A. Pescosolido & Boyer, 2010). The model posits that help seeking is a fluid, dynamic, and complex process embedded within an interactive network of social network and social structures. Moreover, the NEM asserts that an individual’s entry to mental health treatment can take
multiple forms: choice, coercion, and muddling through, or uncertainties about how one got into treatment (B. A. Pescosolido, et al., 1998).

In the NEM, individual help-seeking behaviors are shaped by four systems: social content or episode base for the individual, social support system, the treatment system, and the illness career (B. A. Pescosolido & Boyer, 2010). The first system of social content or episode base for the individual refers to the social and geographical location (gender, age, education, work status, marital status, income, occupation), personal health background (prior history of illness, coping style, medical insurance), illness characteristics (severity, visibility, duration, acute vs. chronic), and organizational constraints (e.g. organization, accessibility, and financing of care).

The second system, social support, includes the network of individuals with whom one interacts. The NEM views people as pragmatic and social decision makers. Thus, their decisions (when, how, if) to obtain mental health care are influenced by interactions with others in their social support system. These network ties exert their influence through their structures (e.g. size, density, duration, reciprocity), content (e.g. beliefs and attitudes towards health, medical care), and functions (e.g. information, advice, regulation, types of support). For example, over the course of an illness, one may consult with various individuals (e.g. family, friends, healers, professionals) about one’s mental health condition (B. A. Pescosolido & Boyer, 2010). These interactions influence how individuals define their illnesses, the type of care they deem appropriate for treatment, and their help-seeking decisions including the use of outpatient mental health treatment.

The third system refers to the formal treatment system (e.g. mental health services). Similar to the social support system, the treatment system influences individual help-seeking behaviors through structure (e.g. size, density, duration, reciprocity), content (treatment efficacy,
diagnostic capacity and technology, modalities, attitudes and culture towards health, clients, community), and functions (e.g. information, advice, regulation, types of support). The fourth system of illness career is an individual’s experience and roles associated with having a mental illness and the temporal and cumulative dimensions of the experience (e.g. duration of illness, events that happen to the individual over time) (Pavalko, Harding, & Pescosolido, 2007). Unlike other utilization models, the NEM extends beyond explaining how an individual enters mental health treatment and examines help-seeking behaviors throughout one’s illness career. In the NEM, illness career consists of key entrances into mental health treatment (e.g. sick role, patient role, chronic role, disabled role, dying career), key exits from treatment (e.g. termination of care, recovery, death), and key timing and sequencing throughout treatment (e.g. combination and ordering of consultations, degree and length of compliance) (B. A. Pescosolido & Boyer, 2010).

More recently, the NEM extended the model to include cultural systems and their influence on help-seeking behaviors (Olafsdottir & Pescosolido, 2009). Cultural systems are norms, values, expectations, and beliefs that shape individuals’ definitions of mental illness and help seeking. The model posits that individuals seek support from people within their social networks, also referred to as cultural mapping. An individual’s definitions of the causes and consequences of mental illness and cognitive assessment of the appropriate source of cares for the mental illness influences to whom they go for help within their cultural mapping. Currently, the NEM cultural mapping includes medical provider, specialty provider, general doctor, and specialist as sources of care that individuals with mental illness may seek out (Olafsdottir & Pescosolido, 2009). As such, the NEM conceptualizes mental health service use as a process embedded within an individual’s illness career and influenced by mechanisms within the social support, treatment systems, and cultural systems.
The ABM and the NEM thus provide useful starting points for this study’s aim to understand how first-generation Vietnamese Americans enter outpatient care. The ABM takes into consideration predisposing and enabling factors at the individual and systems level that can promote or hinder help-seeking behaviors, in addition to one’s perceived need for care. The model helps to predict and explain who are likely to seek out care and what makes some more likely to do so than others. Thus, among first-generation Vietnamese Americans with mental illness, some have certain sociodemographic characteristics that make them likely to seek out mental health treatment (e.g. previous education in psychology, English language proficiency). Moreover, those who eventually seek treatment must perceive that they have a mental illness that requires professional attention. However, enabling factors that make it possible for some individuals to utilize care – such as available services in and near the area where individuals live, affordable services, and insurance coverage – are limited for many Vietnamese American immigrants.

The NEM adds that help-seeking behaviors are dynamic, and furthermore, mechanisms within the social networks, the cultural systems, and the treatment systems influence individuals’ movements in and out of mental health care. In the context of this study, the NEM would posit that how a first-generation Vietnamese American enters outpatient mental health treatment is a process that may take place over years, and may take multiple forms (e.g. by choice, coercion, or uncertainties about how one got into treatment) (B. A. Pescosolido, et al., 1998). While the NEM takes into account the influence of sociodemographic backgrounds on decisions to obtain care, it puts greater emphasis on the influence of social networks and structures. It is common for Vietnamese Americans with mental illness to be kept at home; when outside help is initiated, indigenous healers are often the first line of support (Phan & Silcove, 1999). Thus, the family
and informal support systems become critical sources of influence on these individuals’ interface with the mental health service system. Further, first-generation Vietnamese Americans’ conceptualizations of the nature of and appropriate source of care for mental health problems further guide the choice of where they go for help (Q. C. X. Nguyen & Anderson, 2005). For example, traditional healers and herbalists are sought out to restore balance and harmony, whereas religious leaders are consulted for spiritual-related mental health concerns (Phan & Silcove, 1999). Moreover, factors within the mental health service system such as the lack of culturally- and linguistically-appropriate services, proximity to treatment centers (Kang, et al., 2010), and cost of treatment (Bemak, et al., 1996) could affect their decisions to enter outpatient care.

Limitations of the models. While the ABM and the NEM aim to predict and explain what factors can facilitate or impede decisions to seek out mental health services, they are limited in explaining the how, why, and context underlying an individual’s decision to initiate care. Pasick and colleagues (2009) pointed out the implied universality in the broad application of health behavior theories and their constructs. Whether and how constructs within the ABM and the NEM apply to the sociocultural context of immigrant communities remains poorly understood and untested. The ABM appears to assume that individuals share a common, universally applicable system of thought about mental illness conceptualizations and expectations for mental health care. However, research has found cross-cultural variations in how mental disorders are understood, experienced, manifested, and treated (Fabrega, 2001; Kagawa-Singer & Chung, 2002; Kleinman, 1988), such that Asian Americans’ assessments of susceptibility and severity of mental illness may differ from that of the mainstream community. While the view of mental illness in the United States is guided by the Western biomedical model (Aneshensel & Phelan,
1999), many first-generation Vietnamese Americans attribute mental illness to causes relating to mind/body interconnectedness, cosmology, and supernatural or animistic beliefs (Phan & Silcove, 1999). These models also assume that individuals have the knowledge to recognize their emotional difficulties as a mental health problem, whereas it is possible that many Vietnamese American immigrants may not even know or recognize their difficulties as such. The ABM further assumes individual rational choice in help seeking, but decisions to seek mental health treatment may be influenced by a variety of reasons other than voluntary decisions, including family members forcing the individual to come to the appointment, or court orders.

The NEM’s categorization of cultural mapping narrowly focuses on medical provider, specialty provider, general doctor, and specialist but does not explore aspects of cultural mappings beyond Western professionals as sources of care. However, Vietnamese Americans with mental health problems may seek out indigenous healers such as herbalists, shamans, or religious leaders for healing (Phan & Silcove, 1999). Moreover, prior studies using these models do not adequately address the sociocultural and ecological circumstances of immigrants, and their influence on the help-seeking behaviors of this group (Pasick et al., 2009). There is a limited understanding of the meaning and significance of factors such as English language proficiency, affordability of services, cultural appropriateness of mental health services, and meaningful social support sources and types in the lives of first-generation Vietnamese Americans impacting their decisions to enter mental health treatment. For Vietnamese American immigrants, in particular, it is essential for researchers to take into account the lasting impact of the traumatic pre-migration experiences and difficulties with post-migration adjustments on the mental health of this community (Hsu, et al., 2004; Tran, 1993).

**Conclusion**
In sum, both the ABM and the NEM models provide useful starting points and sensitizing concepts for understanding how first-generation Vietnamese Americans with mental illness move into treatment, but the effectiveness and validity of these two models in explaining help-seeking behaviors specific to first-generation Vietnamese Americans have not been examined. The constructivist grounded theory methodology (Charmaz, 2006) guiding this study is appropriate for this study’s aim to develop a preliminary conceptual model that clarifies the help-seeking processes used in accessing outpatient mental health services among first-generation Vietnamese Americans, from the perspectives of the participants and within the contexts of their lives. This methodology further allowed for the exploration of the how, why, and in what context of this help-seeking process. This research could contribute to the development of a conceptual framework that moves away from a monocultural, Western European-centric model to a multicultural model that illuminates the beliefs, values, and sociocultural context of first-generation Vietnamese Americans (Kagawa-Singer, 2000; Pasick, et al., 2009).
Chapter 4: Design and Methodology

This chapter describes the study’s methodology and covers the following areas: 1) rationale for the inductive research design using the constructivist qualitative tradition, 2) its underlying conceptual framework of symbolic interactionism, 3) sampling and recruitment, 4) data collection, 5) data management, 6) data analysis, 7) trustworthiness of data, and 8) researcher reflexivity. The chapter concludes with a brief chapter summary.

Rationale for Inductive Research Design and Qualitative Inquiry

Despite research indicating high prevalence rates of depression and PTSD among first-generation Vietnamese Americans, very little is known about the experiences and perceptions of those suffering from mental illness and how they access outpatient mental health care. Hence, there is a need for further research using a design that will illuminate this unexplored area and that will give voice to individuals living with mental illness to tell their stories. The inductive paradigm is the most appropriate approach to address the aims of this study since no research has been done from this perspective, and no data exist to answer the research questions. The goals were to understand first-generation Vietnamese Americans’ perceptions about mental illness and expectations for treating mental illness, how these perceptions influence decisions to utilize outpatient care, and in what context first-generation Vietnamese Americans with depression and/or PTSD enter outpatient treatment. Given the research questions, the unique sample, and the lack of prior targeted findings, the inductive paradigm using qualitative methods was the most appropriate and powerful method in which to discern the behaviors, perceptions, and experiences of first-generation Vietnamese Americans. Specifically, I used qualitative inquiry, guided by an inductive paradigm, to explore and understand the meanings and processes of a
phenomenon – mental illness – in its natural setting and from the perspectives of people who experienced it.

The inductive approach begins with an open exploration of the topic and further elicits an in-depth understanding of participants’ perspectives about the topic (Lincoln & Guba, 1985). Conclusions are then generated based on the patterns that emerge from the data. While various traditions of inquiry exist within qualitative research (e.g. phenomenology, case study, grounded theory, ethnography, narrative/life history research) (Cresswell, 1998), common features are woven throughout these traditions. The interpretive underpinning assumes that reality is multiple and constructed by and among its participants (Lincoln & Guba, 1985). Qualitative research assumes the fluidity and evolving nature of a phenomenon and views it as time- and context-bound (Lincoln & Guba, 1985). Thus, the researcher interacts with participants in their settings to better understand how meanings and processes are formed and experienced (Corbin & Strauss, 2008). Research questions are answered using methods that elicit an in-depth exploration of the inner experiences of participants within specific cultural contexts.

Grounded theory. Constructivist GT is one variant of Grounded Theory, also known as classic GT, developed by sociologists Barney Glaser and Anselm Strauss in the 1960s (Charmaz, 2006). Classic GT was influenced by both Glaser’s Columbia University positivism tradition and Strauss’ Chicago School tradition of interactionism and pragmatism (Corbin & Strauss, 2008) and was developed as a method to study processes and develop a theory (Charmaz, 2006). Over the years, classic GT has morphed into an array of methods that vary regarding epistemology, methodological strategies, assumptions, and conceptual directions (Charmaz, 2009).
The methodology of this study was guided by Charmaz’s constructivist GT tradition (Charmaz, 2006). While constructivist GT carries the key features of classic GT, its underpinning moves towards a constructivist understanding of meanings, experiences, and actions. Constructivist GT assumes that reality is multiple and socially constructed, and data are mutually constructed through the interactions between the researcher and participants. As such, it embraces the idea that the researcher’s interpretations of the data are a subjective reconstruction of the participants’ stories. Constructivist GT also makes explicit the positionality of the researcher, or the understanding that one carries personal and interdisciplinary biases into one’s research (Charmaz, 2006). The researcher strives to get as close to the reality of the participants as possible and to make explicit the meanings and assumptions that shape their actions and experiences.

Constructivist GT begins with inductive logic, is open to multiple meanings that individuals ascribe to their experiences and behaviors, and explicitly acknowledges and integrates the influence of context (e.g. time, place, culture, social circumstances). Charmaz views the actions, meanings, and experiences of participants as shaped by situations, conditions and social circumstances. This underpinning is appropriate for the objectives of this study to better understand how mental illness is perceived, experienced, and managed among first-generation Vietnamese Americans. Moreover, an underlining assumption of this study is that the participants’ experiences are intricately intertwined with decades of the Vietnam war, post-war migration, and the social and economic disadvantages of their role as ethnic minority and immigrants in the United States society. Moreover, constructivist GT is used to study actions and processes, which is appropriate for this study’s aim to develop a conceptual framework.
about the pathways through which first-generation Vietnamese Americans arrive at outpatient treatment.

Guiding Conceptual Framework: Symbolic Interactionism (SI)

Constructive GT is informed by the symbolic interactionism (SI) perspective (Charmaz, 2006). SI can be traced to the work of its principle founder George Herbert Mead (1863-1931) whose contributions to SI are influenced by pragmatism, Darwinism, and behaviorism (Charon, 2007). Pragmatism assumes that individuals actively interpret what goes on around them and selectively define and act upon something according to its usefulness. Pragmatism thus acknowledges multiple realities, and how people make decisions is based on what is most useful for the situation at hand. Mead’s work was also influenced by Darwinism, which takes a naturalistic approach to understanding humans. In this view, humans are part of and thrive in the natural world. Humans have unique abilities to develop language, to reason, to learn, understand, and act on a situation, and to adapt to the constantly changing environment. Thus, individual behavior is viewed as a response to the environment and an ability to adapt to change. Further, SI was influenced by behaviorism, or the study of observable behaviors. However, SI goes beyond understanding humans through physical and observable behaviors to look at the non-observables or unspoken meanings and influences. It emphasizes the role of the human mind and its appraisal of the situation at hand to guide behaviors.

There are five key assumptions of SI that inform the methodology of this study. First, humans are social beings and actively engage with their surroundings. Second, humans hold the ability to think about the “self” in relation to the situation. Third, humans take actions based on the meanings they ascribe to situations. Fourth, human actions are informed by social
interactions and definitions of the situation in the present. Fifth, humans actively make decisions in response to the environment.

In SI terms, reality is co-created in the interactions between people. Thus, social interactions shape the meanings, actions, and experiences of the participants. This underpinning is congruent with the inductive approach of this study that aimed to understand the perceptions and behaviors of first-generation Vietnamese Americans with depression and/or PTSD and how they are constructed within the context of this group. The present study began with the assumption that there are cultural variations in the symbols, meanings, and rules of interaction pertaining to mental illness and help seeking and ways in which they are supported or negated in a new cultural context in the United States (e.g. the U.S. mental health service system and its assumptions about mental illness and treatment). The goal of this study was to illuminate the shared rules, language, and meanings around how mental illness is defined and experienced, where individuals with mental illness go for help, how and why individuals initiate outpatient treatment, and participants’ perceptions about outpatient care. An inductive, interpretive understanding was the most appropriate methodology to answer this study’s aims.

**Sampling & Recruitment**

Sampling in constructivist GT is generally purposive, open, and flexible and aims to gather rich, in-depth information of the phenomena under study; it takes place in two major phases, initial and theoretical sampling (Charmaz, 2006). This study began with initial sampling, or the early stage of sampling that used general criteria established for the population of focus. I recruited men and women who were in outpatient treatment for depression and/or PTSD. As data analysis progressed, key concepts began to emerge that directed the next stage of sampling, known as theoretical sampling, or focused sampling of data sources (e.g. statements, events,
cases) in order to elaborate and refine the dimensions and properties of categories, for the purpose of conceptual and theoretical development. Given the hard-to-reach nature of the population of this study, a convenience sampling strategy was used. It was not feasible for me to be selective in choosing new participants. Rather, I carried out theoretical sampling strategies in other ways. I revisited the interview transcripts to analyze passages that illuminated particular categories that were of importance to the research questions. The types of questions that I asked in subsequent interviews became more focused on the salient constructs. For example, self worth began to emerge as an important construct to the participants in the early interviews, so I reread earlier transcripts with a specific focus on what previous participants said about self worth. Those early responses also informed the questions I asked in later interviews about the meaning of self worth to generate a more nuanced understanding of this construct and its relationship to other categories. Specifically, I asked questions about how the definition of health was linked to self worth, how self worth fluctuated over time, and how pathways into outpatient care were linked to finding and reclaiming self worth. Thus, theoretical sampling allowed me to expand on and refine the dimensions and properties of the categories and the conceptual link across categories.

In qualitative research, recruitment stops when all categories are saturated or when no new data emerge about the topic under study (Corbin & Strauss, 2008). Studies generally reach saturation at 20 to 30 participants (Cresswell, 1998). I stopped interviewing after completing 21 interviews. This decision was based on several considerations. As data collection and analysis progressed, the codes began to fill the properties and dimensions of the categories and the relationships among categories. The final two interviews did not add significant insight to the descriptions of the categories or to the conceptual development. I also consulted with my
dissertation chairs throughout data analysis and collection. We agreed that the data gathered from 21 in-depth interviews provided enough information for saturation of the key concepts of focus in this study: conceptualizations of health, pathways into outpatient care, and expectations for outpatient treatment.

Recruitment. Participants were recruited from six county and county-contracted non-profit outpatient mental health agencies and one consumer support group serving Vietnamese Americans in Los Angeles and Orange counties. Recruitment took place from September, 2012, through March, 2013. All agencies except one provided multi-disciplinary psychological services such as psychotherapy, psychotropic medication (e.g. administer medication, health monitoring), case management, and consumer support groups. Agency staff included psychiatrists, psychologists, master’s level social workers and marriage and family therapists, care managers (paraprofessionals and bachelor’s level), or licensed vocational nurses. The services consumers received at the agency varied and depended on the individuals’ level of need. To protect the anonymity of the participants in this study, I will not provide a more in-depth description of the recruitment sites.

Southern California has a large Vietnamese American population (approximately 315,000 people according to the 2010 Census), thus making it a feasible location for recruitment. I identified a list of seven mental health agencies and consumer groups using personal knowledge and recommendations from colleagues who work in the mental health profession. I had to first obtain permission from both UCLA and the county human subjects committees to recruit at these sites. Approval took several months. I then made an initial email contact with the agencies’ directors to inform them of the study and ask for permission to recruit participants. I introduced myself as a UCLA graduate student, included a brief description of my research, and requested
an in-person meeting. The initial contact email correspondences took several weeks, and all of the directors agreed to either meet in-person or gave me permission via email to distribute flyers at the site. I met with the directors of five agencies to discuss the study and address any questions they had. Two agencies did not require an in-person meeting and preferred to post the flyers in the waiting areas themselves.

Gaining access and permission to recruit from the agencies was a lengthy process with multiple challenges along the way. The agencies were very busy, and an additional request to conduct research was an added task for their over-burdened staff. Getting staff cooperation to inform prospective clients about this study was a challenge because there was no incentive for them other than the research and clinical benefits of this study. Some agencies had questions about the research and how it could benefit the agency and the clients. I had to emphasize why my research was important to the agency’s mission, and how the research would be done respectfully and would not disrupt daily operations and staff time. It took several months for me to build relationships with the agencies; I made multiple visits to the agencies to meet with the directors and key staff members. I also had to make changes to the recruitment protocol to meet the agencies’ requirements such as: posting flyers in the waiting area only; no announcements made at staff meetings or support groups; and, no on-site rooms used to conduct the interviews. The personal relationships I had with colleagues who are working mental health professionals in the community were extremely instrumental in getting the agencies’ support and permission to recruit.

Upon receiving permission to recruit, I posted flyers in the waiting areas of the agency offices. At some agencies I attended staff meetings to announce my study and distributed flyers to the staff so they could inform prospective clients about my research. I also handed out flyers
at consumer support groups and answered questions about my study. Meeting in person with the agencies and support groups was an opportunity for me to introduce myself and my research, which added familiarity with and credibility for the research. I was able to recruit more participants from agencies where I had met with them in person than from those where I had limited or no in-person meetings with the agency workers and consumer groups. Participants contacted me directly by phone to set up interviews if they were interested in participating in the study.

_Sampling._ The sampling procedure for this study followed purposive sampling guidelines. Inclusion criteria were that a participant had to: 1) be born in Vietnam; 2) be born on or before 1973 (at least two years of age by 1975 when the Vietnam War ended); 3) have left for the United States after age 12; and 4) currently be receiving treatment for depression and/or PTSD for three or more months from an outpatient mental health agency. Screening took place over the phone when participants called to inquire about the study using the above criteria. All screening interviews were conducted in Vietnamese. Participants who responded “no” to any of the criteria were not eligible to participate.

To screen participants for depression and PTSD, I asked the participant what he/she was in treatment for, and if the participant mentioned depression and/or PTSD, he/she qualified to participate in the study. In case the participant did not know his/her diagnosis, I used the Hopkins Symptoms Checklist (HSCL-25, Vietnamese version) to screen for depression (R. Mollica, Wyshak, de Marneffe, Khuon, & Lavelle, 1987) and the Harvard Trauma Questionnaire (HTQ, Vietnamese version) to screen for PTSD (Mollica et al., 1992). Both instruments have been validated with Vietnamese Americans through expert panels, back translation, and methods of resolving differences following steps in cross-cultural instrument development (R. Mollica, et
al., 1987; R. F. Mollica et al., 1992). The HSC consists of 15 items that ask about depressive symptoms, and the HTQ has 37 total items that assess for traumatic events and symptoms. Respondents who scored >1.75 on the HSC and at least a score of 2.5 on the HTQ were considered symptomatic and were qualified to participate in the study.

Four participants in this study did not know their diagnosis and were screened over the phone first, using three questions from the HSC and three questions from the HTQ. These four participants reported experiencing the symptoms on the HSC and/or HTQ to some degree and were invited to do the in-person interviews. The questions from the HSC were: 1) difficulty falling asleep, staying asleep, 2) worrying too much about things, 3) headaches. The questions from the HTQ were: 1) difficulty concentrating, 2) recurring nightmares, 3) recurrent thoughts or memories of the most hurtful or terrifying events. I consulted with two Vietnamese American clinicians in the community who suggested that these items would be most appropriate to use as preliminary screening items with the participants. I did not ask the participants all of the questions on the HSC and HTQ over the phone due to the length of the instruments and the possibility that the participants would be deterred from participating in my study if I asked them many questions without even having met them in person. When we met in person to conduct the interview, I screened these four participants once again using the entire HSC and/or HTQ at the end of the interview. I decided to administer the HSC and/or HTQ after the interview so that its concepts related to depressive, anxiety, and traumatic symptoms would not prime the participants to respond the questions asked during the interview in any particular way. Three participants were symptomatic on the HSC, and one participant was symptomatic on the HSC and HTQ.

The exclusion criteria for the study included anyone with a diagnosis of schizophrenia, bipolar, or psychotic disorders. Individuals with one or more of these diagnoses were excluded.
from this study because they might not have been able to engage in an interview that requires reflecting on personal experiences and recalling the help-seeking process. During initial screening, I asked the participant whether he/she was in treatment for any other diagnosis, and if the participant mentioned any of the three diagnoses he/she would be disqualified from the study. Six participants were not eligible to participate in this study because they were not in treatment for depression and/or PTSD, were not in outpatient treatment at the time they called me, or did not meet the minimum age requirement. In these cases I explained to the participants why they were not eligible and thanked them for their interest in the study. Five participants found out about the study through my recruitment flyer posted in the waiting area of the agencies from which they were receiving treatment, and one was handed information about my study from another staff member at the agency. In total, I received 27 calls: 21 calls from the 21 participants who qualified to participate, and 6 calls from the participants who did not qualify to participate. No one declined to participate. I interviewed 21 participants in a span of 6 months, from late September, 2012, to late March, 2013.

**Data collection**

When a participant called or asked me about the study, I explained the purpose of the study, the informed consent process, and the length and content of the interview. If the participant expressed interest in participating, an interview was set up at the time and place of the participant’s choice. The plan was to conduct the interview at a location that was private and safe for the participant and for the interviewer, and comfortable for the discussion of personal issues. Most of the interviews took place in a room at the outpatient treatment agency or at the participant’s home. When neither of these options was available, the participant and I agreed on conducting the interview at a park, although one person wanted to be interviewed in a car in front
of her apartment. I made a reminder call three days before and again the night before the scheduled interview.

All participants in this study had limited English language proficiency and preferred to communicate with me in Vietnamese. Thus, informed consent as well as interviews were conducted in Vietnamese. Before the interview, participants were given an information sheet. Among first-generation Vietnamese Americans, there is a historical distrust of disclosing personal information to someone in authority. As a researcher I would likely be viewed as an individual of authority. Thus, IRB approval was based on verbal consent. No participant refused consent.

Data were collected using in-depth, one-on-one interviews, commonly used in grounded theory research. This method is congruent with the study’s aim to gather a rich understanding of first-generation Vietnamese Americans’ perspectives about mental illness, help-seeking, and outpatient mental health. The open-ended semi-structured interview guide consisted of a list of questions and topics to be covered, but the order is determined by the respondents’ lead from the initial questions. During the interview, I asked questions, probed, and clarified to gather relevant information. Interviews averaged 2 hours and 6 minutes in length (ranging from 70 minutes to 4 hours and 53 minutes) and were audio recorded. This is in addition to the time I spent before the interview to go over the information sheet and after the interview to complete my hand written notes. Two participants refused to be recorded, necessitating extensive note taking and summarizing the notes with the participants. During the interviews I drew a timeline of the participants’ life stories, marking time points when they reported significant changes in their lives and/or their health (e.g. Vietnam War ended, marriage, leaving Vietnam, quitting their jobs, being completely debilitated by their health). After the interviews, I expanded on the notes.
The semi-structured interview guide developed for this study had two parts (Appendix B). The first part asked about basic demographic information (e.g. age, years in the U.S., education, and employment status), providing a general background about the participants. The second part included open-ended questions pertaining to the participants’ perceptions about health/mental health, experiences living with mental illness, entry into outpatient care, and expectations for and perceptions of mental health treatment. The inductively designed interview guide did not directly ask about these concepts but rather started with broad questions that elicited the participants’ own words and understanding relating to their health conditions and help-seeking processes. Prior to starting data collection, I conducted a pilot study using the interview guide with three first-generation Vietnamese Americans with mental illness to check for question appropriateness and clarity. These interviews were useful for revising questions to include simpler words and concepts that were more meaningful to participants. For example, the revised interview guide asked about participants’ conceptualizations of health, what being healthy means, and what the absence of health looks like. Participants were then asked to describe what prompted them to get help outside of their family, and the individuals or circumstances that led them to the current treatment place. They also were asked to describe their treatments, who treated them, and how the place had or had not been what they expected. During the interview, I pursued the leads to probe and explore ideas and concepts relevant to the objectives of this study (e.g. mental illness, depression, PTSD, outpatient care). I did not use terms such as mental illness, depression, help seeking, outpatient treatment, and therapy because the pilot study and initial interviews suggested that these terms were unfamiliar to most participants, and those who had some ideas about what they meant provided very formulaic definitions that they had picked up during their time in outpatient care.
The semi-structured interview guide provided a starting point for asking questions about help-seeking behaviors and mental illness among first-generation Vietnamese Americans. The interview guide was provisional and changed during the research process. In some cases I followed through with topics that participants brought up in conversations that were relevant to the aims of study but were not in the interview guide. For example, at the beginning of the interviews participants talked extensively about their past experiences during the Vietnam War and their migration to the United States as key markers that influenced their health. These stories took some time to unfold, but by carefully listening to them I gained tremendous insights into the historical, political and social contexts and the long-term impact on the mental health of the participants.

At the stage of theoretical sampling, the questions I asked were much more focused in order to clarify, expand on, and refine the properties and dimensions of concepts and categories that emerged from the data. For example, the participants talked about the financial gains they received in treatment as a major contributing factor to their improved health. The subsequent interview questions relating to participants’ expectations for and experiences in outpatient treatment focused on and explored this emerging concept.

At the conclusion of the interview, I asked each participant if there was anything else related to his/her illness experience that he/she wanted to share, and I offered to answer any questions. I then handed them the incentive gift card and thanked them for their time and most importantly for sharing their intimate life stories with me. I also asked for their permission to contact them again if I had questions about the interview. After the interview I would stay with those participants who wanted to show me their gardens or poems they had written. Field notes were completed after each interview (e.g. interview summary, my reactions, the setting of the
interview, observations of participants’ verbal and nonverbal cues throughout the interview) recorded the context of the interview and supplemented information about the participants gathered during the interview.

Taking into consideration the stigmatized topic of mental illness, I took precautions during the informed consent process and throughout each interview to use utmost respect. Before beginning the interview, I asked participants how they heard about my study, and what motivated them contact me. I explained to them that whereas the study was focused on the experiences of Vietnamese Americans with depression and/or PTSD as worded on the flyers, I was more interested in learning about their rich life stories and what brought them into treatment. I did not focus much on the labels and diagnosis but rather showed my interest in learning about their lives and their health. This strategy seemed to make the men and women comfortable and less concerned about having to report to me about their mental health problems. Moreover, I chatted with the men and women about my own background as a boat person and how my interest in the topic came about as a way to connect with them. This initial rapport building was critical in easing the participants into the interview. I was cautious to not intimidate them in any way that would make them feel coerced to participate in the study or to answer questions that would provoke distress. I explained to the men and women that they did not have to answer any question that made them feel uncomfortable, and anything they shared with me remained confidential and would not affect the care they received from the agency. I also explained that they could withdraw from the study at any time with no effect on the care they received from the outpatient agency. During the interview a few participants appeared hesitant to answer certain questions, and most were teary when they spoke about their past and present struggles with life in the United States. I relied on my clinical and interviewing skills to respond to these situations
by giving the participants time to process, expressing nonverbal cues to show my sympathy, staying in the moment with the participant, validating the participants’ experiences, and offering the participant the option to move to another question.

**Sample Description**

I screened 27 participants, and of those, 21 were eligible to participate in the study (17 females and 4 males). Most participants (n=17) were in treatment for depression only, while the remaining were in treatment for PTSD (n=2) and depression and PTSD (n=2). Their length of time in treatment averaged about 4 years (range 3 months to 17 years). Participants had an average age of 60 (range 42 to 74), and their time in the United States averaged 19 years (range 6 to 34). All except one participant had a source of income from SSI, SSDI, food stamps, or student financial aid averaging about $7,020 a year (range $0 to $10,000), and none were employed. The majority were married (n=11); four were divorced; four were single, and two were widowed. Many participants (n=10) did not graduate from high school; seven graduated from high school; two completed a college degree, and one completed a Master’s degree in linguistics and was working on his dissertation when the Vietnam War ended abruptly in 1975, which prevented him from defending his dissertation. Only two participants re-enrolled in college after they arrived in the United States: one completed her A.A. degree while another was completing her B.A. degree. All of the participants also had one or more physical health conditions: hypertension, high cholesterol, diabetes, chronic pain, cancer, arthritis, osteoporosis, stomach problems, allergies, asthma, psoriasis, poor vision, seizure, and scarring of the lungs. While it is difficult to make any meaningful comparisons between the characteristics of the men (n=4) and women (n=17), there were a few differences between the two groups. On average, the
men were older, had slightly higher income, had been in treatment much longer, and had been in the United States for a slightly shorter number of years than the women.

In terms of employment history, none of the participants was working at the time of the interview. The men and women had been unemployed as recent as 6 months ago to as far back as 20 years ago. Participants explained that they were laid off or stopped working due to health problems. Since then, they have had difficulties finding another job because of health problems, limited English language proficiency and jobs skills, and/or older age. Upon arrival in the United States, the participants reported that they worked in full-time or part-time manual jobs that did not require English language skills or high job skills. These jobs also paid low-wages, and most did not provide health insurance coverage or long-term benefits. These jobs were in: garment shops (n=3), hair shop (n=1), home construction (n=1), babysitting (n=1), janitorial work (n=1), and assembly line work (n=8). Two women bagged groceries or cashiered at a market. Two women stayed home to take care of their young children, and two participants reported that they could not find a job since arriving in the United States due to their old age and limited English language proficiency. One woman reported that she transitioned out of her assembly line job and worked as a clerk at the Internal Revenue Service office.

Participants held a variety of jobs in Vietnam, most of which were in sales and street/market vending where they earned enough to support their families. The participants reported their occupations in Vietnam as follows: high school teacher (n=1); chef at a hotel (n=1); small business owner selling fish (n=1), clothes (n=1), and coffee (n=1). One woman worked as an English tutor and a government worker (she did not want to specify her position), where she reportedly earned high income and had a comfortable life. The rest of the participants reported working as a vendor selling goods on the street or at a local market. Three men
reported that they served in the military during the Vietnam War, and one was a part-time lecturer at a university prior to joining the military. After the war ended in 1975, they helped their wives who worked in street/market vending.

Most participants (n=16) described their English ability as not knowing any English. Two participants said they knew very little English to ask basic questions such as how to find a street or an item at the market, but they could not communicate beyond that. One participant attended community college in the United States and described her English good but that she was not fluent. Three stated that they studied English in Vietnam but that the language skill was of little use when they arrived in the United States due to the differences in the pronunciation and language usage between Vietnam and the United States. One was a woman attending college who described her English as limited and that she had a hard time understanding the materials in class as well as communicating with a health care provider in English. The others were two men who could communicate in English as needed but that they could write more than speak.

Table 2 provided additional information about participants’ health prior to coming to the United States and current mental health treatment status. Over half reported having no health problem, and approximately 9 reported some health problems, most of which came about during or after the Vietnam War ended. Among those who had been in treatment for two years or less, their treatment generally included psychotropic medications, therapy, and/or support groups. They also stated that they were slowly doing better and wanted to go back to work in the future once their health improved. Among those who had been in treatment for longer than 2 years, treatment generally included psychotropic medications and/or support groups. These participants reported overall improved health but also realistically could not work due to health problems and/or old age, and all were receiving Supplemental Security Income (SSI).
Table 1. Sample Demographics (n=21)

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<td></td>
<td>Total</td>
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<td>Age</td>
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<td></td>
<td>60 (42-74)</td>
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<tr>
<td>Estimated annual income¹</td>
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<tr>
<td>(sources: SSI, food stamps, SSDI)</td>
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<tr>
<td>Time in treatment</td>
<td>4 years (3 months – 17 years)</td>
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<td>Years in the U.S.</td>
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<th>Frequency</th>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Female</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td></td>
<td></td>
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<tr>
<td>Marital status</td>
<td></td>
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</tr>
<tr>
<td>Single</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Married</td>
<td>11</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Divorced</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Widowed</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Highest education²</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;H.S. Grad</td>
<td>11</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>High school</td>
<td>7</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>College</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Master’s</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Diagnosis³</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Depression</td>
<td>17</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>PTSD</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Depression and PTSD</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

¹ Two women did not disclose income amount.
² Highest education was completed in Vietnam; 1 college grad was currently re-enrolled in college.
³ The diagnoses of 17 participants were based on self-reports. Four participants were screened using the HSC and the HTQ.
Table 2. Participants’ Characteristics: Health Status before Coming to the U.S. and Treatment Status (n=21)

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age (years)</th>
<th>Years in US</th>
<th>Education</th>
<th>Health status before coming to the U.S.</th>
<th>Time in treatment</th>
<th>Current treatment</th>
<th>Treatment progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aunt KTM</td>
<td>58</td>
<td>24</td>
<td>&lt;HS</td>
<td>“weak” health, “got sick easily”</td>
<td>3 months</td>
<td>meds, group, therapy</td>
<td>SSDI?, making slow progress, wants to go back to work</td>
</tr>
<tr>
<td>Aunt Target</td>
<td>61</td>
<td>23</td>
<td>BA in VN, AA in the U.S.</td>
<td>no health problem</td>
<td>5 months</td>
<td>meds, group, therapy</td>
<td>SSDI, making slow progress, wants to go back to work</td>
</tr>
<tr>
<td>Aunt Perfume</td>
<td>59</td>
<td>8</td>
<td>HS</td>
<td>no health problem</td>
<td>6 months</td>
<td>meds, therapy</td>
<td>Making slow progress, is looking for part-time job</td>
</tr>
<tr>
<td>Aunt Moon</td>
<td>61</td>
<td>26</td>
<td>&lt;HS</td>
<td>no health problem</td>
<td>6 months</td>
<td>meds, group, therapy</td>
<td>SSDI, making slow progress, wants to go back to work</td>
</tr>
<tr>
<td>Sister Cat</td>
<td>42</td>
<td>16</td>
<td>HS</td>
<td>had suicidal thoughts throughout teenage years; never attempted</td>
<td>6 months</td>
<td>meds, therapy</td>
<td>SSDI, making slow progress, wants to go back to work</td>
</tr>
<tr>
<td>Aunt Giau</td>
<td>55</td>
<td>12</td>
<td>&lt;HS</td>
<td>no health problem</td>
<td>9 months</td>
<td>meds, group, therapy</td>
<td>Making slow progress, wants to go back to work</td>
</tr>
<tr>
<td>Sister Park</td>
<td>40</td>
<td>6</td>
<td>BA in law, linguistics</td>
<td>no health problem</td>
<td>9 months</td>
<td>meds, therapy</td>
<td>SSDI, making slow progress, wants to go back to work</td>
</tr>
<tr>
<td>Aunt Banana</td>
<td>61</td>
<td>27</td>
<td>&lt;HS</td>
<td>no health problem</td>
<td>1.5 years</td>
<td>meds, group, therapy</td>
<td>Making slow progress, wants to go back to work</td>
</tr>
<tr>
<td>Aunt Jewel</td>
<td>53</td>
<td>34</td>
<td>HS</td>
<td>no health problem</td>
<td>2 years</td>
<td>meds, group</td>
<td>SSDI, feeling healthier, cannot work</td>
</tr>
<tr>
<td>Participant</td>
<td>Age (years)</td>
<td>Years in US</td>
<td>Education</td>
<td>Health status before coming to the U.S.</td>
<td>Time in treatment</td>
<td>Current treatment</td>
<td>Treatment progress</td>
</tr>
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<td>-----------------</td>
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<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Aunt Lai</td>
<td>61</td>
<td>33</td>
<td>&lt;HS</td>
<td>no health problem</td>
<td>2 years</td>
<td>meds, group</td>
<td>SSDI, making slow progress, wants to go back to work</td>
</tr>
<tr>
<td>Aunt Recycle</td>
<td>67</td>
<td>8</td>
<td>&lt;HS</td>
<td>stomach indigestion problems, headaches, difficulties sleeping</td>
<td>2.5 years</td>
<td>meds</td>
<td>SSI, feeling healthier, cannot work</td>
</tr>
<tr>
<td>Uncle Recycle</td>
<td>73</td>
<td>9</td>
<td>&lt;HS</td>
<td>headaches</td>
<td>3 years</td>
<td>meds</td>
<td>SSI, feeling healthier, cannot work</td>
</tr>
<tr>
<td>Aunt Taxi</td>
<td>55</td>
<td>25</td>
<td>&lt;HS</td>
<td>no health problem</td>
<td>3.5 years</td>
<td>meds, group</td>
<td>SSI, feeling healthier, cannot work</td>
</tr>
<tr>
<td>Aunt North Flower</td>
<td>68</td>
<td>23</td>
<td>&lt;HS</td>
<td>Headaches, some nightmares</td>
<td>3.5 years</td>
<td>meds, group</td>
<td>SSI, feeling healthier, cannot work</td>
</tr>
<tr>
<td>Aunt Barbie</td>
<td>60</td>
<td>19</td>
<td>&lt;HS</td>
<td>no health problem</td>
<td>5 years</td>
<td>meds, group</td>
<td>SSI, feeling healthier, cannot work</td>
</tr>
<tr>
<td>Aunt White Flower</td>
<td>60</td>
<td>11</td>
<td>HS</td>
<td>chronic asthma, attempted suicide 3 times</td>
<td>5.5 years</td>
<td>meds, group</td>
<td>SSI, feeling healthier, cannot work</td>
</tr>
<tr>
<td>Uncle 6T</td>
<td>73</td>
<td>15</td>
<td>HS</td>
<td>post VN War, increased headaches, difficulties controlling anger, “weak” health</td>
<td>6 years</td>
<td>meds</td>
<td>SSI, feeling healthier, cannot work</td>
</tr>
<tr>
<td>Aunt Ocean</td>
<td>55</td>
<td>18</td>
<td>&lt;HS</td>
<td>post VN War, was hospitalized once in early teens: disinterested in life, increased social isolation</td>
<td>8 years</td>
<td>meds, group</td>
<td>SSI, feeling healthier, cannot work</td>
</tr>
<tr>
<td>Participant</td>
<td>Age (years)</td>
<td>Years in US</td>
<td>Education</td>
<td>Health status before coming to the U.S.</td>
<td>Time in treatment</td>
<td>Current treatment</td>
<td>Treatment progress</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
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<td>-----------</td>
<td>----------------------------------------</td>
<td>-------------------</td>
<td>-------------------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>Aunt Ginseng</td>
<td>69</td>
<td>23</td>
<td>HS</td>
<td>no health problem</td>
<td>8 years</td>
<td>meds, group</td>
<td>SSI, feeling healthier, cannot work</td>
</tr>
<tr>
<td>Uncle Van</td>
<td>74</td>
<td>19</td>
<td>PhD in linguistics</td>
<td>Post VN War, “lived in fear” of local government</td>
<td>10 years</td>
<td>meds, group</td>
<td>SSI, feeling healthier, cannot work</td>
</tr>
<tr>
<td>Uncle MT</td>
<td>54</td>
<td>21</td>
<td>HS</td>
<td>was caught in crossfire at age 10; began to experience “weak health” and increased social isolation</td>
<td>17 years</td>
<td>meds</td>
<td>SSI, feeling healthier, cannot work</td>
</tr>
</tbody>
</table>

1 Group refers to support groups at the treatment agency
2 SSDI is Social Security Disability Insurance
3 SSI is Supplemental Security Income
Data Management

Interviews were audio recorded, transferred onto my computer, and deleted from the recorder. The participants were informed of their right to refuse to be recorded or request to edit, review, or erase their interview recordings. The interviews were transcribed verbatim into the language in which the interview was conducted (Vietnamese) by a hired transcriptionist fluent in both English and Vietnamese. I listened to each audio file while checking the transcripts for accuracy, and inserted notes about nonverbal cues or interactions that occurred during the interview that were not captured by the audio files. I also changed the names of individuals, agencies, and places to protect the identity of the participants. The participants’ pseudonyms were chosen based on a unique characteristic of each participant that I particularly connected with during the interview. Interviews were kept in the original language for analysis. All personal identification was removed from the transcripts, and each participant was assigned a number. A sheet matching the first name and identifying number of each participant was kept in a password-protected file that only I could access. Copies of the recorded interviews and interview transcriptions were kept in a secure place accessible by only myself. All computer files related to this study were password protected on the computer used for analysis.

