VIETNAMESE AMERICAN FAMILIES’ PERCEPTIONS OF CHILDREN’S MENTAL HEALTH: HOW CULTURE IMPACTS UTILIZATION OF MENTAL HEALTH SERVICES

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Abstract

More research is needed in the area of counseling children (Thompson, 2007) and specifically with ethnic minority children. Despite the large population and higher prevalence of mental health concerns due to refugee and immigrant status compared to the overall American population, the Vietnamese American population underutilizes mental health services. The current study expands on existing research using a constructivist lens and multiple case study approach. Semi-structured interviews were conducted with four Vietnamese American mothers who had children 12 and under who had or are currently using mental health services. Two primarily were Vietnamese speaking and two were primarily English speaking. Participants shared perceptions of mental health for Vietnamese American children, and described their experiences with mental health services for their children.

The findings of this study indicate that Vietnamese beliefs and values, perceptions of problems, perceptions of factors contributing to mental health, approaches to addressing mental health concerns, and experiences of treatment all impacted the participants perceptions of their children’s mental health service use. Implications of the findings will be detailed according to the Ecological Systems Theory (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 1998; Bronfenbrenner & Morris, 2006), combined with an integrative model for Vietnamese Americans (Lam, 2005), and detailed in regards to practice, training, and future research.
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Chapter 1: INTRODUCTION

From the period of 1980 to 2000, the Asian American population increased by 204% (United States (US) Census Bureau, 2002). According to the US Bureau of the Census (2010), the Asian American population grew faster than any other race group in the United States between 2000 and 2010. In 2000 there were 10.7 million Asians constituting 3.8% of the total American population while in 2010, the number increased to 14.4 million constituting 4.6% of the total American population, a 43.3% increase. By 2050, the Asian American population is projected to increase to 34.4 million people and account for 7.8% of the US population (Nguyen, Leung, & Cheung, 2011). Vietnamese Americans signify the fastest growing trend in the Asian American population (Nguyen et al., 2011), with over 1.73 million Vietnamese having settled in the US, approximately triple the number of Vietnamese totaled in the U.S. in 1990 (US Census Bureau, 2010). Over 50 percent of Vietnamese American have settled in Texas and California (Kaplan & Huynh, 2008; Thai, 2002), where it is projected that children of immigrants will outnumber Caucasians (Thai, 2002). In 2007, approximately one fourth of Vietnamese in the United States were children under the age of 18 years, with 83.7% of those children born in the United States (National Center for Education Statistics, 2010). Thus, counselors are likely encountering the unique mental health needs of Vietnamese American children in a variety of settings.

Studies indicate that Asian American youth are more likely to have serious psychiatric conditions than other minority groups when entering treatment, yet underutilize services available, highlighting that Asian Americans may wait to seek help only after mental health has severely declined (Chun & Sue, 1998). Vietnamese American youth may especially need mental health services as there are unique mental health concerns due to immigration history, refugee
status, and intergenerational conflicts as children are raised by their parents in American culture (Kaplan & Huynh, 2008; Leung, Boehnlien & Kinzie, 1997; Pyke, 2000; Thai, 2002). Despite the significant prevalence of mental health concerns among Asian American youth, this population comprises only 1.4% of children enrolled in the California System of Care, an integrated public mental health service system that aims to provide individualized and coordinated services across systems (e.g., education, child welfare, juvenile justice, mental health) to youth who are challenged by severe mental health concerns. This is in comparison to the actual population of 9.4% (Mak & Rosenblatt, 2002). Additionally, Asian American children were less likely to receive psychological or emotional counseling than white counterparts and often receive less than half as many counseling sessions as their white counterparts (Alegria, Atkins, Farmer, Slaton, & Stelk, 2010). One key reason for the underutilization of mental health services among Asian American families in general, and Vietnamese American families specifically, may be cultural norms that discourage help-seeking behaviors for children’s mental health concerns.

The underutilization of mental health services by Vietnamese Americans has often been attributed to language, unfamiliarity with counseling, stigma towards mental health services, and difficulties distinguishing between mental and physical health (Coleman, Parmer, & Barker, 1993; Leung, et al., 1997; Kaplan & Huynh, 2008; Nguyen & Anderson, 2005; Thai, 2002). With language barriers, when professionals do not speak Vietnamese or translators are unavailable, treatment compliance significantly lowers (Kaplan & Huynh, 2008). Vietnamese Americans may be unfamiliar with how counseling in the United States can be a long-term therapeutic relationship between mental health provider and patient, whereas clinics in Vietnam typically provide short term walk-in treatment focused on immediate physical symptoms (Kaplan
Huynh, 2008). There is also a high amount of stigma towards mental health, where problems are perceived as shortcomings of the individual, encompassing a negative reflection on the family (Nguyen & Anderson, 2005). Difficulties distinguishing between mental and physical health come from the belief that psychological difficulties are organically based, where medical services are sought instead of mental health (Nguyen & Anderson, 2005). Additionally, these barriers often lead to inappropriate assessment and service delivery practices by counselors due to lack of understanding of the Vietnamese American culture (Kaplan & Huynh, 2008; Locke, 1998). For example, Vietnamese culture places the family at the center of importance to a person’s well-being and there are family hierarchal structures that emphasize importance on deference toward elders in the family (Kaplan & Huynh, 2008).

The urge by a counselor to empower and individualize a client may directly conflict with cultural norms, especially for children who may not feel comfortable with interventions that seem to “blame” their parents (Kaplan & Huynh, 2008). Despite some initial exploration of the relationship between Vietnamese American parents and the utilization of mental health services among their children, many questions remain unanswered.