Data Analysis

Data analysis was carried out following constructivist GT analysis methods that occur in three hierarchical phases: initial, focused, and theoretical. To begin analysis, I coded for actions, meanings, assumptions, and processes described by the participants. However, my coding was not necessarily carried out in the rigid constructivist GT hierarchical order. Rather, data analysis was an iterative and messy process, wherein I moved back and forth across the coding steps to make sense of the data, to fill the properties and dimensions of a category, and to build
conceptual linkages across categories. This involved many moments of reflection, memo-ing, sleeping on the ambiguities, and consulting with my dissertation chairs and colleagues. Along the way emergent codes prompted me to return to earlier segments and transcripts to recode with the new concepts in mind. Thus, I could see the same passages differently as data analysis progressed. I consulted with my dissertation chairs and decided to keep the transcripts in Vietnamese for coding to preserve the meaning of the participants’ narratives; the true meanings could be lost if the transcripts were translated into English before coding.

**Coding.** Initial coding involved line-by-line coding of the data. I began by reading the interview transcripts to gather an overall sense of the content. During initial coding, I asked two questions to move beyond descriptive coding toward coding for actions, meanings, and processes: what is happening in the data, and what does it mean? I applied codes using gerunds to stay close to the words and actions of the participants. This method of coding was useful in the initial stage of data analysis to ground my codes in the words of the participants, rather than apply my own preconceived notions about the topic to the passages. I applied initial codes to five transcripts to get a general grasp of the data and the emerging concepts that arose relating to the research aims of this study. Initial coding informed my next step of focused coding. I hand-coded two transcripts and from then on used the qualitative software program Atlas.ti to organize and code the rest of the transcripts.

At the next level of focused coding, I moved beyond a line-by-line reading of the data toward a more conceptual coding for the most significant and frequent codes that emerged. Thus, the earlier initial codes were now condensed and grouped into related codes. This strategy helped me to manage large chunks of data and to stay focused on the emerging concepts that were identified by the participants. I also paused during the coding to look within and across
transcripts to see what the same or other participants said about the concept; looking back and forth was important to the development of properties and dimensions of an emerging category. I encountered numerous ambiguities during this coding stage, often reflecting on what a particular passage meant and how it may or may not fit with a particular category. Some codes also raised additional questions and highlighted gaps in the data or about a concept, all of which helped to guide my subsequent interviews and coding. Once the focused codes began to form properties and dimensions of a category, I began theoretical coding to conceptually link within and across categories to form a conceptual framework. Theoretical coding occurred during the later interviews and toward the end of the data gathering phase. I continued to read within and across transcripts to draw relationships among the concepts. At this stage my coding was also much more focused on the relevant segments that would deepen my understanding of the established categories. Further, I drew diagrams and continued to revise them to better visualize the conceptual framework that linked health, help seeking and outpatient care.

At the end of each transcript coding, I wrote an impression memo that summarized the characteristics and contexts of the participants, as well as questions or insights that emerged after reading a participant’s transcript. Several key steps were relevant throughout the coding process: constant comparative method, in vivo coding, and memo-ing.

*Constant comparison.* Constant comparison refers to a systematic comparison of data (e.g. incidents) within or across participants to find similarities and differences of a concept (Corbin & Strauss, 2008). Throughout data analysis, I went back and forth across transcripts and within the same transcript to identify the range of variation in how certain concepts were discussed. This process of comparison was a way to elaborate and refine the properties and dimensions of concepts and categories, for example, identifying what one participant said about
a particular code and comparing that to what another participant said. Further, comparisons illuminated the gaps and questions about the concepts and categories that guided the next steps of data collection and analysis.

*In vivo codes.* Data were also coded for “in vivo codes,” or terminologies that carry significant meanings for the participants and that are widely used within their context (Charmaz, 2006). These codes further the understanding of how participants’ actions and experiences were constructed around these words. The men and women in this study used phrases in the Vietnamese language that illuminated cultural influences on conceptualizations, manifestations, and responses to mental health concerns. Thus, I highlighted these codes throughout my coding to capture context-specific expressions relating to beliefs and perceptions about health, mental illness, help seeking, and mental health treatment from the perspectives of first-generation Vietnamese Americans. I reviewed these codes periodically to ground my analytic progress in the words and experiences of the participants.

*Memo-ing.* Memo-ing is an analytic tool for interpretations and reflexivity that takes place from the start to the end of the research process (Charmaz, 2006). Throughout the research process, I wrote memos to document thinking, analytic decisions, and the conceptual and theoretical progression of the research. Early on, I wrote short notes, reflections, and diagrams about questions, things to follow up, descriptions of what happened during an interview, and thoughts about early codes. As the coding progressed, I used memos to write about emerging categories and draw out their properties and dimensions. I continued to expand on these memos as new codes that emerged added new dimensions. At later stages of the interviews, I used memos as writing and thinking exercises to link categories and subcategories, and to refine the development of my conceptual framework. Throughout the analysis and writing stages, I wrote
memos about any spontaneous thoughts that came up regarding my data. I also revisited and integrated ideas from these memos to interpret the meaning of the data, to link the codes into a conceptual understanding of the experiences of the participants, and to develop a preliminary framework on help seeking among first-generation Vietnamese Americans. Thus, memos served as another source of data for the study and were integrated into the writing of my dissertation. In addition, I wrote self-reflection memos about my research process, how I as the researcher influenced and was influenced by the research itself.

**Trustworthiness of Data**

In qualitative research, standards for ensuring trustworthiness of the data are evaluated through the criteria of *credibility, dependability, and transferability* (Bloomerg & Volpe, 2008).

*Credibility* refers to whether the researcher’s interpretation of the data fit with the actual experiences of the participants. In this study, I followed the constructivist GT coding steps to ensure that I stayed close to the data and presented the participants’ stories as closely as possible to their experiences. I wrote memos about analytic and conceptual progression and about my personal biases and their possible influences on the research process. I also debriefed with my colleagues, advisors, and other Vietnamese American mental health professionals for feedback and support throughout the research. Toward the later part of the data collection phase, I carried out member checking with the participants regarding particular concepts and ideas that emerged from previous interviews to get their validation and feedback; I also discussed emerging categories with the participants and asked for their reflections about my interpretation of the earlier narratives. Some participants agreed with the interpretations (e.g. money is important to health and self worth, particularly in the United States), whereas others provided further insights into the dimensions and properties of the categories (e.g. self worth is linked to the ability to be
self sufficient, to provide for one’s family, and to be a contributing member of one’s community.

The *dependability* criterion refers to having sufficient information so that another person can trace the steps carried out in research (Bloomerg & Volpe, 2008). Clear documentation of each step taken in data collection and analysis strengthens the openness of the research process (Padgett, 2008). In this study, I provided detailed descriptions to clearly document the methodological procedures (e.g. recruitment, sampling, data analysis). Other research-related processes were documented in memos, field notes, and coding notes and maps to provide an audit trail for the steps in the study.

The *transferability* criterion refers to how much of the process found in the present study may be transferable to other similar contexts. The goal of this study was to generate data specific to the experiences of first-generation Vietnamese Americans with depression and/or PTSD and their decisions to seek outpatient care. While the study’s findings emanate from the particular context and participants of this study, some elements of the findings may be shared or have applications for other populations or settings, such as perceptions and help seeking among 1.5 or second generation Vietnamese Americans or other first-generation immigrant and refugee populations. I provided rich, detailed descriptions of the participants and their contexts that could be used to expand the relevance of this study’s findings to other contexts and populations.

**Researcher Reflexivity**

I began this research with preconceived notions, assumptions, and disciplinary knowledge, all of which influenced my work. I conducted my research through several lenses: as a Vietnamese refugee and as a graduate student who was educated in the United States. My background as a 1.5 generation Vietnamese American, came to the United States before age 12,
certainly introduced issues related to transference and counter-transference to the individuals and stories I encountered in my interviews. I relied on memos and regular debriefings with colleagues, dissertation chairs, and other community members to process any influences of my experiences on the research.

I consider myself an “insider” in the Vietnamese American community. My background as a 1.5 Vietnamese American has indeed predisposed me to the Vietnamese culture and experiences that many first-generation Vietnamese Americans share. I was a part of the Vietnamese refugee experience and am deeply connected to my grandparents’ and mother’s stories about the Vietnam War, escapes from Vietnam to the refugee camp, and resettlement in a new country. More specifically, I have witnessed the long-lasting psychological impacts of war, migration, and resettlement on the mental health of my family and my community. I believe that my first-hand knowledge and experiences fortified me as I was able to relate to the first-generation Vietnamese Americans I interviewed in profound ways that led to further questions about their private lives and experiences – and their willingness to share their stories with me.

I am also aware that this prior knowledge could hinder my research, because I began the research with particular assumptions about the lives of Vietnamese American immigrants, their beliefs about mental illness, and their help-seeking behaviors. These preconceived ideas, or cultural blind spots, hindered my ability to listen to and explore participants’ unique experiences, especially when those experiences differed from what I heard and witnessed in my own family or in the Vietnamese American community. For example, I assumed that Vietnamese Americans living with mental illness would disclose their condition to their family before doing so to someone else. However, that was not always the case. I also assumed that Vietnamese Americans were simply ashamed to get help for their mental illness when in fact some
participants did not think or know that they had a mental health condition until a doctor or someone else told them.

My self-identification as a 1.5 Vietnamese American also means that aspects of my self concept were shaped by the Western culture and educational system. I came to America at age 11 and have spent 20 years in the United States. My education in sociology, public health, psychology, anthropology, and social work has informed my understanding of mental health. An assumption of my research was that mental health treatment can help people with mental illness improve; therefore, a goal of this research was to understand ways to improve mental health service use and quality of care for first-generation Vietnamese Americans. Concepts such as mental illness, help seeking, coping, and barriers have specific meanings for me but were understood differently among the participants in this study. I learned early on that my research aims and the phrasing of my interview questions were based on the assumptions of someone who was educated in the United States. I was imposing my own knowledge and mental health concepts and jargons onto the participants during the interviews and soon learned that they did not relate to and did not understand my questions. At some points I was frustrated because the participants were not answering my questions, or the data did not address my research aims. Throughout this research process, my honest reflections in memos and debriefs with colleagues and chairpersons challenged me to face my own assumptions. I learned to be humble and respectful in my questions by using the terminology that participants themselves used (e.g. discomforts versus mental illness, getting help versus seeking mental health treatment, the place of help versus outpatient care). I also temporarily removed my social worker or researcher hat to simply listen to the participants and their stories. When this happened, they shared with me more openly, and I was able to elicit rich life stories and interpret the data very differently.
I also came into this research with the mentality that my participants knew what research was. While I assumed the role of a researcher, the men and women really had no idea what exactly a research project meant, or what was expected of them as research participants. At the beginning, I frankly did not realize the importance of taking the time to explain these things. Research came so natural to me because I am surrounded by people who are constantly engaging in this activity. In a sense, I walked into the interviews with a privileged mentality that I am the researcher and that my participants’ role was to answer my questions. It was not until several interviews later that a participant challenged this by asking about my educational background and for an ID that would prove my identity. At first I was offended by it because I felt that my desire to help the community through research should be a good enough proof. Upon reflection and after debriefs with my dissertation chairs, I realized that the participant had all the reason and the right to demand that I proved my credibility and legitimacy. I should have done that all along even if they did not ask. After all, I was an outsider and a stranger who requested to ask the men and women very personal questions about their lives. This request itself was intrusive. Further, the community’s lack of familiarity with research and experiences with interrogation during and after the Vietnam War understandably raised doubts and anxiety among the participants when I, a stranger, approached them to ask questions about their lives.

After this incidence, I became much more aware of how my assumptions affected my interactions and rapport building with the participants. I realized that being explicit about my biases in the research proposal was one thing, but experiencing it first-hand in the actual conduct of research was the real lesson. Reflexivity was/is a continuous learning process.

Two other issues also came up during my interviews: age and gender. In my encounters with the participants, it was clear that I was much younger than most of them. I tried to
anticipate how this age gap would affect the participants’ connectedness to me and how it would affect the types of information they would disclose. The age gap became more real when I introduced myself to and sat down with the men and women. Some appeared indifferent to my being younger, whereas others asked questions to get a sense of my background and credibility. Some of the questions participants asked me included: how old are you, are you married, where do you live, where were you born, when/how did you get to the United States, what are you studying, and why are you doing the interviews. In spite of the caution for researchers to remain objective in the conduct of research, it was important for me to be honest and respectful toward the participants in order to get information from them. It meant that I had to respond to their questions. This decision was critical to my rapport-building with the participants because they felt connected to me in other ways in spite of my age, and this helped ease my way into the interview.

My gender was another factor that influenced my research. Most of the participants were women. Four were men. I immediately felt a distance between myself and the male participants as we sat down to do the interviews. It was much easier to talk to and connect with the women. The men were hesitant, and their responses were short. During these interviews I did my best to connect with the participants by disclosing a bit about my background as a Vietnamese American immigrant or a granddaughter of a former South Vietnam prisoner of war. I also expressed my excitement about helping the Vietnamese American community and learning about the experiences of the “aunts and uncles” who came before me. I was conscious of the fact that my youth also did not help to facilitate the conversations, and wondered if I could have gotten more information if I were a male or older. In spite of the limitations that my age and gender posed to the research, I knew that my rapport with the participants had achieved success to some degree.
when some told me that this was only the second time they had told someone their personal stories (the first time to their doctor or therapist), and that they welcomed more questions and were willing to answer them so that my school work could be completed; some sat down with me for two or three hours to share their life stories.

Conclusion

This chapter described the research methodology of this study. The rationale for the inductive research design and the guiding conceptual framework of symbolic interactionism were discussed, followed by details about sampling and recruitment, data collection, sample description, data management, and data analysis. The chapter concluded with a discussion of research considerations regarding trustworthiness of data, and researcher reflexivity to address the scientific rigor of the inductive research paradigm.
Chapter 5 Results

Summary of Emergent Themes, Dimensions, and Properties

The study’s goal was to explore and describe the experiences of first-generation Vietnamese Americans receiving outpatient treatment for a diagnosis of depression and/or PTSD. In seeking to understand this phenomenon, the study proposed the following three aims:

4. explore the conceptualizations of health among first-generation Vietnamese Americans living with depression and/or PTSD,
5. illustrate the pathways through which first-generation Vietnamese Americans with depression and/or PTSD obtain outpatient mental health services, and,
6. describe their expectations and perceptions of outpatient mental health treatment.

In the following section, I will outline themes, dimensions, and properties that emerged from the data and how they addressed each of the three research aims (Table 2). Research Aim 1 was answered using data from the theme of conceptualizations of health; its three dimensions of the historical, political and context of health, physical and emotional discomforts, and self worth.

Research Aim 2 was addressed using the theme of getting help for one’s discomforts. This theme’s six dimensions included experiencing something out of the ordinary, getting worse by the day, going public, learning about options to alleviate discomforts, navigating one’s way, and actual service use; and their properties. Research Aim 3 was addressed using data from the theme of experiences in mental health treatment; its five dimensions were initial expectations, the doctors, the ladies, the groups, and the place; and its dimensions. Stigma was a dimension that was relevant to all the research aims.
Table 3. Categories and Dimensions on the Experiences of First-Generation Vietnamese Americans Living with Depression and/or PTSD

<table>
<thead>
<tr>
<th>RESEARCH AIM 1</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Themes</strong></td>
<td><strong>Dimensions</strong></td>
<td><strong>Properties</strong></td>
</tr>
</tbody>
</table>
| Losing One’s Self Worth | Historical, political and social context | Life during and after the VN War  
Escapes from Vietnam by boat  
Migrating and adjusting to life in the U.S.  
Critical markers of changes |
| Physical and emotional discomforts | Defining health | History of health problems/discomforts  
Nature of discomforts  
Causes of discomforts  
Impact of discomforts  
Managing health  
Visibility of discomforts |
| Self worth | Ability to function | Social roles  
Purpose  
Relationships  
Security and stability  
Dignity, respect |

<table>
<thead>
<tr>
<th>RESEARCH AIM 2</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Themes</strong></td>
<td><strong>Dimensions</strong></td>
<td><strong>Properties</strong></td>
</tr>
</tbody>
</table>
| Finding One’s Self Worth | Experiencing something out of the ordinary | History of health problems/discomforts  
Ongoing discomforts  
Keep on going |
| Getting worse by the day | Worsening health | Being at one's worst  
Making attributions of discomforts  
Not having a name for it |
| Going public | Suicide attempts | Being told that one is sick  
Disclosing to others |
| Learning about options to alleviate discomforts | Involuntary hospitalization | Receiving referral to relieve discomforts  
Receiving no referral  
Stumbling upon the place |
## RESEARCH AIM 2

<table>
<thead>
<tr>
<th>Themes</th>
<th>Dimensions</th>
<th>Properties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finding One’s Self Worth</td>
<td>Navigating one's way</td>
<td>Navigation pathways</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Facilitating factors</td>
</tr>
<tr>
<td>Actual service use</td>
<td></td>
<td>Personal readiness</td>
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<td></td>
<td></td>
<td>Pragmatism</td>
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<td></td>
<td>Trying it out</td>
</tr>
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</table>

## RESEARCH AIM 3

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<thead>
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<th>Dimensions</th>
<th>Properties</th>
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</thead>
<tbody>
<tr>
<td>Reclaiming One’s Self Worth</td>
<td>Initial expectations</td>
<td>Going to the place for help</td>
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<tr>
<td></td>
<td></td>
<td>Doing as told</td>
</tr>
<tr>
<td>The doctors</td>
<td></td>
<td>Receiving expert confirmation that one is sick</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Receiving medication to relieve discomforts</td>
</tr>
<tr>
<td>The ladies</td>
<td></td>
<td>Receiving expert advice to manage one’s illness</td>
</tr>
<tr>
<td>The groups</td>
<td></td>
<td>Learning to manage one's health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The economics of self worth</td>
</tr>
</tbody>
</table>

## RESEARCH AIM 1, 2, 3

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<th>Themes</th>
<th>Properties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stigma</td>
<td>Personal stigma</td>
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<td></td>
<td>Public Stigma</td>
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Overview of Organizing Framework

In this section I will provide a brief overview of how the emergent categories and themes formed an organizing framework about the experiences of first-generation Vietnamese Americans living with depression and/or PTSD. “Bounded within these four walls” and finding one’s way to “a place where I am respected” emerged as overarching processes through which first-generation Vietnamese Americans living with depression and/or PTSD described their experiences: a movement through losing, finding, and reclaiming one’s self worth. As depicted in Figure 1, each aim of this study parallels the participants’ movements through losing, finding, and reclaiming self worth.

Figure 1. An Overarching Framework of Study Aims and Corresponding Findings:

A Process of Losing, Finding, and Reclaiming Self Worth

The paths taken usually started with deteriorating physical and emotional health that stripped participants of their ability to function and to fulfill social roles, embedded within the historical, political and social context of the Vietnamese American experience (Aim 1).
Consequently, participants lost their sense of worth as they were no longer productive and contributing members of their family and community. Over time the men and women began to engage in a help seeking process that unfolded over months or years (Aim 2). It started with participants noticing something unusual about their health and seeing their health worsen, to encountering individuals who prompted them to do something about their deteriorating health, and finally to navigating their way into a place of help for the first time. This process was symbolic of participants finding their self worth because participants had found the place and people who could help to alleviate the symptoms that they had crippled them for some time. Participants’ engagement in outpatient treatment marked the beginning of a new chapter in their lives: receiving the assistance of a team of doctor and agency workers to improve their health and attaining the financial means to reclaim their long lost self worth in spite of living with a mental illness (Aim 3). The men and women had a chance to regain some of their ability to function and fulfill their obligations to their family. Within this journey were smaller paths that each individual took, paths that varied with time and situation. The participants described the journey as a process marked with losses, sacrifices, disruptions, stigma, resiliency, coming into terms with one’s condition, and managing one’s illness. Nonetheless, participants remained optimistic on this road to reclaiming self worth, knowing that it is a work in progress.

The following chapter will present findings related to Aim 1.
Aim 1 Results: Explore the Conceptualizations of Health among First-Generation Vietnamese Americans Living with Depression and/or PTSD

Table 3 below lists the theme, dimensions and properties related to this aim. The dimensions included: 1) historical, political, and social context, 2) physical and emotional discomforts, and 3) self worth.

Table 4. Research Aim 1 Themes, Dimensions and Properties

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<th>Dimensions</th>
<th>Properties</th>
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<tbody>
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<td>Historical, political and social context</td>
<td>Life during and after the VN War</td>
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<td></td>
<td>Escapes from Vietnam by boat</td>
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<td>Migrating and adjusting to life in the U.S.</td>
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<td>Physical and emotional discomforts</td>
<td>Defining health</td>
<td>History of health problems/discomforts</td>
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This section first discusses the reasons for revising the original research aim and then elaborates on the findings that are related to the aim. The original Aim 1 was to explore the beliefs and perceptions about mental illness and depression and PTSD among first-generation Vietnamese Americans. The intent of this aim was to gain participants’ understanding of why they are in outpatient treatment, and whether this understanding reflects the diagnoses (depression and/or PTSD) given to them in treatment by mental health professionals. Following the first few interviews, I found that my questions about participants’ conceptualizations of mental illness, depression, and/or PTSD did not yield insight as I expected. Participants only provided prescriptive definitions that they had picked up in treatment and were not talking about their own illness experiences, which I was most interested in. This was because the original question had missed the mark and did not use words that were synchronous with the participants’ understanding of their emotional discomforts. On the basis of the early interviews, I revised Research Aim 1 to explore the conceptualizations of health among first-generation Vietnamese Americans living with depression and/or PTSD.

The participants’ knowledge of mental illness consisted of descriptions of people who are locked up because of their “crazy” and “violent” thoughts and behaviors, or of people who have lost their mind. This term did not in any reflect the participants’ own experience with mental health problems. Furthermore, participants all acknowledged that they were in treatment for emotional problems. Most were able to name “depression” as the diagnosis that was given to them by the outpatient mental health treatment team. A few “guessed” that they were in treatment for a condition known as “depression” after commonly hearing about depression and its symptoms being discussed at the mental health agency or on the Vietnamese television or radio programs. The word depression was a newly acquired vocabulary that had a direct
translation into Vietnamese but yet did not carry much meaning to the participants because mental illness diagnoses were nonexistent in the world of the participants, until they came into the outpatient setting. A few stated they were in treatment because of *khung hoan* or being in a state where one is startled, frightened, unsettled. The formal diagnosis “PTSD” was not something that the participants could name as a condition for which they were in treatment. The diagnosis PTSD did not have a Vietnamese label in the vocabularies of the participants.

As such, participants were unable to explain how the label depression was meaningful to their experiences as individuals living with mental illness. They simply did not use this label to describe their presenting mental health problems or to explain why they came into treatment. Rather, the men and women talked about their physical and mental health problems as interconnected. Thus, the original Research Aim 1 was formulated with the assumption that participants in this study shared the same worldviews and understanding of mental illness, PTSD, and depression as the researcher. This turned out to not be the case as participants could not relate their experiences to these labels. Thus, Research Aim 1 was revised to elicit a more holistic conceptualization of health, so the beliefs and perceptions about mental illness and depression and PTSD part of the aim was changed to conceptualizations of health.

**Aim 1 Conceptual Model**

The next section presents findings related to Aim 1. Figure 2 below depicts the participants’ conceptualizations of health that consisted of three identified dimensions: the historical, political and social context of their past and present, physical and emotional discomforts, and self worth (referenced in Table 2).
As depicted in Figure 2, the participants’ conceptualizations of health consisted of three dimensions: historical, political and social context of their past and present, physical and emotional discomforts, and self worth. As such, participants’ definitions of health were not simply about physical or mental health problems they faced each day. Participants provided a holistic conceptualization of health that was deeply embedded within the context of their lives as citizens of a war-torn country during and after the Vietnam War, as immigrants and refugees who struggled to rebuild their lives in the United States, as working and productive citizens, and as family members whose utmost obligation was to their loved ones. The following section will discuss in detail key aspects of health from the perspectives of first-generation Vietnamese Americans.
Aim 1 Findings

**Historical, political, and social context: linking past and present**

The participants discussed their health as intricately connected with the historical, social and political context of their past and present. The Vietnamese American experience is characterized by decades of war and post-war migration away from one’s homeland. The resilient spirits of the Vietnamese American people helped them endure many years of hardships and uncertainties about what the next day would bring. For these participants, their experiences were characterized with “sacrifices,” “losses,” weathering storms, and a “relentless will” to live. Obviously, the physical and emotional well-being of first-generation Vietnamese Americans suffered from chronic wear and tear throughout the decades. In the words of Uncle Van, “it catches up with you” and you “hit a point of exhaustion.” It is not possible to fully understand participants’ health apart from their lives during and after the Vietnam War and post migration to the United States.

*Life during and after the Vietnam War.* Everyone in this study was affected by the Vietnam War, either as a child growing up in a war-torn country, or a father, military serviceman, or wife. Nonetheless, all were citizens who lived through traumatic daily realities of gunfire, uncertainties about the future, losses, and hardships. A few participants were victims of war violence, whereas others were witnesses to the violence. This traumatic past left deep scars on the physical and emotional states of the men and women. The quotes below are recollections of the past that still haunts the minds of the participants:

When I was ten I was caught in a crossfire during the Vietnam War. There were bombs and shootings, and houses burning down everywhere. I remember that one day vividly when I ran between my [burning] house and another house to seek safety and was hit with the shrapnel. My stomach tore open. Someone put me on a bicycle and took me to the hospital. My intestines were hanging out. The sky was bright red from all the crossfires. I got to the hospital, and it was packed with injured people, so the nurse said
to put my intestines back into my stomach until they could operate on me later. Look, I still have the scar from that surgery. Because of that experience, until now, little noises would make me jump. I also take very small sips of water now because I drank water filled with oil [from burning homes and gunshots] that day while hiding in the shack with my family, and I could taste the oil . . . every time I drank water. But other people don’t understand that and they wonder why I slowly sip on water the way I do. (Uncle MT)

I would be sleeping in the middle of the night and all of a sudden I would be wakened, only to realize that I was dreaming . . . I was dreaming of my past, of the scenes [during the Vietnam War] where people carried dead bodies, and people were crying and screaming over these bodies. You know, like the family members . . . They would carry the bodies past me, and I would shake my head every time. . . . It haunts me like that to this day. I would jump up from my sleep and tell myself that I was just dreaming, but the scenes that I saw in my sleep were just so real. (Aunt Ginseng)

I was caught in a bomb explosion that affected my head. That’s why I have been getting head pain since. Back then I also had this chest problem, this pain in my chest. When I lay down, my wife would have to help me get back up to ease the [chest pain] because I was hurting. My body was hurting. It was from that injury [convoy attack during the Vietnam War]. The fumes of the explosion blew everything up. It was so serious. The car was totally damaged. All damaged. A few guys who were with me also died. Their bodies blew up into pieces. (Uncle Recycle)

Life after the Vietnam War was another chapter of a traumatic past for the participants, all of whom were subjected to the “oppressive” regime that took complete control of peoples’ lives: changing currency, confiscating properties, treating citizens as suspects. For participants who served in the South Vietnam military and for families that were part of the South Vietnam movement against the North, the end of the Vietnam War meant that they had lost their country and their identity. Narratives about “oppression,” “persecution,” and “differential treatment” toward the participants and their families were all too common.

Two participants who were South Vietnam military officers recalled the endless torture they endured during and after the re-education camp; it scarred their bodies and their minds. An ex-military officer of South Vietnam developed problems with his head because of the hardships he had to face in prison: “burying too many friends who died,” “being locked up,” “being insulted,” “being tortured,” and “being starved.” After the men came home, they and their
families were constantly harassed and singled out by the government. Uncle Van explained the lasting impact of this experience on his health:

… I was imprisoned and was traumatized by what was going on. And then, when I came here (to the United States)… I still had nightmares. It’s like being traumatized by the things that happened… I had all kinds of nightmares… Sometimes in my sleep I would think that I was under their [Vietnamese government’s] mercy, yelling at me. When I came back from the reeducation camp, they [the local government] heard here and there that I was an officer for the South Vietnam military and kept calling me in to give me a hard time. The local police were torturing me… They kept calling me into their office to make reports, saying things like someone reported to them that I violated the law. They gave me a really hard time. For example, I was selling coffee to make a living, and they would accuse me of illegally trading coffee. I had to give them something [to bribe]… and I just had to keep doing that to make it through each day. (Uncle Van)

Other participants who were wives, children, or relatives of someone who served in the war struggled to raise children while their breadwinners were away. A few participants were civilians, who nonetheless faced similar hardships of postwar life. All worked in arduous jobs in the fields or as street vendors to feed their families, and they were “suspects” in the eyes of the local government. Working hard jobs to survive day to day, and dealing with poverty and oppression from the local government were all too common experiences for the participants and their families. This continued for years after the Vietnam War and until the day they left Vietnam. One participant was separated from her husband, and was forced to relocate to the rural development area because he served for the South Vietnam military. He ended up escaping multiple times from Vietnam. She recalled the hardship of working alone to support her entire family:

I made money, for example 1,000 VN dong [currency] in a month sewing clothes. I would pay about 500-600 of that toward medication. I drank meds all the time. I have a scar on my stomach from being so sick back then because I developed stomach problems and had to see a medicine man to treat me. When I gave birth to the oldest son, my saliva was pouring out constantly, but I didn’t know why… Part of it was that I was crying all the time. I was sad that my husband had escaped and left Vietnam. And then you won’t believe this but I started working just two weeks after I gave birth… Then years later, in 1986 when my husband escaped from Vietnam by boat [again], that year, I was hit with
two things. One was my husband leaving me, then the other was I had a cyst in my breast, and at that point I thought I had cancer. I had to go to Saigon for a health checkup to see if the cyst was harmful. But then my mom also had cancer at that same time that I had cancer. My husband was gone, and my mother had cancer, and I was sick… So at that moment I had to ignore my health problems to take care of my mom. (Aunt KTM)

**Migration to the United States.** The migration to the United States marked another point of drastic changes for the participants and nonetheless another chapter in their life that influenced their long-term health. Some escaped Vietnam by boat, while others migrated through a government program designed for ex-military officers, or through the sponsorship of a family member who already lived in the United States. Separation of families was common during the migration, and many participants had to leave behind their parents, children, siblings, spouses, or relatives.

Many participants attempted to escape Vietnam by boat, but only a few did so successfully. Those who escaped risked their lives and endured dangerous journeys across the South China Sea where encounters with “thirst and starvation,” being “threatened by pirates,” “near death experiences” in “stormy weather,” and “sinking boats” were commonplace. Once they made it to the refugee camp, participants endured months of living day by day, awaiting the news of when and which host country they would be sent off to. These individuals and their families also survived on limited rations of food. Nonetheless, they were lucky enough to have made it across the ocean to land. Aunt KTM recalled the hardships of life in the refugee camp:

> There were three of us, my two children and me. You know, I would see my children craving, craving for food, but I didn’t have money to buy food for them. That… pained me, pained me a lot. At times I would buy fermented beans [cheap food] to eat, but when I ate that food my stomach problems would act up. So my health wasn’t so good at that time. (Aunt KTM)

Some participants arrived in the United States through the state-sponsored program known as the Humanitarian Operation (HO) program for South Vietnam military servicemen and
their families. The migration from Vietnam to the United States began with great anticipation for a better life and the opportunities that America had to offer. Participants expressed hopes and dreams for “success” and -- of utmost importance -- a “future for their children.” However, the reality of life in the United States was not the ideal life participants had imagined. Acclimating to life in the United States was difficult for all the men and women, who “did not speak the language,” did not have skills” to get a high paying job or “to compete in the job market,” and were “older.” All participants had to “start working right away to make money” because they had to pay for housing, food, and transportation. Aunt KTM was in tears as she shared her experiences of getting a hysterectomy right after she arrived in the States, being alone in the hospital without knowing any English, and having to work immediately to earn income for her family. She illuminated the possible long-term strain that this experience put on her health on top of the hardships she had to endure in Vietnam to support her family:

After two weeks [of arriving in the United States], my stomach was in pain. I couldn’t bear it. It felt like I was going into labor because the cyst was getting bigger… So, when I went to the ER, the doctor asked if I was pregnant… My husband was with me and told the doctor that I just came from the refugee camp two weeks ago, and that I could not possibly be pregnant… I actually had a cyst that was growing in my stomach. They operated on me immediately. I was hospitalized, but I didn’t speak any English. I remember that I was so hungry and didn’t know how to say that I was hungry in English, so I cried. My husband was working and wasn’t able to be at the hospital with me. He was working the night shift and taking care of our sons during the day… I was left in there by myself. Then, the doctor told me to rest and not work for two months… but I think it was three weeks after the surgery that I had to buy a sewing machine and bring it home to start working to support our family. Hence, in my life there were two times when I was at my weakest but yet had to work… it was when I gave birth to my children, and the other was right after my surgery. (Aunt KTM)

In spite of the challenges during the initial transition to the United States, the participants pushed on to find jobs and shelter, with the determination that they would better themselves, and if they had children, they would sacrifice for their children. Worries about their stability and security were exacerbated by the high cost of living in the United States compared to Vietnam.
As Aunt Ocean explained, “I noticed that I am not used to the way of life in the United States. It makes you worry and think too much.” This is a common sentiment among the participants. In Vietnam, participants were able to speak the language and navigate the local ways of life to survive. They had some control over the security of their day-to-day lives. However, once in the United States, participants noted the loss of self worth and purpose because they were stripped of the means to fulfill social roles and maintain control and stability and certainties in their lives.

Uncle Van reflected on the struggle to survive among Vietnamese American immigrants when they arrived in their host country:

You worry about your survival, what’s in front of you, the lack of stability in your life, how to make a living. At the time [after arrival in the United States], I was not eligible to apply for SSI benefits. I was only able to apply for food stamps to help me through each day. I was already old when I came, and it would have been very difficult for me to work in the market or as a waiter. It’s so hard to find those jobs in this area… I couldn’t find any… Back in Vietnam, I baked muffins and sold them on the streets. I packed coffee. I could still manage life then. (Uncle Van)

Aunt Perfume felt secure that she had a roof over her head in Vietnam and did not have to worry about monthly rent in addition to making a living, but this was not the case when she arrived to the States:

When I came to the States, I saw that life here is all about… you have to worry so much more than if you were in Vietnam. I honestly think so. My life was hard in the past [in Vietnam]… Life was hard but I had a home. People say that first you need housing stability then you can focus on your career… And then you would be assured… and then your life becomes more comfortable. But in the United States, you have to worry about all kinds of things. (Aunt Perfume)

Adjustments to life in the United States became most difficult for participants who had gained relative success in Vietnam in the years just prior to their migration to the United States. These participants described the “shock” they faced when they “gave up all their wealth and jobs” in Vietnam only to find themselves in low-wage jobs and living from paycheck to paycheck in the United States. One woman and her husband had a fishing business in Vietnam
and lived a “comfortable life” with a home and a lucrative business. This all changed when she same to the United States and had to rely on her siblings for temporary housing and worked in low-wage jobs. Another participant was a younger (40 year old) highly educated woman who earned law and English language degrees in Vietnam. She was making good money and enjoyed a “comfortable” life, but upon arriving in California, she was abandoned by her older brother [the sponsor], lived an impoverished life for over a year, could not secure even a low-wage job, and could not use her previously-learned English skills because “people would not understand my English, and I also could not understand the English that was spoken here.”

Moreover, participants explained that family problems became a major source of stress that negatively impacted their health, once again linking their own health to “family happiness.” Family held a central role in the lives of Vietnamese Americans and was a source of mutual support that helped participants cope through many years of hardship and uncertainties. Thus, the cohesion and well-being of the family remained of utmost importance to the men and women. Aunt Target said, “I only need my family. I don’t need anything else,” a sentiment that many participants also shared. Aunt Giau similarly said, “I am healthy when my children are healthy.”

Participants came to the United States with the expectations that they would provide a brighter future for their families, especially their children. A common theme across all participants' narratives was being a good parent, which meant providing shelter and raising children to be successful people in the United States. When participants saw that they did this successfully (such that one’s child attends college, has a good job, has a happy family), they could enjoy a sense of fulfillment and accomplishment as a parent. Besides having successful children, parents also yearned for reciprocated love and respect from their children. Aunt Lai
stated that all she wanted was to have her children be good to her because she worked so hard and sacrificed so much for them; other participants shared this same hope. Participants explained that as parents, they spent many years working in arduous jobs, sacrificing their futures and educations so that they could provide for their children so they would one day “succeed” and be “good, loving” children. Yet, this narrative of achievement and successful parenting was not always attained. The painful experiences of failing as a parent triggered “difficulties sleeping,” “headaches,” “thinking too much,” “worries,” and “pain.”

Understandably, the men and women lived through the hopes, dreams, and achievements of their children. Aunt Moon described her disappointments:

I’m ashamed because my daughter moved in to live with her boyfriend, but she can’t be doing that. First, we are Catholics, and I told her we cannot do that. And she told me she has no other choice because she is unemployed and has to move in with her boyfriend. You see… I told myself I wouldn’t care about her. She followed her White boyfriend, and that White guy doesn’t want to marry her. He’s just going to live with her like that because he’s also in a hard situation… At this point my daughter is in love with him. And I don’t know if he’s planning to marry her or not. But what can I do? (Aunt Moon)

Aunt North Flower described the pain of having a “shameful” daughter, and furthermore having failed as a mother because her youngest daughter went down the wrong path:

To be honest with you, in the past years, one of my children… was wandering in the streets. She’s a girl. At the time when it all happened, she was 14 or 15 years old. She was going to school at the time, but then she started playing around, and started dating all these guys who were not so good. She was out there with them. And then she got pregnant with this one guy. When I think of it, it still pains me. I raised all the other children well, but there’s she who turned out like that. (Aunt North Flower)

Aunt Target expressed a longing for children who would obey her:

For quite some time now, there hasn’t been a day when I am free, there hasn’t been a time when I am at peace. Until now…. I am being bombarded with all these problems around me. It’s like a needle that stabs your body. That’s not having peace. Peace is being free from thinking about any worries, and then in your family there isn’t any conflict or problem. You don’t hear or see anything, any remarks that would hurt you. You don’t suffer because of your children. Your children do not yell back at you, and they don’t disobey you. That’s peace. I want that kind of peace. (Aunt Target)
Aunt KTM spoke about how painful it was to see her children not have an ideal life after all that she had sacrificed to raise them:

This time around I am sick the most, to the point where I have to use medication to help me sleep... It’s because all these things kept coming on to me, and then my son became unemployed. He became unemployed and started working in this very demanding job. I love my children, I feel so bad for them, so I am in pain. I hurt so much inside... When I arrived in the states, I only had my husband and my two sons... Did you know that I carried them both in my arms [during the escape from VN by boat], and now that he’s grown ... and then I think about how his wife does not cook for him. I love my son, and I take care of him, even what he drinks and eats, but now that he has a wife his wife doesn’t even take care of him. I see that and it makes me sad. I feel sorry for my son. But I can’t do anything about it... and my older son, he’s unemployed and yet he got married... and you know what else I found out-- that my daughter-in-law was also unemployed... My son studied architecture and worked in the real estate market, but after the housing market collapsed he was laid off, and he didn’t have anything to do. He was just lying at home. And when I saw that I was really sad and worried. (Aunt KTM)

The participants’ narratives about problems within their family and with failing to raise their children well, in particular, highlighted the importance of successfully fulfilling the role of a parent. As such, the context of participants’ health is closely tied to the happiness of the family unit.

**Physical and emotional discomforts**

Participants commonly referred to the presence of multiple physical and mental health problems as a starting point for describing declining health. All participants had at least one of the following health conditions: hypertension, high cholesterol, diabetes, chronic pain, cancer, arthritis, osteoporosis, stomach problems, allergies, asthma, psoriasis, poor vision, seizure, and scarring of the lungs. The focus, however, was on the physical and emotional problems associated with their declining health. Participants described in retrospect the daily physical and emotional ailments as a constellation of symptoms they experienced. While the discomforts were pinpointed to specific parts of the body, their impacts were all interconnected. The most
common complaints “suddenly began with head pain, and headaches, or sensations of a “heavy head.” One participant described her headache:

I kept getting headaches. The headache was like… it tightens your head and makes it feel heavy. You feel disoriented… it makes you… you don’t feel healthy at all. When you are healthy, your head feels free, right? But my head was stressed out, it’s like really stressed out… (Aunt Ocean)

Head pain worsened day by day, and many participants wondered why the pain was felt in specific areas of the temples, the back of the head, or the top of the head. At some point the pain would become unbearable:

It [the head] aches, aches just like a hammer just chopped through my head. Just think of it this way, if anyone touches it, it would explode… It burns like fire. I have to get a wet napkin and put it over my head. The pain always goes up to my head like that. (Aunt Banana)

Over time, participants noticed that the pain spread to other parts of the body such as the shoulders, the back, and the body, without any cause. They noted quite frequently pain in the stomach that made it difficult to digest food or even have appetite. Discomforts were also felt in the chest, described as sensations of chest pain, “heavy feeling in the chest”, or rapid heartbeats near the chest area.

Head and bodily pain was a crippling experience for many participants, whose daily activities were often controlled by the “unpredictable,” “fluctuating,” “unbearable” pain. Some pain was manageable so that participants could carry out a task for an hour or so, whereas other pain was crippling to the point that participants had to “just lie in bed” when the pain hit, or “bang their head into the pillow” to feel better. Aunt Recycle shared that,

I told you that if I am healthy, everything is fine. It’s like right now I can do little things around the house, but when the pain hits me, I cannot do anything at all. I can’t even eat, how can I do anything? … So today is my healthy day. I haven’t seen anything come up, yet. Nothing has come up since this morning. But if it comes, that’s it. I am done. (Aunt Recycle)
Aunt Banana explained that she had to cater to her pain, and said that “I am in so much pain that I have to use a very soft pillow. You see, if I use a pillow that isn’t what it [the pain] wants, it would act up.” Another stated that she “would have to adjust to the right side of the body” in order to get some rest on the bed.

The participants in this study were low-income, had limited English language skills, were older, and were unemployed. Concerns about the security of having a home, holding a job, and having financial stability were central to their lives. So it is not surprising that some described their discomforts as the head causing them to “think too much so that it distresses you” and “worry” about the present and the future. One elaborated, “The thoughts in my head, they, they keep messing me up. It’s like the thoughts keep coming, keep coming. I am always thinking. There is not any one day when I am at peace so that I could be healthy.” Sister Park illuminated how the lack of money became the source of her worries that haunted her throughout the day:

When I ran into a problem or when I was worried, I became even more worried to the point where I wouldn’t be able to do anything. For example, during the time when I was stressed out… I wouldn’t dare to drive. Because I know that if I was really worried, I would get into a car accident. My concern about getting into the car accident isn’t that I am afraid to get hurt and die, but it’s more like I would have to pay for the damages. So it’s like one thing leads to another, you know. When other people drive a car, they don’t want to get into a car accident. They drive safely because they want to protect their life… but I on the other hand am afraid to get into a car accident because I am afraid I would have to pay for the damages… So you see that it all starts with me not having any money… It starts with me not thinking about my own self … So when you are not healthy, you are not able to do anything. (Sister Park)

Participants elaborated that their headaches and worries led to difficulties sleeping as they would “lie there” in bed all night thinking about their problems, or their head would hurt so much that they were unable to sleep. A good night’s sleep for some was about four to five hours, whereas for others it meant sleepless nights. Aunt Moon recalled her experiences with chronic sleeping difficulties:
I have not been able to sleep for a very long time… There are many times when I lie down at night, something would come to mind that would sadden and bother me [not having money, being sick, not being able to provide for family, not working]… So then I can’t sleep because of it. There are many times when I would stay up all night. I just can’t sleep because of all these things that come to my mind. I would wander alone in the living room. I would wander alone at night quite often… My husband would wake up in the middle of the night to use the bathroom, and he would see me and think that I was a ghost wandering in the house. (Aunt Ocean)

Participants noted that their discomfort also affected their memory and mental focus, and found themselves “being forgetful.” They talked about the sudden loss of focus and not remembering anything that they had done: “It’s like… I don’t remember. I forget left and right,” “I would do something like cooking and would walk away and forget that I was doing it, cooking and leaving things on the burner,” or “putting too much salt or sugar in the food and not realizing which is which.” The participants spoke about their experiences and the extent to problems with their memory and focus became routine:

In the past, I often ran the red light… I was just not at peace. I worried about all kinds of troubles… I was thinking too much to the point that I drove past the red light a few times. People around me would shake their heads when they saw that. (Uncle 6T)

So you see how I’m alert right now as I’m talking to you, but there are moments when my body would itch so much. The psoriasis would make my body itch so much! I would become very irritated. There are times when my thoughts aren’t the way I want them to be. They keep changing. They are all over the place. I just cannot concentrate. For example when I try to do my homework, I cannot concentrate on my studies because other thoughts would take over my mind. It keeps coming and coming to me like that. (Sister Cat)

My suffering all comes from the problems I have with my husband, the problems in my marriage. I thought that it was a big mistake when I married him… He tortured me from head to toe. He tortured me all over. That’s why I haven’t had any time for myself and to be at peace with myself, even to this minute. I haven’t had any happiness. There is not a day that I am at peace. All these problems make me think too much… I have lost sleep for many days and months because of my suffering. (Aunt Moon)
Others described their lack of focus and poor memory as “an empty head” or “whatever inside the head disappeared”, “losing one’s logic, (mat li tri), or “losing one’s soul.” Aunt Recycle described her ailments:

Since the day I became sick until now, it seems like my head is empty. There is just nothing in there. And then at other times I suddenly think of this and that, worry about this and that, and feel anxious here and there… Then there’s also this problem… in the afternoons, I have a hard time lying down to sleep. I just lie there thinking, and these random thoughts would run all over my head, and then my heart would beat fast. (Aunt Recycle)

Participants explained that ruminations about daily realities of job loss, children not doing well economically, and not contributing to the family could “take one’s mind” to this dark place of not caring, no interest in life, no desire to live. Aunt Ocean described her experiences with intense moments of hopelessness and despair, “It [your head] leads you to this place, all you know is to find the only way out, which is to not exist in this world [ending one’s life]. Then you’ll feel good” about your life. Aunt Banana explained what it was like for her “head” to be taken to this difficult place:

I didn’t want to do anything at all. I didn’t want to talk to anyone, I didn’t want friends. I didn’t want that. Even my children, I didn’t want to talk to them…. It drove you to that point where you didn’t love anyone. You forgot everyone and everything. It’s like you didn’t even love yourself. (Aunt Banana)

A few participants reported more serious psychological impairments, such as when they “worried” or “did too much thinking” about the troubles in their lives, they started to see ghosts in the house, to hear voices, or to become suspicious of things like “other people wanting to harm you,” or “hearing the phone ring” when other people around them were not hearing or seeing these things happening.

Health and self worth
Despite participants’ numerous experiences with physical and mental health discomforts, self worth emerged as the core concept for defining health among first-generation Vietnamese Americans in this study. As one participant explained, there is a Vietnamese saying, *suc khoe la vang*, or health is golden, because having health allows “us to do the things we want.” This expression touched on the core concept of self worth that participants used to define health, and the two dimensions of self worth: fulfilling one’s own goals and fulfilling one’s social roles. Health is above all and is needed to fulfill one’s social functions and roles. Participants further elaborated on what health meant to them by framing it as the ability to achieve, and to fulfill the things one wants to do, that give one purpose and that give meaning to life (related to the idea of self worth). Relinquishing control due to discomfort is a salient aspect of defining health because it marks the slow and painful loss of one’s independence and productivity.

*Health and Functioning.* Participants described their health as not healthy or unsettled by contrasting their past and present functioning, marking that moment of interruption when they “began to sink” and became engulfed in their discomforts. Experiences with ailments became a real health problem to participants the moment they noticed a decline in their ability to carry out daily tasks that they were no longer able to do. At this point, the participants necessarily relinquished purposeful activities that had been part of their daily routine.

Aunt Ginseng provided a famous Vietnamese proverb that exemplified the importance to health of being able to eat and sleep: *An duoc ngu duoc la tien*, or “being able to eat and sleep is heavenly.” Thus, losing enjoyment of a good meal or not getting enough sleep were the first steps toward a decline in functioning because they reduced the energy necessary for being productive. The disruptions to routine started in the home where participants were unable to carry out tasks and responsibilities, such as not cooking, “just lying around the house,” and
neglecting all household chores. Aunt KTM remembered how she lost her ability to do things around the house:

You know at one point I wasn’t able to hold the pot to cook. I was hurting here [shoulders]. I couldn’t even put on my bra… and I didn’t know why, but it started with my shoulders, then my hands… I couldn’t even hold the pot. I was even crying [in pain] when I drove around… I could not do work for a long period of time… like standing to wash the dishes. For example, in the morning when my husband went to work, I would prepare lunch for him, but I could only stand around for about two hours. By then my back would feel like falling apart, and I would have to go lie down… I had to take a rest to be able to continue. (Aunt KTM)

For participants who arrived in the United States as immigrants, health meant having the ability to maximize one’s potential, such as learning English, finding a steady job, having a home, driving a car, furthering their education. These were goals that many wished for; they were tied to a sense of accomplishment and elevated status in the United States. Aunt Ocean described how health impairments could strip one’s ability to fulfill these goals:

You look at other people and you see that they have a good life. You see that they are so happy. To have health is to love life. You can do anything. You see? You can pretty much do anything. As long as you have health, you will love life, your body will feel very pleasurable. You can do the things that your ability allows you to do such as study English, and then you can find a job. And then you can participate in your community and live among other people…. If you do not have health, that means you are sick. If you are sick, it is like you are caught up in your worries, it affects you [emotionally] because your family does not have happiness, and then it turns you into… it’s like your health keeps going down. You don’t have that positive outlook. You don’t have health. You don’t have anything, any reason that would make you love life. (Aunt Ocean)

For Sister Park, being in school was a personal fulfillment that she wished to complete upon coming to America, because she was educated with a law degree and a linguistic degree (in English) in Vietnam. She worked two jobs and attended school during the day and boasted about having the ability to do that. However, her lack of health meant that she was not able to maximize her fullest potential after she came to the United States:

I have always loved school, you know. But I realize that I cannot go through with my studies. When I study, I have to drag myself to do it. I do school work and cry at the
same time. I am not able to do the things I want to do even though I really love school, even though I know my capability to do well in school. (Sister Park)

Working to “make money” was the most important task for all participants because their survival in the United States depended on their ability to work and make money. Thus, discomforts became most pronounced and disruptive when they affected job performance. Sister Cat recounted how difficult it was to go about her day because of her ailments, “Prior to my psoriasis, I have to say that I was among the best workers there.” But after having psoriasis, she said,

Ever since the psoriasis started to grow all over my body, everything became chaotic. At that time I felt very irritated at night and couldn’t sleep. I couldn’t wake up in the morning. And this kept going on, and I kept missing work too much, so then the work place of course had to lay me off. You see? The psoriasis made it difficult for me to sleep at night. When you are not able to sleep, you are late for work in the morning. It itches and it affects your mind quite a bit. You understand? My health problem (psoriasis) impacts me a lot. Back then I was working in the assembly line in the stock room, so the job was pretty simple. I only needed to keep count of the stock, but I kept messing up. It [the psoriasis] made me mess up, and I wasn’t able to focus. When I got laid off, I wasn’t sad about it because in my mind I knew that the fault was mine and that’s why I was laid off. I knew that if I hadn’t messed up, people wouldn’t have to lay me off. (Sister Cat)

Aunt Moon shared how her ailments interfered with her ability to focus on tasks at work:

I have back pain, and when I sit for long periods my back pain would kick in. It’s just as simple as standing, and I would get back pain. I can’t do any work when that happens. And now I have this problem where my mind can’t even focus and can’t remember. For example, when I was still working and was cutting hair, the customer would come in and ask me to wash their hair. I would cut their hair and just let them leave without washing the hair… I kept forgetting on my job. (Aunt Moon)

Aunt Target described the time when she became overwhelmed by her worries,

“My stress was just too much. My worries were just too much. There were problems with my children, money problems, house rental problems, all these things. I couldn’t bear it any longer so I fainted. Within two hours, I fainted three times.” Aunt Target explained further how her health problem disrupted her ability to focus on the job:
The job I was doing was too detailed. I was scared and worried... never in my life had I been that scared of my job. I was really scared! It was because of my old age. I was just so nervous on this job, especially every time they [my work place] counted the time it took for me to do my work. At that time I was still in training, so they kept track of my productivity within a certain time frame. That made my heart beat fast, faster and faster.... I kept thinking of the time, and how I was not on track with my tasks. I was doing that job for three, four months. I worked until 11, 12 o’clock at night and came home past 12 midnight. I worked the night shift so I threw up a lot. When the weekend came I was really relieved that I didn’t have to go into work... Pretty much my job made me very scared. My entire body was scared. (Aunt Target)

Health and social roles. The participants’ declining ability to carry out daily tasks marked only the beginning of a diminishing self worth. The more relevant aspect of defining health was the ability to fulfill social roles. According to the men and women, the health is interconnected with one’s relationships with others and with the ability to fulfill social obligations. To the participant, having good health meant loving life, having happiness in one’s family, and having peace. Having health meant “living a meaningful life... meaningful for yourself and for others... like your husband, your children, or your brothers and sisters.” All the qualities of the participants’ conceptualization of health thus revolve around their relationships to others and their responsibilities to the larger group.

The men and women talked extensively about their role as a family member and how health was important to carrying out this role. Two described themselves as fathers, or providers for their family. Fifteen were mothers, or the nurturers whose responsibilities were “to take care of husbands and children,” keep the family together, and ensure that their children “would have an education and become successful.” Eight were children whose obligations included being caregivers to their parents. All participants were also members of an extended family network in which their roles were to be a contributor by giving financially whenever they could. In order to fulfill these primary social roles, the participants needed to be able to provide for the family through tangible means: cooking, cleaning, and providing shelter and financial support. Having
good health and having employment contribute to one’s ability to fulfill obligations toward one’s family. Thus, experiences with physical and emotional impairments were most pronounced when they disrupted a participant’s ability to fulfill social obligations.

Providing for the family financially was the most important social obligation, according to the participants. They all voiced that one “needs money” to be worthy and to have a good life in the United States, whereas life in Vietnam did not demand the same level of finances in spite of its third world status. Aunt Recycle explained that “while you also need money to live in Vietnam,” the value of money is much more here in the States, and a family’s stability depends on meeting financial demands. The ability to work and make money enables contributions to fulfilling social obligations, thus becoming the core of one’s self worth. One participant said: “It all comes down to money.”

Physical and emotional impairments, particularly pain, lack of sleep, and lack of focus, severely affected a participants’ job performance. Many participants held low-wage labor jobs on an assembly line or in sewing shops. Such jobs required attention to detail and/or long periods of standing to complete assigned tasks. This posed problems for participants because they were not able to “concentrate” or they “forgot” what they had to do, or the pain in their body would get worse after two hours of sitting or standing. This health limitation posed a problem for sustaining employment; many participants were eventually laid off because of the “troubles” they caused on the job. While working, one is still productive and is making a tangible contribution to the family regardless of salary, which ranged from $5 a day to $500 per month. Sister Park voiced this sentiment, “I know that joyous feeling to be successful in your job… and I realize now that in order to have happiness, you have to have a job. That’s one way you can affirm your worth.” Common to all participants’ narratives was the persistence in finding work
and continuing to work in spite of physical and emotional discomforts. Aunt Taxi kept pushing herself to work because she was a single mother and had a son to raise. She talked about working while being ill:

You see, sometimes I fainted at my work place. You know I had to clean up all these rooms on my job, like the table, the toilet. I got sick to the point where I could no longer put up with it. I fainted on the spot…. [because of] the smell. I fainted and then I had to get back up to continue working… Nobody knew because I worked by myself during the night shift…. That went on for several years. But I got sick, got sick, and I kept working in spite of being sick….because I had to take care of my son. I was a single mom. I gave birth to him, so I had to take care of him. (Aunt Taxi)

However, as soon as participants became unemployed, they noticed that their worth and value within the family declined. Aunt Perfume mirrored this sentiment and explained that she only got sick starting when she became unemployed and stayed home, and just “laid around the house” without contributing much to the family. Aunt Ocean’s reflections illustrate the link between making tangible, financial contributions and one’s self worth:

You know, when you were in Vietnam you heard that when you come to the United States you would live a good life and have money. The reality is my husband is older, so his job can be very challenging for him at times. That’s why he doesn’t make much money at work, and then we end up not having the finances to support our family. So that makes my head think too much. That is what causes distress for me. And then I also realize that my health is not good, and I cannot do a lot of tasks or heavy duties, and that’s something I have to accept…. so sometimes you reflect on your life…. you want to do something for yourself when you come to the United States, such as learning to drive but that I can’t even do. And then you want to work to make money to help your family, and that I can’t do either. I don’t know any English, but everywhere you go here you need to know English. So all of these things make me think about how I’m not doing anything for the family. At the time that my children were growing up, I wasn’t able to do more for them. All day long… all I knew to do was to cook and take care of them. I didn’t know anything else…. When I think of that, it makes me sad. When I lie down at night, I think about these things, and I can’t sleep. I lose my sleep, and it causes insomnia, and from that point on I cannot find meaning in my life. (Aunt Ocean)

Other than earning money through employment, most participants, especially the women, had additional responsibilities of tending to the household, which included taking care of their families by cooking, cleaning, and keeping the family happy. Thus, physical and emotional
discomforts became problematic when participants were no longer able to fulfill familial responsibilities. When Aunt Moon’s hepatitis worsened, she had to go on medication treatment for about a year during which she experienced fatigue and was unable to function normally or go to work. Aunt Moon noted that her husband began to change his attitude toward her because she was not fulfilling her household chores. She recalled,

And he [my husband] told me that I was lazy. He said that I was lazy and that I didn’t want to cook. I didn’t want to do anything. But in reality, I was getting serious side effects from the medication. Even my own self didn’t want to live nor eat each day… how could I cook? … [He] blamed me for not wanting to work. But I told him that how could I go to work. I was sick. Even the government had to take care of me. So how could I work. (Aunt Moon)

Aunt KTM shared her struggles with not having the ability to fulfill her role as a mother and a caretaker for the family:

So now, I am also worried about this situation… my daughter-in-law is about to give birth… and my son wants me to come to their house to help take care of the daughter-in-law after she gives birth… but, I know that I am not healthy. I cannot do a lot of work, but they [son and daughter-in-law] are very lazy, and they will leave all these things for me to do, and I will not be able to do all of that. So that’s why I want to say no to helping them, but I don’t know how to say no. My conscience would not allow me to do that either because… that’s my son’s first baby. So how can I not do what he asks me to do. I feel that I am not right if I refuse, but if I do help them out, I am afraid I will not be able to do all of that. I want to help them, but I am afraid that my health wouldn’t allow me to. (Aunt KTM)

The women opened up about their health’s hindering their ability to maintain the intimacy of their marriage, another aspect of self worth that is tied to their health. There would be days when the women were so drowned in their worries and despair that they did not care about intimacy with their spouse. However, according to three women, one of the worse disruptions to health and self worth was undergoing a hysterectomy. Aunt Ocean remarked about the impact of her surgery on her failing ability to keep alive the happiness of the family:

Ever since my surgery my motivation and outlook in life kept going downhill. I thought about the fact that I am sick like this now, about how there’s nothing more to my life…
They took everything. Everything. And because of that, it made my life meaningless. I couldn’t live with my husband, and I was also self-conscious. If my husband had been understanding, then we would have lived happily together. But I was also concerned about what if my husband could not understand me. What would happen to my life then? You see? That’s why I think about these things, and it makes me sad. Sometimes I wonder if my husband loves me or not. (Aunt Ocean)

In addition to not being a contributing member to their family, participants were aware of the burden they became for other family members. Aunt Target talked about how her children were tired of her being there and hearing her problems:

I have sacrificed and suffered for many years, but it seems like my children are heartless because they don’t take this into consideration. Even though they are all adults… every time I bring up anything that troubles me to share with them, they always ask me why is it that I complain too much. They even say things like I bring my problems onto myself. I only do that [vent to them] because I get sad often when I think about all the sad things in my life. So I want to vent to them, and if they are children who truly love their parents… they would love me more and find ways to help me to lessen my suffering, but they don’t do that for me. (Aunt Target)

Aunt KTM explained that she was tired of not feeling healthy and constantly burdening her husband, who probably got tired of seeing her that way day in and day out. Aunt KTM was herself tired of being in an unhealthy state and seeking the support of her husband, who appeared to have become exhausted over time:

I know that my husband loves me, but I have been sad lately because I see my children going through a difficult financial situation. And my husband sees that it affects me and I worry a lot, but he doesn’t say anything to support me. All I do is vent to him all the time [about my worries], but I can’t do anything about the situation. So that gets him irritated, and he snaps at me. When he does that I get even sadder. I feel like I am lonely and don’t have anyone by my side. (Aunt KTM)

Aunt Giau reflected on the sacrifices her husband has had to make to take care of her:

My husband has to do everything for me. He has to remind me to take my medication. He asks me, if he finds a job, who would take care of me then. I can’t remember and can’t focus on anything that I do, so he has to help me with every little thing. And then sometimes I get irritated and snap at him, but he doesn’t say anything back. I feel so bad. Recently, he developed diabetes, and I think it’s because he got so stressed out with all these things happening. (Aunt Giau)
Participants in this study all left behind their parents, children, or siblings when they migrated from Vietnam. As such, many remained connected to the transnational family and carried an added layer of caregiving responsibilities toward those left behind because they became “well off” once they arrived in the States. This expectation became a major source of stress for the participants whose physical and emotional problems stripped them of the ability to work. This doubled the burden for participants who were unable to fulfill their obligations to their family in the United States and in Vietnam. Uncle Van reflected about the responsibilities he owed to his family in Vietnam:

I still have brothers and sisters in Vietnam, and parents in Vietnam... I can help [my family in Vietnam] a little bit. My relatives in Vietnam live a hard life. They work really hard for their living. When it comes to my children’s generation, they don’t have to worry much about sending money back to anyone. But for me, I still have a connection to the people in Vietnam, my relatives in Vietnam are my blood. So I have to help them. (Uncle Van)

The inability to fulfill familial expectations severely compromised participants’ health. The following quotes mirror participants’ struggles to provide for their families in Vietnam, even if they themselves had barely enough to survive each day in the States:

My children are still in Vietnam. If there’s anything happening to them… such as they are not well or something, they call me right away to ask for money. When this happens, my heart suddenly becomes restless. I get worried… That’s why I tell my children that “you know I have high blood pressure, so don’t do anything to make me sad.” I told them that they should let me be healthy so I can be happy…. not let all these burdensome things get to me. I get easily worked up. When this happens, I am not able to have dinner. Then I am not able to sleep… I lie there thinking about things and worrying. (Aunt Ginseng)

Sometimes I think about my parents who are still in Vietnam. They are in their 80s. They’re old. To be honest, I only carry the fame of being from the United States. Sometimes I want to work to make money so I can help my family and my parents for the days they have left. But the reality is that I came to the United States and have all these health problems, so I cannot do anything to help them. It makes me sad, so then I feel like I have lost my purpose in life, and I lose sleep because of this. (Aunt Ocean)
When I was working, I could pay for housing and help my daughter in Vietnam… even if that was just $100 once in a while. Even so, I had money at the time because I was working. When I became unemployed, I didn’t have money to send to her. I can’t help my children. (Aunt Perfume)

Another salient aspect of defining health was the ability to fulfill one’s social role of as a contributing citizen and member of the community. The participants voiced that being a “participating” member of their community was important because it gave them a sense of dignity and worth. Participants often talked about health by comparing themselves to others of the same age, in terms of expected ability and accomplishments for individuals of their age. This was particularly salient among younger participants in their 40s and 50s who felt that they should be productive given their young age. One 55 year old participant explained,

So when I came here to the United States, I started to have high blood pressure and diabetes. And then I started to get sick [cyst in ovaries] and had to go to the hospital to get a surgery and was there for four days. And then when I came home, I started to think too much about what was happening, and that made my mind feel like it had no motivation, no will to live. I thought about my life and how I was still young but couldn’t be like others. And my health got worse day by day. And everywhere you go you need English, but I didn’t know any. I didn’t even know how to drive. That’s why… because of that my mind started to wander and think all these things, and it ended up on this path where you couldn’t find a solution to your problem. That’s why… the only path for me was to find a way to leave this place. That’s the only way I could be well. (Aunt Ocean)

Aunt KTM expressed a desire to be like others of her age, such as her friends and her in-laws, who were functional, productive members of society. However, she realized that the reality of her physical and emotional problems has stripped her of this ability:

My body is like the body of an old person. For example, other people who are the same age as me are not weak like me. They are healthy because they have not, have not gone through illnesses, sadness, and hardship in their lives. That’s why they are healthy. When I go out with my husband’s friends, I feel very self-conscious because I see that other people are older than me and yet they are so healthy. But I on the other hand, why am I constantly getting sick? I am only 59 years old. Yes, that age could be considered old, but we are in the United States where fifty something years old is not old…. (Aunt KTM)
Sister Park spoke about the challenges of her health that made it difficult for her to keep up with schoolwork. She spoke with embarrassment about falling behind others in school, a task she saw as a simple task that most other students were able to fulfill without much trouble:

Let’s compare me to an average college student who perhaps works full time or part time to earn extra money… I can’t even do that. As a matter of fact, all I do is go to school and I already feel so exhausted. When it comes time to submit my work, I always get really disorganized and freak out. Or, I get exhausted when I study, I get really sleepy… my muscles get tense and I get really stressed out, or I would get really tired… my eyes would get tired… my stomach would get painful. For example after spending a day at school, I would come home and wouldn’t be able to turn my neck left or right. It’s like that… you see, an average college student would be able to do all of this and work part time… and I don’t think that they would end up in my [health] situation… (Sister Park)

The little taken-for-granted activities that could be done for others on a daily basis became a daunting task for some of the participants. Aunt White Flower talked about the severity of her health problems that prevented her from doing simple things for others. She saw her worth diminished each time she could not do something to help those around her:

Let me tell you… the other day … it was very windy. The postman came by, and his truck’s door popped open, so all the mail fell out. And the mailman stopped to pick up the mail, but the wind kept blowing everything away. I saw that so I ran over to help him… Oh my god, once I picked up the mail and handed them to him, my face was blue. I was so tired that my heart stopped beating. I was too tired… and once the mailman left, I sat down and held my chest and gasped for air… I held on to one of the poles in the streets, and I began to get tired and more tired. I took my meds out and pumped some into my body. I was really that tired. You see. I don’t have health. I don’t have energy, so how am I able to help other people? (Aunt White Flower)

While participants expressed hopes for becoming contributing members of the community just like everyone else, their physical and emotional discomforts gradually stripped them of their ability to function and to fulfill social obligations. This reality had a crippling impact on their connectedness to others and withered their hopes for being able to help their communities. Experiences with physical and emotional discomforts over time took the participants to a place of unproductivity and isolation. All of the participants eventually reached
a point where they could neither work nor contribute financially to the family. Many remained at home and withdrew into an isolated world of their own. They also spoke about “not knowing how to drive,” “having fears about getting lost with public transportation,” “not speaking any English,” and having “low socioeconomic status” as disadvantages that made it even more difficult for them to participate in the daily workings of their communities.

Participants described their day-to-day lives as monotonous routines and bounded within the four walls of their homes, walls that insulated them from stigma but further isolated them from the community. Isolation was a defense mechanism participants used to shield themselves from others’ judgments and potential reactions to a person who has mental health problems, is unemployed, and is receiving government assistance. Nonetheless, participants were well aware of the public stigma toward individuals with mental illness as “crazy” and “not normal” people. As such, participants explained that being physically able but emotionally disabled meant that they could pass as a “healthy” person around those who did not know about their mental illness. They did not have any noticeable, visible, physical deformities; so others assumed that they were “healthy.” However, participants’ attempts to have some connection to others outside of their home meant that they had to put on a healthy front around others to avoid rejection if they were known to have a mental illness. One woman explained:

> When people look at me from the outside, they think that I am enjoying life, very much enjoying life. I don’t show any tired look on my face. I am always cheery and smiley. That’s why they don’t think I have any illness because I don’t show any visible indications. Do you see any visible sign of a sick person when you look at me? See, I’m good at that, at hiding my health problems. Only those who live with me or hear stories from me would know that I have so many illnesses.

> Having to live up to others’ standards of being healthy by “acting healthy” can be a tiring task for the participants. Thus, distancing oneself from others provided a relief from having to act healthy all the time when in fact they did not feel healthy. The men and women reflected on
the persisting misconceptions and lack of knowledge about mental illness within the Vietnamese American community that made it difficult for them to receive acceptance and have relationships outside of their homes. Over time, participants drifted further and further away from their surroundings into a life described as “bounded within the four walls,” living under “house arrest,” or living a closed-off life like “an oyster.”

**Conclusion**

The participants in this study conceptualized their health as a complex concept, linking physical and emotional discomforts and self worth with the context of their past and present life experiences. As a starting point for their discussion of health, they spoke extensively about experiences with physical and emotional discomforts. What emerged as a more meaningful aspect of their definition of health, however, was when and how the discomforts caused participants to lose their functioning and ability to fulfill social obligations, particularly to their family. As immigrants, the participants focused on making money to provide for their loved ones and did not have the luxury to stop and think about their health problems, until these problems become disabling. Participants pushed on and kept working until they lost their ability to contribute to their family through employment and tending to household responsibilities for the family. At this point they were stopped and were forced to face the reality of their health problems. Moreover, participants’ discussions of their health were framed as a long-term outcome of the exhaustion caused by their experiences in the Vietnam War, life post war, and difficulties with adjustments to life in the United States (finances and family problems). These contextual issues have implications for diagnosing and treating this population, which will be discussed further in chapter 8.
Chapter 6 Aim 2 Results: Illustrate the Pathways through Which First-Generation Vietnamese Americans with Depression and/or PTSD Diagnoses Obtain Outpatient Mental Health Services

Aim 2 of this study highlights the help-seeking experiences of Vietnamese Americans who found their way into outpatient care. Table 4 below lists the theme, dimensions and properties related to this Aim; the dimensions start with experiencing something out of the ordinary and end with actual service use.

Table 5. Research Aim 2 Themes, Dimensions and Properties

<table>
<thead>
<tr>
<th>RESEARCH AIM 2</th>
<th>Dimensions</th>
<th>Properties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finding One’s Self Worth</td>
<td>Experiencing something out of the ordinary</td>
<td>History of health problems/discomforts, Ongoing discomforts, Keep on going</td>
</tr>
<tr>
<td>Getting worse by the day</td>
<td>Worsening health, Being at one's worst, Making attributions of discomforts, Not having a name for it</td>
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<tr>
<td>Going public</td>
<td>Suicide attempts, Being told that one is sick, Disclosing to others</td>
<td></td>
</tr>
<tr>
<td>Learning about options to alleviate discomforts</td>
<td>Involuntary hospitalization, Receiving referral to relieve discomforts, Receiving no referral, Stumbling upon the place</td>
<td></td>
</tr>
<tr>
<td>Navigating one's way</td>
<td>Navigation pathways, Facilitating factors</td>
<td></td>
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<tr>
<td>Actual service use</td>
<td>Personal readiness, Pragmatism, Trying it out</td>
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Aim 2 Conceptual Model

The conceptual model based on these research findings (Figure 3) is an attempt to capture the complexities of participants’ pathways into outpatient care. While the paths appear to be
linear and sequential across phases, getting into outpatient care involves circuitous processes of ambiguities, benchmarks and turning points wherein participants move from dealing with discomforts on their own to finding their way to a place to alleviate their symptoms. The process of getting into outpatient mental health services has six phases; time spent in each phase, and movement along phases varies widely. This chapter elaborates on the pathways that led participants into outpatient mental health care.
Figure 3. First-generation Vietnamese Americans’ Pathways into Outpatient Mental Health Treatment for Depression and/or PTSD
Aim 2 Findings

Phase 1 - Experiencing something out of the ordinary

All of the participants started out in Phase 1, where they experienced “something out of the ordinary” for a period of time but kept going because their discomforts neither interrupted their routines nor were viewed as problematic. The first phase of experiencing something out of the ordinary consisted of: history of discomforts, ongoing discomforts, and keep on going.

History of discomforts. The participants in this study all experienced physical and emotional discomforts for a considerable period of time, some from as far back as early childhood and teenage years. A few participants recalled noticing “something different” about themselves while they were still living in Vietnam. Uncle MT remembered his family telling him about the months after his injury from the Vietnam War Tet invasion crossfire, when he walked to the river every day and sat there by himself for hours. He did not remember this time period, however. He also talked about the years that followed when he became very “shy” and “physically weak” and “did not have any friends.” Other people constantly wondered about him, and asked “why is this boy so socially timid?”

Aunt Ocean noticed that something was different during her teenage years: she would get up in the middle of a date with her boyfriend to walk home alone. She also vaguely recalled a period in her late teens when she was “disinterested in life” and “did not want to talk to anyone,” and was hospitalized for about a week. She said a lot of other young people in Vietnam had similar experiences at that time, referencing the time after the Vietnam War ended. Aunt White Flower had chronic asthma since birth, a debilitating condition that stripped her of a normal childhood because she was unable to do any activities without an asthma attack. She began “closing inward” and distancing herself from others because she did not want any pity; she
realized she could not have a normal life. In her twenties and feeling isolated, she attempted to commit suicide several times. Sister Cat grew up in a poverty-stricken broken family and recalled all the mishaps of her childhood. In high school, she wrote a suicide note but did not commit suicide. Aunt North Flower experienced nightmares when she was in Vietnam but never paid attention to them or understood why she was getting them. She stated, “Back then I always had nightmares, then my head hurt... In my sleep, I was frightened of my surroundings. I saw horrible scenes.”

In spite of the various accounts of ailments these participants experienced early on, they recalled these problems merely as “something out of the ordinary” at that moment in time. They kept going because these discomforts did not disrupt their routines and functioning. The participants did not have a name for what they were experiencing nor did they associate it with a mental health condition because their experiences were not what the local people would consider “mental” conditions. They lived their lives and graduated from high school, got married, and held jobs just like everyone else.

**Ongoing discomforts.** For most participants, their discomforts began after they arrived in the United States, in the context of adjusting to a challenging new life here. Several participants who reported a history of discomforts in their early years had already moved on with their lives and only re-experienced these discomforts after they came to the U.S. Participants made references to increasing worries about finances, securing jobs, raising children, and family happiness that made them “think too much.” Participants talked about “headaches” and “loss of sleep” as common ailments they had as a result of living a worrisome life in the United States; these went on for several years.
Keep on going. These physical and emotional discomforts did not interrupt participants’ routines or their abilities to carry out social obligations. Everyone kept on going to school, going to work, and tending to household responsibilities. At this point the participants did not see the need for intervention because the lack of sleep, headaches, or worries did not suggest “abnormality” nor did they alert the participants to the fact that they may have had a mental health problem. The participants did not tell others about it or reach out to anyone for help. Many observed in retrospect that they “did not think I was sick” or “did not know I was sick” at the time. They simply thought that “suddenly the body is acting up” or that “I thought I was just sad about my life situations, but I didn’t think that I was sick.”

Phase 2 – Getting worse the by day

In Phase 2, participants noticed “worsening health,” and some even reached a point of being at their “worst health.” Participants grappled with increasing discomforts and deteriorating health but tried to continue on as they did in Phase 1. Most did not have a name for their worsening condition, and notably, did not think that they were experiencing a mental health problem. The second phase of getting worse by the day included: worsening health or being at one’s worst health, making attributions of discomforts, and not having a name for it.