One key question that has yet to be explored, and which is critical to children’s mental health services with this population, is the conceptualization and expression of mental illness among Vietnamese American families. Conceptualization and expression of mental distress can differ amongst cultures, which can shape access, outreach, and determination of treatment and appropriate service delivery (Dogra, Vostanis, Abuateya, & Jewson, 2005; Dogra, Vostanis, Abuateya, & Jewson., 2007). Ethnic and racial minorities in the U.S. include populations where mental disorder may be thought to be incurable or where minorities are unresponsive to treatment (Algeria et al., 2010).
Minorities may also differ in understandings about mental illness and treatment due to services historically available to them in their country of origin, along with differences in beliefs about what a counselor can do for them (Alegría, et al., 2010). This is especially pertinent for Vietnamese Americans, as they are considered “contemporary immigrants”, with the bulk of immigration having occurred between 1975 to the 1990s (Pyke, 2000). In addition, the role definitions, familial expectations, hierarchical relations, caution in emotional expressiveness, and collectivist values associated with family systems of Vietnamese culture contrast sharply with the emphasis on individualism, autonomy, egalitarianism, expressiveness, and self-development valued in mainstream US culture (Pyke, 2000).

Little is known about what underlying beliefs and values Vietnamese Americans may adhere to from Vietnamese culture that may impact their views on children’s mental health, but there is some information on general mental health. More traditional Vietnamese Americans may view mental illness as due to harmful spirits or punishment by gods for an individual or family’s misdeeds in a past life (McKelvey, Baldassar, Sang, & Roberts, 1999), and a manifestation of feebleness in the mind (Tran, 2012). Definitions of mental illness can be more constrained in Vietnamese culture, and apply to severe psychotic disorders, where the person’s behavior overtly disrupts social order. More internalizing emotional problems, such as anxiety and depression, are seen to be normal parts of life that are to be endured and dealt with alone (McKelvey et al., 1999).

Stigma is attached to mental illness, and families take great effort to restrain and hide ill family members from public view (McKelvey et al., 1999), with the mentally ill seen as less important contributors to society (Tran, 2012). More traditional Vietnamese families may seek treatment from magical sources such as a spiritual healer or sorcerer (McKelvey et al., 1999).
The key is to further explore family, along with cultural beliefs and values to understand how Vietnamese American families perceive children’s mental health.

Families have the primary decision making role in the care of their own children (National Federation of Families for Children’s Mental Health, 2008) and there is a call for consumer and family driven research and services (President’s New Freedom Commission on Mental Health, 2003). Recent research with Vietnamese Americans have been centered on adult and adolescent mental health (Hoang, 2011; Mai, 2009; Nguyen, 2006; Vo, 2005), but there is a limited knowledge on Vietnamese American children’s mental health (Nguyen, 2006) and the role of families in children’s access to services. Specifically in exploring minority children, such as Vietnamese Americans, examining family members’ cultural perspectives or perceptions on mental health care and help-seeking can aid in meeting the services needs of the population and move research forward to overlooked areas (Dogra et al., 2007; Murry, Heflinger, Suiter, & Brody, 2011). Therefore, the purpose of this qualitative study was to gain insight into Vietnamese American families’ cultural perspectives of children’s mental health through their own words.

**Statement of the Problem**

A review of the literature indicates that there is a dearth of research on Vietnamese American families and children’s mental health. Overall, there is a general lack of preparation, professional development, and research in the counseling profession focused on mental health practice with youth ages 3 to 17 (Mellin, 2009; Mellin & Pertuit, 2009). There is even further lack of research on the counseling needs of culturally diverse children and their families (Thompson & Henderson, 2007). Yet in 2011, the Agency for Healthcare Research and Quality (AHRQ) reported that mental health conditions were one of the five most treated medical
problems in children. This is indicative of the prevalence of mental health problems for children, but lack of professional preparation and research to work with them.

In order to aid with outreach, appropriate intervention and retention, it is necessary to understand the perspectives of mental health from youth and adults in minority families because conceptualization and manifestation of mental health concerns can differ across cultures (Dogra et al., 2005; Dogra et al., 2007). Similar concerns have been noted by researchers in other fields on the need for examining cultural perspectives in children’s mental health and illness, such as social work (Johnson, Davis, & Williams, 2004), psychology (Tucker, 2002), and psychiatry (Minnis et al., 2003; Nguyen, Huang, Arganza, & Liao, 2007) and the impact on service utilization.

Vietnamese Americans were highlighted specifically in other fields on attitudes toward children with disabilities (Saenz, Huer & Doan, 2001) and perceptions of rehabilitation services (Hampton, Yeung, & Nguyen, 2007). Previous studies on minority groups have attempted to clump Vietnamese Americans with Asian Americans, but Vietnamese Americans have marked differences between major causes of mental illness due to the lasting effects of trauma such as war (Hampton et al., 2007) and boatpeople immigration, or those who fled the country by boat. Many Vietnamese boatpeople experienced piracy, starvation, thirst, loss of life, sexual assault, and cannibalism as part of their journey (Kaplan & Huynh, 2008). Asian American groups also differ according to education, dialects, occupation, and immigration backgrounds and although there are common cultural aspects, caution must be taken in making generalizations about Asian Americans because there are notable variations (Kim, 1995).