Worsening health or being at one’s worst health. The men and women in this study endured their physical and emotional discomforts for quite some time before they moved into the second phase of recognizing and acknowledging that their health was “getting worse by the day.” This recognition was marked by noticeable behavioral or emotional deviations from normal conduct, and disruptions to a participant’s functioning and ability to fulfill social obligations. This phase is distinct from Phase 1 in that the participants had a consciousness that something was indeed unusual and troublesome about their health problems, a thought that they had not
entertained previously. In Aunt Barbie’s words, “you know yourself;” and so you know when something troubling is happening to your health. At this point, indications of worsening health extended from “difficulties sleeping” and “headaches” to a multitude of symptoms such as “I yell at my husband/children for no reason,” “just lying in bed,” “losing appetite,” “losing interest,” “losing weight,” “spreading pain,” “stomach problems,” “worrying” and thinking about Vietnam and life here in the States and what’s going to happen,” and “being forgetful.” Participants were aware of the increasing “unusualness” of their appearance, thoughts, and behaviors and questioned the mismatch between some of their thoughts and reality such as “being afraid to watch movies with fighting scenes” or having to put one’s bare feet on the gas pedal when driving to be assured that one was in fact in control of the car. Two participants described her experience with worsening health:

There were times when my period wouldn’t come for months, and after that it led to these cysts growing in my breasts. And then I had stomach pain. So all those things happened one after another, you know. I felt like my illness was an opportunistic illness, meaning everything just started happening all at once. I also noticed that I was getting crazy. I wasn’t normal… I was doing things that were just unreasonable. For example… normally, I am a very gentle and caring person… But when I talked to my friends over the phone, I snapped at them often. I didn’t respect them. Whatever they said, I would snap at them… or, I didn’t care that what I said hurt other people’s feelings. I was just talking all kinds of nonsense. Another thing was my driving. I was getting into a car accident every month… So the reason I came in to see Doctor F [psychiatrist] was that… and even she agreed with me on this point… that I am so forgetful, and I had lost my mind. For example, I couldn’t remember what I just said, or I didn’t remember that was cooking something in the kitchen, or I forgot to close the door when I left the house. I couldn’t remember anything when I studied. I knew I was stressed out, but I didn’t think it got to that extreme. At one point, I even forgot to flush after I used the toilet, and it wasn’t just once or twice. It was multiple times, and my family couldn’t deal with it any longer. I was forgetting my keys… and forgetting to give people their money back when I borrowed. So it had gotten to a point where I didn’t even realize that I was doing these things. (Sister Park)

I compared myself to my friends who were of the same age as me, and I saw that they were still very strong, and that made me question why was it that I was in that state I was in. So I started to suspect things a little bit… I suspected that I wasn’t normal… and then it got to my being anxious and worried very easily. For example, my daughter-in-law
who was living with me told me she didn’t like to eat leftovers that I had cooked, and I was worried because I didn’t know how to cook just the right amount so she wouldn’t have to eat the leftovers. And then over time I couldn’t think of what kind of food to prepare for the family… My worries were so unreasonable though, don’t you think? And then I noticed that I was strange. I wasn’t like before. I was easily agitated… and something was just wrong with my body. I wasn’t able to sleep, or eat. (Aunt KTM)

While some participants noted worsening health, others reached “rock bottom” and recounted that their health had gotten to the worst state ever. This was an identifying moment for the participants, a new awareness that their health had slipped into a troubling state that was clearly distinctive from their healthy state. The past discomforts of “headaches” or “lack of sleep” described in Phase 1 were no longer the primary concerns at this point. Rather, participants described being in a state with “no care” and abandoning all the activities they used to do, and even abandoning their loved ones. Some described retreating to their rooms and no longer caring about anyone or anything in this world, not even themselves. They did not cook or tend to the house chores or interact with their families. These participants talked about “finding death” as the only thing on their minds. They also had observable, physical changes of “drastic weight loss” or “looking like a ghost/skeleton” because they had let themselves go and did not eat or shower regularly. The participants discussed what “being at their worst” health meant:

You know, I looked in the mirror, and I looked like a ghost and no longer a person. At that time, I don’t know why but I was just sad all the time and was hopeless, and just wanted to die. I wanted to overdose on meds. I don’t remember exactly but that was probably five or six years ago. I didn’t want to brush my hair, and the clothes I wore were just messy. I was disinterested in a lot of things… I didn’t care about my husband or daughter… And then I was really irritated and was very difficult toward my family. I yelled at my daughter. I didn’t want to be intimate with my husband. I was afraid of it. I couldn’t cook or do the household chores, and my husband had to help me with everything… I started to lose weight. I was under 100 pounds. I went from 120 to 90 pounds… I was worried about all kinds of things, and then I couldn’t sleep. I cried all the time, and my mind was just so unsettled. For other people, when they are sad, it only happens to them on some days. But for me, given that there are 30 days in a month, I was crying all 30 days. And I also did not want anything in this life. I only wanted to find death. Oh my god, did you know that I prepared the meds and planned to overdose on them several times? But I never did it. (Aunt Barbie)
I was just lying there… and didn’t want to get up. I didn’t want to go anywhere and didn’t want to talk to anyone. I just wanted to die and to get it over with. It was like a state of complete debilitation… I just lay there and didn’t want to do anything or love anyone. I didn’t even love my own self. I wasn’t thinking about anything. The illness forced you to just lie there. At that point you stopped thinking… if anyone asked me something, then I’d answer, but I didn’t want to talk to anyone. It [the illness] took me to that extreme place, but of course at the time I didn’t realize that [I was sick]. (Aunt Banana)

It [the illness] made me… it pushed me to that end of the extreme, it took away my spirit, and I did not want to live any longer… I had no purpose in life, no motivation for living. I didn’t want to live. I didn’t care about my children or husband. When I got hospitalized [for seizure], I did not care about anything; even if you put gold or money in front of me I wouldn’t have cared. That’s what I mean by losing my spirit. My children could do whatever the heck they wanted. They could come and go as they pleased. I didn’t care.… All I knew was that I was about to die… I prayed to Jesus to take my life away. I always wanted to die. I didn’t want to live because I was suffering so much, so what’s the point of living…. Therefore, I didn’t want to live. My life was miserable…. It hit rock bottom. I was tired… I didn’t talk to anyone. My head was aching a lot… and then… I didn’t want to do anything… there was only hopelessness in me. I was lonely. And the only thing left on my mind was… thinking of my suffering. I wondered why I had to suffer so much. (Aunt Target)

*Making attributions of discomforts.* Reflecting on their worst moments, participants recounted rationalizing about the possible reasons for their worsening symptoms. Participants had noticed something unusual for some time, but they often attributed this “unusualness” to other existing health problems or simply worsening health. They did not see this as a “mental health” problem nor did they perceive the need to get help. Other participants thought their discomforts were due to aging: “I’m probably getting older.” Participants explained that at the time they thought that because they were getting older, in their fifties and sixties, their health would be different from when they were middle aged. One participant explained:

Back then, for example, I was healthy and was eating a lot, but now I eat very little compared to back then. My health was okay back then, but now it [the illness] makes me feel sad, and it makes me feel like I have no energy. And my head feels unsettled. I also wonder if it’s because I’m aging and that’s why my health is declining. I don’t know…
The men and women recounted that in spite of worsening health, they did not connect their discomforts to “mental health problems” or “mental illness.” Participants relied on their cultural context to make sense of their symptoms. According to the participants, their discomforts did not fit their knowledge and belief systems about “mental illness” that they had learned while growing up in Vietnam. Words such as depression and PTSD were non-existent in their world. Someone who “lost their mind,” “is locked up,” “is talking to self,” or “is violent toward others” were common examples of what participants witnessed and heard about “mentally ill” people while growing up in Vietnam. The participants could not fathom the possibility that they had a “mental” problem because their discomforts did not fit these categorizations. They proved their point by emphasizing that “I am still physically able. I am not locked up in a mental institution” or “I’m not locked up; I’m not mindlessly worshiping deities.”

*Not having a name for it.* In this phase, many grappled with the ambiguities of what was happening to their health. One thing they were certain about was the marked decline, but most “did not know that they were so sick to that point.” Participants were also puzzled by a worsening health that had “no name” and did not fit with their existing knowledge of common physical health problems such as high blood pressure, diabetes, and high cholesterol. Aunt Ginseng asked, “How would you know that you are sick?” Other participants were also puzzled by their symptoms:

I didn’t know I was sick. At the time, I just wondered to myself why was it that something suddenly was wrong with me. That’s all...It wasn’t until I came into the mental health treatment place that they gave me materials to read about mental illness that described some of the things that I experienced back then, and then I realized, oh maybe I had that illness back then. (Aunt Banana)

And at that time I was getting worse, but I didn’t think I was sick. How would you know that you were sick, you know. But other people could tell that I was sick. I think maybe I was worrying too much. Uh huh, that’s what I thought of it at the time. But later on, when I went in to get treatment, and I came out of my illness, then I knew I had been
sick. But before that I didn’t know I was sick. Is there anyone who would say that they are crazy, right? (Aunt Ginseng)

In Aunt KTM’s case, she was puzzled by her worsening health and did not know exactly what was happening for some time. She began to suspect that she had a mental illness after reading through emails about illnesses that her husband’s friends had sent:

At that time I noticed that my symptoms were not normal. I wasn’t like how I was before. There were times when my husband’s friends would send emails to him with information about all types of health problems, and there was one email on mental illness. I read it, and I thought, oh, the symptoms sound like what I have. I was experiencing those things that were described in that email. So, then I wondered to myself if I had that illness, but of course I didn’t say anything to other people, but at that moment I already suspected that perhaps I was sick. (Aunt KTM)

Many participants went on with their day in spite of persisting, debilitating discomforts and a consciousness of troubled health. Participants did not do anything about it because they did not think they were sick, did not have a name to identify their experience, or did not think about getting help. Worsening health remained a private matter that the participants kept to themselves and dealt with on their own. Some reflected in retrospect that their family members observed their worsening health, particular the spouses, but that the family most often left the participants alone and let them be.

**Phase 3 – Going public**

Phase 3 marked a turning point wherein participants were eventually noticed by others for their “sick” outer appearance and behaviors. They were told that they looked “sick.” This often precipitated participants’ disclosures about their experiences with their ailments, although several participants disclosed without prompting from others. Three participants attempted suicide. In this phase, participants’ debilitating discomforts became apparent to others and no longer remained private. Participants moved from making sense of the ambiguities around their worsening health on their own, to hearing from others or verbalizing to others that something
was really wrong with their health. Their worsening health, puzzling thoughts, or uncertainties were no longer private matters. These behaviors alarmed participants in new ways, wherein other people now knew about problems that had been kept private for months or years. The third phase of going public included: suicide attempts, being told that one is sick, and/or disclosing to others.

_Suicide attempts._ One possible path within Phase 3 of going public was suicide attempts. Aunt White Flower attempted suicide three times while she was living in Vietnam, and two other women attempted once while living in the United States. Aunt White Flower shared that she developed severe asthma as a young child and had to build her entire life around the illness. She had to “limit her food intake,” or “stay home all the time” because her asthma did not allow her to eat anything or wander out and about. The frequent asthma attacks took a toll on her health, and the limitations it had on her life led to a point of “severe social isolation.” She wanted to end her life so that she could escape the tortuous illness but yet survived every attempt. Sister Cat was “going through a really bad heartbreak,” and Aunt Lai was “being mistreated by her children, particularly her youngest daughter” to a point where they both wanted to end their lives because they had no reason to live. Two women overdosed on pills while one drowned herself in the ocean.

While participants’ narratives revealed a sense of despair and longing for death, only three participants attempted suicide out of the 21 men and women. Those who did not act upon their suicidal ideation explained that their religious background of Catholicism does not condone such “sinful act” or that as Buddhists they believed in enduring and paying for their karma. Others said that in spite of wanting to end their lives, they needed to continue living so that they could be there for their children and grandchildren.
**Being told that one is sick.** Being noticed and told by another person that “you are sick” was a turning point that led to outpatient care for many participants. In Phase 3, participants eventually encountered at least one of the three scenarios. First, another person noticing and telling the participant about a “sick” outer appearance prompted a movement toward getting help. Second, some participants disclosed their condition to others after being told they looked “sick.” There was something alarming about hearing for the first time from a doctor, a friend, or a family member that “you are sick.” It forced participants to face head on for the first time the possibility that someone else had seen that something was indeed wrong with them. They were alerted to the urgency of their worsening physical condition/appearance and behaviors. These findings reveal the indirect, implicit norms for Vietnamese Americans to communicate about illness. The observations and indications did not touch on emotional problems but rather focused on visible outer appearances, “pale skin, loss of life in skin tone,” “the head,” “lack of sleep,” or “dull looking eyes.”

Family members had interactions with the participants on a daily basis and were often the ones who took note of their “unusual” appearances and behaviors. However, few voiced their observations to the participants when they retreated into their room and laid in bed all day, did not shower, or did not tend to the house chores. They simply ignored their behaviors and let the participants be. This often continued for months.

In Aunt KTM’s case, the participant’s family did take note of her continuous forgetful behaviors and eventually voiced the concerns to her:

This one time, my husband was with me and he saw what I was doing and called me out on it. I was at the market and was paying for my things, but I walked off without them, and I also didn’t take my change. My husband saw it and just kept following me to observe me, to see why I was like that. So he stood there to see what I would do. I kept walking away without my groceries and my change, so my husband called me to come back, and I asked him what’s going on. Then he asked me why didn’t I take my
groceries. I said I didn’t know. It was things like that that started happening to me. (Aunt KTM)

Prior to entering outpatient mental health care, the only interface any participant had with a medical professional was during visits with a primary care physician (PCP). In some cases, the PCP took note of the participants’ drastic health declines (i.e. weight loss, complaints about sleep loss, headaches, loss of appetite, worries) and told the participants that they were “sick” and needed to see another doctor to help them. They explained:

My doctor noticed that I kept coming in for a checkup for all these health problems. I complained a lot about my headaches and that I was crying all the time. And I also complained about my aching body. I couldn’t sleep. So then she told me I was sick and that she would introduce me to this program at the same health clinic. She said there was a mental health doctor there, and that if I was willing, she would make an appointment for me immediately. (Sister Park)

I was telling my doctor the discomforts I was experiencing. So some time later the doctor told me the health problems I had been experiencing meant that I was really sick. She didn’t say much more about what kind of sickness, but she only said I was sick, and she said that it wasn’t okay for me to continue on like that, and that I had to go see Doctor H, who is another doctor at the same health clinic. All she said was she had to send me over to see Doctor H and asked if I agreed to it. That’s all. (Aunt Banana)

Other participants recalled being noticed and alerted by other individuals such as their neighbors, friends, or church member that they were sick. The observation of being sick was most often based on participants’ physical appearance. One participant shared:

It got worse and worse by the day… it was so serious. And I only realized that I was sick when I came to the agency [outpatient treatment], all thanks to this lady who showed me this place. It all happened like this… I went to church this one day. I ran into this lady, and I didn’t know who she was at the time even though we went to the same church. For some reason she could tell that I was really sick. I guess she saw my [sick] appearance… so she came to me and told me “I notice that you look really sick. Let me show you to this place.” So she gave me a phone number to call. She didn’t say much else except to “call this number and talk to this worker.” That’s all she said. Nothing else. (Aunt Barbie)

Sister Park’s friends repeatedly pointed out that they noticed her distress and changing behaviors, but she kept pushing along as though everything was fine. She explained:
My friends told me that they could tell I was really stressed out, and I should just stop going to school… but that’s one of my dreams and biggest thing that gave me purpose in life when I came to America, you know. So I told them I could not quit school. And they asked if I wanted to push myself in spite of being so stressed out just to get my degree and then suffer from health problems and possibly die from it. Or, did I want to do something about it and live happily, and recover slowly so I could go back to school again when I am well. Another friend also told me that anyone who met me would say that I have some mental health problem. When my friends told me that, I reflected on things. I was severely stressed out at that time, but I still insisted to my friends that nothing was wrong with me. It’s like I thought I could keep my head in check, but in reality there were things that I did that I couldn’t control, and other people could see that, you know. It’s like I couldn’t control my thinking and my behaviors… and a lot of other things. (Sister Park)

**Disposing to others.** The point at which participants disclosed to others their worsening health sometimes followed someone’s observation that “you are sick.” For others, they disclosed because they were trying to make sense of their unusual discomforts and hoped others could help them figure out what might be happening to their health. Sometimes their self-disclosures happened simultaneously while being told by others that something was wrong, usually to their PCP or to a friend.

The participants in this study all had multiple health problems and saw their PCP on a frequent basis for monitoring. Thus, disclosure to the PCP took place during a routine check up, when a few participants voluntarily reported to the PCP that they “had not been able to sleep,” “were worried,” “were getting headaches,” or the unusualness about their health. In a few cases, the PCP inquired further about possible causes of these concerns, such as asking “are you experiencing a lot of stress in your life,” upon which the participants elaborated on their experiences with the physical and emotional disturbances. Sister Park’s story illuminates such a disclosure; her PCP was alarmed by her worsening health within a short time period and asked her about possible causes:

Oh, because Doctor F saw that I had so many illnesses, such as irregular menstrual cycles, a cyst in my ovaries, abnormal lymph nodes in my lymph nodes, stomach
problems, and muscle tension problems . . . the doctor asked me if I was really stressed out about my life. And I told her that yes, I was really stressed out. Dr. F then asked me what was going on, and I told her that . . . part of it was money, and the other part was I wasn’t taking care of my health, and another part was because I was too stressed out because there were a lot of difficulties in my life that I didn’t think I could overcome. (Sister Park)

In other cases, the participants shared that they had seen their PCP for quite some time before some were eventually asked about or disclosed their mental health problems. Aunt KTM explained that in her case she “accepted that I was sick” and wrote her symptoms on a piece of paper to bring to her appointment with the PCP. During the meeting, she read off the unusual discomforts she had been experiencing, and only then was the PCP alarmed by indications of mental health problems and “wrote a referral to a mental health doctor . . . . She told me that I am stressed out and I have depression . . . . So that’s why she referred me to the mental health doctor so that they can talk to me.” If Aunt KTM had not taken the initiative to disclose to the PCP her ongoing health problems, the PCP may not have taken note of her mental health concerns. This was the case for some participants who, in spite of seeing their PCP for routine care, continued to endure their emotional problems that remained undetected. One participant shared her story:

Oh, this doctor I had was really simple in how he did things . . . . I didn’t understand why, but the way he did health checkups with the patients was so simple. Every time I saw him, I only got my blood pressure checked . . . . or he just checked to see which medication I was on and gave me refills. When I needed anything more, then I would ask him to do it, like checking my heart or lungs to make sure they were okay. It was only then he would put the stethoscope on me, and then he would tell me everything was really good. (Aunt Ginseng)

In other cases participants disclosed minimally only in response to the PCP’s inquiries about their discomforts only when asked. Some participants saw their role as passive patients who went along with the doctor’s cues, and nothing more. One woman shared her response to the PCP’s question about her emotional well-being: “Yeah, the doctor did ask, and I told him. I
said my mental well-being has gotten worse compared to before, and that’s all I said.” She reported that the PCP did not follow up after she responded.

Some participants did not disclose their health concerns to the PCP, and the PCP also did not pick up on the mental health-related concerns underlying the participants’ health problems. One participant shared that, “I don’t really say anything [to the PCP], nothing at all. I don’t really think about it. I just go to see them, and whatever they treat they will treat. That’s all I thought. Nothing more.” Aunt Ginseng explained that she would tell her PCP about her worries only if the doctor took his time to ask how she was doing: “I would only tell him if he asks me. If he doesn’t ask, then I don’t really tell him much. I don’t want to talk a lot during the visit. I see that he is so busy with a lot of patients. I don’t want to take up his time.” Another remarked:

You know if I hadn’t known about this place [outpatient agency], I wouldn’t have gone, and I would have gotten more and more sick because Doctor H [PCP], she kept… she thought that I had stomach problems or thought that I had other illnesses, but she did not focus on my mental health. And the main thing I needed was someone to talk to me, but she did not pay attention to that. So that’s why I got sick, and it kept getting worse.

(Aunt KTM)

Some participants disclosed their worsening problems to neighbors or friends simply out of curiosity about what may be happening with their health. For these participants, hearing that someone had had similar experiences was comforting and sometimes elicited further disclosures about their ailments. This often led to discussions of what participants could do to alleviate their symptoms, as illustrated by the following quotes:

I’ve lived in the States for several decades, but I didn’t know anything about the mental health treatment place. I had only gone to get my check up with my family doctor. I didn’t know what exactly was happening with me, but I noticed that I was getting worse by the day. I wasn’t like how I was before. So I told her [the neighbor] that I was sick but that I didn’t know where to go to get treated… Then she told me she didn’t know either, but that back when she was sick she came to this one place, and there was a doctor who gave out medication. I did notice she was getting better. So then the only thing I asked her was what exactly was this place she was referring me to, and she said it’s a place that treated all kinds of illnesses: high blood pressure, diabetes, high cholesterol,
and others. So when she said that, I just listened to whatever she said and came here to get help. And then when I came to the place, I found out that it’s related to mental illness. (Aunt Taxi)

I have this friend…he noticed that I was sad and worried too much, and I also kept telling him that I lost a lot of sleep, so he told me that meant I have some problem with my mental health. At that time I also lost my appetite and my sleep because I was so sad and upset with other things that were going on with me… This friend had already been treated at this place for similar problems. He was a lieutenant in the Vietnam War… He told me to go there and ask for medication so that I would feel better. (Uncle Van)

**Phase 4 – Learning about options to alleviate discomforts**

Participants’ movements into Phase 4 took several paths: involuntary hospitalization, no referral, stumbling upon the place, and receiving referral to relieve discomforts. Among those who did not receive any referral post hospitalization or after disclosing to others and/or being told that they are “sick,” they reverted back to Phase 1 or 2 and eventually received referral to seek help at some point. Most of the participants eventually received information and referrals to relieve their discomforts. This was a turning point in participants’ pathways into outpatient care, wherein participants learned about the various options to alleviate the debilitating discomforts they had long experienced. Upon receiving referrals participants either took immediate action, delayed care for months, or were forced to seek care. One participant stumbled upon the place and sought help on her own.

*Involuntary hospitalization.* Aunt Ocean and Aunt White Flower were the only two participants who were hospitalized in Vietnam. They recalled returning home and continuing on with their lives without seeking any help thereafter. Aunt White Flower said she had three repeated hospitalizations, but she resumed her routines after the third time and never attempted suicide again. Mental health treatment was an unfamiliar concept to Vietnamese at the time, and outpatient mental health care was unheard of. Both Aunt Ocean and Aunt White Flower were examples of cases where participants were involuntarily hospitalized but also returned to Phase
1. They went on with their lives in spite of experiencing unusual discomforts, until their health worsened after they arrived in the United States. At some point after that they received referrals for treatment.

Sister Cat and Aunt Lai were two participants who were hospitalized in the United States following suicide attempts. While Sister Cat received referrals for follow-up mental health care immediately post hospitalization, Aunt Lai did not and returned home and continued on with her life. Aunt Jewel was another participant involuntarily hospitalized in the United States directly from Phase 2, and remembered that her health worsened following her divorce and loss of custody of her three children. She vaguely recalled falling deeper and deeper into her sadness and losing her job; then she “wandered in the streets all day.” Her father eventually called the police to hospitalize her after observing her repeated behavior of wandering in the streets so much that he thought something had to be done. She stayed in the hospital only briefly before being released with a referral for follow-up outpatient mental health treatment. She recalled:

> It was going on for about a year… What happened was I kept leaving home to wander in the streets by myself. I wandered aimlessly and wasn’t aware of anything going on around me. And then…one day I came home and he [father] called the police to take me to the hospital because he could no longer watch me. He told the police that I kept leaving the house and screamed loudly in the house. So the police took me away for real. (Aunt Jewel)

No Referral. Several participants did not receive referrals even though they were told that they looked sick or they had disclosed their discomforts to another person. The lack of referrals appeared to be due to these individuals’ (i.e. PCP, friend) lack of knowledge about possible sources of help. Participants who did not receive referrals reverted back to Phase 2 where they continued to experience declining health without knowing about options for care. At some point they moved through Phase 3 again where they eventually were noticed by someone
or they disclosed to someone about their condition, at which point they were referred to a source of care.

Findings from this study highlight, for this population, the lack of linkages to mental health care in primary care settings. There were cases where participants had seen the same PCP on a regular basis for years, and reported to the PCP that they were having difficulties sleeping, head pain, and worries. In retrospect, the participants pointed out that their PCPs did not detect any mental health issues, or, if they did, they did not bother to link participants with further care. One participant explained, “No, he never told me about any mental health treatment place.”

Another also shared her non-referral experience:

He didn’t make any referral, but he knew I had that illness… Every time I came in to see him for a checkup, he would talk to me. So whatever health problems I was experiencing, I just reported them to him. I didn’t know anything about Doctor M [psychiatrist at her outpatient center] or going to any hospital to treat my illness. So he [PCP] kept telling me I had a mental illness and that he would ask my husband to come in to see him so he could explain to my husband how to help me and how to live with me at home. There were times when I asked him for sleeping medication to help me with my problems, and he gave them to me. (Aunt Ocean)

In some of these cases, the PCP addressed these discomforts in-house and gave participants “sleeping pills” or “medication to calm their mind.” Participants managed their discomforts with medications until they received referrals from either their PCP or another source. One woman explained, “I lost sleep for many months, oh my god… and then I asked for medication. I didn’t go to the doctor; I just asked for medication to calm me, and when I took the medication, I was able to sleep.” Another shared that:

Oh… I did tell my PCP [about the headache]. He said the headache thing meant I was sick, but he didn’t say I had that illness [mental illness]. I found out only after I came here [outpatient agency]. He only gave me sleeping medication to help me sleep.

Stumbling upon the place. Aunt North Flower was a rare case of stumbling across an outpatient care agency and initiating use on her own. She experienced a period of worsening
health but was never told by another person that she was sick nor did she confide in anyone. She kept going until one day when she stumbled upon the place that could relieve her symptoms:

For a while my children and I were on MediCal and welfare, so I had to go to this place... like some organization or some place in order to renew my paperwork once a year. I don’t quite remember. And later on, I found out that this place had Doctor M [psychiatrist]. When I wandered by this place… I ran into some people and asked them why they were there, and they told me they came to see the doctor to help them… so then I started to come in too. (Aunt North Flower)

Receiving referral to relieve discomforts. Sooner or later, everyone in this study, with one exception of the woman who stumbled upon the place, received information about care options from the person who told them that they were “sick,” or from the person to whom they had disclosed their discomforts. Upon receiving referral, participants either delayed seeking care, took immediate action to seek out the source of help, or were forced to seek care.

Delay seeking help. Most participants waited several months to two years to find a place or a doctor to help them. The participants had suffered silently for some time, and the thought of receiving help from an unfamiliar person or place raised doubts about whether those at the clinic could understand their experiences. Participants’ thoughts were, “I wondered if they would understand me,” or “I was hesitant, I wasn’t sure if they could help me resolve anything.”

Others were just hesitant to contact a person or place that was unknown to them. Aunt Barbie explained that her husband questioned the place from the start and did not support her initiating contact because he had no idea what the place was:

I had the phone number, but I didn’t call right away. I waited several months. So what happened was I told my husband that I would call this place right away, but he wouldn’t let me. He asked me why was I calling that place, so I waited several months to call. I didn’t call right away. So one day, my husband went out, so I just called the place. (Aunt Barbie)

Uncle MT was not clear what his doctor saw at the social service office years ago, but the doctor did suggest that Uncle MT should see a mental health doctor. The doctor’s advice
prompted him to seek out “this place,” although he had no background information about the place. He simply followed the doctor’s order but also waited for some time before he took action:

I went to see him [the doctor] for the third time, and then he told me that I should call the department, something like the mental department. He’s a doctor at the social [service] office. So after that, I came home but I didn’t call right away. It took me some time. I didn’t know why he told me to go see a mental department. I really didn’t know. I just did what he told me… I don’t remember what prompted me, but one day I just did what he advised. I looked in the yearbook [phonebook] or something like that, and I just called one of the numbers listed under mental department. I chose any number with the same area code as where I lived thinking it would be close to where I lived. (Uncle MT)

In Aunt KTM’s case, she ignored the PCP’s referral to see a “mental health doctor” because the doctor’s secretary told her it would be really costly. Aunt KTM did not have health insurance at the time so her rationale for delayed care was partly financial:

First, I couldn’t find a way to get to that doctor’s office because it’s far away. I can’t drive far these days... And second, I had to pay cash to see the doctor. The secretary and nurses in the [PCP’s] office told me that seeing that [mental health] doctor was going to cost a lot of money, and that I wouldn’t be able to afford it. Instead, they gave me a phone number to go to this meditation place that could help me... but I didn’t go there, either. (Aunt KTM)

The participants expressed concerns about being associated with anything “mental” as a factor in their delays to seek out help. Several participants were initially hesitant to even consider seeking help from the identified source after hearing that the place or person who could help them was associated with “mental.” Aunt White Flower recalled having strong reactions to the doctor’s suggestion that she see a “mental doctor.” She thought her health problems did not resemble anything “mental” and rejected the idea that she needed to see such a doctor. Another woman spoke about her hesitation to seek help:

I was hesitant because I had to give it a lot of thought. Personally, getting treated for this illness [mental illness] didn’t sit right with me because I thought that if I had to get treated for that kind of illness, I would be really ashamed. I thought to myself, I was normal, but yet I had that illness [mental illness]. That’s why I was hesitant to get help. I
mean… I was normal, so how was it possible that I have that illness. I was embarrassed at that thought… Who would even think that someone like me was sick? So I waited several months to come in. At first I didn’t want to go, but some time after, I just thought whatever. If I was sick, then I would have to take care of myself and couldn’t be hesitant and embarrassed about it. So that’s when I went in. I wanted to come in to see the doctor so he could treat me, and if he was treating me for the right thing, then I would be cured. To be honest, it was because of this one day when I was worrying and thinking too much and feeling really sad that I decided to go. I told my children and my husband that I planned to go into that place to get treated, and they were supportive and told me to just do it. They agreed with me and supported me, and told me to go. (Aunt North Flower)

Take immediate action. Several participants took immediate action to seek out a source of help. These participants were either following the doctor’s orders post involuntary hospitalization, or they were following their PCP’s suggestion to see “another doctor” in a newly formed program housed at the same health clinic. Both Sister Cat and Aunt Jewel received referrals for follow up care after they were released from the hospital. Those who received referrals from their PCPs explained that the PCP first asked if they would consider seeing this doctor in this new “program” who could help them with their discomforts. All of these participants followed through with the PCP’s suggestion and booked an appointment to come back to the see the doctor.

In another case, Uncle Recycle had experienced head pain for some time and had fallen deeper into the isolation of his home after not being able to work because of poor health. Then he received referrals from a coworker to go to “this place” that would help provide him with financial stability:

Back then I worked at the sewing shop with this guy, and he told me about a doctor and eventually took me there so that I could get the sick papers [proof of disability] that would help me get through my citizenship application. If I got U.S. citizenship, that would help me get the other money (United Nations Higher Commissioner for Refugees). He wanted to help me. He said, “You should ask for papers [proof of disability]. You’re already old, you need the sick papers for your head problems so you can get money.” (Uncle Recycle)
**Forced to seek care.** Aunt White Flower and Aunt KTM received information about options to alleviate their discomforts but then they were forced to seek help. Aunt White Flower’s interface with the mental health system began with her repeated hospitalizations due to severe asthma attacks. During the hospitalizations, Aunt White Flower recalled bits and pieces of the story about the doctor first alerting her brother and sister at the hospital that she needed to see a mental health doctor: “At the time my sister brought me to the hospital, and the nurse told her that she needed to take me to see a mental health doctor… but she never told me.” Aunt Flower also remembered seeing the word “mental” on a piece of paper that the nurse was holding. Though she did not know enough English to understand everything else on that paper, she knew enough to understand the term “mental.” She came back to the hospital the second time and saw the same thing written on her chart. Aunt White Flower recalled: “At some point the doctor asked me what I liked, and I said I would like to die early. You see! That’s why they thought I was mental.” She explained further:

The doctor and nurse asked me if I would go see a mental doctor, and I said no… and they asked me why. I said I wasn’t sick or anything, I didn’t have a mental problem, so why should I go. And they told me that I had to go. They forced me to go. They forced me to go, and after the third time, I finally went. They forced me to go or else they would not treat my asthma. That’s why I had to go. (Aunt White Flower)

Aunt KTM described her entry into outpatient care as being forced by her daughter-in-law who studied psychology and had a family member with a mental illness, so she discerned Aunt KTM’s mental health problems:

This one day… she [daughter-in-law] and her mom came to visit me. They knocked on the door, and when I opened the door, they saw my face… something was just different about it. I guess she [daughter-in-law] looked and she knew immediately. She knew because my eyes looked lifeless. My daughter-in-law told me “Mom, you have to go to this place so they can talk to you. You don’t have stomach problems or any other illness. You have mental health problems. You need to go to this place so they can help you.” I didn’t want to go, I didn’t want to go… I don’t know why but at the time I was hesitant… but, she made me go. She has a really strong personality. She said, “You have to go.
You cannot let yourself be like this.” And then she said, “Ok, on this day I’m going to be free so get ready, and I will come by to drive you there.” So then she came and forced me to go, so that’s why I went. (Aunt KTM)

Factors affecting participants’ willingness to seek help. Several factors were key to the participants’ decision to follow through with the referral they received and to seek help. These factors were: framing of referral, receiving constant encouragement, familiarity and trustworthiness of referrer.

Framing of referral. The framing of the referrals played a key role in how participants responded to them. Most participants did not know what they were getting help for or from whom they were getting help. Most initiated contact with the person or place under the impression that this was a place that had a “doctor” who could help them sleep better or help their headache go away with a pill. According to the men and women, an acceptable way of framing the referral was to be implicit and indirect, and to use ambiguous terms that did not contain any stigma or indication that the source of help was mental health related. Participants were commonly told that “you should go see” “this one lady” or “this doctor” or “that place” to help you “with your head” and give you “medicine.” The referrals came with reassurances that they would “feel healthier,” “sleep better” and that their headaches would go away. The details were not any clearer or more specific than that, and participants did not ask further questions. The language of the referrals was non-stigmatizing and non-specific to mental health or mental illness, and referred more generally to a place or a person that could help alleviate discomforts. This wording normalized the participants’ discomforts and reassured them that there was available help. Very few referrals were much more explicit in the wording, and very few made references to mental health or mental illness. Several individuals were advised to go to a “mental department” or a “mental health doctor.” However, this was as detailed as it got.
The presentation of the source of care made a difference and eased people’s anxiety and hesitancy to seek out the unfamiliar. Uncle Van recalled his friend’s encouraging words:

My friend told me that “This place can help you, to help ease your mind, to help you feel better.” He told me about this place, so I became curious and came… He didn’t say that this was a hospital or anything… He just said this place was a place that helps your mental health. I would feel healthier; I would sleep better. At the beginning, I was a little scared… I was hesitant. I told my friend that I wasn’t crazy. My friend said, “Oh no, you just go to that place to get your medication to help you sleep and to get healthier.” At first was scared, you know. (Uncle MT)

**Receiving constant encouragement.** Constant encouragement and others’ checking in during participants’ time of contemplation became important ingredients in this help-seeking process. When the referrer followed up -- “have you gone there yet” or “you should try it out” -- doubts and ambiguities about whether one should take action decreased. Support and encouragement from significant others appeared to be a critical factor in the decision to seek help. Often, the family would encourage the participant to seek care so that he/she could be “cured,” especially in those cases where the family was aware of the participant’s condition, and knew of available sources of help. In one case, the participant’s spouse was not supportive of her decision to call the agency because he was not familiar with the agency. A few participants, after months of contemplating, continued to receive encouragement and check-ins from supportive referrers. They offered participants helpful encouragement to try the place out and reminded them of its effectiveness in alleviating symptoms. Two participants spoke about how their neighbors kept encouraging them to check out the place:

See, she kept telling me… and at some point I realized that she had a point. So then I just called in [to the outpatient agency]. I waited for two years after she told me about this place to finally come in. I came here in 2003. At first, I didn’t have the guts to come here, yet. I really wanted to come in, but I was afraid that the doctor or other workers here… I didn’t know if they would understand me, if they would understand my illness or not. And whether they could cure me… according to how I wanted it. (Aunt Ocean)
Familiarity and trustworthiness of referrer. Familiarity with and trustworthiness of the individual who made the referral were important factors in convincing the participants that perhaps they should try the place. The referral from their PCP was accepted as expert advice, and participants recounted that they simply followed the doctor’s suggestions and did not think further about it. The PCP was also a familiar face and a trusted individual whom participants had seen on a frequent basis. Referrals from other individuals such as family, friends, and neighbors were trusted when they were from individuals who themselves had received help from the referral, and who had positive results with feeling “healthier” or “getting better sleep.” As such, participants valued hearing positive feedback about the referral. Other important factors were how familiar and closely related the participants were with the referrers. Uncle Van felt comforted when he received his referral from an ex-lieutenant of the South Vietnam military, expressing his camaraderie with a fellow South Vietnam officer. Other participants received information about possible sources of help from neighbors or relatives. All saw this person as someone they knew or who could relate to their experiences because they had had similar discomforts and had sought help to ease them. Participants valued knowing that this place was a good place for them because it would treat their problems, and allow them to feel better, just as it had helped their friend/referrer. Thus, there was something comforting about being supported by someone who cared, normalized, sympathized, and empathized with their experiences. They shared:

My friend noticed that I was sad and worrying a lot. I kept telling my friend that I was losing a lot of sleep, so he told me that I must have a problem relating to my mental health. My friend, a lieutenant during the Vietnam War, already got treated for similar problems as mine. So he told me to come in and get some meds so I could feel better… And I did. I actually came in first. I saw results. I drank the meds, and I felt healthier. My wife also experienced this thing where she was forgetful. She has suffered a lot because of me [post Vietnam War when he was imprisoned and wife had to raise children
on her own]. I asked her to come in after I came here. So then we both came here together. (Uncle Van)

Back then I didn’t know about this place and also didn’t know that it treated illnesses like that. I learned about it from this one lady [neighbor] who was sick like me. Her situation was that she lost everything, but she found a way to resolve her problems. She found this place a long time ago, and she was doing better after that… She noticed that I was sick like that, and she kept telling me to go [to the place], but I had no idea what kind of illness I had to even go to this place. She kept encouraging me, so I finally went in. She told me “You know, I can tell that something is going on with your health.” So that’s how I found my way to this place to treat my illness. (Aunt Taxi)

**Phase 5 – Navigating ones’ way**

In Phase 5, navigating one’s way consisted of navigation processes and facilitating factors. The move from having a referral to actual outpatient mental health care was for some a smooth transition, but for others, it was another complicated process of navigating through twists and turns to get into the outpatient treatment center. What was certain was that participants did not know that they were getting mental health treatment or going into an outpatient mental health agency for therapy and psychotropic medication. This source of help was unfamiliar and nonexistent for the participants. The realization that the place was an outpatient mental health agency came about only after participants entered mental health care. At the time of initiating contact with “the place” of help, participants did not inquire further about cost or transportation or distance. Participants had to simultaneously navigate their way and locate this place of help; most did not even know what the place was called. Only a few understood that the place of help in which they were able to receive help was related to “mental” problems. One participant went directly from Phase 2 to navigating her way into mental health care.