Additionally, few studies on Vietnamese Americans include a clinical sample (Mai, 2009), which means those who have or are currently receiving mental health services. By
focusing on a clinical sample as rather than a general sample, actual service utilization can be explored rather than just treatment preferences (McKelvey et al., 1999). How a family experiences and prefers to be involved in treatment are dependent on culture, yet these aspects are seldom assessed together (Algeria et al., 2010). When exploring how families come to receive services and what service utilization was like for them, I can attempt to derive what cultural perspectives in the family influenced the decision making that led to using mental health services and how they were used for their children. This can be especially pertinent for minority groups, such as Vietnamese Americans, in understanding how families come to receive services and what service utilization was like.

There is a growing number of studies on ethnic minority children’s mental health in the United States and the impact of family cultural background. Populations that have been studied include African American (Mukolo & Heflinger, 2011; Murry, et al., 2011), Chinese American (Lowinger, 2009; Lau & Takeuchi, 2001), Hispanic children (Arcia, Fernandez, Jaquez, Castillo, & Ruiz, 2004), and Cambodian American families (Daley, 2005). A population that has not been examined is Vietnamese Americans, the population of focus for this study. Researchers in other countries such as Britain, Australia, and Palestine, have strongly encouraged and used qualitative and mixed methods approaches to examine minority children’s mental health (Anstiss & Ziaian, 2010; Bradby et al., 2007; Cinnirella & Loewenthal, 1999; Dogra et al., 2007; Dogra et al., 2005; Thabet, Gammal, & Vostanis, 2006). Compared to quantitative studies, however, qualitative inquiries have only relatively recently begun to emerge in the United States (Arcia et al., 2004; dosReis, Mychailyszyn, Myers, & Riley, 2007; Lowinger, 2009; Mukolo & Heflinger, 2011; Murry et al., 2011; Vera & Conner, 2007), despite the advocacy for the appropriateness of qualitative research to study multicultural issues (Merchant & Dupuy, 1996).
Qualitative studies are critical to understanding the relationship between the culture of minority parents and the utilization of mental health services for their children because it allows the researcher to examine the underlying structure behind attitudes and belief systems that may not be captured through fixed responses typical in quantitative approaches (Cinnirella & Loewenthal, 1999) and aid in filling in gaps from previous research (Bradby et al., 2007). Additionally, in contrast to other ethnic minority groups and studies abroad, there is a lack of qualitative studies for culturally sensitive data gathering with Vietnamese Americans regarding mental health (Hoang, 2011; Mai, 2009; Vo, 2005).

Qualitative approaches are important in the exploration of culturally different groups in counseling and aid in overcoming cultural barriers (Merchant & Dupuy, 1996; McLeod, 2011). Whereas research has historically focused on experiences of mainstream White, middle-class, male populations to generalize or use as measures (Merchant & Dupuy, 1996), qualitative methods work well with exploring culturally different groups because methods are not focused on testing or confirming existing theories (McLeod, 2011). Qualitative methods are discovery-oriented, using open-ended questions to further expand understanding to follow where the data may lead (McLeod, 2011).

In a review of the literature on Vietnamese Americans, discussed in further detail in Chapter Two, studies on Vietnamese Americans have been predominantly quantitative, with very few focused on the mental health of Vietnamese American children (Nguyen, 2006; Nguyen & Anderson, 2005), and none to date that specifically examine the perspectives on the mental health of Vietnamese American children using qualitative methodology.

The overall aim of this research study was to describe how Vietnamese American families that have utilized or who are utilizing mental health services perceive and incorporate
children’s mental health into their lives. Qualitative methodology was used to accomplish this aim through interviewing families that currently have a child 12 years of age or under who has received, or is receiving mental health services. Insights into the meaning making of these families towards children’s mental health were captured through thick descriptions that are not found through quantitative methods (Hays & Wood, 2011, McLeod, 2011; Patton, 2002). The following research questions helped achieve this aim.

**Research Questions**

Three research questions guided in this qualitative study. In the research questions, certain terms such as Vietnamese American, culture, mental health, family, and children are used. I will elaborate on the terms in the *Definition of Terms* section of this chapter and in Chapter two.

**Research Question 1:** “What are the cultural values and beliefs of Vietnamese American families on children’s mental health?”

**Research Question 2:** “What mental health concerns is a/are Vietnamese American child(ren) facing, and what do their families think impacts their child(ren)’s mental health both positively and negatively?”

**Research Question 3:** “How do Vietnamese American families address mental health concerns for their children, and what were their experiences like?”

**Significance of the Study**

This current study builds on previous studies (Hoang, 2011; Mai, 2009; Nguyen, 2006; Nguyen & Anderson, 2005; Vo, 2005) in three important ways. Firstly, this was the first exploratory study to focus on the mental health of Vietnamese American children ages 12 and under (Nguyen, 2006) as impacted by their family. In the past, research has focused on
adolescents and college students but very little is known about Vietnamese American children (Nguyen, 2006), especially concerning various aspects of familial impact. It is important to study children as there may be developmental differences and builds on Nguyen’s (2006) study as the researcher examined parent and adolescent self ratings of emotional and behavior problems as they relate to acculturation of children 12 and above.

Secondly, by including a clinical sample of participants, I explored factors that have encouraged families to participate in mental health services (Mai, 2009; McKelvey et al., 1999). Previous studies have rarely included clinical samples. Inclusion of a clinical sample (Mai, 2009; McKelvey et al., 1999) may help to expand knowledge in outreach, early intervention, treatment, and retention in counseling Vietnamese American children. In addition to treatment preferences, further information can be gathered on actual service utilization (McKelvey et al., 1999) and what experiences of treatment were like. Including a clinical sample can help in gathering a wider breadth of information for comparison with nonclinical samples (Mai, 2009).

Lastly, this study helped capture the cultural perspectives of Vietnamese families towards children’s mental health through the perceptions, opinions, and understanding of four participating mothers. This was important because it helped in discovering information not captured through quantitative methods. Information gathered from this study may be especially important for counseling with immigrant, particularly refugee Vietnamese American families, focusing on the impact this can have on the mental health of children in the family. More specifically, due to the trauma experienced through war, refugee status and immigration, past studies involving Vietnamese immigrants indicate a high prevalence of mental health disorders including trauma, PTSD (Post Traumatic Stress Disorder), depression, and anxiety (Kaplan & Huynh, 2008) that go beyond those who experienced the war and extends to their children who
were born and raised in the United States (Ida & Yang, 2003). Children of refugees often can exhibit the same mental health concerns as refugee children despite not being refugees themselves. These mental health concerns include navigating being a part of two cultures, exposure to the same potential family problems such as depression, and family grief over numerous losses (Wahmanholm & Westermeyer, 1996). Children can experience secondary trauma resulting from their parent’s experiences that may affect their attachment to include insecure, ambivalent, or disorganized attachment. In young children, this can lead to a lack of trust and adverse effects on exploratory behavior, initiative, and trust. In older children, this can be exhibited through externalized aggressive behaviors or internalized anxiety and depression (Wiese, 2010). When Vietnamese American families seek help, they will likely need mental health services as there is a unique grouping of mental health concerns that relate to immigration history, refugee status, and intergenerational conflicts when parents raise their children in American culture (Pyke, 2000; Leung, et al., 1997; Thai, 2002).

**Boundaries of the Study**

There were three primary research boundaries (Miles & Huberman, 1994) to this study: (a) researcher bias; (b) sample representation; and (c) data collection technique. Firstly, I share the cultural background of the sample for this study and I am also a professional who has had experience in working with the mental health of Vietnamese American children, which can help with the quality of the study. This helped in recruitment, building rapport, and understanding cultural dynamics. This could have also skewed my views, however, throughout different parts of the study and contributed to researcher bias (Patton, 2002). For example, I may have made unintentional assumptions about participants due to feeling like I am a cultural insider. I addressed this bias by employing various strategies such as member-checking, reflexivity, and
peer-debriefing to enhance the trustworthiness and quality of my study (Creswell, 2007). In Chapter Three, I discuss techniques implemented in this study to ensure trustworthiness.

Secondly, my sample was recruited from one of the most known and earliest established Vietnamese ethnic enclave in Orange County, California with the largest density of Vietnamese Americans in the US (Kaplan & Huynh, 2008; Leninger, 2002), which limited diversity in gathering participants from other geographic locations. It is important, however, to highlight that the aim for this study was not generalizability but transferability, such as the degree to which results are transferable to other settings (Hays & Singh, 2011; Patton, 2002). Thus, the goal was to provide sufficient information about the research process so that readers can make decisions about the degree of applicability of the research findings to the context of their work (Hays & Singh, 2011). Thus, results from this study may be most transferable to Vietnamese American families residing in the Orange County area and possibly in other ethnic enclaves in the United States, as opposed to families living in more isolated areas.

Lastly, within the resources available to me, I used individual interviews as the primary source of my data collection. Interview data has limitations that include possible distorted responses due to personal bias, anger, anxiety, lack of awareness of emotional state during interview, recall error, reactivity of interviewee to interviewer, and self-serving responses (Patton, 2002). Interviews, however, are an ideal and flexible method to gather the rich data (McLeod, 2011; Patton, 2002) needed for capturing meaning making and lived experiences. I make recommendations in the final chapter for use of other data collection in future studies. Now that possible limitations in the study have been noted, it is important to clarify the definitions of several key terms.
**Definition of Terms**

The following section provides definitions for important terms used in this study. Defining these terms was important because they helped with clarity and understanding of the research questions. The following definitions are framed by recent scholarship and my experiences as a counseling professional and researcher.

**Culture.** There are various definitions of culture in the field of counseling, but a broad definition used with counseling children is the shared meanings, norms, and values of a large social group (Thompson & Henderson, 2007). In this study, when examining cultural views of participants, understanding can be gained through exploring deeply engrained beliefs and values from Vietnamese culture (Kaplan & Huynh, 2008). In examining the cultural identity of participants, to account for variations and subtleties in culture, I emphasized the multidimensionality of culture (Brown & Trusty, 2005; Richardson & Jacob, 2002) to encompass seeing people from multiple cultural identities that can include race, ethnicity, social class, age, developmental level, gender, religion, spirituality, nationality, disability status, and family characteristics. Although I targeted a specific ethnicity in this study, I reported on all the other different dimensions of cultural identity for the participants’ in the study. Previous studies examining culture frequently incorporate enculturation and acculturation, described as the process of adaptation from one culture to another, including retaining selected aspects of one’s indigenous culture (Kim & Atkinson, 2002). Several different models have been presented in the literature (Chung, Kim, & Abreu, 2004; Kim & Atkinson, 2002; Shen & Takeuchi, 2001), but the aim of this study was not to prove or disprove any type of model. Instead, the aim was to capture how that process manifests for each participant as it related to their children’s mental health.
Mental health. At the core level, “mental health” is in itself a cultural construct shaped by American society through cultural agents such as counselors, psychiatrists, the legal system, and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) that reflect underlying Western-majority culture (Alegría et al., 2010). American society has an age-old and apprehensive cultural view of where the parameters of mental illness should lie and has debated what should be considered “normal” (Algeria et al., 2010). Thus, when an Eastern-oriented population is introduced to the American mental health system, differences in cultural worldviews towards mental health can be distinct. For the purposes of this study, mental health was both psychological and physical aspects of health that are often intertwined or used interchangeably by Vietnamese Americans. Specifically for Vietnamese Americans, who tend to somaticize psychological disturbances (Kaplan & Huynh, 2008; Leung et al., 1997; McKelvey et al., 1999; Nguyen & Anderson, 2005), including physical symptoms will help capture how psychological disturbances manifest physically. The most important aim for this study was how families view mental health and how they define it.