*Navigation processes.* The typical navigation process for some participants was smooth and straightforward: they “called” the place, spoke to “someone,” were given an “appointment,” and either received a ride from a family member or friend or drove themselves (the few knew
how to drive) to the initial appointment. Participants vaguely remembered that they had asked the agency or another person for directions and went there soon after. One woman explained how she initiated contact with the agency:

So I called, and I talked to Miss Dee [therapist at agency]. It’s really hard to reach her because she’s really busy. But that day I was lucky. She picked up right away. I only talked to her over the phone, and she interviewed me over the phone. She asked me a lot of questions and then she gave me an appointment to come in to see her. My husband even yelled at me when I told him that I called, and I explained to him that… that lady [church member who referred her] told me to just go there and they would give me medication to feel healthier. I should just go. I really didn’t think about what would happen when I went to that place. I didn’t even know what that place was. That lady just told me that she’s giving me a number, and I should just call to talk to that person. (Aunt Barbie)

Other people had a more complex process, and encountered a few detours while navigating their way to find this place of help. Aunt Target recalled the complex process of finding the “doctor” to help her get better after her sister-in-law mentioned “a doctor” who treated her and cured her of her discomforts. She said that her sister-in-law described her own ailments as: “having a tired heart and probably having a tired heart like me.. just being tired but she wasn’t stressed out, but she had some sort of mental health problem. And that man treated her… she went to see him, and he cured her. So she told me to go find him.” Aunt Target saw him once when he came to check in on her, and she was excited to see him for after-care. However, she was unable to track him down after she was released from the hospital and had to go through multiple places and individuals to find the place that could help her:

After much searching, this one office finally told me that I should call this place. So I called because I was determined to cure my illness. I wanted to cure my mental health problem. So when I called, that place once again told me to call another place. But after that, they called me back and this one lady told me she knew I would continue to be referred to one place after another and that she wanted to help me. I was so lucky that she offered to help me. And that’s how it all started… She came to my house to open a case for me and asked me all kinds of questions… the thing was that this place served people over 60, and on paper I am not 60 yet. But she still helped me… Her agency helped people with mental illness… but they made an exception for me. Several months
later, she told me that I should go to Clinic C… She said there was a program for people under 60 or 65 or something like that. So I went to Clinic C and have been here since. (Aunt Target)

Another participant reflected on the complicated process that she had to navigate to get into outpatient care:

It started like this. There was a nurse at the hospital where I was getting treated, and she was my sister’s friend. She translated for me and gave me a phone number and told me to go see a mental health doctor. So I called that number and all I heard was English, so I said “I speak English not well. I need a translator for me.” So they understood me and got an interpreter to talk to me. I asked for the address so I could head there. When I got there, my file was already there. I think they [the hospital] transferred it there. I didn’t know anything about it. When I got there I spoke to someone named Miss Dee. She’s Vietnamese. She asked me why did I go to her agency when I lived in Donnyville. It’s really far away from where I lived. I said I didn’t know anything and that the hospital told me to go to her place. Then she told me that there was another place that was closer to where I lived, and there was also someone by the name of Miss Dolly who would take care of me once I got there. She also said she would let that place know that I would be heading there instead. I didn’t know what was going on. I just did what she said and went to the place and have been here since. (Aunt White Flower)

Facilitating Factors. Several factors facilitated participants’ abilities to find their way to the source of help. Finding transportation was a major factor in getting to the outpatient setting. While several participants could drive, they were limited in how far they could drive. These participants also expressed fears of driving and did it only out of necessity. Most participants did not know how to drive and relied on family and friends who readily offered to take them to their initial appointment. Aunt Ginseng shared the importance of having her brother to help drive her to the various places that she was referred to prior to finding the current outpatient center:

After being released from the hospital, my brother took me to the doctor. It was a Vietnamese, no, Taiwanese doctor. He was far away. I don’t remember how long I was with him, but the doctors kept changing me to different places. Transferring, transferring, transferring… It was because one clinic closed, and I had to go to another. And I kept following through… until I came to this clinic. It’s been two years. (Aunt Ginseng)
Given the participants’ limited access to transportation, the convenience of having a place of help that was near their home (about a 30 minute drive or less) and in a familiar location (e.g. at the same health clinic) helped ease the navigation process for the participants. Further, having access to an in-language worker when calling the place of help made it easier for participants to set up the initial appointment.

**Phase 6 - Actual Service Use**

In the final phase, Phase 6, participants eventually reached a place that could help ease their discomforts. However, what this place looked like or could provide remained unknown to the men and women. Personal readiness to seek help, a pragmatic outlook on doing something about one’s worsening health, and a desire to just try it out were key factors that enabled participants to act.

One participant in this study transitioned into care after being forced by her primary care doctor to do so; if she had refused, he would not have treated her asthma. The other men and women in this study made their way into outpatient mental health care voluntarily. Two participants made a transition into outpatient care after they were hospitalized in the U.S. Three factors were crucial to this transition from receiving the referral to actual service use: personal readiness, being pragmatic about getting help, and trying it out.

*Personal readiness.* At this point the participants had hit a phase where they noted a declining health and worsening discomforts. Thus, many sensed the urgency of their situations and the need to do something. Some participants told themselves that if they kept going on like this, they would end up dying. Aunt Barbie thoughtfully summed up this moment of readiness:

That one day I thought to myself; I wondered if I had any sickness, and then I wondered why was it that I was getting worse and worse by the day…. I mean you look in the mirror and you can tell what’s happening to you, right? So then… I thought about it, and I thought you know, I should go there so that they… they can help me to get better.
Pragmatism. Being pragmatic about getting help was another key factor. Some participants believed that if they had an illness, they should see a doctor to help them feel better. The following quotes illustrate this idea:

No, no, I am not embarrassed at all because I understand that every one of us has an illness of some sort. Everyone has some sort of either mental health or physical health problem, this and that, and when we are sick, we should get treated for it. We need the support of others because we don’t have the expertise, the knowledge, the experience [to treat ourselves].

I just have a little bit of problem with my mental health. I am not to the point where I am sick. I am just too stressed out, and sometimes I can’t deal with the stressors so I have to find something out there that can help me… To me, when I realized that I was sick, I needed to get treated. And I also realize that it’s not just a one-time visit, but it will take multiple times if I want to cure my illness. (Sister Park)

I got help because I wanted to be normal, to be healthy. Why should I have to suffer, suffer from my illness? I wanted to be cured to get it over and done with. I don’t care about other people laughing at me. They can think whatever they want. I don’t mind. I don’t mind. If I did mind, I wouldn’t have called all over to look for a place to go to for help. I was determined to find it and wouldn’t stop until I found it…. I don’t mind [the embarrassment] because only I could save myself. No one else could. If I minded, then I would die for no reason... So that’s just with everything in life. You cannot worry about what others think or be afraid. (Aunt Target)

I didn’t have curiosity or anything like that. All I thought was… it’s what I wanted to do. I simply thought that place has a doctor, and at the time I didn’t have paperwork [insurance] to go see a doctor. The guy who worked with my husband who told us about this place made it sound so simple. He said that I could just come here and see a doctor for my problem. Hearing that… why wouldn’t I seek it out, right? If I were sick, I needed to ask for medication. That’s all there was to it. I didn’t think anything more than that. (Aunt Recycle)

Uncle Van shared his pragmatic approach to initiating help. He simply wanted to get the medication that is supposed to help him sleep better and ease his headache. In spite of initial worries and hesitancy, Uncle Van stated,

I sought help because I wanted for me… for my mind to be better. At that time I was unemployed. My financial situation was difficult, and then my siblings in Vietnam were going through a hard time, but how was I supposed to send them money while I myself wasn’t stable here in the United States. I was getting older. I was over 60 years old at
the time. How could I find a job at that age… so I went there to get meds. My intention was to get medication. (Uncle Van)

*Trying it out.* The participants also voiced wanting to try out the “place,” the “doctor,” or the “pill” that had helped cured their family or friends’ discomforts. Participants figured that it would not hurt for them to try it out. After all, their friends or referrer who already sought help from this place assured them of the results. The men and women were motivated to try out this place that supposedly could cure them of the physical and emotional discomforts that they had long endured. Some wanted to see first-hand what this place was all about. Two women said:

> You see… I was really pushed to do it [by the doctor who was treating her asthma at the hospital]. I became curious to see what it was like at that place and what “mental illness” was like, and whether mental illness was what I had because other people kept saying I had mental illness. So I had to go there to check it out. (Aunt White Flower)

> After hearing that, I went in. I was telling her about my situation, and she told me, “You should go to that place and try it out.” So I was just going in to try it out, but I didn’t know what it was. I only knew that… I heard other people saying that that place belonged to the government, but I didn’t know exactly what type of government place.

**Conclusion**

The men and women in this study suffered silently from their debilitating conditions for some time. For these participants, finding help for their discomforts took months and sometimes years because they did not have a name for their experience, and their discomforts did not fit with their knowledge of mental illness or any other more common illnesses. The process of moving into outpatient mental health care was a long and often circuitous road with ambiguities, puzzling thoughts and unanswered questions. An important turning point was when participants found out that they had options to do something about their debilitating discomforts. When participants finally arrived at an outpatient center, they had found a place that could help them regain their health: a return to normal functioning and the ability to fulfill social obligations.
Thus, getting into outpatient treatment marked the beginning of participants’ journeys to finding their self worth.
Chapter 7 Results

Aim 3: Describe the expectations and perceptions of first-generation Vietnamese Americans of outpatient mental health treatment

The following chapter examines participants’ expectations for outpatient care and what they feel they actually gained from mental health treatment. Table 5 below lists the theme, dimensions and properties related to this Aim; the dimensions included: 1) initial expectations, 2) the doctor, 3) the ladies, 4) the groups, and 5) the place.

Table 6. Research Aim 3 Themes, Dimensions and Properties

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<th>Dimensions</th>
<th>Properties</th>
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<td></td>
<td>Reclaiming One’s Self Worth</td>
<td>Initial expectations</td>
<td>Going to the place for help</td>
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<td>Doing as told</td>
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<td>The doctors</td>
<td>Receiving expert confirmation that one is sick</td>
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<td>The place</td>
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Aim 3 Conceptual Model

All of the participants came to “the place” that could help alleviate their symptoms with no preconceived expectations. Participants had no idea what would happen on the first day or days after, or who would be helping them. The only expectation they had was that they would see “the doctor” and get the “medicine” for their “headaches,” “difficulty sleeping” and “worries.” Participants’ narratives about the treatment process revealed more about the crucial
roles of the agencies and key individuals -- “the doctors,” “the ladies” and the “groups” -- in their journeys toward reclaiming self worth. Figure 4 illustrates the participants’ understanding of the outpatient treatment process.

Figure 4. Linking Outpatient Mental Health Treatment to the Reclaim of Self Worth
Aim 3 Findings

Initial Expectations

*Going to “the place” for help.* Participants recalled that they made the initial visit to “the place” of help with the understanding that they would see someone or a “doctor” who “treats the head” and get “medication” to make their “sleep problems” and “headaches” go away. Participants framed their expectations in a very matter-of-fact way, just as they would for any other health problem: they were simply seeking immediate relief for their “head problems.” Other than that, they had no other expectations and they were unaware that they were going into outpatient mental health treatment. They simply “did not know.” The participants similarly expressed that: “Oh I had no clue… I only knew that there’s a doctor who treats people, and that’s why I came” or “The first time I was there I said I wanted to see a social worker so I can ask her for meds to treat my illness… because I didn’t have health insurance. Nothing… so all I needed was the medication.” Another participant similarly said, “Back then, I couldn’t sleep at night. My head was hurting. I wanted to come here to treat my illness… to get help so that I could sleep. That’s all. I didn’t have any other idea.” Uncle MT described his initial expectations:

I don’t remember exactly why [I came here], but I think it was more like just doing what the doctor [at the welfare office] suggested. My intention wasn’t to come and talk to the people here… But it was more like I was simply doing what the doctor advised. I could not imagine what this place was like… I thought that perhaps… perhaps it’s similar to the [welfare] clinic I went to but with more doctors to treat all types of illnesses like mental illness or other illnesses. I thought it was going to be like that. I had no idea that it was going to be like this. (Uncle MT)

At one particular agency housed within a health clinic, the participants already were familiar with the clinic and simply thought that they were “going in to see another doctor” there to check out their problems. Even the few who were told that they should seek help for their
“mental” problems did not know what to expect from “the place.” When Aunt White Flower came to the agency for the first time, she said she was clueless: “I did not even know who the person behind the window was. I was told [by the doctor] to go get treated, so I went.” This ambiguity about “the place” and what it could do to help ease one’s discomforts also raised questions and stirred anxiety among the participants. Aunt Ocean talked about her experience:

Before I came here, I wasn’t sure how the doctor would go about treating me. Or what kinds of opportunities they would give me. I didn’t know. Of course I was worried, you know. I was worried about whether it would work out. (Aunt Ocean)

Aunt Target was one of the participants who had to navigate through so many referrals that she almost gave up the hope of ever finding any relief for her health problems. She expressed her joy when she finally found the place that could help alleviate her discomforts:

Let me tell you… when I met the lady [worker at the agency] for the first time, I was so happy. Oh my God, I told myself maybe God had made the arrangements for me to meet this lady. I finally found the place. I was so happy because I found the person I was looking for, to guide me and to cure me of all my illnesses. That was my only expectation since the beginning... I was so happy because I tried really hard to find Dr. V [a psychiatrist or psychologist in the Vietnamese community] but never did. (Aunt Target)

One exception was a gentleman who stated that he sought help from the “place” because he heard it could help him apply for his citizenship and SSI, a benefit that had been denied because he was not a United States citizen.

In short, participants did not have expectations for outpatient mental health treatment and could not envision what the place would be like or what would happen once they arrived. The men and women explained that they had no knowledge about mental illness, mental health treatment agencies, and the roles of the agencies and their workers. These things were non-existent in Vietnam. The only mental health treatment places in Vietnam were psychiatric hospitals or places that locked up “crazy” people.
Participants vaguely recalled the first time they came to the agency and met with one or two female staff to fill out “a lot of paperwork” and answer questions. Most met with a worker who spoke Vietnamese. A few met with a worker who spoke another language but had interpretation assistance. Following the meeting to complete their paperwork, participants were given a second appointment to come back to see another worker or a doctor.

Doing as told. Participants’ accounts of the initial engagement period were merely about going with the flow and doing as they were told. The men and women did not question the process and why they had to “fill out paperwork,” “answer a lot of questions,” or meet with various workers at the agency. Some participants explained that they were sick at the time and their minds were not aware of what was really going on during the first few meetings. They did not remember what they were asked, nor were they able to answer questions during the initial paperwork meeting about “things that happened back then.” Participants also did not recall any discussion about the cost of getting help or that they would “have to pay.” The following quotes illustrate participants’ initial impressions of the first meetings:

Whatever they [the workers] told me to do, I just did it. I didn’t know what was going on, really. If they told me to come in, I came in. If they told me to go home, I went home. Whatever day they wanted me to come in, I came in on that day. (Aunt Barbie)

The reason why I kept coming was because… that social worker or the doctor or someone told me to come to the next, next, next appointment, so I did that and kept coming. I just did what they told me. At the beginning, I was a little hesitant. I didn’t like to meet other Vietnamese people here. I was afraid that I would run into people I knew. I didn’t like that at all. But I think it was all the talking and the appointments they gave me that kept me coming. (Uncle MT)

I was filling out a stack of paperwork… I didn’t know what it was for… I got there and she [a worker] told me to do this and that, and I did just that. And a few days after, Miss Dee [therapist] gave me this piece of paper to come in to see the doctor. I asked her where do I see a doctor, and she said, “Here”. That’s when I knew… that I was sick. That’s why I had to see Doctor F. Other than that, no one said anything else to me.
Following the initial meetings to complete paperwork, participants were scheduled to come back in a week or so to see the doctor and the workers at the agency. During this time the men and women carried out their roles of patients who followed the workers’ directions by attending appointments and reporting their health histories to the agency workers in order to get help. Participants’ accounts of what happened next involved meeting with the workers who asked them more questions about their lives and their health history, and meeting with the doctors who asked about their health history and offered medication that would help to alleviate their symptoms. Participants also expressed the anxieties they had during this time about the unfamiliar places and workers they encountered, and particularly about not knowing what was going to happen to them. They wondered if the “place” could do anything to help them. In the following quotes, participants offered their impressions of their initial experiences at the agencies:

So I met Miss Dee [therapist] several times and after that made an appointment to see the doctor. I alternated my weeks to see the doctor and Miss Dee: once every week or once every two weeks. I really thought Miss Dee was… was the doctor’s helper… like someone who interviews people and talks to people to write down information about that person. I didn’t really know as much about her role as I do now… And then there’s the activity group with a lot of Vietnamese people… about seven or eight people… So that’s how it was at the beginning. They talked to you, then gave you medication, and the doctor monitored you to see how you reacted to the medication, if your body was okay with the medication. (Uncle MT)

Of course when I first came here… I wasn’t sure if these two ladies sitting next to me were going to do anything to me, or if they were going to be mean to me, or if they were thinking badly of me. And then… they kept talking to me about all kinds of things. So whatever I had going on with me, I just told them. And that helped to ease the tension in my head. Slowly, I got used to it. At the beginning, I was very uncomfortable to see the ladies. Whenever I came in to see them, I was very scared. Whatever they asked, I just told them a little bit here and there. If they didn’t ask, I just sat silently. But now… I am much more outgoing. I always say hi to the ladies. I’m used to it now. I’ve been here for seven years already. (Aunt Ocean)

At the beginning I didn’t really ask [the workers] anything because I was not familiar with Miss Tee [case worker]. It was later that I realized that she was very friendly; then I
started to talk to her more. But before, I was afraid of her. And I remember telling her that my feet hurt and was swollen, and my head also hurt. She told me this place only treated the head, and I had to go to another doctor who specializes in the feet for my feet problems… And that I could only ask for medication for the head, but not for the feet because this place does not specialize in foot pain. So I figured that at this place I would be under the care of the doctor to cure the problem with my head. (Aunt Recycle)

The “Doctor”

The doctor was the key expert who determined that participants were “sick,” made decisions about how to treat them and with what “medication,” and gave expert “advice” on how the illness could be managed. Participants’ first encounters with the doctor were immediately after the paperwork was completed. This was the person whom the participants had been expecting to help them. Most participants had no specific knowledge of the specialty or title of the doctor such as psychiatrist or psychologist. At some agencies the participants only knew of one doctor who provided medications for sleep problems and headaches. Participants referred to this doctor by first name, such as Dr. Max or Dr. Eunice. At other agencies, the participants differentiated between the two types of doctors they met; one prescribed medication and the other did not prescribe medication but simply talked to them. A few were able to say that the “talk” doctor was the “mental health doctor.” Aunt Banana provided a simple explanation, shared by other participants, of the doctors’ responsibilities, “Doctor Fey does not give meds. Doctor Fey only talks to me and shows me the different things I can do to help ease my discomforts.”

The participants were less concerned about the specialties of the doctors than about the fact that they had an expert to monitor and treat their health problems. Being under the care of a doctor became “comforting” for them because they knew that they were “taken care of” by a “trusted” expert who specialized in the “head” problems. Further, the expert’s proposed
solutions of treating discomforts with medications were most consistent with the participants’ prior expectations that they would need medications to relieve their symptoms.

At their first meetings, participants recalled being asked what was going on with them and reporting about their discomforts to the doctors, just as they would at any routine medical appointment. While a few expressed some hesitation in disclosing “everything” at the first meetings, most participants saw the doctors as experts who could help them, so they readily disclosed their concerns:

Doctor Eunice asked me how I was doing lately, and about my illness. So I told her that I was always feeling sad and that I had no purpose in life. And then at night, I always wanted to find, find a way to end everything. I just didn’t want to think anymore. My head was hurting, my head was hurting a lot, and my chest was also hurting. Once in a while I felt this sharp pain right here [pointed to chest]. And I would sit there and cry all the time. I wasn’t able to sleep at night. (Aunt Banana)

Back then, I thought to myself that I wasn’t going to hide anything from the workers. If I was sick, then I would just tell it as it was… If I hid things from others, how were they going to treat me? I noticed that other people often hid their illness, but I am not like that. I told the doctor everything so that he would know what to do to treat me… I thought that if I told the doctor everything, then I would recover quicker. (Aunt Ginseng)

Receiving expert confirmation that one is sick. Following the initial meetings with the doctors, participants recalled being told that they were “sick.” Unlike a physical ailment like hypertension or diabetes that can be identified by exams and tests at the PCP’s office, proof for a “mental health” condition for the participants was through an expert determination. Before coming to the outpatient agency, some men and women had already been informed of the possibility that they were “sick” by their PCP. However, for others, this was the first time they had received expert confirmation that they were “sick.” The men and women were not immediately told about their specific diagnosis of depression or PTSD. They were either given a glossing diagnosis of being “sick” or “sick with that illness” or else were told that they had a “mental illness” or a “mental health” problem. However, receiving word that they were sick
with a “mental health” related problem was the extent that participants knew about their condition.

Though the participants had experienced long periods of physical and emotional disturbances, they did not think that they were sick and also did not have a name for it. As one participant said, “Back then I was debilitated and was lying in bed all day… and it wasn’t until I saw the doctors and they gave me medication that I realized I had fallen into this sickness, but of course I didn’t know this back then.” To have a “doctor” say that “you are sick” was validation that something indeed was going on with their health. It was also during this moment that participants finally discovered that there was a name for their discomforts and that they were having more than simple difficulties with sleep, headaches and worries. This finding out moment provided relief for the men and women after months and years of uncertainties about their worsening health.

Upon finding out they were “sick,” some participants accepted the doctor’s confirmation and did not ask further questions. The term “sick” was an acceptable and common way for the men and women to communicate all types of illnesses. A such, these participants were satisfied with the “sick” label that the doctor gave them– an ambiguous term that signified something was wrong with their health. The participants’ accounts further revealed the lack of doctor-patient communication; there was no need to question if the doctor confirmed “you are sick.” It also revealed the participants’ assumption that doctors did not tell participants their specific diagnosis as a way to not hurt their feelings. One participant shared, “None of the doctors here told me that I am sick. No doctor has said anything like that to make me sad.” Participants therefore never directly addressed any questions to or asked for clarifications from the doctor. Others
voiced that they did not see the need to bother the doctor if it was a given that they are sick. The
following women explained:

I told him that I was sick like this and like that… and at night there is this sound in my
ears, and I also see ghosts and devils. Then he told me that my illness was serious. But I
didn’t really ask further to see what kind of illness I had. I just listened to whatever he
told me… He only told me that I was sick, but he didn’t give a name of the illness. He
wrote in the file, but I had no idea what he wrote. I just sat and looked at him and
reported to him my illness, and that was it… I didn’t ask [about the name of the illness]
because he already told me that I was sick based on what I told him about my situation,
so why even bother asking him further. I mean, all the things that he described matched
what I was experiencing, so I knew that I had fallen into that illness. (Aunt Taxi)

Dr. Mary didn’t say anything to me [about my illness]. But I figured out that I was sick,
and that it hadn’t gotten too serious. I didn’t dare to ask her, but I knew... I didn’t want to
ask because I was afraid that would make the doctor sad. I should leave the doctor alone.
I was sick, and that’s why the doctor gave me advice to do this and that to feel better… so
that meant that I was already sick. I didn’t want to bother the doctor any more than I
needed to. I didn’t dare to ask the doctor why did I have this sickness and such, why did
it happen to me, and how did it come about. I didn’t dare to say that. (Aunt Banana)

Other participants also explained that they were “not concerned about finding out” the
specifics of their illness, or else they did not want to know because knowing would exacerbate
their “anxiety.” What mattered was that they were treated for their discomforts with medications
and with the support of the doctors and workers. Uncle Van explained his view on why he did
not ask the doctor for the exact name of his illness:

It [the illness] is not important, not important. The doctor empathized with the
experiences of immigrants like us, of people who left their homeland behind…. He
doesn’t talk about the fact that I am sick with this and that… he only gives me medication
to ease my mind… (I think) that is a good thing… I think it’s best that he doesn’t say
anything because that would affect… affect us and make us worry even more, cause
anxiety. We would worry about our illness. Just don’t say it. Better yet, say
encouraging, supporting words, that’s better… My liver doctor told me that I have to take
my medication until that day when I lie down, and then I will have to bring another jar of
medicine with me… so I can continue drinking it in my grave…. Those words haunt me.
So it’s better to not say anything… if you’re a social worker, you should just be
supportive and encouraging toward others, bring happiness to others, bring laughter to
others. That’s more effective than a dose of medicine. (Uncle Van)
A few participants had strong reactions to the doctor’s disclosures that they had “mental illness” or “mental health” related problems. These men and women explained that the labels did not match their experiences with the discomforts and strongly believed that they did not have a mental illness. A few even challenged the doctor by expressing disagreement with the “mental” label. In these cases the doctors exerted their authority and assured the participants that they did have a “mental health” problem. One woman recalled vividly the doctor’s response to her challenge that she was not “mental” as “Oh wait… am I the patient, or are you the patient?” Several women spoke about their initial reactions to learning that their illnesses were related to “mental” conditions:

At the beginning, I told them that I was normal. I argued with them and said I didn’t have that illness. It’s because at the time, I just couldn’t sleep. I was frightened. That’s all. They [the workers and doctor] told me that I didn’t understand what was going on with me, and that my illness was just the beginning of it [mental illness]. So I listened to whatever they told me… And I thought that perhaps I do have it. They told me that my illness was more like at the beginning stage… I don’t have that illness… that illness meaning mental illness. So then they told me that “Oh no, you have it but you just don’t know. It’s just the beginning stage. You just don’t know.” And I even argued with them and told them that I don’t have that illness. They told me that my illness was in its mild form, and this place only treats people with mild cases. As for the serious cases, they don’t really put them here. They transfer them to a different place. (Aunt Ginseng)

I came in here to see what mental illness was like, and if mental illness was really like what I have because other people [doctor and team treating her asthma] told me that I have mental illness, so I wanted to come here to see if that was the case. And it’s not like what I have… The first time I came here, I saw a lot of people talking to themselves. Then other people were sleeping and snoring, or just sitting there. It was really strange to me. You see, that’s different from me… They told me I am “mental.” At first I rejected that word mental because I didn’t think that I was crazy or had a mental illness… I told him [the doctor] that I was not mental. I didn’t have that illness. I was normal. I was not sick… how could I be labeled mental?... So in response to that, Dr. M asked me if I knew what kind of illness I had. I told him I didn’t know. He then asked me if I didn’t know, then why did I come into the agency. I told him that’s because people [doctor treating her asthma] told me to come here, but I really don’t know what kind of illness I had. Then he asked me if I was sleeping okay at night, I said no. “So that means you are sick,” he told me. “You have the illness where you can’t sleep, mental illness” was what he simply told me. (Aunt White Flower)
Most participants explained that while they were not informed of specific diagnoses, at some point they were able to infer that they had “depression” or a “trauma” related illness (PTSD) based on learning more information over time. Most participants were exposed to mental health terminologies through other clients, workers, doctors, other educational materials distributed at group meetings, or “talk sessions” at the agency on mental illness. Others knew about depression from other media sources outside of the outpatient center. They explained that they learned about depression through “watching the Vietnamese television” or “listening to the radio shows” that explained what depression looks like. These were shows that ran weekly on the Vietnamese radio or television with a focus on community mental health issues. Thus, the men and women were able to “guess” that “depression is what I have” because the descriptions of the symptoms they had heard and picked up on sounded similar to “what I have.” Two participants spoke of how they came to the conclusion that they had depression:

I only knew about depression recently. For some time now, people have told me about it but I really never paid attention… I had no clue what depression was so I did not even think about the possibility that I had depression… I only heard people talking about it. I really didn’t know about it until I came into this program, and then I found out what it was. Then I realized that I have had depression for some time now…. They [the workers at the agency] explained to me that it starts with stress, with having too much stress. And when you endure too much, it slowly leads to depression. And depression is an illness where you’re thinking about death. You don’t want to live. You don’t want to do anything… it’s like you let it all go… you don’t care about anything, and you just want to end your life. So like people who want to commit suicide, that means they have depression. (Aunt Target)

No, no doctor ever said to me that I am sick… I asked the doctor why was I experiencing this and that, and then the doctor said to me, “Auntie, I think you must have something going on with you that leads to those things.” And when I started to share with her [the doctor] and disclose to her what’s going on with me, the doctor told me that I shouldn’t be sad anymore… so the doctor didn’t tell me that I was sick. It’s more like I went home and thought about it and eventually guessed that’s [depression] what I have. I attended those talks [at the agency] and from what I understand, my condition is only the beginning. It hasn’t gotten to the point of mental illness, or that I’m crazy. (Aunt Banana)
Receiving medication to relieve discomforts. What was most important to the participants about their relationships with the doctors was being treated by experts and receiving medications for their ailments. After informing participants that they were sick, the doctor took action and prescribed medication to immediately relieve participants’ discomforts, to help them “sleep better” and make their “headaches go away” or “calm their mind.” The participants felt reassured that they were under the care of the doctors they had heard about who could give them medications. This was consistent with their only expectation prior to coming into the place for help. Thus, treatment began with “taking medications” and anticipating immediate relief. At the beginning, all the participants cared about was that “Doctor Eunice has a lot of medication to help my head problem go away,” or “I go in and see Dr. Max for a medication prescription and bring that home.”

Starting medication regimens was not always a perfectly smooth process. Some participants remembered having side effects from the meds when they first took them, but the doctors often checked in with them and “made adjustments to the medication.” Others disclosed that they did not like taking medications and stopped taking them early on because of the “hotness” or the “dullness” sensations they caused. However, they found that their “discomforts came back” when they stopped, and realized they should follow the doctor’s expert advice and continue with their meds.

Others expressed hesitancies and concerns about “whether the medication would be good or bad for me.” However, experts’ promises and reassurances of improved health and relief from discomforts were important in participants’ decisions to continue following their regimens. One participant shared, “He told me that for the illness I have, I have to take medication, and it will slowly get better.” Another said, “The doctor told me that this medication is very good… his
patients who drank this have gotten better.” Most obeyed the doctor’s order and continued to take their medications after the doctors cautioned them “to not stop taking the meds” or their “discomfords would come back.” The following quotes illustrate this point:

He told me to take the medication to help me feel healthier. So I listened to him and did whatever he said. I didn’t dare [to stop the meds]. I had to continue taking the medication… (even though) I was afraid to take too many medications. Some days I was taking up to eight or nine types of medication… I trusted the doctor. The doctor said that if I took the medications, I would be healthy. So I was happy to hear that. He is the doctor, you know, and if he is able to make me healthy again, then I would be happy. I don’t need anyone. I only need the doctor. (Aunt Taxi)

I wouldn’t dare to stop my medication… If I stop it, my headaches will come back… I have to listen to the doctor. What he prescribes to me can be unpredictable. Sometimes it’s two kinds, three kinds, four kinds. I don’t really ask. He told me to take this medication, one or two pills a day, so I just do as he directed. I don’t ask what kind of medication it is… There are too many of them, so I don’t even know what this one is for, or what the other one is for… But he did explain to me this bottle is to help me to sleep, to help me feel healthier, this and that. (Aunt Barbie)

Oh my God, at the beginning when I took the meds, my head was spinning. It was like I wasn’t used to the medication. Then the doctor told me to not worry… It’s the side effects that made my head heavy and painful… but I got used to it slowly, and the doctor told me it’s okay and to take it slowly. It made my eyes blurry. I was scared and asked the doctor if something was going on and why the medication was so strange. And he told me “See, it hasn’t even been that long and you’re already scared.” So the first time when I ran into that problem, I wanted to stop taking the medication. But Dr. M yelled at me and told me that I would get used to it. (Aunt Ginseng)

One participant had been in treatment for about six months but had not taken her prescribed medication. She explained the reasoning behind her hesitancy:

In my mind, I have this belief where I don’t like to take medication, especially medication for mental health problems… Even when I am in pain, I don’t even take pain medication. Because I don’t want to make my body get used to the medication, and in the end, I have to increase the dose. So I have to find a way to endure it and make it through. Even though I know that I don’t have the strength to do that, but I still don’t want to take meds. I met with the doctor two or three times to talk about medication, but in the end I still did not take the meds… because that’s just part of my habit and my personality. I have never wanted to take medication. I only take medication to cure an illness, but not for things like not being able to sleep, or because I am too sad, or am too stressed out… Second, I consulted with a pharmacist friend to see if anyone knew about the medication that was recommended to me by the doctor [at the outpatient agency].
She told me that truthfully, I would not be addicted to the medication if I took it, but if my problem has an underlining mental health cause, then I needed to find a way to make it through using my mind instead of relying on medication. (Sister Park)

Nonetheless, the immediate results reaffirmed the doctors’ legitimacy as experts who knew what they were doing, further increasing participants’ trust in their care. The men and women described their improvements: “I’m doing a lot better because of the meds he gives me, so my head is a lot better now” or “[The medication]… it helps me sleep, and the doctor also tells me that it helps… me to worry less, and I do see that… and at night, it helps me sleep.” Several participants spoke about the immediate relief of their symptoms with medication:

At the beginning, I wasn’t able to sleep. So I told Dr. M about it, and Dr. M said I should go home and try this medication for a month and see if I could sleep better. So I took the meds, and I did sleep better… I even told my husband that I was able to sleep better with this medication, whereas I wasn’t able to sleep in the past. And my sleep problems had been going on for a while. So the medication helped. (Aunt Recycle)

I took this med, and I knew I was taking the right med for my condition. Because when I slept, I didn’t hear any voices. And in the morning… I felt very energetic, I felt like loving life, so that must mean I was taking the right medication for my illness… And now, I feel a 50% or 60% improvement. (Aunt White Flower)

I came to the place to get medication. When they gave me medication to drink at night, I noticed that I was slowly doing better… My spirit was uplifted. I was able to sleep.. to eat… I didn’t worry as I did before. It’s like having someone to take care of you… So then I made more appointments to continue coming. (Uncle Van)

The immediate relief of discomforts marked a major step in participants’ reclaiming self worth. The medications provided relief from the crippling symptoms of sleepless nights, constant worries and anxiety about one’s life, or head pain that haunted participants for years. Thus, being able to get a few hours of sleep a night, having decreased pain, or feeling less pressure in the head came with a renewed sense of vitality once again, something participants had not felt in years.
Receiving expert advice to manage one’s illness. Participants explained that another role of the doctors was to give advice to participants so they could manage their illness and live a happy life at home. Advice was given during the time they meet with the doctor for medication, or at one agency participants specified meeting with the other doctor whose job was solely focused on “talking” and “giving advice.” The doctors helped them to make changes to their lives by giving them “advice” and saying “supportive things” to lessen their sadness and worries. The doctors encouraged participants to do things to stay “happy” and “healthy” such as “exercising” and “staying busy.” In other instances, the doctors offered support by helping participants “find a job” or “take a computer class.” Several participants spoke about their experiences:

When I see the doctor, it’s just like what you and I are doing right now. We sit and she [the doctor] asks me all kinds of things, and then she tells me that I should give myself time to think about things. And I take her advice and reflect on the things I had done and whether they were right or wrong. And that helps me to put things in perspective. (Aunt Perfume)

When I come here, I just report [to the workers] whatever illness I have. And by doing that, I have been able to understand my illness better, to understand my way of life better. The help I receive from this place helps me learn how to make changes to my life at home… For example, the doctor gives me advice, and he explains to me that these are my options, so it’s up to me to choose. He sits and listens to me, and then he also shares his thoughts with me. It’s sort of fun. Sometimes I even tell him about my husband’s illness and how it affects our family life. I follow the doctor’s advice, and I see that I live a happier life…. My family life is better… So that is one opportunity the doctor gives to me. (Aunt Ocean)

I do see a lot of improvements in myself. My mind is better. And then I have a place where I can go to talk things out… It’s like when I see Doctor Dese, I would sit there and tell her all kinds of things. She just sits there and listens. She can’t really speak Vietnamese that well… One time I even told her that, “Doctor, I am here to see you, but you don’t say much. I do all the talking.” She told me that she wanted to give me the opportunity to talk, and she just wanted to listen. (Aunt Target)

As such, the doctor’s advice also was an added tool to improving participants’ health and another step toward reclaiming self worth. The men and women learned how to manage their
lives with illness by taking medications, making modifications to their daily routines, and becoming more active.

Participants’ descriptions of their relationships with the doctors revealed a key yet unspoken expectation for being a patient: following orders and obeying expert advice. One of the initial motivations to get into care was to find a “doctor” who could “treat” one’s difficulties with sleep and headaches. This came with the assumption that the participants would obey expert advice and do what was necessary to “get healthy again.” This meant “doing as I was told” from the moment they stepped into the mental health care agency. There was not much questioning on the part of the clients to understand what exactly their diagnoses entailed, why certain meds were prescribed, and how to be active participants in their treatment processes. They did not challenge the expert advice but rather took whatever was told and given to them:

Every time I go to the doctor, I don’t really know how to ask questions… That’s why my husband is upset with me. He told me that it’s difficult enough to even get an appointment with the doctor, but why is it that I don’t ask questions when I see the doctor… I asked him what should I ask my doctor. So finally he explained to me what I should ask the next time I see my doctor… this and that. I am just not curious, and I don’t ask questions… Whatever they [the doctor] tell me, I listen… I am stupid like that. (Aunt KTM)

I didn’t really question the doctor (why she had to take the medication). Because the way I think of it is that… the doctor knows what to do to treat me, so whatever medication he gives me, I will take it. If I ask too many questions, then the doctor might say “Are you the doctor? Why are you questioning me?” There are people who would say that, you know. They would tell you things like, “Are you the doctor, or am I the doctor?” if you ask them questions. So I just take the medication as the doctor directed me to. I wouldn’t dare to ask questions. (Aunt Ginseng)

You know… us Vietnamese… we understand the unspoken. We pick those things up really quickly…. I mean, of course we know that we are sick and that’s why other people give us advice and supporting words so that we won’t be sad anymore, so that we don’t get worse, so that we get better and improve… Knowing that, we are not going to ask them things like why do I have this illness, when am I going to fully recover, or why are you giving me this medication. Americans, on the other hand, are different. They are hard to please. They ask so many questions, and that would drive the workers crazy… I don’t want to make my mental health worker or my doctor have headaches by giving
them a hard time. I don’t like to do that. I have to let them be so they can do their job and take care of other people who are in even more serious situations than me. I am not that bad yet. (Aunt Banana)

The “ladies”

Prior to coming to the outpatient agency, participants generally looked forward to meeting the doctors and getting the necessary medications. The men and women did not expect additional assistance from two “ladies” for whom most did not have an official title or job description. Participants simply named them based on what they did: “the paperwork lady” and “the talk lady.” These ladies became key to the participants’ engagement with and continuation in treatment. Uncle Van commented on this importance:

It is due to the warmth and welcoming gestures of the social workers… who readily and happily welcomed me every time… and that made a good impression on me. But if they were not nice to me, I wouldn’t bother coming here. (Uncle Van)

Some participants made the slight distinction between the roles of the two ladies by explaining that the “paperwork lady” focused mostly on assisting with their paperwork while the “talk lady” was someone they met with to have one-on-one talks about their problems. A few were able to label the “talk lady” as the “consultant,” a formal title used when they were introduced to the ladies. Some participants recalled that the talk lady was the first person to whom they had disclosed their entire life stories. However, their relationship with the talk lady was also short-term because they stopped seeing her after a year or so. The “paperwork lady” was described as the more constant figure with whom participants had worked since they came to the agency. Their relationship with this worker was critical because the “paperwork lady” was the go-to person for everything. In spite of these differences in the ladies’ roles, participants described many commonalities in the things the ladies did for them throughout their time at the
agencies. More importantly, the relationships with and the resources from “the ladies” at the agencies were critical to the participants’ journeys to reclaiming their health.

*Receiving assistance with paperwork.* The “paperwork lady” was the first worker with whom most participants interacted from the moment they arrived at the agency. She helped the participants with the initial paperwork and with scheduling doctor appointments. In some cases, other participants first met with the “talk lady” to complete their initial paperwork for enrolling in agency services. What appeared at first to be a mundane responsibility gradually transformed into a functional and significant aspect of each participant’s experiences at the agencies.