Vietnamese American and other ethnic labels. Ethnic identities can be extremely subjective, political, and related to oppression (Malott, 2009). In the literature, researchers have used Vietnamese, Vietnamese American, Southeast Asian American, and Asian American. When referring to previous literature, I utilize the language used by the researcher or researchers. A detriment in discussing particular ethnic groups is the inclination to stereotype all members of the group with the same characteristics and to overlook individual qualities and changes in culture (Thompson & Henderson, 2007). Thus when researchers discuss Asian Americans or Southeast Asian Americans, they may be looking at a wide breadth of groups from different national origins with pronounced cultural differences. Even when discussing a specific country,
such as Vietnam, there are distinct interethnic differences that cannot be encompassed in one particular label. For example, a major geographic interethnic difference would be those who identify as originating from North or South Vietnam (Locke, 1998). Therefore in this study, I used the language of how participants self-identify, as there are sociopolitical implications of identifying as Vietnamese due to history of war and negative attitudes towards the current communist government (Kaplan & Huynh, 2008; Zhou & Bankston, 1998).

**Family.** Definitions of family may look different in Vietnamese American families due to mass immigration, where severe disruptions were wrought on immigrants and refugees. Due to loss of relatives from separation and death (i.e. child without parents, husband without wife), the criteria for “family” has shifted and expanded (Kibria, 1993). Thus in defining family in the Vietnamese American context, I included others such as friends or distant relatives who form ties of fictive kinship to substitute for blood relatives (Kibria, 1993). Family members can also come from multiple generations, including those who fled Vietnam as refugees, children born in Vietnam who arrived with their parents, younger children who were born in the US, and relatives who later immigrated to reunite with their families (Kaplan & Huynh, 2008; Zhou & Bankston, 1998). Therefore, family is defined in a multigenerational context to account for varying generations within a family. In this study, the intent was to interview people, in this case, mothers, that made key decisions regarding mental health for their children and were also responsible for ensuring that they received treatment.

**Children.** For the purposes of this study, children are defined as those ages 12 and under. Since I am specifically focused on Vietnamese American children, I describe the categories of immigrant children. Children in the study fall into the categories of immigrant children, children of immigrants, and native born children of native parentage (Cheung &
Nguyen, 2001; Portes, 1996). In this study, immigrant children have emigrated from Vietnam themselves, while children of immigrants would have parents who have emigrated from Vietnam. Native born children of native parentage would be U.S. born children who have U.S. born parents that can trace their ancestry to Vietnam.
Chapter 2: REVIEW OF THE LITERATURE

Evidence suggests that the present mental health system is failing to deliver quality mental health care for diverse children and families, and critical attention is needed to diversity, culture, and context. This is indicated by low rates of service entry, high dropout rates, and increased rates of unmet needs for mental health services (Alegría et al., 2010). Despite reports that Asian American youth have a higher prevalence of serious psychiatric conditions than other minority groups when entering treatment, they still underutilize services available, highlighting that Asian Americans may wait to seek help only after mental health has severely declined (Chun & Sue, 1998).

Vietnamese American children may especially need mental health services as there are unique concerns such as depression, anxiety, family grief, attachment problems, and intergenerational differences related to parental or familial war and refugee experiences (Kaplan & Huynh, 2008; Leung et al., 1997; Pyke, 2000; Thai, 2002; Wahmanholm & Westermeyer, 1996; Wiese, 2010) that may exacerbate mental health disorders.

Vietnamese American families raising children will likely present with a unique grouping of mental health concerns that relate to immigration history, war, refugee status, and intergenerational conflicts when parents raise their children in American culture (Leung et al., 1997; Pyke, 2000; Thai, 2002). Although Vietnamese Americans have often been grouped under Asian Americans in previous research, Vietnamese Americans have major differences in causes of mental illness due to the lasting effects of trauma through war and boatpeople immigration (Hampton et al., 2007). A majority of Vietnamese immigrants to the United States are people that fled by boat, and many experienced piracy, malnutrition, threat of death, sexual assault, beatings, and cannibalism. Research with Vietnamese immigrants show a high incidence of
mental health conditions including trauma, PTSD (Post Traumatic Stress Disorder), depression, and anxiety (Kaplan & Huynh, 2008; Leung et al., 1997). Often times mental illness in adult family members can negatively affect the development of the children in the family (Leung et al., 1997), extending past those who experienced the war and transmitting to their children who were born and raised in the United States (Ida & Yang, 2003).

Children of refugees often can exhibit the same mental health issues as refugee children. These mental health issues include exposure to the same prospective family mental health problems such as depression, navigation of different cultures, and family grief over various losses (Wahmanholm & Westermeyer, 1996). In addition, children of refugees can have secondary trauma resulting from parental and familial experiences that may negatively affect their attachment (Wiese, 2010) and development of interpersonal skills (Leung et al., 1997). For example, younger children can exhibit detrimental effects on exploratory behavior, initiative, and trust while older children can exhibit outward aggressive behaviors or internalized anxious and depressive symptoms (Wiese, 2010).

A key issue for the underutilization of mental health services among Vietnamese American families may be cultural barriers that inhibit help-seeking behaviors for children’s mental health concerns. Barriers to use of mental health services by Vietnamese Americans has often been attributed to language, reluctance to disclose personal history, unfamiliarity with counseling, stigma towards mental health services, conflicts among generations of Vietnamese families, and difficulties distinguishing between mental and physical health (Coleman et al., 1993; Kaplan & Huynh, 2008; Leung et al., 1997; Nguyen & Anderson, 2005; Thai, 2002).

Despite some initial exploration of the relationship between Vietnamese American families and the utilization of mental health services among their children, further exploration is
still needed. More information is needed on how these aspects manifest in the lives of Vietnamese American children and their families, such as through examples given by families and the meaning they draw from their experiences.

To improve outreach, intervention, and retention, researchers have noted the importance of understanding the perspectives of mental health from youth and adults in minority families because conceptualization and manifestation of mental health concerns can differ across cultures (Dogra et al., 2005; Dogra et al., 2007). Examining diversity, context, and culture can shed important information on the meanings of mental health for children and families. Cultures differ in regards to meanings given to illness and the way they make sense of subjective experiences of illness and distress. Meanings influence how people from different cultures are driven to seek treatment, how they cope with symptoms, how supportive families and communities are, where they seek help, what pathways to obtaining services look like, and how well they do in actual treatment (The Center for Health and Health Care in Schools, 2007). Therefore, the following review of the literature uses ecological theory as a lens for exploring how the culture of underrepresented ethnic families impacts help-seeking for children who experience mental health concerns.

To begin, there will be a description of ecological systems theory (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 1998; Bronfenbrenner & Morris, 2006), a theory chosen to guide in both the literature review and development of this study. First, the conceptual framework for ecological systems theory, categorized into five systems: micro, meso, exo, macro and chronosystem (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 1998; Bronfenbrenner & Morris, 2006), will be presented and how these relate to the research focus. Second, an integrative model of the ecological framework that expands on cultural factors specific to the
Vietnamese American population will be described (Lam, 2005), including two constructs of acculturation and ethnic identity imperative to examining Vietnamese Americans. Next is a literature review pertaining to Vietnamese American children’s mental health. The categories for the literature review are divided into three different aspects of population, topic, and methodology.

Following that is a brief description of how research in other fields on minority children’s mental health continues to grow. In conclusion, a rationale for how counselor education needs to build on the lack of research on working with children and youth, especially with minority children, will be presented. Furthermore, specific examination of the overlooked population of Vietnamese American children and their mental health using a qualitative approach can fill gaps concerning the population and topic, contributing to research in the field of counseling.

**Ecological Systems Theory**

To examine the literature on Vietnamese American children’s mental health and develop this study, Bronfenbrenner’s (1979) ecological systems theory is applied. In his theory, Bronfenbrenner (1979) describes the interaction of multiple ecological systems that surround a child, and overlap and change to determine the path of child development (see Figure 1). The first is the microsystem which pertains to the pattern of activities, roles, and interpersonal relations experienced by a developing person in a given setting with particular physical and material characteristics. This includes family, school, and peers (Qin, Han, & Chang, 2011).

Since children are still minors, thoughts on what constitutes a mental health problem, decisions on whether to seek treatment, and how treatment is utilized, are primarily in the hands of their families and other key adults that have the power to initiate action (Algeria et al., 2010; Qin et al., 2011). Applying ecological systems theory, the family plays the primary role in a
child’s mental health. Decades of research have noted that the most important developmental context for a child is family, especially in terms of how it impacts children’s mental health. Most studies examine the microsystem such as family, school, and peers (Qin et al., 2011). Thus, I applied the concept of microsystem to examine the literature on Vietnamese children’s mental health to focus on the importance of family and as a rationale for examining the family of a Vietnamese American child when designing my study.

The next system is the mesosystem, where there are interrelations among two or more settings in which the developing person actively participates, such as for the child, relations among home, school, and neighborhood peer group (Bronfenbrenner, 1979). In sum, it is the interaction of the child with the outside world, along with interactions of microsystems in a child’s life (Qin et al., 2011; Santrock, 2007). When reviewing the literature, attention will be given to how the existing literature has investigated the mesosystem. For example, a school based mental health referral could illustrate the relationship between home, school, and the mental health systems, and could be seen as interaction between three microsystems in a Vietnamese American child’s life. This helps frame the literature reviewed and also helps frame the importance of examining interactions of microsystems in a child’s life.

The next system is the exosystem, where one or more settings that do not involve the developing person as an active participant, but in which events occur that affect or are affected by the child (Bronfenbrenner, 1979). It is the external environment that indirectly influences a child’s development, such as a parents’ place of work (Qin et al., 2011). Thus, the exosystem is used to examine the literature that includes examination of indirect influences on a child’s mental health. In using the parent’s place of work as an example, discrimination and oppressive circumstances may be existent in a parent’s workplace, causing strain on a parent’s mental
health. This could jeopardize the parent’s ability to parent effectively thus affecting the emotional well-being of the child.