The simple tasks of applying for social services and filling out the necessary documents were daunting for the men and women in this study. They talked about the “fears” and “anxiety” surrounding their doing paperwork or managing any governmental documents in English due to their lack of English language proficiency and their limited knowledge about the social service system. This was something that participants could not do on their own and also something too burdensome for their busy family members. In some cases, participants talked about the hassles that they had to go through to get their children to do something for them, such as “nagging” them to call a particular doctor’s office or looking into a paperwork process for them. One participant expressed appreciation, common among all participants, of the ladies’ time: “Don’t you agree that people here [the United States]… no one really has time, right? Even our own family, but people here [at the agency] takes time out for us. That’s priceless.” The ladies, however, readily and willingly offered their services any time the participants came to the agencies. Participants explained that having someone translate documents for them and answer questions about paperwork eased their anxieties and worries. The following comments highlight this common sentiment:
If there’s any paperwork that the government sends to me, and I don’t know anything about it, I would ask her to help me so she could give me some guidance. I have nowhere else to go. I am clueless about those things… Sometimes on Fridays… when they send paperwork home to me, and I don’t know what to do with it, I just drive in [to ask for help]. (Aunt Taxi)

I don’t know a lot about doing paperwork, especially the ones from the SSI office and things like that. If I receive notices from them, I get very worried… but when I bring it here, it’s just not that big of a deal. They take care of it easily… so I know that when I come here, I can worry less [about the paperwork]. Whatever paperwork I have, this place will help me take care of it. Otherwise, I would be so worried having to do it on my own… I get worried about things like… for example, if I have to renew my application, I wouldn’t know what to do exactly. So, I bring it into this place, and the ladies, the doctors take care of it in an instant, like it’s no big deal…. I tell you, if I don’t have this place to take my paperwork to, I wouldn’t know what to do. I would worry so much. (Uncle MT)

Role of confidantes. Over time, participants developed bonds with the ladies and saw them as trusted advisors and confidantes. One participant said of the paperwork lady: “I really don’t know what Miss Tee’s role is, but if there’s anything I want, or if I really want to get help with my paperwork, I would go to Miss Tee and tell her.” Others praised the talk lady, saying, “To be honest, I depend on Miss Dee for everything” or “For example, if I had any papers, my private consultant with help me do it… papers such as traffic school notices, or being called into court… or any problems I have with medication. She takes care of it.”

Participants began to see the ladies as individuals they could trust and share “heart to heart talks” about what was going on in their lives, from family problems to their past in Vietnam to their daily struggles with illness. Participants said:

Like the other day, I came in to meet with Miss Dese, and I told her what was on my mind, and that helped me feel better. It’s because I had kept this to myself for a long time, and now that I was able to release it, it felt, it felt… like that really helped me. So now, when I talk to you about my problems, I don’t mind. Because I had already poured everything out the first time to Miss Dee, so doing it again is not a problem. At the beginning, I wanted to hold everything to myself and not tell anyone but not anymore. (Aunt KTM)
When you tell other people [about your problems], it’s just casually talking to them about things. If you don’t study this subject area, you wouldn’t really know what advice to give me, right? And at times you might even get irritated and wonder, “Why is she talking so much?” Right?... But for the workers here, they studied this and this is their job... and sometimes they don’t need to talk. They just listen to me. Moreover, I don’t hesitate telling them things because they are not my family and I wouldn’t worry about what if they told someone else. That would lead me to not trust them and not tell them things. But I don’t have to worry about that when I talk to the workers here. (Sister Park)

In some cases, participants would consult with the ladies regarding their treatments and take into consideration the ladies’ advice. Aunt Recycle shared the extent to which she trusted and valued her paperwork lady’s opinion:

With anything, I want to consult with Miss Tee first... and if there’s anything that needs clarification, she explains it to me. There are people who wouldn’t take time out to do that for you. And then... whatever I ask Miss Tee, she has an answer for me and explains to me. So whatever I have in mind, I always ask for Miss Tee’s idea first. Like the other day, I planned to stop taking my meds, so I asked her about it. I asked her if it would be okay for me to stop my meds because other people told me that taking too much medication could harm my stomach. Miss Tee then told me that given my [mental] illness, I need medication, but that I should consult with the doctor. (Aunt Recycle)

Other participants described the “talk lady’s” role as the person who would sit down, talk to them, and give them advice. She listened and asked questions and allowed participants to “let all the problems out,” and for the first time they told someone about what had happened to them over many years. The “talk lady” also advised participants on ways to manage the difficulties in their lives at home and ways to manage their illnesses.

In spite of the rapport participants developed with the ladies at the agency, a few said that the younger “talk ladies” appeared to have a more difficult time connecting with their experiences due to their “limited Vietnamese language skills” or “lack of experience.” While some participants did not see these traits as problems, they nonetheless observed these limitations and were delighted when they shared that the talk lady’s “Vietnamese has gotten so much better over time.” A few participants shared the difficulties that had in relating to and
communicating with the workers who spoke limited Vietnamese or were of a younger Vietnamese American generation. Sister Park emphasized such difficulty with her talk lady:

I have a feeling that when I talk to Miss Den, she is stressed out or something because she is not able to understand me. She tries really hard… but it’s the language and the cultural difference between us that makes it hard to communicate. Miss Den can’t relate to some of the things I tell her. (Sister Park)

Linkages to resources. The men and women sought help because their physical and emotional discomforts had stripped them of the ability to function and fulfill social obligations. As such, a key function of “the ladies” was linking participants with resources such as part time jobs, free medical exams at health fairs, or tai chi groups. The ladies thus become connectors to free services and opportunities that enhanced participants’ treatment processes, and in the long run, their self worth and health. Aunt Banana spoke about the ladies’ resourcefulness:

I am happy when I come here because when I come here… I receive good information such as… the ladies give me the newspaper to read about a free flu shot event… or, sometimes they call me to go to this center to pick up a free fan… I don’t really know how to go on the computer to find this information, and if I ask my children, they have to study; they don’t have time to look online for me. So, the ladies usually let me know about these things. (Aunt Banana)

Another therapeutic aspect of participants’ relationships with the “ladies” was getting connected with social services that would provide the financial means for participants to once again become self sufficient and contribute to their families. Programs such as food stamps, housing, citizenship, and SSI became tools that enabled participants to establish stability, regain control of their health, and reclaim their self worth.

“The Groups”

Participants explained that the “groups” was another important aspect of their treatment and was something they looked forward to. Most participants were currently attending a group; only a few were no longer attending due to transportation difficulties or their personal
preferences to not be in a group setting. The men and women did not specify a name for these groups (i.e. socialization or support groups at the agency). They simply described this group as a group that met weekly or twice a month and were venues for participants to escape the isolated, lonely lives “bounded by the four walls,” and to find friendships with other clients. Two participants explained the importance of having the group to go to that allowed them to break away from their monotonous routines and lonely homes:

This place not only makes me happy, it also helps my health improve. You know why, because all day and night I just lie at home. It’s really boring. And when you lie there with nothing to do, you start thinking about all kinds of things. My daughter is in college, so she only comes home every two to three weeks. You see? My life gets really boring. (Aunt Barbie)

At the beginning, there were a lot of activities every Monday, Wednesday, and Friday. There were classes, for example English classes. And then you also got to see the doctor. I was looking forward to coming here because this place was much cozier than my home. I was alone at home. I came here and had a doctor who gave me meds, participated in activities, had individual sessions that were really good, met friends, talked to other people. And during the holidays, I got to sing karaoke… A lot of people gather together. It’s fun. (Uncle 6T)

Relationships. The relationships participants fostered over time encouraged them to keep coming to the group spite of some hesitancies they had at the beginning. At the group, participants found acceptance, empathy, and mutual support from others with similar experiences. The men and women talked about the comfort of knowing that others were in similar distress, which helped them normalize their long struggles with debilitating physical and emotional problems. Participants also felt worthy in the groups because here they were not viewed as the “mentally ill” person. Rather, they were respected for who they were. The socialization groups offered unconditional acceptance and friendship to the participants, something that they had not been able to find before in their lives. It further offered a place of refuge from their distress, where they could have fun and not think about their problems.
Instead, they could share with others the things they enjoyed such as their talents and hobbies like cooking and gardening. Participants had much enthusiasm for their socialization group and what it offered:

When you come to this hospital [outpatient agency], you join the weekly group. You meet friends. And then each person shares their problems with each other, and then all of us develop this mutual understanding and empathy among each other. And that helps you to become happier when you go home. You have a better relationship with your husband, your children. To be honest with you, coming to the United States at my age… you run into so many difficult situations… but when you come here, there are these sisters [other clients] who support you… We all gather together as a group and get a chance to go places. That helps to clear my mind; I notice that it puts me in a good state of mind. Otherwise, I would be bogged down in bad thoughts and irritation. (Aunt Ocean)

I come here to participate in the group, and meet other friends, and talk to them. At times they teach us all kinds of activities in the group… [Outside of here] I don’t have any friends at all… because they [other people] know that I am really sick… They don’t really talk to me, so I just keep quiet and don’t really talk, so people do not befriend me. (Aunt Jewel)

I didn’t want to go, but Miss Aida kept encouraging me to come, and she told me that I should come because the group would be very helpful for me… so I went and the group helped me a lot. I sat and listened to other women talk, and it helped me realize that I wasn’t alone in having this illness, but that many other people also experienced the illness like me. And then, if I wanted to talk, then I talked. If I didn’t want to, I just sat and listened. It helped me because I listened to other women and realized that other people were in similar situations like mine. And then some people were in worst situations than me. So I realized that my case was not that severe. There are other people who suffer much more… Like the other day, this lady in our group told us about her daughter who uses drugs and got pregnant and brought the baby back to her house for her to take care of. So, that helped me to put my situation in perspective, and I realized I had to try my hardest to not get sick, to not let my illness negatively impact me and my family. (Aunt KTM)

*A place for resources.* The groups also offered “educational materials” or held group discussions about different types of health and mental health problems. This was a common way participants learned about their own illnesses and how to manage them. One participant shared that,
Back then there was a teacher who came every week… He worked somewhere else, but he would join us on Fridays to go eat with us. On other days, he would show us this thing on the wall, where he talked about the different types of illnesses. That’s one way to motivate us, to help ease our worries. He told us to not think too much. He was very encouraging of us, and that helped us to be happy and healthy again, and that eased our illness. Before that, there was no one to encourage me and to show me support, so every night I would think about all kinds of things, and that led my health to become worse and worse… I feel lucky to be here because the ladies do things wholeheartedly. They help us, show us all kinds of things, take us places that we didn’t know about. We even went to the beach. And then we would go Macy’s or Ross to look at the sales, and buy whatever I could buy. Once in a while, we cook food and bring it in to share with everyone. (Aunt Ginseng)

An escape. The socialization groups also provided the opportunity for participants to stay connected to the larger community from which they had long been isolated. At one particular agency, there were weekly group outings, the highlight of participants’ days. The participants explained that they do not get a chance to leave their homes or know how to use public transportation. Many were afraid to get lost and not know any English to find their way back home. Participants expressed appreciation for the group facilitators who drive and show them around each week so that they could be part of the community. This was something that even their family members had not offered to them.

The outings gave participants a chance to learn about what was out there, and also to be a part of the community’s daily activities from which they had been disconnected. Many shared their joy with being able to “eat at a restaurant,” “go shopping,” or travel to “this and that part of town.” This was the one day they could be just like everyone else and be a part of the normal, routine workings of their community. This was a rare relief and freedom from the four walls of their homes. Some participants expressed their gratification:

This place exceeds my expectations. When you come here every Friday, the ladies respect your ideas and take you places that you want to go to, like the market and such. When I am at home, I have to rely on my husband, and I really don’t want that. I am hesitant to bother him. But when I come here, whatever I need, the ladies will take me to the market to buy, and then us sisters [other clients] go out to eat together… It’s the time
I get to spend with my friends, and then we all tell each other things and then provide support to each other… and keep in touch outside of group time. For example, I grow things at home, so I bring them here to give to others. That’s one way to treat my illness. Or other people share ideas about how to manage certain health problems, so I learn from that. It’s really fun. We are all grown-ups in here, but we act like we are still young when we are around each other. I am so used to coming here that even if I am busy with anything on Friday, I still have to make an effort to come here. When I meet other women here… and hang out with them, that helps to lessen my worries. When I come here, I have no reason to fear anything. It’s just like being with your friends who understand you. (Aunt Ocean)

Thus, the groups played a critical role in participants’ reclaim of self worth by offering them friendships, relationships, a space that was not judgmental of their mental health problems, and a day to be just like everyone else in their community.

“The place”

Prior to arriving at the agency, “the place” that participants had heard about was a mystery. All they knew was “the place” had doctors and medicine that could ease their discomforts. However, the longer the participants stayed, the more meaningful the place became. In the initial months, it was just a place where they went to in order to see the doctor and get their medication. They maintained their appointments out of necessity so they could get needed treatments.

Learning to manage one’s health. After the first few appointments and an ambiguous process in an unfamiliar setting, participants began to comprehend where they were and why they were in treatment. Participants remembered seeing “people in the waiting area” who “stare blankly” and have “soulless eyes.” One woman explained,

I didn’t know. I only knew that this place specialized in treating the head, that’s all. And then it was only after I came that I knew that this place was for people with mental illness. I knew because I sat there, and then I noticed people around me who were just out of it…staring blankly… or couldn’t control their behaviors… their saliva was dripping all over. So when I saw that, I became curious and asked Miss Tee, and she told me that there were people here who have severe illnesses. That’s the extent of what I know about this place. (Aunt Recycle)
A few understood more when they saw the word “mental” on the appointment paper. Over time, the participants became used to the routines of showing up for appointments, and they became acclimated to their interactions with the workers, the doctors, and the various ongoing activities at the agency. Participants commonly referred to the agency as “the place,” “the hospital,” “the hospital that treats the head,” or “Miss or Doctor’s place.” The term “outpatient mental health agency” had yet to become part of any participant’s vocabulary.

Participants who had gone to treatment for at least several years (some more than ten years) saw the place as very different from when they first came. The “mental” association was now accepted rather than feared or rejected in spite of the awareness of the public stigma toward mental illness. The participants mainly focused on the positive contributions of the agencies to their self worth. Over time, the agency became a safe space where they could turn. As one woman said, “When I come here, I can talk to other people, and they’ll listen. At home, I can’t talk to anyone. I don’t dare to speak up.” Another participant shared, “Honestly people out there don’t really help you like they do here. People out there… they aren’t really honest people. Here, they do things wholeheartedly and with good intentions to help you.” Another woman elaborated on the importance of the agency to her:

If you stay home all the time, your head becomes… it’s like you’re imprisoned. When you come here, the ladies are really warm and welcoming, so I really like that much more (than being home). Plus, when you’re home you don’t have anyone to talk to. My husband doesn’t really talk that much. I just stay home, keep to myself, remain silent, and do the household chores. That’s all. But when I’m here, I meet friends, hear other people talk, I learn things from them. It’s beneficial. (Aunt Ocean)

One participant currently receiving treatment from an outpatient program housed within a health clinic highlighted the importance of integrating mental health care in health care settings.
She explained the decreased stigma when she sought help from the agency because it was just like coming in to any other medical appointment:

I think that this program… is very beneficial. First, it is housed in this health center, so the patients… they want to save face, you know. So when they come here, they can just say that “I am going to the doctor.” They don’t really have to say that they are going to this mental health program, you see. It’s very convenient. (Sister Park)

The thought of not having an agency was daunting to some participants whose current lives had been built around the agency’s existence. One woman expressed concerns about the program “ending soon” after hearing from her paperwork lady that the funding for the program was only temporary. She wondered what would happen to individuals like her who needed help and benefited from the service. Others similarly worried about the services ending:

The other day, Dr. F [psychiatrist on site] was thinking about retiring, so now Miss Dee is super busy because she has to interpret for all these [Vietnamese] people who come in to see the new American doctor for the time that Dr. F is out. Oh my god, if Dr. F retires for good, that’s going to be a big problem… I like having Dr. F. It’s so much better because he understands my entire history. If another person comes in, that person will ask me to report everything all over again. That person wouldn’t have a clear grasp of my situation. And to me, that’s important. I wish to myself that this place doesn’t move anywhere. If it moves, that will be a big problem for me… I would have to take all these buses. If it’s nearby, I can walk… It takes about 20 minutes. (Aunt Ginseng)

If this place moves, I would be really sad, really sad. This place is a place that makes me happy, it nourishes my mind… I told Miss Dee, if Miss Dee is not there, if Dr. F is not there… I would be really sad. When I am at home, I don’t really do anything other than the household chores… and when I get tired, I sit in one place and wait for my brother to come home and cook for him. That’s my routine. If it’s always going to be like that, then I will head toward death, that’s all. (Aunt White Flower)

The economics of self worth. The participants’ narratives about the relationships they developed with the “doctors,” the “ladies,” and the “groups” over time revealed how these relationships were instrumental to reclaiming their self worth. Living with multiple health and mental health problems meant that the men and women had to reorganize their lives around their
illnesses in order to function and fulfill social obligations. Priorities had to be shifted because participants no longer had the health to do their usual activities.

Participants learned from their “talk ladies” and “talk doctors” that they had to shift their orientation to “living in the present” and let go of their troubling pasts and uncertain futures. Thus, a key aspect of their treatment was to learn strategies for managing their symptoms and taking control of their health day by day. One way to do this was to “take the medication daily” and follow the advice of the treatment team. Participants over time accepted that “we are sick so we have to take the meds continuously, so that it [the illness] doesn’t get worse.” The men and women noted that they became “healthier” during the time they received treatment, a change that their family and friends also observed. Some participants even stated that the agency had “saved their lives.” Participants expressed appreciation for the work of the agencies in improving their health:

If it were not for this center, I probably would not live to this day. Back then when I was sick, the doctor gave me medication, so I got better. All thanks to the doctor and this center… Otherwise, I would have died. Now that I am awakened, I realize that I was sick. If I hadn’t come here, I think I would not have lived. I would have done stupid things and would have harmed myself… Now, I am about 50 to 60% better… The lady who referred me saw me again [at church]. I told her that I came to get treated, and she said, “No wonder… I can tell that you’re looking better now.” (Aunt Barbie)

When I first came to the United States, my health was not good. But now, I notice that my health is better… and I am loving life more… my husband is really happy that I came here to treat my illness. He takes me here and doesn’t complain about anything because he understands [the importance of] why I come here. He told me that thanks to this place, my life is more meaningful, and he sees that change, and he really likes that. (Aunt Ocean)

The men and women had redefined what it meant to stay productive and purposeful within the context of their declining health and within the confines of the “four walls” of their homes. The relief from headaches, sleep problems, and worries enabled participants to slowly reclaim their functioning. Staying active and busy in their daily routines once included “going
out and about” and “working long hours.” Now, participants engaged in less physically demanding activities such as “walking,” “gardening,” “cooking,” “reading,” and “watching TV.” A few who could drive short distances would head to nearby markets and walk around to let time pass. These activities kept participants occupied so that they did not have to “think too much” or “worry” and also kept them active and away from their beds. As one participant explained, “When you have too much time, you start thinking too much.” The men and women made it through each day by “staying busy.”

Living in the present also meant that participants had to do what was best for their health, shifting the focus onto themselves. A common advice for them was to “take care of myself.” Aunt KTM shared that talking through her problems with other workers in treatment made her consider putting aside her worries for her children and the family; instead she had become a more “selfish” person who focused only on herself. However, she also struggled doing so because it went against her value of caring for her loved ones, something she had done all her life. Aunt Moon similarly was advised to forget about her children, but she made it clear that as a mother, she could not do that. She explained:

Dr. Hoa told me that my children do not think, and that’s why they do not appreciate me and the sacrifices and sufferings I have had to go through to raise them. That’s why they put me in such misery. So the doctor told me to just forget about them and just focus on myself so that I can get my health back… That’s what Dr. Hoa said, but I am their mother, I cannot just forget about them. (Aunt Moon)

Aunt Moon expressed a sentiment common among the participants: the importance of fulfilling social obligations to their families that superseded self-interest. Getting healthier meant that participants could once again do things for their family members. Thus, the men and women reorganized their definitions of productivity and purpose around doing things for the family within the confines of their homes: “cooking” for the family, “cleaning” the house,
“babysitting the grandchildren,” and doing “chores for the family members” while they were at work. Participants shared that even doing little things gave them meaning each day. They were happy if they were able to “cook for my brother,” “burn a movie DVD for my sister or do her laundry,” or “prepare meals for my children when they are home from college.”

Participants’ stories about fulfilling social obligations in spite of existing health and mental health problems further illuminated the economics of self worth. This was a core aspect of participants’ definitions of health and remained central in their narratives about how outpatient treatments contributed to the gradual reclaiming of self worth. Having money commanded respect and “worth” as a person for many reasons. As a few participants said, life in the United States “all comes down to money,” and “If you don’t have money in the United States, that’s going to be stressful.” The men and women in this study were aware of their limited finances, but at the same time spoke about the value of having some money so they could do little things that made life meaningful and reaffirmed self worth. One participant shared what having some money could do for her:

You know, you need money in order to live. You cannot have no money. For example, you want to buy something, and you don’t have any money in your pocket, what do you do then? Aren’t you going to thinking about it and feeling so horrible about it? Wouldn’t you wish you had money to buy something you like? I’m the same. I wish I had money to buy this and that, just little things that I can afford… so money does make you happy to some extent. For example, when Christmas comes, everyone in the [socialization] group brings in a little gift to exchange. If you don’t have money, what would you have to exchange with other people? Like Miss T, a friend in the group, she really likes this item. So if I had money, I would go out there and get it for her and bring it that day and give to her. She would be so happy, and so would I. So, if you don’t have money, you will not be okay. Because you can’t even afford the little things in life, even one piece of onion, you still can’t buy it. (Aunt White Flower)

Whereas in the past being a contributing family member meant “going to work” and “making money,” most participants accepted that they were no longer able to secure and hold employment. As such, a key part of reclaiming self worth for participants during their time in
treatment was the linkage to social programs: MediCal, Medicare, California’s MSI (Medical Services Initiative), food stamps, and Supplemental Security Income (SSI). A few participants came into the program already having MediCal, but most had no medical insurance. Participants aged 65 and older received assistance from the “ladies” to apply for MediCal and Medicare, often seen as the ultimate package “because the doctor told me that if I had that paper I can go to any doctor I want” and “get all kinds of medication” without incurring high co-pay costs. For individuals under 65 years of age, MediCal and MSI were the only available options, and had benefit restrictions such as limited numbers and types of tests in a year, limited medications, and an out-of-pocket requirement. Sister Cat spoke about her experience with having to pay for medications each month in spite of having MSI:

The thing is I have a lot of medication that I take. And if MSI doesn’t pay for it, then I will have to pay out of pocket, but my money is very limited… For example, the current medication prescribed by this place [outpatient center] is not covered by MSI, so I have to pay out of pocket. But there is a coupon that the center gives me, so on average I pay about $100 per month. (Sister Cat)

Having some access to medical care eased participants’ financial burdens and also provided them access to health care they otherwise would not have had. This made a difference for the participants in this study who were uninsured and of low-income. It meant that participants could “see the doctor” or “get mental health treatment” or “medication” without having to worry about high costs or paying out of their own pockets. It also gave participants the means to take care of their health and a chance at recovery. One participant shared that when she was previously uninsured, she had to use her husband’s medication because she could not afford it. Now, she could get her medication through MediCal. Another woman insightfully shared that, “If I were poor, I would have died a long time ago,” highlighting the importance of having access to affordable medical care to manage her severe health problems. She further explained
“I wouldn’t have these medications. They are too expensive. You know this one right here… it’s $250 a box. And this one, too. So each month costs over $1,000.” Participants all said that if they had to pay to get mental health treatment, then they “would not come” because they “would not have any money” to pay for the service. Sister Park reflected upon the value of having access to free mental health care:

I think this program is very beneficial. . . It helps people like me. For example, when I come here, I am reassured that there is a place that will treat my illness for free. That’s a blessing that I am thankful for... If I have to pay, I wouldn’t have the money to do so. Even if I needed it [treatment], I wouldn’t be able to afford it. And if I am forced to come here and have to pay, that’s going to be an added stress to what I am already dealing with. Because I have to find ways to pay for it, right? (Sister Park)

While access to free and low-cost medical care was important to participants’ health and wellness, what was most valuable was participants’ access to social services that provided stability in the forms of money and housing. For the participants in this study who were unemployed, low income, and who spoke limited or no English, money became essential to reclaiming their self worth and dignity. Money allowed participants to achieve independence and self sufficiency and “to not burden” their families. Money also allowed the men and women to do resume the expected role of a family member: by doing meaningful things for those around them and to make tangible contributions to their families.

The high cost of housing was one of the biggest worries for participants who had to budget for rent payments so that they would not end up on the street the next day. For participants who had spouses or working children, or siblings who were able and willing to help, this financial support eased the burden of monthly rent. For those who were single, cost of housing was a great worry because they were solely responsible for their rent. With the help with “the ladies” at the agency, a few participants were able to secure housing while others continued to be wait-listed. One participant spoke of this program and how it kept her family off
the street: “It really helps lessen my worries and my sadness. If I don’t have it, I would be really worried… if I didn’t have housing, I would be homeless.”

Hence, while medications and the advice participants received helped to ease their distress, the economic gains from social programs were key factors in reclaiming self worth. Participants explained that, “having money… one can do anything,” and having money was associated with “a person’s worth.” This was particularly true in the context of having the financial means to pay for living expenses so that participants “do not have to depend on their family” or could “make small contributions” to the family. At the time of the interview, several participants each received a few hundred dollars a month from retirement pensions and/or from food stamps. This amount was not enough for them to live on their own. These participants had to stay with another relative or depended on their spouse and/or children for additional financial support. Aunt Lai received approximately $400 per month from food stamps and her retirement. She lived with her son and did not have to pay rent, but she explained that having this money earned her some respect because she was not “completely dependent” and could pay for the little things that gave her meaning in life such as “a bus pass to go to the market, a pot of flowers to bring to church, or “plants for the garden.” Aunt Perfume said that she had been sleeping in the corner of her sister’s living room for a few months and was cautious to not be more of a burden on her sister. The money she received from food stamps was used to purchase food for herself. Another participant said that food stamps allowed her “to temporarily make it through while I treat my illness and look for a job.”

The ultimate social program, however, was the monthly income that participants received from SSI; this enabled them to carry out their social obligations. One participant reflected on the difference of having and not having SSI. She said back then “I didn’t have any money” and now
things are better because “I have a little bit to help my family.” Many participants did not know they would get SSI when they came in to the agency for help. They simply expected to see the doctor and to get medication for their discomforts. However, they learned from the “ladies” and friends in the “group” that there was a program to help people who are “sick” and “cannot work” by providing them with monthly financial assistance. The monthly “$600 something dollars” (for those who were married and had a spouse who also received SSI) or “$800 something dollars” (for single individuals or individuals whose spouse was not receiving SSI) was life-changing. Participants recalled what it was like to not work due to health problems and yet to have to depend on their families for assistance. Not being able to contribute and having to rely on others were detrimental to their sense of worth. This painful loss of worth and dignity continued for months and years while participants sat at home sinking deeper into their illnesses. Having SSI meant more than just having money each month. It meant being able to buy things for oneself and for one’s family. It meant a difference between having a roof over one’s head or “living in the streets,” between being perceived as a lazy, burdensome family members or being of some “worth.” For the older participants, it meant having some savings to “prepare for my funeral.” The following quotes highlight what having SSI meant to their health and self worth:

Back then I survived on $200 cash from the program for people who don’t have citizenship, and $18 of food stamps… Life was harder then… I had to live according to the way my brother’s family lived… I ate whatever they ate because I was depending on them. But after a while, he [brother] told me that there was nothing more he could do to help and that I needed to take care of myself. So I applied for food stamps. I had to wait until my ten-year mark was here to apply for citizenship and SSI. (Aunt Ginseng)

I am happy now… I have money. I save my money. I save $100 this month, and $100 the next month. I spend about $50 or $30 per month… I save my money, and at the end of the year, I send a little money to my aunt in Vietnam… she’s over 80 years old and doesn’t really have any money… and then my other relative in her 70s… Honestly, I am happy when I have money…. If I am unable to do these things, I would be really sad, really sad. I never ask my brother for money. Never. Even if I don’t have money, I don’t ask him. It’s good to have my own money now. (Aunt White Flower)
Getting approved for program benefits was not an easy process. Participants spoke about the difficulties of navigating the system and the importance of “receiving help” from the “ladies” at the agency to find their way. No one knew what the process entailed or how to do the paperwork. The ladies were instrumental in guiding the participants on where to go, what to do and even helped to correspond with the offices and filling out the paperwork.

Others came to the United States through the sponsorship of another family member who was legally responsible for taking care of the participant for ten years. During this time, participants were not eligible to apply for any social program payments. They explained that the only exception was if the sponsor signed an agreement under which they would “pay” the government to contribute to the participant’s enrollment in a social program. Another requirement for SSI eligibility was “citizenship,” which was the reason why participants worked so hard to “pass their citizenship exams.” Thus, while waiting for their sponsorship period to end, participants had to “survive on my own.” Participants faced various challenges due to the sponsor liability requirement:

I was in a financially tight situation, so someone from the sewing shop took me to fill out the paperwork. At that time I didn’t know anything. They saw that I didn’t have any money, so they wanted to help me. They drove me to the place [social service office], and that place gave me a piece of paper and told me to bring it home to the person who sponsored me so he could sign it. Oh my god, you know… I brought the paper home to my younger brother, and he yelled at me and told me if I were to apply for this, then I should pack my stuff and get out of his house. At that time, he was still responsible for me according to the immigration rules… He is only relieved of his responsibility for me after my tenth year in the United States, but that year was my ninth year… I think he didn’t want to be held responsible for anything if he signed. So I had to wait. (Aunt Ginseng)

The reason why I couldn’t apply for anything was because my son sponsored me here… I was 69 or 70 at the time and couldn’t apply until I got my citizenship, and also because my son had to take care of me for at least ten years… I kept getting denied for citizenship because I could not speak English… and I couldn’t apply for SSI. So I had to wait until my time was up. (Uncle Recycle)
A few women could not apply for social programs because they were financially linked to their spouse’s income under the household income criteria, but they also explained that they did not use their spouse’s money and did not want to be dependent on their spouses. Aunt Moon was not able to apply for any benefits in spite of having a hepatitis condition that prevented her from doing any work: “My SSDI [social security disability insurance], which is the money I accrued from working in the past, it’s very little. From what I understand, I receive monthly payments until it runs out. I can’t apply for SSI because my husband’s retirement and his part-time job pay altogether a little over $2,000.” She explained further that she did not use her husband’s money and lived off of the little that she had each month. Aunt Moon was concerned about what would happen when her SSDI ran out.

Having SSI benefits became a source of empowerment and greater self worth. The men and women accepted that their health had stripped them of the ability to work and earn income and therefore SSI was their last resort. At the same time, the label had consequences for their reputations. While social programs enabled participants achieve some degree of self sufficiency, these social programs could also stigmatize and label participants as lazy, non-working, nonproductive citizens who were taking resources from the government. Participants spoke extensively about stigma toward those receiving SSI benefits. All participants were aware of the negative attitudes and perceptions toward those who rely on social welfare programs. Within the Vietnamese American community, SSI is known as the “sick money.” Individuals who were recipients of SSI were known to be “eating sick money.” The expectation was that these individuals were “sick” or had visible disabilities or illnesses that prevented them from working.

Thus, participants shared that they were faced with the social norms and expectations around “the sick person” when they received the monthly SSI check. The public typically thinks
of a “sick person” as someone with visible physical disabilities such as having “broken arms and legs” or “being unable to walk.” The men and women explained that people failed to see the invisible yet crippling emotional problems that participants experienced in their lives. On one
hand, the lack of a visible physical disability could mask participants’ illnesses from others and could be a protective factor in social interactions. On the other hand, this meant that participants were questioned for their lack of productivity given there were no visible physical health problems that prevented them from working. Participants had been challenged and questioned by others such as “You don’t look sick, so why are you receiving SSI?” or “You don’t look sick, so why are you not working?” Being a recipient of SSI required participants to justify why they deserved the benefit. Younger participants explained that people in their 40s, 50s, and 60s could still work, so they were held to the same standard by the public. Older participants in their late 60s and 70s explained that it was more justifiable for them to receive SSI because they were “older” with health problems, and that the money was “meant for older people.” This perception subjected to the older participants to less stigma because they were deemed more deserving of the money in the public eye.

A few participants could not and did not make a distinction between the two programs: “money for the old” [SSI for the elderly] and “sick money” [SSI for individuals with disabilities]. They simply referred to it as “SSI.” They explained that it did not matter to them the exact type of SSI they were receiving. Moreover, the more general label of “SSI” allowed them to just tell others that they were receiving SSI because they were old, when in fact they were receiving “sick money” or SSI [for individuals with disability].

Participants’ reflections on what it was like to receive SSI revealed another paradox that participants faced. Participants came into treatment so that they could be a healthy, independent,
and working and contributing member of their family and community. However, their health limitations and circumstances made it impossible to apply for any job and thus they had to resort to social programs for assistance. By accepting social program benefits, particularly SSI or “sick money” they accepted that they were “sick.” This was a stigmatizing and shameful label for the participants because they were labeled as “a sick person” with all the negative stereotypes held by the public. Many participants internalized the shame as recipients of SSI:

I am not happy [about getting approved for SSI] because I want to be healthy, I want to be a normal person. I don’t want to be a sick person to receive this kind of money, but now that I am sick, I have to resort to this so that I can have access to health care and things like that. Truthfully… it’s better to be a healthy person than a sick person. I don’t want to say that I am sick. (Aunt KTM)

Only my family knows [about her SSI]. Only my sister knows. This is not anything good, nothing to be proud of. When people hear that you have SSI, they don’t like you. The people who are able to work… they have to pay taxes to pay for you. That’s why they don’t like you… I know this because I watch the Vietnamese television, and they say that other working people pay taxes to fund SSI. So I am very ashamed. I pray to Jesus that my illness would go away so that I can go to work, to give me a chance to not depend on this money. I don’t want it any longer. I don’t want to have this money. But it’s because of my situation… I don’t have money, and I am also sick. I can’t go to work. No one would hire me, and I am also old. I am already 60… I am telling you right in front of Jesus [pointed to Jesus figure in living room], I don’t ever want this money. Back then, my husband’s sister told him to apply for this money and that money, but he didn’t want to. He said that as long as we are able to work, as long as we have these two hands, we are not going to burden the government. (Aunt Barbie)

I am really ashamed because I still have working arms and legs, so why is it that I have to apply for such money? But, I also realize that I cannot work, so what do I do now? If I don’t have the sick money, how would I make it day by day, you understand? So everyone in there [outpatient center] is like one another… We receive benefits and we tell each other about our benefits. But, I am hesitant to tell other people outside of that group. I only tell people who I am really close to, but in general, I am very closed up to others. No one knows anything about me. They look at me and think that I am healthy because I am cheery. They ask me if I am healthy, then why don’t I go to work. Why am I always at home, but they don’t know what’s really going on with me and that I drink a pile of medication each day. No one knows, you see. That’s also a skill that I have [to hide illness]. (Aunt White Flower)
Participants also described the misconceptions people had about them: that they sat on piles of money collected every month and became lazy, unmotivated individuals. However, the realities of their lives revolved around worries of survival. In spite of the importance of “living in the present,” participants had realistic concerns about “not knowing when I might end up living on the streets,” “if I would have enough money for my funeral,” or “what would I do if my benefits get cut.”

The men and women’s stories of “living on the verge” revealed their struggles to make it from month to month with food stamps or SSI money they received each month:

I don’t even have $1000 in my bank… my monthly rent is $800, and then phone bills, and utilities… and car insurance. That’s $1000 already. So my husband and I have a few hundred left, so I save some of that to buy food for my daughter when she comes home from college. She comes home twice a month, so that’s a few hundred dollars’ worth of food. Sometimes she makes extra money at work; she gives me a little bit for gas or to buy clothes. There are months when I have to borrow because I don’t have enough… I wear all used clothes. Just this past year, my husband’s mother passed away, and we had to ask around to borrow just so that my husband could make a trip back to Vietnam because people would say horrible things about him and how ungrateful he was to his mother if he didn’t go back. Especially when he is the eldest son in the family. Each person lent us a few hundred dollars, so he used that money to buy a ticket and to pay for her funeral… It’s been several months. We are still paying off that debt slowly. (Aunt Barbie)

One thing that I really want to get out of my treatment is to have financial stability, and that would help to lessen my worries because I am always worried and anxious. I am always thinking about tomorrow and what would happen when my money runs out. How would I live? And right now I don’t have the health to work to make money… They [younger brother and sister in law] have been threatening to kick me out of the house… I’m just living there until whenever they kick me out… They told me that I can’t live with them forever even though they are my siblings. Right now, I pay them for the room, and I also take care of myself. They charge me $300 per month, which is much cheaper than rent elsewhere that costs about $400 or $500. My brother’s wife told me to start looking… she sort of yelled at me… She told me to prepare myself mentally because I will have to move out… I can afford a room now because my brother gives me a discounted price… But where do I find money to pay for a room elsewhere that’s going to be higher? So the women in the [socialization] group told me to just put up with it and don’t say anything because if I make my sister-in-law mad, she will kick me out even sooner. So I have to endure this situation as long as I can… I keep praying that my sister-in-law does not open her mouth any time soon and ask me to move. Right now my SSI is
not even enough because my rent is half of the monthly amount I get, and then I have to pay for my expenses and help my children in Vietnam when they need me. (Aunt Ginseng)

Participants’ reflections about their future hopes and dreams -- in spite of their health limitations -- revealed relentless motivation to be productive individuals, family members, and community citizens:

My wish is to be healthy, and nothing more. I want to be healthy… so that I would have the energy to take care of… my husband, my children because they need me. You know, those days when I was really sick, I couldn’t think of what to cook; my entire house was falling apart. Even though I don’t make money, without me, the house would fall apart. (Aunt KTM)

At this point, there isn’t anything else that I want other than to get medication that would help my head problems go away. And if I can see the doctor and listen to the doctor’s advice, then that also helps me feel less sad. I do feel happier now, but my head problem is still there. It makes me really groggy. I wonder how would I be able to cure it so that I could recover completely. And then to focus on my job, and take care of my children so they can go to school, to have a good life. That’s all. That alone would make me happy. (Aunt Banana)

Other participants’ stories challenged the public stereotypes of them as dependent, unmotivated people who want to live off taxpayers’ dollars. This was particularly salient among younger individuals in their 40s, 50s, and early 60s who were desperate to find work so that they could break away from the public watch and the stigma of receiving public assistance. A few even refused SSI and insisted that they would continue to look for work as long as they could:

I wish that I could be healthy, have the strength to work, and most importantly my mental health… to have an alert mind so that I can finish my schooling and find a job and do the things that I want to do. I believe that I can achieve this because if I keep trying, and with the help of my family and my community, I think I can do it. (Sister Park)

I am contacting that place that helps people find jobs… On Friday I’ll go there to meet this guy named Aiden. He will help me find a job that suits my health, a job to hang clothes up at the thrift store. I want to work… find something part time. (Aunt Target)

You see, after I was laid off, I was asked if I wanted to apply for disability benefits. But that was something I didn’t want because I still had the ability and the potential to work.
So I kept working. I kept working and kept getting laid off repeatedly, but I continued working. (Sister Cat)

Conclusion

Participants initially came into “the place” for help with few expectations. Along the way they met doctors and agency workers who introduced them to services and possibilities that they never knew existed. The relief of “headaches,” “sleep problems,” and “worries” were consistent with participants’ expectations for getting their health back and resuming more normal functioning. However, an unexpected element of outpatient treatment was the financial gain from social program benefits that enabled participants to address their family and social obligations. Most participants, particularly older ones, accepted the reality of their declining health and understood that full recovery was no longer an option for them. Others, especially younger participants, still held hopes of “getting my health back so I can go to work.” In the present moment, participants accepted that they could only make the best of their situation and maximize their potential and social obligations as best as they could given the realities of their health. Reclaiming their self worth remained a work in progress. Most participants still did not know exactly what outpatient mental health treatment meant, or the specific titles of their treatment team such as caseworker, therapist, psychologist, or psychiatrist. What mattered most was what the treatment team’s importance to them and what the team had done for them on their journeys toward reclaiming their self worth, part of what had been lost due to their debilitating physical and emotional health problems. For the participants, the little financial means they had to do something for themselves and for their family was enough to move them from “being bounded within these four walls” to “a place where I can be respected.”
Chapter 8: Discussion and Implications

Introduction

The common narrative of the Asian American experience, and of the Vietnamese American experience specifically, is a glorified model minority myth of achievement and success in America. While this narrative is important for recognizing the accomplishments of immigrant and refugee families, it has omitted the voices of those who have not succeeded and who continue to live at the margins of their ethnic communities. The social justice value of our profession requires that we undo this silence by engaging in research that gives voices to first-generation Vietnamese Americans living with depression and/or PTSD so that they can tell their stories about living with mental illness, and inform the social work profession about what it can do, or do differently, to better serve their needs. The intent of this study was to uncover the experiences of first-generation Vietnamese Americans living with mental illness and provide a rare opportunity to tell the untold stories about the resilient spirits of a forgotten group of Vietnamese Americans through their journeys to find hope and live meaningful lives in spite of suffering from depression and/or PTSD.