The macrosystem is where consistencies in the form and content of lower-order systems (micro, meso, and exo) exist, or could, at the level of the subculture or culture as a whole, along with any belief systems or ideology underlying such consistencies (Bronfenbrenner, 1979). The macrosystem is the overall societal systems such as cultural, political, social, legal, religious, and economic processes (Qin et al., 2011). The macrosystem is where culture and contextual influences operate, but the influences are subtle, elusive and hard to capture (Cauce et al., 2002). It is here, with the integration of micro, meso, and exosystem, that I examine the interaction of culture amongst all systems to holistically examine the context of Vietnamese American children’s mental health, especially in regards to the impact of culture.

The latest system that Bronfenbrenner developed is the chronosystem, referring to the patterns of environmental events and transitions over time in the life span, inclusive of sociohistorical conditions (Bronfenbrenner & Morris, 1998; Bronfenbrenner & Morris, 2006). The chronosystem can have a major influence in determining a minority child’s future achievements (Santrock, 2007). In the case of children from a Vietnamese American background, there may be a family history of trauma, oppression, and adjustment hardships that may transfer across time to how the child develops in his or her life. Although not having directly experienced war or refugee trauma, Vietnamese American children can still be exposed to this through family oral narratives and observations of family members throughout their lives.

**Integrative Model for Vietnamese Americans.** To further focus ecological systems to the Vietnamese American population, Lam (2005) proposed an integrative model specific to Vietnamese Americans. In this model, the author highlighted the need for ecological systems
theory to consider characteristics specific to ethnic populations. He then proposed an integrative model for use with Vietnamese Americans that included sociopolitical and cultural constructs that are salient to ethnic minorities in general and the Vietnamese American population in particular. Lam (2005) stated that there are common constructs that are relevant to all minority ethnic populations that influence psychological distress. These constructs are embedded in the different systems, which include social and political (i.e. social class, discrimination) in the macrosystem, community environments (i.e. schools, local, neighborhood) in the meso and exosystem, peer and family relationships (i.e. cohesion, conflict) in the microsystem, and individual (i.e. acculturation, ethnic identity).

Specific factors salient to the Vietnamese American population would include ethnic enclave, mental health beliefs, and the refugee experience. These constructs occur across the various systems (see Figure 1). For Vietnamese Americans, living in an ethnic enclave means the opportunity to experience their culture as dominant. The enclave can be a source of community support, a buffer from external influences, and a source to foster social integration. However, it can be a source of strict control through the closely interwoven community, negatively influencing emotional wellness (Lam, 2005). Attention will be given to the samples and location of studies in the literature review to assess whether participants are part of an ethnic enclave.

The cultural context of mental health beliefs is another important specific factor for Vietnamese Americans. Beliefs about mental health include the integration of psychological and physiological distress, the influence of supernatural forces that can disrupt mental and physical health, and the psychological distress as a moral and religious issue due to the deterioration of
the individual’s inner strengths. In the literature review, the focus is on the topic of mental health beliefs, noting cultural influences.

Another specific factor is the refugee experience, as almost all Vietnamese Americans are either refugees or offspring of refugees (Lam, 2005). Refugees experienced war, oppressive government, family disruption, and profound hardships to flee Vietnam. Many developed psychological strains such as post traumatic disorder. Refugee parents with depression, anxiety, and grief risk endangering their children’s development and acculturation (Lam, 2005). These will be taken into consideration during the literature review to examine articles addressing the refugee experience and the relevant after-effects on mental health.

**Constructs.** In the integrative model, Lam (2005) emphasized the importance of acculturation and ethnic identity in examining the Vietnamese American individual (see Figure 1). Acculturation is the process of integration and differentiation of values resulting from contact with majority culture. Ethnic identity is the degree to which a person identifies with their own ethnic group, but also extends to include bicultural competence in which a Vietnamese American can be able to adapt or change to fit into numerous social and cultural contexts.

There has been much research and importance placed on examining the connection between Asian American children’s acculturation and ethnic identity to their mental health (Lopez, Escoto, Monford-Dent, Prado-Steiman, 2011; Qin et al., 2011). More research is needed, however, to examine parental and family acculturation and its impact on children’s mental health (Qin et al., 2011). Despite the need to examine these constructs, there is still much debate on the conceptualization and measurement of acculturation and ethnic identity (Lopez et al., 2011). In this literature review, consideration is given to studies that examine acculturation and ethnic identity.
Figure 1. Bronfenbrenner’s ecological theory of development (Bronfenbrenner & Morris, 1998; 2006) adapted to the Vietnamese American (Lam, 2005) child.
Vietnamese Families and Children’s Mental Health

To comprehensively understand the landscape of research on the population of Vietnamese American families and children’s mental health, the literature review will begin with broadly describing the research on different subsets in the population that include adults, college students, and adolescents. Due to the lack of research on Vietnamese American children (Nguyen, 2006), the literature review expands to Vietnamese minority children in other Western countries.

Quantitative studies with adults. Several studies have quantitatively examined the attitudes of Vietnamese American adults towards mental health services. In Nguyen and Anderson’s (2005) study, the researchers examined the relationship between culturally based variables and attitudes toward seeking mental health services among a community sample of 148 Vietnamese Americans. Citing the inconsistent results of previous studies utilizing acculturation measures, the authors proposed the use of five specific cultural dimensions rather than broad acculturation level or a one-dimensional measurement. The authors in this study demonstrate examination of the macro level elements of attitudes and ideologies of culture in how Vietnamese American adults view seeking mental health services. Variables examined included stigma, traditional beliefs about mental illness, help-seeking preferences, problem prioritizing, and disclosure. Through a chronosystem perspective, the authors display examination of the patterns and transitions of these adults since settlement in the United States by requiring participants to have lived at least eight years in the United States.