This study offers a more nuanced understanding of how participants made sense of their emotional discomforts, how they found their way to a place that could help ease these discomforts, and what they unexpectedly gained from outpatient mental health care. Together, their rich stories portrayed participants’ journeys through losing, finding and reclaiming their self-worth that had been threatened and crippled by a legacy of war, trauma, and migration to the United States.

This chapter provides a brief summary of the key findings from each aim, and synthesizes their implications for social work research, practice, and policy.
Discussion

Aim 1: Conceptualizations of health

Aim 1 focuses on the perceptions of health among first-generation Vietnamese Americans living with depression and/or PTSD. As presented earlier, Figure 2 shows how this group’s perceptions of health are embedded within a unique historical, political and social context, and are also influenced by a sense of self worth and physical and emotional discomforts.

Figure 2. Conceptualizations of Health among First-Generation Vietnamese Americans with Depression and/or PTSD

In the first phase of losing one’s self worth, participants’ narratives about declining health were expressed through the presence of multiple physical and emotional discomforts. Participants’ definitions of health seemed to focus on the time when daily functioning and ability to fulfill social obligations first became disrupted by illness. This conceptualization is intricately interconnected with the pre- and post-Vietnam War and migration experiences of the men and women. Before the illness onset, they were productive and able to go to work and take care of families, but then, the presence of health problems interrupted their routines and made it difficult
and, in some cases, impossible to carry out normal tasks. The participants described the time when they “began to sink” deeper into the engulfment of their impairments and slipped farther away from what was of utmost importance to their self-worth: being a productive individual and fulfilling social and familial obligations. Participants moved from being active members of their communities to being “bounded within these four walls” of their homes, linguistically and socially isolated from the Vietnamese community and the larger American society.

The findings from this study raised questions about what mental health problems mean in the context of first-generation Vietnamese Americans specifically, and ethnically diverse populations more broadly. Results revealed that participants conceptualized physical and mental health as intertwined and inseparable, and that it was not possible to gather meaningful information about what mental illness meant to them without framing it as a larger mind/body issue. The participants’ definitions of health began with an emphasis on the escalating physical and emotional discomforts that they had experienced for years, some of which were similar to the cluster of depressive and/or PTSD symptoms listed in the DSM. In retrospect, however, participants did not discuss their health problems in terms of clinical symptoms of “depression” or “PTSD.” At the time they did not have the knowledge to recognize that it was a mental health problem. Even after they had entered outpatient care and had been exposed to the terminology and workings of the mental health service system, these clinical diagnoses were not the lenses through which the men and women saw their mental illness experiences. The diagnostic labels of “depression” or “trauma,” referencing PTSD, were only meaningful to the extent that they were labels participants had picked up over time in mental health treatment to describe their symptoms. Yet, these words still had little or no meaning to them. Rather, participants described their illness experiences as involving multiple physical and emotional disturbances.
This finding is consistent with previous literature that health is a holistic concept for Asian Americans (D. Nguyen, Shibusawa, & Chen, 2012; Phan & Silcove, 1999). First-generation Vietnamese Americans living with depression and/or PTSD do not necessarily perceive their illness as a mental illness but rather more broadly as a constellation of physical and emotional disturbances. Further, they may express their emotional distress somatically (Kawanishi, 1992).

Also consistent with the literature on Asian Americans’ conceptualization of mental illness (Kim-Goh, 1993; Lien, 1993; H. Nguyen, Yamada, & Dinh, 2012; Sue & Sue, 1999), participants in this study described anything related to the idea of “mental” -- such as mental illness, mental health problems -- as a state where one is crazy, violent, or losing one’s mind, and as such, “mental illness” did not accurately describe and reflect their health concerns.

Participants’ understanding of mental illness as being more extreme or severe differed from the Western concept of mental illness. Moreover, their knowledge of the Western concept of mental illness was very limited.

What emerged as an important aspect of participants’ conceptualizations of health was the impact of physical and emotional discomforts on their lives and how they impaired their functioning and ability to fulfill social roles. In spite of having multiple physical and emotional health problems, participants’ assessments of their health were closely tied to their ability to do something for themselves and more importantly, for their loved ones. The men and women in this study were aware of the public perceptions of them as “mentally ill” individuals who were sick, incapable, and dependent. Thus, one way to reclaim their self worth in spite of illness was to maintain their ability to function and fulfill obligations to their families, the only remaining support system for some participants. This finding is consistent with findings from another study.
of Japanese American cancer patients who defined their health through their ability to fulfill social roles with and for others (Kagawa-Singer, 1993).

The family is a defining aspect of the Vietnamese American experience that has carried participants through the Vietnam War, post-war mayhem, and the initial hardships of living new lives in the United States (Kibria, 1993). Participants in this study emphasized the utmost importance of fulfilling expected roles and responsibilities, and making sacrifices for the family. As such, losing one’s ability to work and contribute to family was detrimental to their sense of self worth, and thereby health. The immigrant narrative of success emphasizes resiliency and overcoming adverse circumstances to achieve the American dream (Leong, Ebreo, Kinoshita, Inman, Yang, & Fu, 2007). For the participants, this meant leaving Vietnam as a way to escape poverty and looking to the United States as the land of opportunity where they could prosper and achieve economic success. This narrative of success became the gold standard for the participants and their families: to strive toward working hard, making money, and supporting their children so they could succeed, defined as completing higher education, holding high paying jobs, and having a home and family of one’s own. This expectation has clearly lifted many families to successful lives in the United States; yet, it has also marginalized and silenced those who have not succeeded. The study participants’ narratives revealed the stories of those in the latter group of marginalized and forgotten individuals – those with low SES, limited to no English language proficiency, and primarily low education. Participants kept going in spite of suspecting or knowing something was wrong with their health. They simply did not want to show personal weakness and failure and to taint the image or face of their group by failing to contribute their share of the joint effort. When these participants were no longer able to do their part, their failure isolated them from those who had succeeded, and at times this meant isolation
from their very own family members. Moreover, the stories of these men and women illuminated the isolation of first-generation Vietnamese Americans with mental illness from their ethnic community despite living in or within proximity to this community.

The concept of individuality, which is very important in the United States, does not translate well to other cultural groups that view the individual differently (Marsella, Devos, & Hsu, 1985). Western thoughts about the self revolve around individualism, freedom, and independence. However, Eastern cultures define the self as interconnected with the larger group, also known as the interdependent self or a functional unit of a larger web of interdependent others (Markus & Kitayama, 1991). Self-validation is through relatedness to others, and through keeping harmony with the expectations for self and the group’s expectations and well-being. The needs and goals of others are put ahead of one’s own needs. A self without the ability to fulfill role expectations, and without relationships with others is meaningless and can disrupt a state of well-being (Marsella, Devos, & Hsu, 1985). This concept sheds light on this study’s findings that participants built their definitions of health around self worth, or being self sufficient so they would not burden their families, and moreover, being able to exercise their role responsibilities and provide for parents, spouses, children, and extended family members.

Moreover, this body of literature helps to contextualize the participants’, mostly the women’s, narratives about wanting to die when describing their worsening health. The symbolic meaning behind the women’s suicidal thoughts was to alleviate burden to the family. For these participants, failing to contribute to the family due to declining health greatly reduced their sense of self worth, as they no were no longer doing their part for the group. Participants lost their meaning in life when they could no longer provide for their families; thus, death became a preferable option. Declining health and unemployment were particularly damaging to the
participants who expressed hopes and dreams of coming to the United States so that they could succeed and provide good lives for their families. As such, their self worth became more compromised when they could not work and then became financially dependent on their families. They were firstly not contributing and secondly further burdening and requiring care from significant others. Thus, the possibility of suicide provided them a means to relieve their family members of caregiving burdens.

Findings show that the participants’ conceptualizations of health were also intricately interconnected with their traumatic past and experiences as Vietnamese American immigrants and refugees seeking new lives in the United States. Their mental health has to be understood as a byproduct of the Vietnam War trauma (loss, death, poverty, persecution, uncertainties) and post-migration adjustments (social and linguistic isolation, competing for low-wage employment, making ends meet) (Hsu, et al., 2004; Kibria, 1993; Zhou & Bankston III, 1998). The study participants’ lives during and after the Vietnam war were filled with a range of sacrifices made so their families would survive: giving up their education early on, working in arduous manual labor jobs, and ignoring their health problems in order to take care of their families. Some women endured dangerous journeys at sea and nearly lost their lives only to land at refugee camps where they lived meagerly and awaited the international community’s decision to approve their migrations into the United States and other host countries. Once the men and women got to the United States, they again made sacrifices of working multiple low-wage jobs and passing up opportunities to learn English or attend school so that they could have roofs over their heads, their children could have educations and futures, and their families would be fed. While these experiences were natural extensions of caring for their families, participants eventually became exhausted from the accumulation of physical and emotional demands on their
health over time, and from unresolved fears, anxieties, and unbearable memories of the atrocities of war and loss of family, friends, and identity. This finding suggests the possible wear and tear on participants’ health as a result of their experiences with persisting hardship and lasting, unresolved trauma over the past four decades (Hsu, et al., 2004; Kibria, 1993; Tran, 1993). This assertion is plausible considering research on social determinants of health that finds worse health outcomes among individuals with lower education, of ethnic minority backgrounds, and of lower SES (Aneshensel & Phelan, 1999). Moreover, current mental health research approaches that examine psychological factors at the individual level can potentially strip the individual attitudes from the dynamic and complex sociocultural systems within which they are embedded (Abe, 2012; Olafsdottir & Pescosolido, 2009).

Results from Aim 1 highlighted the potential disconnect between providers’ and clients’ definitions of mental health and recovery and expectations for mental health treatment. Findings also clarified and broadened the conceptualizations of health in terms of what it meant to this population: it was embedded in the historical, political, and social contexts of their lives; there was interconnectedness between physical and mental health; and it meant having the ability to be self-sufficient and to do things for those who were important to them. American mental health professionals’ conceptualizations are dominated by the biomedical model’s definition that views mental disorder as “a disease or a disease-like entity with a physiological, genetic, or chemical base that can be treated through medical means” (Aneshensel & Phelan, 1999). Mental health clinicians’ assessments continue to separate physical and mental health. The findings of this study question the usefulness of this current definition in working with populations across various cultures that hold different conceptualizations of health. To assume the generalizability of the biomedical model’s definition of health is problematic and a hindrance to delivering
culturally sensitive services (Sue & Sue, 1999). Thus, we need to broaden and enrich our understanding in order to capture the complexity of how groups other than those of Western European descent cultures define health (Kagawa-Singer, 1993).

**Aim 2: Pathways into outpatient care**

Aim 2 of this study illustrated the pathways through which first-generation Vietnamese Americans with depression and/or PTSD obtained outpatient mental health services (Figure 3). Prior to getting into outpatient treatment, participants tried to carry on with their lives, often for many years, in spite of the presence of physical or emotional disturbances. They did not know that the emotional disruptions of their health had a “name” or that it would affect their functioning and ability to fulfill family obligations. After enduring these discomforts for an extended period of time and prompted by others’ observations, personal disclosures, or hospitalizations, participants began to realize that they might be “sick.” At this point participants’ health concerns were no longer a private matter they kept to themselves. They were now known to others. Participants eventually received referrals and found their way to outpatient mental health treatment, hoping to regain their health. However, they had no expectations about what mental health care could do for them. Most did not know what mental health treatment meant or even that it existed, nor did they know that the referrals they received pertained to an outpatient mental health agency. Nonetheless, finding their way into outpatient treatment marked the start of their journey to regain their sense of self worth.

As noted in Chapter 3, the current ABM and the NEM models provided some explanations of help-seeking behaviors. What is not known is whether or how these models and their concepts apply to first-generation Vietnamese Americans seeking outpatient mental health services. This study adds to the current literature by providing a conceptual model of pathways
into outpatient mental health care from the perspective of individuals who experienced the process. The model generated by this study (Figure 3, Chapter 6) specifically reflects the help-seeking experiences of first-generation Vietnamese Americans who had low income, limited English language proficiency, low educational attainment, and a diagnosis of depression and/or PTSD. The results highlight some potential similarities and differences between the ABM and NEM and the model generated by this study. Findings also clarify what the constructs in the ABM and NEM look like within the context of the Vietnamese American immigrant experience, thereby adding potential new dimensions and illuminating previously unknown contextual factors that these two models had not explored, and highlighting the limitations in the models that could be addressed in future research.

There were several similarities between the concepts in the model of this study and those in the ABM and NEM: facilitating factors (ABM), social networks (NEM), and the fluid, complex help-seeking process that unfolds over a long period of time (NEM).

Several facilitating factors were identified in first-generation Vietnamese Americans’ decisions to seek help (referenced in Phases 4 and 5 of Figure 3). In “Phase 4 - learning about options to alleviate discomforts,” participants referred to the framing of referral, constant encouragement, and familiarity and trustworthiness of the referrer as key things that motivated them to seek help from the place or the doctor. In spite of not knowing exactly what this place or who this doctor was, participants took comfort in knowing that someone they knew and who had gone through a similar experience trusted and benefited from these sources of help. Furthermore, the framing of help seeking as simply going to check out the place, to get medication, or to see a doctor simplified what could have been a daunting process. The referrer’s not using words like getting mental health treatment or going to take medication for
mental health problems made it less stigmatizing for the participants. In “Phase 5 - navigating one’s way,” participants identified transportation, proximity and familiarity of location, and having in-language workers or interpretation services as enablers in their actual service use. While the participants and their referrers did not explicitly mention cost in the discussion of going to get help, participants expressed that they would not have sought help if it had required a payment. These findings were expected considering the literature’s identification of stigma, cost, transportation, and language as persisting barriers to mental health care for Asian Americans (Kang, et al., 2010; Leong & Lau, 2001; Marshall, et al., 2006; Rhee, 2009). While the facilitating factors identified in this study’s conceptual model were similar to the enabling factors in the ABM, this study clarified the concept of “enabling factor” in mental health service use from the perspectives and experiences of first-generation Vietnamese Americans.

As discussed in chapter 2, Vietnamese Americans who experienced mental health problems kept their problems within the family, and when help was initiated it was often from informal sources of support rather than from mental health professionals. These findings are consistent with the NEM’s emphasis on social networks and their influence on individuals’ mental health service use (B. A. Pescosolido & Boyer, 2010). This current study further confirms the importance of informal networks in alerting individuals to the severity of their condition and the need to get help. The participants suffered silently for many years with their debilitating physical and emotional ailments. Then, when their health worsened or became unbearable, they were able to reach out and/or receive help from their family, friends, neighbors, or primary care physicians (PCPs). While this process took some time to happen, the participants’ social networks were what prompted them to get help for their physical and emotional discomforts. As such, a turning point in each participant’s pathway into outpatient
care was influenced by his or her social network, a finding that is consistent with literature on the key role of social networks in promoting help seeking among Asian Americans (Sue & Sue, 1999).

Participants’ narratives about how they got into outpatient care revealed a complicated process of mental health service use, with multiple pathways and movements through the phases. All participants started by experiencing some type of discomfort. However, how participants moved from there varied in terms of pathways and time. Most participants continued with their routines in spite of their ailments until they were told that they were sick and were prompted to get care. Others never received referrals and reverted to experiencing worsening health until they received information on sources of help. A few participants were hospitalized early on and then went back home for years before getting care. Participants ended up in care by going voluntarily, under duress, or haphazardly, by stumbling upon the place. This particular finding of Aim 2 supports the emergent behavioral theory development of the NEM that conceptualizes help seeking as a fluid and complex process and moves away from the assumption of service utilization as a linear process, such as that of the ABM (B. A. Pescosolido, 2010; B. A. Pescosolido & Boyer, 2010; B.A. Pescosolido & Kronenfeld, 1995).

The model developed in this study expanded upon a key concept in the NEM: the role of the primary care physicians (PCP) as a member of one’s social network, a concept that appears to be missing from the ABM. Findings highlighted the critical role of the PCP in detecting and responding to mental health problems through referrals for follow-up mental health care. While the NEM’s concept of social network included health providers, the nature and extent of the PCP’s role in the help seeking process was elaborated in details among the participants in this study. Participants’ only interface with health professionals was during routine visits with their
PCPs for health problems, but broad variations existed in how the PCPs responded. During these visits, some participants disclosed that they had difficulty sleeping and were given sleeping pills. In other instances the doctor would continue the normal routine, basically ignoring or missing a potential mental health problem. Other participants kept seeing the physician without disclosing their discomforts, and without the PCP detecting any psychological problems. Several participants mentioned that their PCP eventually referred them to another doctor at the same clinic for their problem after a new mental health program was opened there. While the role of PCPs in participants’ outpatient care utilization was not the focus of this study, the participants’ narratives clearly revealed many missed opportunities in primary care settings for the PCP to provide education and address their mental health needs. All of the participants saw Vietnamese American PCPs who spoke Vietnamese. Yet, there appeared to be a breakdown in communication between the doctors, who are usually considered to be expert sources of help, and their patients. This finding is concerning, but it is not surprising considering research reports that indicate the lack of detection and linkages to mental health care among PCPs (USDHHS, 2001; Unutzer, Katon, Sullivan, & Miranda, 1999).

The model developed in this study challenges several assumptions held in the ABM and NEM. In particular, the ABM portrays individuals as rational decision makers who perceive a need and subsequently seek out care. In the context of this study, one assumption of the ABM was that participants knew that they had mental illness, and that they knew where to go to find help. Findings from this study revealed otherwise. The participants were not aware that they had a mental illness because their discomforts at the time did not match their perceptions of mental illness. Mental illness as they knew it consisted of violent behaviors, completely losing one’s mind, or repetitive odd behaviors such as bowing to a deity all day long. Participants had
ambiguities about their physical and emotional disturbances because they could not label them. Some interpreted their health problems as unusual and out of the ordinary, and maybe related to aging or other physical health problems. Others wondered about the strange discomforts they were experiencing, or recognized that their health had worsened. However, they did not at any point acknowledge that they had a mental illness.

Further, from the perspective of current Asian American service utilization literature, one barrier to mental health service use among Vietnamese Americans is the shame associated with seeking help for mental illness (Lien, 1993; Q. C. X. Nguyen & Anderson, 2005; Phan & Silcove, 1999; Sue & Sue, 1999), implying that individuals are aware that they have such conditions.

The assumption that individuals have an awareness of their interface with the treatment system (as suggested by the NEM) does not apply to these participants who had no awareness of the mental health treatment system. Throughout the pathways into mental health care, participants did not know that they were getting into mental health treatment, what mental health treatment entailed, or that a place existed to help people with experiences like theirs. Many were also not aware that their physical and emotional discomforts were called mental illness. A few knew they were getting help for a “mental” problem, but what exactly that meant was unclear to them. Thus, existing literature’s assumptions that help seeking is preceded by an individual’s recognition of a mental health need (in the ABM and NEM) and interface with the mental health treatment system (in the NEM) does not fit with the experiences of the men and women in this study.

While the study did not intend to focus on exploring the concept of culture influencing participants’ pathways into outpatient care, the men and women frequently referred to the
influence of Vietnamese beliefs and conceptualizations of health that shaped their understanding of their own health problems. As such, cultural influences are relevant to fully understanding how individuals from diverse ethnic backgrounds seek care for emotional distress (Kagawa-Singer, 2012). Yet, culture remains poorly developed and understood in the ABM and NEM, two widely used models in help-seeking research. This is a major limitation of not only the ABM and NEM, but also other current behavioral service utilization models and should be addressed in future studies.

This study’s findings highlighted two other potential limitations of the ABM and NEM. One key aspect of this study’s model is that it is marked by turning points such as worsening health, being at one’s worst health, being noticed by another person, or being given information and encouraged to seek help. For many participants, it was not until they encountered one of these scenarios that they began to consider the possibility of seeking help for persisting physical and emotional discomforts. Yet, these critical markers are not apparent in the ABM or the NEM. Moreover, findings revealed that the historical, political, and social contexts of the participants’ past and present experiences were interconnected with their conceptualizations of health and pathways into outpatient care. The extent of the models’ references to an individual’s background is limited to social and geographic location (NEM) and the individual’s demographic and social predisposing characteristics and their contexts (ABM). The findings of this study highlight the importance of a service utilization model that captures the migration contexts for pathways into outpatient care among immigrant groups (Gong, Xu, Fujishiro, & Takeuchi, 2011; I. Kim, Chen, & Spencer, 2012; Pasick, et al., 2009), such as first-generation Vietnamese Americans.
In summary, the ABM and NEM provided some useful concepts for understanding pathways into mental health service use among first-generation Vietnamese Americans. The conceptual model developed from this study pointed to some similarities with the ABM and NEM. This study’s model further expanded some of these concepts in the context of the lives of Vietnamese American immigrants. Nonetheless, the study revealed that some of the assumptions of these models about need and interface with the treatment system were inadequate with this population, as discussed above. The concepts in the ABM and NEM fail to capture the social, political and historical as well as the cultural influences on the context that frames the current conditions of these individuals and that which influences their decision making.

Aim 3: Expectations and perceptions of outpatient mental health care

The focus of Aim 3 was to describe the expectations and perceptions of outpatient mental health treatment among first-generation Vietnamese Americans living with depression and/or PTSD. Figure 4 below provides an overview of the dimensions of this Aim and their contributions to participants’ reclaimed sense of self worth.

Figure 4. Linking Outpatient Mental Health Treatment to the Reclaim of Self Worth
The third phase of engaging and utilizing mental health services became the process through which participants reclaimed their self worth. Participants simply did what the agency workers asked of them when first entering treatment, but over time, they became socialized to learn the language, labels, and practices of the mental health community, and then, of the sick role. Participants’ reflections about the care they received were filled with expressions of feeling valued, validated, and supported. They drew parallels between their mental health treatment and their reclaimed self worth; they found the emotional, social and financial support needed to reclaim their long lost self worth. The “doctor” was the person who prescribed medication and gave advice to help them sleep better and worry less. The “paper work” and the “talk” ladies were workers to whom they could go to for anything, but most importantly for assistance with applications for social programs. The groups and the agencies became symbolic of places that provided escapes from the constraints of the “four walls” of their home and for some “the place” was their only connection to other people and the outside world. Participants acknowledged the effectiveness of taking psychotropic medications and learning how to manage their physical and emotional discomforts. For the first time they could take back some control of their lives. Also, social welfare programs, and SSI in particular, became important tools for achieving self worth by providing the financial means to achieve self sufficiency and to fulfill responsibilities toward significant others. Multiple health problems and conditions resulted in permanent damage to self worth, so the road to recovery did not result in complete wellness; participants could only do their best and salvage what little they had left. Nonetheless, participants felt worthy because they resumed their roles as contributing members of their groups and no longer were burdens on their families. They could now do “a little something” for self and for others. The resilient
spirits that sustained participants through decades of war and the hardships of the migration process emerged once again to provide them with optimism for the present and the future.

Findings pertaining to this aim highlight the disconnection between participants’ conceptualizations of the outpatient treatment process and social work’s therapeutic process: exploration, engagement, assessment, planning, implementation, and goal attainment (Hepworth, Rooney, & Larsen, 1997). In contrast to the social work -- largely intellectual/cognitive -- process is the participants’ lack of awareness and knowledge about their outpatient mental health treatments. The men and women initially had no clue of what they were getting into when they decided to seek help for their problems. This was not unexpected due to the non-existence of therapy at the time participants lived in Vietnam. The initial question about their "expectations for outpatient mental health treatment" revealed little because the participants did not even know what outpatient treatment meant, what it looked like, and what would happen when they sought it. They simply wanted to see the doctor or go to the place to get the medication to relieve their symptoms. They expected immediate relief due to guarantees and proofs of improvement that others had described to them while urging them to seek help. During the process, participants met experts and workers and realized that medication was only one approach that could help them. This place, in fact, could do even more for their health than they had expected by offering options to participate in socialization groups, and, notably, assistance with their paperwork and applications for social programs. As such, this study clarifies and expands the literature’s assertion that Asian Americans are not familiar with mental health treatment (Sue & Sue, 1999; Uba, 1994; Ying, 2001) by illuminating exactly what this meant for first-generation Vietnamese Americans before and after they utilized outpatient mental health treatment. Moreover, results revealed the participants’ own understanding of the role of the agency and its workers and what
they meant to the participants’ treatment processes, specifically the doctor who gave medication, the talk doctor, the paperwork lady, the talk lady, and the group. The official titles of the workers mattered less than the role these workers played in helping to foster the participants’ sense of self worth.

Findings further demonstrate that the immediate relief of physical and emotional discomforts had added benefits. Participants were ecstatic to see the immediate results of medication that helped them sleep, lessened their headaches, and made their minds more sound or calmed their worries. Symptom alleviation allowed them to regain some of their functioning and to resume household roles and chores. Seeing good results encouraged the men and women to come back to treatment. This finding supports existing literature that shows that Asian Americans prefer immediate symptom relief in the therapeutic process (D. Nguyen, et al., 2012; Sue & Sue, 1999).

Interestingly, these participants also tended to continue in therapy for longer terms that lasted from several years to over ten years. Possible reasons for these long stays in outpatient treatment may be due to the nature and severity of the men’s and women’s health problems. Generally, Asian Americans tend to seek help when their conditions are severe (Chu & Sue, 2011; Wynaden, et al., 2005), somatic symptoms increase (Kung & Lu, 2008; Zhang, et al., 1998), or the condition becomes disruptive (Kung, 2003). The severity of the condition by the time individuals arrive at mental health treatment may make treatment more difficult and may take longer to treat the mental illness. The participants in this study were first-generation Vietnamese Americans who had experienced physical and emotional health discomforts for an extended period of time, from as far back as their early years in Vietnam or soon after they came to the United States. Yet, they only sought help when their health worsened, or when they could
no longer function. The trauma of the Vietnam War also left permanent marks on the minds and souls of the men and women and continued to haunt some of the participants day in and day out. The trauma was an accumulation of several decades of war and migration wear and tear that could not be erased from the participants’ lives (Kibria, 1993; Tran, 1993; Zhou & Bankston III, 1998). Furthermore, the participants in this study were adults and older adults with multiple debilitating chronic health and mental health problems, which likely require a longer-term engagement in mental and physical health treatment.

While the participants acknowledged the value of having immediate symptom relief, they also received services they felt addressed the core of their health problems: free healthcare, food stamp assistance, and most importantly the SSI. Having the financial means to be self sufficient and to be a contributing family member of one’s social network was a crucial aspect of reclaiming health and self worth, particularly in the context of life in the United States where they recognized that money is valued above all. Although the amount of money they received was small, participants felt worthy and enjoyed life when they could buy some food for the house, pay monthly rent, send money to relatives in Vietnam once a year, or set some money aside for funerals. Nonetheless, participants still struggled with paying the household expenses, monthly rent, not being a burden on their families, and making it to the next day. Thus, this study adds to the existing literature by highlighting the additional, and for these participants, major benefits of the financial aspects of treatment, which addresses major functional realities compounding to their distress. As noted, financial assistance addressed the core of participants’ mental health problems by providing self-sufficiency, and by helping them to carry out their social obligations to their families. Further, a participant’s motivation to get well remained largely driven by the desire to fulfill obligations to the larger group and to be interconnected with
others. Participants found meaning in their lives when they could do things and provide for their loved ones. They reported being healthier when they could resume their roles as spouses, parents, children, and other family members, all of which superseded their own needs. This finding challenges us, as social work professionals and researchers, to rethink the goal of mental health treatment that focuses on self-actualization and values the individual’s needs and goals (Sue & Sue, 1999).

The study’s findings also reveal the participants’ expectations about how to be a client, or in their own words, “how to be a patient.” From the moment participants entered outpatient care, they did what the agency workers asked of them. They filled out paperwork, scheduled appointments to come back, came to see the doctor, followed through with medication regimen, and came back to see other workers as scheduled. In spite of not knowing exactly what was going on or what would happen, most participants did not ask questions. Even over time participants generally did not assume an active role in treatment but deferred to workers as experts and followed the advice that was given. Meetings consisted of answering questions about their progress and listening to expert advice. One striking finding was their lack of desire to know more about their diagnoses. Although most learned later that they had depression or PTSD, they initially were satisfied with simply receiving an expert confirmation that they were sick. It was more important to the participants to treat their symptoms and less important to know the specific labels of their illnesses. Some even stated that knowing would increase their anxiety or that inquiring, or, as noted in the literature, questioning the doctor too much would be disruptive and disrespectful toward the doctor. The participants accepted the doctor’s confirmation that they were sick, and this alone validated the fact that they needed help. Moreover, they were glad to be under the care of an expert, and their relationships with the
agency staff provided validation and the sense of esteemed worthiness that they needed. Participants appreciated being heard, being respected, being cared for, and being valued. As such this study also adds the perspectives to the literature of first-generation Vietnamese on their unique patient roles in treatment. This is especially valuable because prior research on counseling preferences used primarily college student populations (Abe-Kim, et al., 2007) and rarely engaged the perspectives of immigrant populations. This finding also highlights the difference between our general Western expectations for a client role that centers on patient empowerment, informed consent, and taking an active role in treatment (Hepworth, et al., 1997) and the expectations of the men and women in this study who assumed mainly passive roles in treatment, roles that were more culturally consonant.

Another key finding is that these participants lived isolated lives in spite of their approximate location to Vietnamese ethnic enclaves. On one hand, ethnic groups and ethnic enclaves are perceived as cohesive and buffer against stress (Kibria, 1993; Zhou & Bankston III, 1998). On the other hand, there is diversity within the ethnic enclave along with the isolation of marginalized groups even within one’s own group. The first factor contributing to separation between participants and the community was their disadvantaged social status compared with the more successful immigrants in the Vietnamese American community. These participants had limited English language proficiency, did not know how to drive, or, if they did, could only drive limited distances, were of lower SES, had low education, and were older. They did not fit the mosaic of model minority Vietnamese Americans who owned homes and nice cars or raised children who became doctors and lawyers. The participants in this study were individuals who lived with the label “mentally ill,” a stigma that removed them from norms of “acceptability” in the community (Lien, 1993; Q. C. X. Nguyen & Anderson, 2005; Yang & Kleinman, 2008;
Yang et al., 2007). Their use of social programs and SSI in particular subjected them to the public stigma of those using rather than contributing to the resources of the government. These added layers of separation further distanced participants from the larger community and even from their own ethnic enclave. While some might see the mental health treatment agency as a closed wall and dim place, these participants saw it as a place that liberated them from the constraints of the four walls of their home, a place of hope and belonging. The treatment center was more than a place of transaction for medication or therapy. It became a place of comfort and safety, of unconditional caring where they could go to for help without expectations for anything in return and sharing. This place had a symbolic role as a lifeline, a connection participants had to the real world and to their communities. Participants found friends in the groups, information about resources in the communities that they otherwise would not have known about, and opportunities to explore restaurants and shopping centers so they could have a few hours of being like everyone else. Findings thus add to the literature about first generation’s perspectives on the mental health agency as a place that offered inclusion and relationships, and connections to the wider world.

**Implications**

Shaping culturally sensitive social service delivery for ethnic communities is an ongoing effort with no easy or straightforward answers. This study focused on a small group of first-generation Vietnamese Americans with depression and/or PTSD and provides some starting points and recommendations for social workers who serve this population, and other similar populations. The following sections highlight implications for research, practice, and policy.

**Implications for Research**
The literature review has provided a background for what is known about Asian American mental health, and Vietnamese American mental health in particular. However, the literature needs to be more culturally grounded in the subjective experiences of the focus population in order to understand how research constructs validated in primarily mainstream populations translate to their world, and whether the social services we provide meet their needs and have positive impacts on the lives of the clients we serve. Prior to this study, little was known about mental health treatment’s congruency with first-generation Vietnamese Americans’ values and expectations. The research aims of this study open an ongoing dialogue about, a culturally-grounded understanding of, and possible solutions to our ability to provide culturally sensitive mental health services to ethnically diverse populations. This approach and the general findings may also be applicable to other Asian American groups or older immigrants and refugees.

Service delivery is effective only if it is useful for the intended clients/ recipients. Validating the knowledge of underserved population groups requires a deep understanding of how clients perceive their needs and what mental health service providers could do to effectively address these needs from the clients’ perspectives (Sue & Sue, 1999). In the past few decades, most research that has advanced our understanding of the mental health of diverse ethnic populations has come from the field of psychology. Brekke and colleagues (2007) voiced this concern in stating that while the social work profession is the largest provider of mental health services, it is underrepresented in translational research that bridges science and the practice setting. Thus, one implication for future research is that we directly engage clients using a methodology that highlights and empowers their voices and that positions the clients as experts of their own lives. Researchers, practitioners and policy makers need to stay in touch with the
realities of the people they serve. As such, inductive paradigms using qualitative methods of inquiry such as in-depth interviews, focus groups, and participant observations are appropriate methods for providing windows into these lived experiences. These methods of inquiry could enrich the deductive, quantitative psychological research that dominates our current understanding of the mental health of diverse, underserved populations by answering questions about how and why they perceive their circumstances as they do within the context of their lives.

Although this research is focused in its scope of understanding on a small group of first-generation Vietnamese Americans, the richness and depth of its discoveries could help stimulate future research with other groups that are similarly neglected or marginalized in the literature. Social work research needs to be more grounded in the cultures, the lives, and the contexts of the diverse communities we serve. Only in doing so will our research yield realistic and meaningful recommendations for policy and practice. Findings such as those presented in this study could transform our current mental health system from one that operates on the assumptions developed and validated with European American clients, to one that is responsive to the needs of an increasingly diversified social work clientele and their communities (Sue & Sue, 1999). This line of research could inform the development of social work processes for effectively working with diverse ethnic groups in order to maximize their potential and empower them to find meaning and hope in their lives.

This study’s conceptual model of pathways into outpatient mental health care provides a starting point for future research. The model illuminates the context of help seeking for an ethnic group whose health beliefs and behaviors culturally and educationally differ from existing models’ assumptions. The continuing application of the existing models to guide research about help-seeking behaviors of diverse ethnic groups can be problematic because their
appropriateness and usefulness have not been validated with these groups (Pasick, et al., 2009). Although these models offer useful starting points for understanding how individuals obtain care, more research is needed to examine these processes and constructs, and whether they even apply to the dynamic contexts of ethnically diverse communities (Henrich, Heine, & Norenzayan, 2010; Pasick, et al., 2009). This study found that cultural beliefs about health were major influences on how the study participants made sense of and responded to their physical and emotional discomforts. One undeveloped construct in existing health behavior models is the role of culture and how specific aspects of culture affect the meaning of health and help-seeking behaviors. Future research must address this important question in order to advance the theoretical understanding of diverse cultures and contexts in service utilization (Kagawa-Singer, 2012). Moreover, most of the existing research has used these models as guiding frameworks for understanding help-seeking behaviors of the population of focus rather to critically examine whether the assumptions and concepts in these frameworks apply to the individual study’s population of focus. More research guided by an inductive paradigm is needed to examine whether the constructs and assumptions underlying health/mental health service utilization models are appropriate when used to understand help-seeking behaviors of diverse ethnic groups (Kagawa-Singer, 2012; Pasick, et al., 2009).

Implications for Practice

Outreach and education. Findings showed that participants did not know they had a mental illness and did not do anything about their discomforts until someone told them they looked sick and needed to go to a place that could help them. Their narratives revealed that many Vietnamese American adults and older adults in the community remained uninformed and did not have the knowledge and information to identify their mental health needs. Thus, they
were likely to rely on their own cultural beliefs and consultations with others, such as family members, friends, neighbors, or PCPs, to make sense of possible mental health-related concerns. Some participants in this study referenced radio programs as places where they learned that their experiences had a name called depression. Thus, outreach and education efforts could best reach this population through networks where they and other community members typically turn to for support or information: the Vietnamese media outlets and primary health care settings.

The media outlets in the Vietnamese American community in Southern California is growing significantly, with several radio stations and multiple television programs that run 24 hours a day in the Vietnamese language. A handful of radio and television shows now offer programming about mental health and well-being issues. These outlets are followed by loyal subscribers throughout California and the United States, serving the more than 1.5 million Vietnamese in the United States (T. A. Nguyen, 2011), many of whom are monolingual adults and older adults, the target population of this research. The men and women in this study shared that what appealed to them about getting help was how that source of help was verbally framed, such as simply “seeing another doctor or a person who could help.” As such, a key aspect of education in the Vietnamese American community is framing mental health problems using messages that resonate with the vocabularies and understanding of the community members (USDHHS, 2013). Diagnostic labels and jargons of the profession such as mental illness, depression, mental health treatment, therapy, and psychotropic medication are neither meaningful nor appealing to community members. Rather, using the same words that participants used to describe their experiences with mental health problems (e.g. difficulties sleeping, headaches, worries, thinking too much) would be more relevant and less stigmatizing. Further, framing mental health concerns in terms of the stressors and challenges Vietnamese
Americans face in their daily lives (with jobs, family, intergenerational conflict, language access, and isolation) is another relatable approach to reach first-generation Vietnamese Americans. Participants revealed that they did not view themselves as mentally ill, in spite of an awareness that the community labeled them as such and that they were in treatment for a mental illness. This speaks to the immense stigma in the Vietnamese American community toward mental illness of any kind as well as differences in cultural understandings of mental illness (Lien, 1993; Phan, 2000). As such, community education efforts could convey educational messages to reduce stigma and clarify the definition and types of mental illness, thus expanding and modifying Vietnamese understandings of mental illness (Phan, 2000).

Participants also explained that an important prompt for getting help was receiving encouragement and assurance from someone else who had experienced similar difficulties and who had gotten help. These were individuals of similar ages who had also experienced the Vietnam War and flight/migration to the United States. Participants said that prior to getting help from the outpatient treatment center, they had doubts and wondered if the workers could help them or even understand them; they had no idea what outpatient treatment was. One recommendation would be to train consumers so they could provide outreach and education efforts in the community. This type of outreach carried out by familiar voices and faces and by individuals with whom they could relate would be effective for this population. Consumer-led outreach seems preferable to having an outside mental health professionals try to connect with these individuals, many of whom live with a mental illness, and who trust strangers less than members from their community.

Findings also showed that the primary care practitioners held a critical role in the detection of mental health difficulties and in linking participants to mental health services. Yet,
the PCPs were little in tune with the clients’ mental health experiences. Better linkages across the mental health systems and primary care settings would be helpful as noted in previous studies (Ida, SooHoo, & Chapa, 2012; D. Nguyen, et al., 2012). Stronger collaboration between social work mental health providers and Vietnamese American primary care physicians would strengthen the ability of PCPs to read cues related to mental health concerns (i.e. signs and symptoms specific to this population) in order to intervene or make appropriate referrals when they detect mental health needs beyond their scope of practice. It is particularly important for immigrant populations who are not familiar with health services and resources to receive linkages from their PCPs. The PCP is often the first and only point of contact that immigrants have for addressing health and mental health problems (D. Nguyen, et al., 2012). As such, the primary care setting could be a natural place for identifying people at risk for mental illness. Moreover, embedding mental health treatment programs within health centers has appeared to be an effective strategy to engage individuals in treatment. PCPs on-site could readily make referrals to the program when it exists at the same location. Such was the case for some participants in this study who stated that their PCP linked them to another program on-site so that they could be examined for their difficulties with sleep, headaches, and worries. Further, the integrated care model for outreach and engagement was much less stigmatizing and intimidating for participants and provided convenient access compared with referring to another off-site agency that was unfamiliar to the participants and even sometimes the PCPs. Such models have proven very effective in serving the Asian American community and would likely reduce the stigma in the larger American society as well (Ida, et al., 2012; D. Nguyen, et al., 2012).

Direct service delivery. Several recommendations emerged that could increase the acceptability of mental health service agencies to first-generation Vietnamese Americans.
Examining the conceptualizations of health from the perspectives of the participants provided culturally grounded and broadened definitions that could be useful for social work professionals working with this population. The participants were in treatment for depression and PTSD, but what these discomforts meant to them was different from the mainstream mental health system’s assumptions and knowledge about these diagnoses. The participants clearly emphasized the social aspects of their health, such as the ability to fulfill obligations to their families. Social workers must be mindful of the way they communicate with their clients about their presenting symptoms and experiences with mental illness. Their communication has to resonate with the conceptualizations of the clients (Fabrega, 1989; Kleinman, 1988; Kleinman, et al., 2006). Otherwise, there could be a disconnection between clinicians’ and clients’ understandings of the participants’ mental health difficulties, which could negatively affect treatment approaches and adherence. Another aspect of delivering culturally sensitive mental health services is clinicians’ knowledge of the history of this population, specifically, the nuances of the unique historical and migration contexts of first-generation Vietnamese Americans. This group suffered through decades of war, enormous losses, and trauma, and this legacy has left a lasting mark on their health and that of their family members. This dark past continues to play a significant role in the mental health of the Vietnamese American community and should be well understood by every clinician working with this population in terms of its lasting impact on their mental health. Participants’ depression and PTSD symptoms arose from a series of experiences during several decades of war and migration. They described having to endure and overcome many years of hardships that eventually led them to a point of exhaustion. Their vulnerability to mental health problems seemed to have begun long before they migrated to the United States, only to be exacerbated once they arrived in this country with limited to no English language skills, low
education, and limited job skills. This understanding highlights the complex situational context and multiple layers of trauma that underlie the depression and PTSD diagnoses given to the participants in treatment (Chung & Bemak, 2006; Hsu, et al., 2004; Marshall, et al., 2005). It also has treatment implications and should inform clinicians about ways to effectively address the mental health needs of this population.

The traditional mental health service delivery model is dominated by the DSM, psychotropic medication, and psychotherapy (Aneshensel & Phelan, 1999; Sue & Sue, 1999). The traditional mental health model also focuses on the individual, with the ultimate goal of self-realization and autonomy. These aspects of mental health treatment can be limiting and ineffective for first-generation Vietnamese American clients because they do not address what participants perceived to be at the core of their problems. Health for first-generation Vietnamese Americans is about the self being interconnected with the group. Participants sought help in hopes of improving their health so that they could resume their social roles as employees, parents, spouses, and family members. With this finding in mind, clinicians must broaden their understanding of the social contexts within which clients define and present their health problems in treatment, and of their culturally-grounded conceptualizations of health (Kagawa-Singer, 1993). They must also move beyond treating the individual and symptoms to engaging in therapeutic strategies that maximize, for each client, a sense of self worth, a restored ability to fulfill societal roles, and most importantly, a feeling of purpose within the family and community (Phan, 2000). Social workers could integrate this knowledge into their practices and modify traditional mental health treatment to fit the beliefs, practices, and contexts of their diverse clientele. If social workers could create meaningful experiences that meet the needs of the clients, then clients could resume their responsibilities and live more meaningful lives.
These first-generation Vietnamese Americans with mental illness were isolated from their larger communities. Thus, participants reported feeling happy when they were able to participate in socialization groups or go on a weekly outing with the agency. Such activities lifted them out of their four walls and therapeutically led them to an enhanced sense of efficacy and empowerment. Attending socialization groups at the agencies provided opportunities to get out of their homes and interact with others. They were no longer alone. Getting into a van for an outing with others allowed clients to be like everyone else: they could go to a restaurant and sit at a table to have a meal like everyone else; they could go to a popular part of town and wander in the shops just like everyone else. Thus, agencies should continue to use socialization groups as part of their treatment; furthermore, they should support useful activities such as English classes, health and mental health education, and arts and crafts classes that showcase clients’ skills. Agencies should also invest in having a van to take clients on outings so they can be more sociable and escape their monotonous, isolated routines.

Another recommendation is to provide opportunities for clients to volunteer, hold part-time jobs, or maintain active and meaningful lifestyles. Clients could be linked to volunteering opportunities at the agency or in the community, depending on what is most feasible for them, to stay engaged in meaningful activities. Clients could also be linked to part time jobs, to work and earn money. At one agency, participants were introduced to a local organization that helped them find part-time employment at a local thrift store. Clients could be referred to other health promotion groups in the community such as yoga, tai chi, and cooking groups. Though attending these groups could be difficult for clients who do not drive or know how to use the bus, it presents a teaching opportunity for the agency and a potential volunteer opportunity for clients to assist other clients by showing them how to use the bus. A related implication for practice is for
mental health agencies to connect participants with programs for education and job training so that they could enhance their English language and job skills, and then acquire employment that would provide them with a living wage or at least part-time work. While it is not the responsibility of the mental health agencies to provide these services, it is crucial that these agencies collaborate with other community-based organizations and businesses to make these opportunities available to the clients. We know the therapeutic values of opportunities for clients to stay active and contribute to the good of the group, which can help alleviate feelings of worthlessness and promote recovery. As such, clinicians must move beyond treating mental health needs using medication and psychotherapy to include focusing on the social aspects of wellness.

*Implications for Policy*

The delivery of culturally relevant services to ethnically diverse communities extends beyond practitioners’ sensitivity toward their clients’ diverse backgrounds or a self awareness of their own limitations (Iglehart & Becerra, 2011). It requires a change in the policies and practices of our health care systems to provide effective, high quality, and culturally- and linguistically-appropriate services to diverse populations (USDHHS, 2010, 2013). California’s Mental Health Services Act (Proposition 63) and the Affordable Care Act (ACA) allocate funding toward education, training, and innovations programs to serve individuals with mental illness throughout the state, and could be a source of financial support to sustain social work’s commitment toward culturally sensitive mental health service delivery.

The findings of this study raised an important issue about elder care, more specifically, the integration of and promotion of self sufficiency among Vietnamese American immigrant elders living with depression and/or PTSD and who are linguistically, economically, and socially
isolated from the community. One response to the above issue is related to another implication of this study: to revive the role and contribution of ethnic specific agencies. This could be done by channeling funding from Proposition 63 and the ACA toward workforce development and specifically, toward expanding and sustaining ethnic specific services. Findings demonstrated the value and importance of ethnic agencies in addressing mental health needs of first-generation Vietnamese Americans, because they provide community members access to culturally relevant mental health services that they otherwise would not have (Iglehart & Becerra, 2011). The participants’ stories highlighted that they and their friends, neighbors, and family members would not have been reached without these agencies. Having doctors and staff who spoke the Vietnamese language was crucial in engaging participants in mental health treatments. Participants clearly emphasized the critical role of workers who spoke their language, understood their culture and experiences, and related to and communicated with them in understandable ways that a non-Vietnamese worker could not. As such, we need to commit funding to recruit social workers from the community to fulfill the demand for ethnic-specific mental health services (USDHHS, 2013). Mainstream mental health service agencies alone cannot respond as effectively to the needs of ethnically diverse clients due to the cultural variations and nuances highlighted in this study, and so must strongly collaborate with ethnic specific agencies. Another implication would be to fund community education programs that actively reach out to ethnic communities (USDHHS, 2010; USDHHS, 2013) as recommended in the outreach and education section above.

A starting point is an investment in the development of a workforce that reflects the diverse needs of our communities (USDHHS, 2010; USDHHS, 2013). In areas populated by Vietnamese Americans such as Southern California, the challenge is to ensure there is an
adequate supply of social workers who would be able to respond to the mental health needs of this community. The number of first-generation immigrants is growing in the Vietnamese American community. As such, we need to acquire funding to actively recruit ethnically diverse individuals into social work programs. Social workers need to be more active and visible in the Vietnamese American community to fulfill this demand by helping to recruit people into graduate schools: distributing information at high school career centers, attending college career days, speaking with student organizations on college campuses, and educating others about college courses and programs that prepare students for post college employment or graduate schools. Social workers could also educate and recruit at Vietnamese American holiday celebrations such as the New Year Festival, on Vietnamese television and radio shows, and at Vietnamese American professional networking meetings. Social work programs need to develop relationships with ethnic agencies and send students to be trained at these agencies to gain hands-on experience with the populations. Some participants in this study revealed that their experiences working with younger Vietnamese American workers were limited because these workers could not relate to their stories and did not have adequate Vietnamese language ability to communicate with them in treatment. This insight indicates that some Vietnamese professionals are not completely bicultural or bilingual, so they are limited in their effectiveness and in the services they can deliver to the community. Notably, being of Vietnamese background does not automatically qualify an individual as bicultural or bilingual, nor can we assume that he or she is providing culturally sensitive services. Cultural sensitivity and competence in cross-cultural social work practice are a continuous learning process that requires ongoing training, reflexivity, and awareness in service delivery (USDHHS, 2010; USDHHS,
Thus, it is important to invest in the recruitment and training of a work force of individuals from the community to respond to the specific community needs.

A positive feature of Proposition 63 innovations program is the flexibility and creativity it allows mental health agencies in creating opportunities for clients to live healthier lives (compared with the traditional approach of medication and therapy) (Department of Mental Health, 2013). In the context of this study, participants’ stories about the values of socialization programs, particularly the ones that took them into the community for the day, challenge us to rethink how funding could be used to build programs promoting efficacy and self worth. Mental health service agencies are accountable to their funders and need to show results with numbers and measurable outcomes regarding the therapeutic progress of clinic clients. For example, if supported in future studies, socialization programs where staff take clients on weekly outings could be integrated into the therapeutic services, because the study participants talked about the importance of creating opportunities for them to move outside of their home and the agency. Measures to capture the value of these socialization outings could be included in the evaluation criteria of the treatment process. While this program might be viewed as time away from the staff’s duties at the office, the therapeutic values to clients are critical to their reclaiming their self worth – simply by having the opportunity to be just like everyone else and to be among members of their community.

Further Considerations

There are several limitations in the conduct of this study. First, the study included a small, purposive sample and might only be adequate for enriching our understanding of these participants’ experiences and specific contexts. This study sample is drawn from a population with severe depression and/or PTSD and chronic health problems who are of low SES and
education and have limited English language proficiency. First-generation Vietnamese Americans with depression and/or PTSD living in regions less populated with Vietnamese Americans, having higher SES and education, or having no chronic health problems may have different experiences from those of the participants. The study also represents the views of a selected group of individuals -- those willing to participate in such a study – and therefore may have not tapped into the experiences of other first-generation Vietnamese Americans. Moreover, I relied on interviews with the participants and gathered their perspectives only. Data triangulation with other sources such as interviews with family members and/or agency workers, or participants’ treatment files would yield additional insights into the experiences of these men and women. Participant observations of participants in their homes or throughout their day could also yield rich information about their daily lives and experiences. Furthermore, I conducted the interviews and data analyses in Vietnamese, and the final write up is in English. The process of translating the analyzed data into English could be limiting due to the possible loss of meaning of particular words, phrases, or ideas in the translation process.

In spite of these limitations, the richness and depth of the data could inform the design of future studies with other Vietnamese Americans and perhaps other Asian American or immigrant populations living with mental illness. Mental health treatment is underutilized among Asian Americans (Abe-Kim, et al., 2007; Matsuoka, Breaux, & Ryujin, 1997), and the first point of contact with mental health care often occurs only when the individual’s condition is severe (Chu & Sue, 2011; Wynaden, et al., 2005) and disruptive (Kung, 2003; Sue & Sue, 1999). Thus, a better understanding first-generation Vietnamese Americans’ views about mental illness, health more broadly, and outpatient care could inform more culturally-based and relevant mental health outreach programs to promote early intervention and retention of these individuals in treatment.
Summary and Conclusion

This study is among the first to illuminate the experiences of first-generation Vietnamese Americans living with depression and/or PTSD currently receiving outpatient treatment, a story that is largely unknown in the literature. It provides knowledge about conceptualizations of health and mental illness that is grounded in the lived experiences of the men and women, insights about the complex processes involved in their pathways into outpatient care, and participants’ perspectives of outpatient care as well as the expected and unexpected gains from mental health treatment.

Chapter 2 discussed in-depth existing literature that documented mental health needs, underutilization of mental health services among Vietnamese Americans, and factors affecting this service pattern. It also framed the Vietnamese American experience in the broader historical, political, and social contexts of the Vietnam War and post-war migration to the United States. Chapter 3 provided an overview of two existing models that have been widely used to understand help-seeking behaviors, along with an assessment of the applicability and limitations of the models to first-generation Vietnamese Americans. Whereas these models were useful in highlighting the individual, community, and structural levels of influences on service use, the application and relevance of these constructs to the participants in this study had yet to be explored. Chapter 4 described the inductive paradigm guiding the methodology of this study, the specific steps that were carried out in this research, and how the constructivist GT tradition guided my research and provided a tool for making analytic interpretations of constructs and processes that emerged from the data. Chapters 5, 6, and 7 discussed findings related to each of the three aims of this study and revealed the ways in which participants’ conceptualizations of health influenced their pathways into outpatient care and expectations for outpatient treatment.
This process paralleled participants’ journeys through losing, finding, and reclaiming self worth. Chapters 8 and 9 concluded with a discussion of key findings and their implications for social work practice, research, and policy and highlighted the potential contributions of this study to a long standing commitment of the social work profession toward providing culturally relevant mental health services to ethnic minority communities.

Individuals living with mental illness are parents, children, family members, friends, and citizens of our community. Their lives are interconnected to each and every one of us in various ways. Yet, they live at the margins of our communities, and their daily experiences with suffering and stigma remain hidden. Research is needed to engage the voices of these individuals so that we can support them through their battle with a mental illness. Fragility from their illnesses puts them at great risk, and the costs of these risks have both social and financial impacts on our society as a whole, particularly when worsening mental health strips these individuals of their ability to be productive and contributing citizens. This was truly the case for the participants in this study who had low-income, limited English language proficiency, primarily low education, and immigrant backgrounds. In the words of Sue and Sue (1999, p.17), “if counselors and therapists are to provide meaningful help to a culturally diverse population, we must not only reach out and acquire new understandings, but develop new culturally effective helping approaches.” Social workers deliver over half of mental health services to the communities (Brekke, Ell, & Palinkas, 2007). Our profession is among those best equipped to take the lead in providing culturally sensitive and competent mental health services through informed research, practice, and policy. Moreover, the social justice value at the core of our social work profession demands that we work to create a more just living environment for this, as well as other marginalized and voiceless groups.
APPENDICES
Appendix A: Eligibility Screener

[Note: All bracketed words will not be read out loud.]

[This serves either as a face-to-face screen or will be used as a phone screen if the participant (first generation Vietnamese Americans) approaches the researcher or calls in response to a flier. In the cases of a face-to-face screen, participants will be screened in the lobby of the outpatient service organization by the PI]

My name is Hannah Nguyen, a doctoral student from the department of Social Welfare at UCLA. Thank you for your inquiry regarding the study, “The experiences of first generation Vietnamese Americans with depression and/or PTSD in outpatient care”.

I need to ask you a few questions in order to determine whether you may be eligible for the research. I will ask you a few questions related to your age, where you were born, age at which you came to the U.S., and what you are in mental health treatment for. Before I begin I would like to tell you a little bit about the research.

The main goal of this research is to learn more about the experiences of first-generation Vietnamese Americans who have a diagnosis of depression and/or PTSD and are receiving outpatient treatment. Some things I am interested in include perceptions of mental illness, healing practices used to treat mental illness, decisions to seek out mental health treatment, and perceptions and expectations toward mental health treatment. The long-range goal is to help service providers offer more effective mental health services that are more attractive and desirable to first-generation Vietnamese Americans with mental illness. This is not a treatment study.

*If you are eligible, your participation in the research would involve a confidential individual interview at a private, safe, community, convenient location of your choice. The interview would be about the topics I just mentioned above.*

Would you like to continue with the screening? The screening will take about five minutes. You do not have to answer any questions you do not wish to answer and you may stop at any time. Remember, your participation in the screening is voluntary. A decision whether or not to participate in the screening will not affect your relationship with UCLA or the organization from which you are receiving mental health services. You will not directly benefit from the screening.

Your answers will be confidential. No one will know the answers except for the research team.

- (A) If you do not qualify for the study, your answers will be destroyed and not kept for any purpose.
- (B) If you do qualify for the study and decide not to participate further, your answers will be destroyed and not kept for any purpose.
- (C) If you do qualify for the study and decide to participate, the answers will be kept along with your confidential research record.
Would you like to continue with the screening?

[If yes, continue with the screening].

[If no, thank the person and end the conversation/hang-up if screening by phone].

**Screening:**

1. Were you born in Vietnam?
   a. if **yes**, continue with screen
   b. if **no**, go to ineligibility script

2. Were you born in or before 1973?
   a. if **yes**, continue with screen
   b. if **no**, go to ineligibility script

3. Did you come to the U.S. after age 12?
   a. If **yes**, continue with screen
   b. If **no**, go to ineligibility script

4. Are you currently receiving mental health treatment?
   a. if **yes**, continue with screen
      i. Have you been in treatment for longer than 3 months?
         1. if **yes**, continue with screen
         2. if **no**, go to ineligibility script
   b. if **no**, go to ineligibility script

5. What mental health diagnosis did your mental health professional tell you that you have?
   a. If depression and/or PTSD, continue to 6
   b. If schizophrenia, any kind of psychotic disorder, or bipolar disorder, go to ineligibility script
   c. If any other disorder (excluding depression and/or PTSD), go to ineligibility script

6. So no professional health provider has ever told you that you have:
   a. Schizophrenia
   b. Bipolar Disorder
   c. Any kind of psychotic disorder
      i. If **no to all (a-c)**, continue with screen
      ii. If **yes to any (a-c)**, go to ineligibility script

7. **If Ineligible:** At this point, you do not meet our criteria for this particular study because you <<either you were not born in Vietnam, were not born in or before 1970, came to the United States before age 12, are not currently receiving treatment for
depression and/or PTSD for three or more months from an outpatient mental health agency, or have an excluded diagnosis >>.
a. Do you have any further questions?
b. Thank the individual for their interest in the study and end or hang up.

8. **If Eligible**: Thank you for answering the screening questions, it appears from these questions that you are eligible for the study. I have just a few more questions about scheduling and your availability.

**Closing Statement:**
Do you have any questions about the screening or the research? I am going to give you a couple of telephone numbers to call if you have any questions later. Do you have a pen? If you have questions about the research screening, you may call Hannah (Hang) at 714-782-2085 and she will answer any questions.

If you have questions about your rights as a research subject, please call the UCLA Office for Protection of Research Subjects at 310.825.7122.

Thank you again for your willingness to answer my questions.
Appendix B: Initial Interview Guide

Greet and introduce self to participant.
Reiterate the study purpose and go over what will happen during the interview.
Ask if participant has any questions.
Review informed consent/obtain informed consent as needed.
Let participant know that I am starting the recording and do so.
Begin interview.

Demographic Questionnaire
First, I’d like to ask some background questions about you.

1. When did you come to the U.S.?
2. How did you arrive in the U.S.?
3. What is your
   a. Age
   b. Gender
   c. Marital status
4. Who currently lives with you in your household?
5. How would you describe your English language proficiency level?
   a. For every day conversation
   b. To understand your health care professionals
   c. To ask questions you have with your health professionals
6. Do you have health insurance?
   a. If yes, what type?
7. What is your highest level of education?
   a. Here
   b. In Vietnam
8. Are you currently employed?
9. What is your annual income?
   a. $0-$5,000
   b. $5,000-$10,000
   c. $15,000-$20,000
   d. $20,000-$25,000
   e. $25,000-$30,000
   f. $30,000-$35,000
   g. $35,000-$40,000
   h. Above $40,000
10. How long have you been in treatment for at this outpatient center?

Interview Questions

1. Conceptualizations about health
   a. Can you tell me in your own words… what health means to you? (probe: live happily, peacefully)
   b. What does it mean to not be healthy? (probe: does not love life, mind is unsettled)
   c. What are some explanations for the lack of health (insert participant’s own words)?
2. **Experience living with mental illness**
   a. How would you describe your health? (Probe: mental health)
   b. When did you feel your health interfered with your ability to carry out your routines (insert participant’s own words)?
   c. What is it that you think underlies your discomfort?
   d. What has it been like to live with the condition (insert participant’s own words)?

3. **Entry into outpatient care**
   a. How/when did you end up coming to this (outpatient care center)?
   b. What did you have to do to get care here?
   c. What were some things that made it easy for you to come here?
   d. What were some things that made it difficult for you to come here?
   e. Please tell me about other treatment places you have been to before coming here (if any)?

4. **Perceptions and expectations towards outpatient care**
   a. Before coming (here), what did you think would happen when you come here for care?
   b. What happens when you come here for care?
   c. How has this place been or not been like what you expected?
   d. What has the treatment providers told you about your condition/treatment?
   e. What does “depression” mean to you?
      i. Does this word describe accurately what you are experiencing? How so?
   f. What does “PTSD” mean to you?
      i. Does this word describe accurately what you are experiencing? How so?
   g. Has coming here helped you feel better with your (health/mental health/insert participant’s words)?
      i. How so?
      ii. If not as much as hoped, what else might be of help?

**CLOSING**
To end, is there anything else that we have not covered that would be important for me to know to best understand your situation and what your hopes are to regain your health?

Turn off tape.
Thank the participant.
Appendix C: Suicide Protocols

Los Angeles County Sites:

The possibility exists that during an interview a participant may discuss suicidal ideation. Although interview questions do not directly ask about suicidal ideation, participant’s discussion of his/her depression and/or PTSD in a private setting may lead to admissions of suicidal ideation. In cases where there is any concern regarding risk of self harm by a participant, the researcher will immediately contact the onsite Department of Mental Health supervisor or program head or designee, or, if unsuccessful, other DMH emergency services. These procedures will help to minimize risk of injury to the research participant to the greatest extent possible. These procedures are also consistent with DMH policies and procedures (the sites where this research will be conducted).

Key Contact:
- Program Head at Long Beach Asian Pacific Mental Health Program – Dr. Mitsuru Kubota (562) 346-1100
- Program Head at Coastal Asian Mental Health Service - Helen Chang (562) 599-9401

Orange County Sites

The possibility exists that during an interview a participant may discuss suicidal ideation. Although interview questions do not directly ask about suicidal ideation, participant’s discussion of his/her depression and/or PTSD in a private setting may lead to admissions of suicidal ideation. In cases where there is any concern regarding risk of self harm by a participant, the researcher will immediately contact the onsite Department of Mental Health supervisor or program head or designee, or, if unsuccessful, other DMH emergency services. These procedures will help to minimize risk of injury to the research participant to the greatest extent possible. These procedures are also consistent with DMH policies and procedures (the sites where this research will be conducted).

Crisis/Hotline Numbers:
- Orange County Crisis Hotline: (714) 639-4673
- Orange County Mental Health Hotline: (714) 834-6900
- National Suicide Prevention Lifeline (800) 273-TALK/(800)273-8255
Appendix D Screening Instruments
HOPKINS SYMPTOM CHECKLIST 25

VIETNAMESE VERSION

NAME ___________________________ DATE ___________ CLINICIAN ___________________________

DATE OF BIRTH ___________________________ SEX ___________ MARITAL STATUS ___________________________

ARRIVAL DATE ___________________________ PSYCHIATRIC DIAGNOSIS ___________________________
Instructions

Listed below are some symptoms or problems that people sometimes have. Please read each one carefully and decide how much the symptoms bothered or distressed you in the last week, including today. Place a check in the appropriate column.

Sau đây là những triệu chứng hoặc vấn đề mà con người thường cảm thấy, xin vui lòng đọc căn thận và coi những triệu chứng đó đã gây khó chịu cho bạn đến mức độ nào trong tuần vừa qua và hôm nay. Xin giữ vào những cBIT thích ứng.

<table>
<thead>
<tr>
<th>PART I</th>
<th>ANXIETY SYMPTOMS</th>
<th>Not at all</th>
<th>A little</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Không hề có</td>
<td>Có chút</td>
<td>Bi khá nhiều</td>
<td>Bi rất nhiều</td>
</tr>
<tr>
<td>1.</td>
<td>Suddenly scared for no reason</td>
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<tr>
<td></td>
<td>Bống đừng lo sợ mà không lý do</td>
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<tr>
<td>2.</td>
<td>Feeling fearful</td>
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<td></td>
<td>Cảm giác sợ hãi</td>
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<td>3.</td>
<td>Faintness, dizziness, or weakness</td>
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<td></td>
<td>Gìm ngất xỉu, ngất xỉu, chóng mặt, suy yếu</td>
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<td>4.</td>
<td>Nervousness or shakiness inside</td>
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<td></td>
<td>Rụng sét hoặc thế hợp trong lòng</td>
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<td>5.</td>
<td>Heart pounding or racing</td>
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<td></td>
<td>Tim đập mạnh, hoặc nhộn</td>
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<td>6.</td>
<td>Trembling</td>
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<td></td>
<td>Tê rung các bắp thit bị giết, run (run rável)</td>
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<td>7.</td>
<td>Feeling tense or keyed up</td>
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<td></td>
<td>Cảm giác căng thẳng</td>
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<td>8.</td>
<td>Headaches</td>
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<td></td>
<td>Bi nhức đầu</td>
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<td>9.</td>
<td>Spells of terror or panic</td>
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<td></td>
<td>Bi nhàng cơn hoảng hốt, lo sọt nặng xảy ra</td>
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<td>10.</td>
<td>Feeling restless, can’t sit still</td>
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<td></td>
<td>Cảm giác bồn chồn, lo lắng khó thể ngồi yên một nơi</td>
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231
<table>
<thead>
<tr>
<th>PART II</th>
<th>DEPRESSION SYMPTOMS</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td></td>
<td>Feeling low in energy, slowed down</td>
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<td>11.</td>
<td>Cảm giác yếu chán, uể oải</td>
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<tr>
<td></td>
<td>Blaming yourself for things</td>
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<tr>
<td>12.</td>
<td>Tự trách mình về mọi việc xanh ra</td>
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<td></td>
<td>Crying easily</td>
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<td>13.</td>
<td>Bắt khóc dễ dàng</td>
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<tr>
<td></td>
<td>Loss of sexual interest or pleasure</td>
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<td>14.</td>
<td>Mất hay bị hổng thú trong việc sinh lý</td>
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<tr>
<td></td>
<td>Poor appetite</td>
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<td>15.</td>
<td>Ăn không hiểu ngon</td>
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<tr>
<td></td>
<td>Difficulty falling asleep, staying asleep</td>
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<td>16.</td>
<td>Khó đi giấc ngủ, khó yên giấc ngủ</td>
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<td></td>
<td>Feeling hopeless about the future</td>
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<td>17.</td>
<td>Cảm giác tổn vong về tưới plant</td>
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<td></td>
<td>Feeling blue</td>
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<td>18.</td>
<td>Cảm giác âm u, buồn rên</td>
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<td></td>
<td>Feeling lonely</td>
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<td>19.</td>
<td>Cảm giác có đành</td>
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<td></td>
<td>Thoughts of ending your life</td>
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<td>20.</td>
<td>Ăn cảm tưởng muốn kết liễu cuộc đời mình</td>
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<td></td>
<td>Feeling of being trapped or caught</td>
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<td>21.</td>
<td>Cảm giác mắc kẹt hoặc không lì thơ</td>
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<td></td>
<td>Worrying too much about things</td>
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<td>22.</td>
<td>Lo lắng quá về mọi việc</td>
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<td></td>
<td>Feeling no interest in things</td>
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<td>23.</td>
<td>Cảm giác không ham thích gì, bắt cả việc gì</td>
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<td></td>
<td>Feeling everything is an effort</td>
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<td>24.</td>
<td>Cảm giác, việc gì cũng khó khăn đôi nhiều cố gắng</td>
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<td></td>
<td>Feelings of worthlessness</td>
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<td>25.</td>
<td>Cảm giác mình là kẻ bất tài, vô dụng</td>
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</table>
SCORING

Responses are summed and divided by the number of
answered items, to generate three scores:

\[
ANXIETY = \frac{\text{ITEMS 1-10}}{10} \quad \rightarrow\quad \square
\]

\[
DEPRESSION = \frac{\text{ITEMS 11-25}}{15} \quad \rightarrow\quad \square
\]

\[
TOTAL = \frac{\text{ITEMS 1-25}}{25} \quad \rightarrow\quad \square
\]

Individuals with scores on anxiety and/or depression
and/or total \(> 1.75\) are considered symptomatic.
See Manual for additional information.
HARVARD TRAUMA QUESTIONNAIRE

VIETNAMESE VERSION

NAME: ___________________________ DATE: ___________________________

CLINICIAN: ___________________ DATE OF BIRTH: _______________ SEX: _______________

MARITAL STATUS: ___________________ ARRIVAL DATE: ___________________

PSYCHIATRIC DIAGNOSIS: ___________________
Instructions

Lời chỉ dẫn

We would like to ask you questions about your past history and present symptoms. This information will be used to help us provide you with better medical care. However, you may find some questions upsetting. If so, please feel free not to answer. This will certainly not affect your treatment. The answer to the questions will be kept confidential.


Part I: Trauma Events

Phần I: Các sự việc gây không hoàn tâm thân.

Please indicate whether you have experienced, witnessed, or heard any of the following events. (Check all that apply.)

Xin cho biết nếu quý vị có kinh nghiệm, chứng kiến, hoặc nghe tới những sự việc sau đây.

E = Experienced (kinh nghiệm)  H = Heard about it (nghe tới)
W = Witnessed (chứng kiến)       N = No (không)

<table>
<thead>
<tr>
<th></th>
<th>E</th>
<th>W</th>
<th>H</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Lack of food or water.</td>
<td></td>
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<tr>
<td></td>
<td>Thiếu đồ ăn hoặc nước uống</td>
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<tr>
<td>2.</td>
<td>Ill health without access to medical care.</td>
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<tr>
<td></td>
<td>Dấu bệnh mà không có phương tiện y khoa</td>
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<td></td>
<td></td>
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<tr>
<td>3.</td>
<td>Lack of shelter.</td>
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<td></td>
<td>Không có nhà ở</td>
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<td>4.</td>
<td>Imprisonment.</td>
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<td></td>
<td>Bị bắt giữ</td>
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<td>5.</td>
<td>Serious injury.</td>
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<td></td>
<td>Bí thương tích nặng</td>
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<td>6.</td>
<td>Combat situation.</td>
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<td></td>
<td>Tình thế lửaダン</td>
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<td>7.</td>
<td>Brainwashing.</td>
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<td></td>
<td>Bị tẩy não</td>
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<tr>
<td>8.</td>
<td>Rape or sexual abuse.</td>
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<td></td>
<td>Bị hiếp dâm hoặc bị bảo hành dâm dặng</td>
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<td>9.</td>
<td>Forced isolation from others.</td>
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<td></td>
<td>Bị cô lập</td>
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<td></td>
<td>Bị nguy hiểm gần kẻ sự chết</td>
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<td>11.</td>
<td>Forced separation from family members.</td>
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<td></td>
<td>Bị ép buộc phải tách rời khỏi gia đình</td>
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<td>12.</td>
<td>Murder of family or friend.</td>
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<td></td>
<td>Người thân thich hay ruột thịt bị giết hại</td>
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<tr>
<td>13.</td>
<td>Unnatural death of family or friend.</td>
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<tr>
<td></td>
<td>Người thân thich hay ruột thịt bị chết bất đắc kỳ tử</td>
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<td>14.</td>
<td>Murder of stranger or strangers.</td>
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<td></td>
<td>Người không quen thuộc bị giết</td>
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<td>15.</td>
<td>Lost or kidnapped.</td>
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<td></td>
<td>Di lạc hay bị bắt cóc</td>
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<td></td>
<td>Bị tra tấn</td>
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<td></td>
<td>Specify:</td>
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<td></td>
<td>Xin cho biết rõ:</td>
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<td>17.</td>
<td>Any other situation that was very frightening or you felt your life was in danger.</td>
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<td></td>
<td>Hoàn cảnh khốn dâm nào khác dem tôi sự đe doạ cho tình mạng</td>
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<td></td>
<td>Specify:</td>
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<tr>
<td></td>
<td>Xin cho biết rõ:</td>
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</tbody>
</table>
Part II Personal Description
Phần II: Miêu tả cá nhân

Please indicate the most hurtful or terrifying events you have experienced, if any. (please specify where and when these events occurred.)
Xin ghi ra những biến cố đau đớn hoặc ghê sợ nhất mà quý vị đã trải qua. (Xin cho biết kỳynthia và lúc nào những sự việc này đã xảy ra.)

Please indicate the most terrifying or hurtful events you have experienced, if any, in this country.
Xin hãy ghi ra những biến cố nào đau đớn và ghê sợ nhất mà quý vị đã trải qua, nếu có, tại nước cư ngụ.

---

Part III Head Injury
Phần III: Bị thương nội đầu

1. Did you experience any of the following?  
   Ông/bà có từng trải qua những việc sau đây không?
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cổ</td>
<td>Không</td>
<td>Ngày tháng</td>
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<tr>
<td>Drowning</td>
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<tr>
<td>Đổ mực nước</td>
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<tr>
<td>Suffocation</td>
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<tr>
<td>Bi ngạt thở</td>
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<tr>
<td>Beating to the head</td>
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<tr>
<td>Đập đánh vào đầu</td>
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</tbody>
</table>

2. Did you lose consciousness?  
   Ông/bà có từng bị bất tỉnh không?
   If yes, for how long?  
   Nếu có, bị bao lâu?
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cổ</td>
<td>Không</td>
<td>Ngày tháng</td>
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</table>

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4
Part IV Trauma Symptoms
Phần IV: Các triệu chứng bị khủng hoảng tâm thần

The following are symptoms that people sometimes have after experiencing hurtful or terrifying events in their lives. Please read each one carefully and decide how much the symptoms bothered you in the past week.

Sau đây là những triệu chứng có người sẽ bị sau khi trải qua những biến cố đau đớn hoặc khủng khiếp. Xin đọc kỹ từng triệu chứng và nghĩ xem quý vị đã bị những triệu chứng nào và đến mức độ nào trong tuần vừa qua.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>(1) Not at all</th>
<th>(2) A little</th>
<th>(3) Quite a bit</th>
<th>(4) Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Recurrent thoughts or memories of the most hurtful or terrifying events. Bij ám ảnh bởi những ý tưởng hoặc ký niệm về các sự việc đau đớn hay khủng khiếp đã trải qua.</td>
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<tr>
<td>2.</td>
<td>Feeling as though the event is happening again. Cảm tưởng như chuyện ấy đang tái diễn lần nữa</td>
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<tr>
<td>3.</td>
<td>Recurrent nightmares. Thường bị ác mộng</td>
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<tr>
<td>4.</td>
<td>Feeling detached or withdrawn from people. Thấy như mình cách biệt hay không muốn giao tiếp với người khác</td>
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<tr>
<td>5.</td>
<td>Unable to feel emotions. Không có thể xúc động được</td>
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<td>6.</td>
<td>Feeling jumpy, easily startled. Tâm trí căng thẳng, dễ giật mình</td>
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<td>7.</td>
<td>Difficulty concentrating. Khó tập trung tư tưởng</td>
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<td>8.</td>
<td>Trouble sleeping. Khó ngủ hay ngủ không yên giấc</td>
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</tbody>
</table>
|   | Feeling on guard.  
|   | Cảm nghĩ dễ phòng  
|   | Cảm thấy khó chịu, hoặc có những cơn giận dữ  
| 10. | Avoiding activities that remind you of the  
|   | traumatic or hurtful event.  
|   | Tránh các sinh hoạt nhắc lại những sự việc đã gây đau đớn hoặc xúc động  
| 11. | Inability to remember parts of the most  
|   | traumatic or hurtful events.  
|   | Không thể nhớ lại chi tiết các việc đã gây đau đớn hoặc xúc động  
| 12. | Less interest in daily activities.  
|   | Không thích thúmayın đến cuộc sống hàng ngày  
| 13. | Feeling as if you don't have a future.  
|   | Cảm thấy như mình không có tương lai gì hết  
| 14. | Avoiding thoughts or feelings associated  
|   | with the traumatic or hurtful events  
|   | Tránh những ý tưởng hoặc cảm giác làm mình nhớ tới những biến cố đó  
| 15. | Sudden emotional or physical reaction when  
|   | reminded of the most hurtful or traumatic  
|   | events.  
|   | Đột nhiên xúc động mạnh تمام lý hoặc có thể khi nghe nhắc đến các biến cố đau thương  
| 16. | Feeling that people do not understand what  
|   | happened to you.  
|   | Cảm thấy người khác không hiểu gì về những việc đã xảy đến với mình  
| 17. | Difficulty performing work or daily tasks.  
|   | Khó làm công việc hàng ngày hoặc hay ở nhà  
| 18. | Blaming yourself for things that have  
|   | happened.  
|   | Tự trách mình về những việc đã xảy ra  
<p>| 19. | |</p>
<table>
<thead>
<tr>
<th></th>
<th>Feeling guilty for having survived.</th>
<th></th>
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<tbody>
<tr>
<td>20.</td>
<td>Cảm thấy có tội lỗi vì đã sống sót.</td>
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<tr>
<td></td>
<td>Hopelessness.</td>
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<td></td>
<td>Feeling ashamed of the hurtful or traumatic events that have happened to you.</td>
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<td>22.</td>
<td>Cảm thấy xấu hổ với những sự việc đau đớn hoặc xúc động đó đã xảy ra với mình.</td>
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<td></td>
<td>Spending time thinking about why these things happened to you.</td>
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<td></td>
<td>Feeling as if you are going crazy.</td>
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<td>24.</td>
<td>Có cảm tưởng như mình sắp diệt.</td>
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<td></td>
<td>Feeling that you are the only one who suffered these events.</td>
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<td>25.</td>
<td>Cảm thấy chỉ có mình là người duy nhất đã trải qua những đau khổ.</td>
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<td></td>
<td>Feeling others are hostile toward you.</td>
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<td>26.</td>
<td>Cảm thấy kẻ khác có ác ý với mình.</td>
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<td></td>
<td>Feeling that you have no one to rely on.</td>
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<tr>
<td>27.</td>
<td>Cảm thấy không có ai để mong nhờ được.</td>
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<td></td>
<td>Finding out or being told by other people that you have done something that you cannot remember.</td>
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<td>28.</td>
<td>Được biết hoặc nghe người khác nói lại rằng mình đã có những hành động mà nay mình không còn nhớ gì hết.</td>
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<td></td>
<td>Feeling as if you are split into two people and one of you is watching what the other is doing.</td>
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<td>29.</td>
<td>Tương chừng như mình phân thành hai người và một trong hai người đó ngắm có người kia làm gì.</td>
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<td></td>
<td>Feeling someone you trusted betrayed you.</td>
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<td>30.</td>
<td>Cảm thấy người mình dặ tin tưởng phân bối mình.</td>
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</table>
SCORING

Responses are summed and divided by the number of answered items to generate the following scores:

**Trauma Events**

Total number of events = Sum of all items for which response differs from "NO."

Total events experienced = Sum of all items with positive response to "EXPERIENCED."

---

**Trauma Symptoms**

DSM/III-R Score = \[ \frac{\text{Items 1-16}}{16} \]

Total Score = \[ \frac{\text{Items 1-30}}{30} \]

Individuals with total scores \( \geq 2.5 \) are considered symptomatic for PTSD.

See manual for additional information.

developed by

INDOCHINESE PSYCHIATRY CLINIC
BRIGHTON MARINE PUBLIC HEALTH CENTER
DEPARTMENT OF PSYCHIATRY
ST. ELIZABETH'S HOSPITAL
AND

THE HARVARD PROGRAM IN REFUGEE TRAUMA
DEPARTMENT OF HEALTH POLICY AND MANAGEMENT
HARVARD SCHOOL OF PUBLIC HEALTH
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