Nguyen and Anderson (2005) found that disclosure, help-seeking preferences, and problem prioritizing were significant predictors of attitudes. Thus, greater inclination to disclose, greater preference for professional rather than family and community resources, and
greater priority placed on mental/emotional health concerns over other concerns, were associated with more positive attitudes toward pursuing mental health services. On the other hand, perceived level of stigma and traditional beliefs regarding mental illness did not significantly predict attitudes. The authors postulated that with higher problem severity, stigma tolerance may heighten as fear of stigma weakens as problems become more severe. In regards to lack of predictive power of traditional beliefs, this may be related to the acculturative process as all of the respondents had to be residents of the United States for at least eight years.

In another study by Luu, Leung, and Nash (2009) on the impact of acculturation, cultural barriers, and spiritual beliefs on the help-seeking attitudes among Vietnamese Americans, the authors surveyed 210 Vietnamese Americans. Participants were age 18 to 75 from the Houston, Texas area, an ethnic enclave where the third largest population of Vietnamese Americans resides (Nguyen et al., 2011). They hypothesized that acculturation, cultural barriers, and spiritual beliefs together will predict attitudes toward seeking professional psychological help.

The authors found that greater levels of acculturation, cultural barriers, age, and occupation resulted in more positive attitudes toward help-seeking and lower levels of spiritual beliefs meant more favorable attitudes toward help-seeking. The authors also address analysis of the macrosystem of attitudes and ideologies of culture in designing their study. Contrasting with Nguyen and Anderson’s (2005) study where holding traditional beliefs about mental illness was not a significant predictor of help-seeking, Luu and colleagues (2009) found that participants who believed less strongly in traditional spiritual causes of mental problems had more positive attitudes supporting findings with other populations such as Filipino and Southeast Asian immigrants. Older participants were also more likely to seek help.
In addition to examining the cultural factors that may influence help-seeking in Vietnamese American adults, Nguyen et al. (2011) specifically examined family problems in relation to help-seeking. By examining family problems and culture, the authors address the macro and microsystem and their relations to help-seeking. Using the 2008 Asian survey with 572 Vietnamese American participants, they found that 46% experienced parent-child conflict and 30% reported depressive symptoms. Parent-child conflict was found to be significantly related to having depression and anxiety.

The results indicated that having parent-child conflict would increase the likelihood of thinking that the problem will be solved naturally by 82%. They also found that having depression increased the chances of seeking medical care through an herbalist 1.718 times and a doctor by 40%. They found that intergenerational cultural dissonance, or traditional Vietnamese authoritarian parenting with children facing traditional values while conforming to mainstream individualistic perspective, can cause parent child conflict. It is a contributing factor that influences Vietnamese Americans’ mental health, but mental health professionals are not the treatment of choice. This study highlights the family system perspective to include the interconnectedness of the mental health of family members.

In two separate studies, Ngo (2005) and Vo (2005) both investigated willingness or attitude of Vietnamese Americans toward psychological help, with mixed results. Ngo’s (2005) investigation of the potential mediator effects of language acculturation and Attitudes Toward Seeking Professional Psychological Help (ATSPPH) in relation to length of residence in the United States and willingness to seek professional help for psychological problems or a mental disorder, yielded no support for the mediator model. Post hoc analyses, however, indicated that participants’ preferred helping sources (e.g. psychologist vs. religious leaders) mediated the
effects of ATSPPH and willingness to seek help for certain psychological disorders. Further, participants’ perception about the causes of disorder seemed to influence their willingness to seek professional help.

Vo (2005) found that acculturation levels, gender, age, generational status, education, personally knowing someone who has a mental illness, having sought help for personal issues, and various perceptions of mental illness did not predict willingness to seek professional psychological help among Vietnamese Americans. With the inclusion of a language variable, however, results showed that English language respondents were more acculturated and displayed more positive attitudes toward mental health and treatment than Vietnamese language respondents. English language respondents who had knowledge of someone with a mental illness were inclined to be more willing to find professional psychological help.

Both Ngo (2005) and Vo (2005) address the macrosystem through examination of acculturation and language, and Vo (2005) examines the microsystem’s possible influence by including how knowing someone with a mental illness can affect help-seeking. Ngo (2005) noted the limitations of the weak measures used in the study and Vo (2005) reported difficulties in translation of instruments, and how most were not normed for the Vietnamese population. Due to these concerns, Vo (2005) recommended examination of perceptions of mental illness and conditions under which Vietnamese Americans would be willing to seek help using qualitative methodology.

**Qualitative and mixed methods studies with adults.** In a mixed methods study conducted in Australia, Silove et al. (1997) examined levels of satisfaction with mainstream mental health services and specialized mental health services for refugees among Vietnamese psychiatric patients and their relatives. Eighty-six (60 percent of eligible) Vietnamese patients
were identified from case notes of mainstream inpatient services \( (n=31) \), community services \( (n=7) \) and specialized refugee treatment \( (n=48) \).

During the interview, they administered a scale measuring satisfaction with treatment, along with measures of anxiety, depression, and posttraumatic stress disorder. The modified satisfaction scale was administered to 56 relatives. The authors used a semistructured interview to elicit more detailed information about possible sources of satisfaction or dissatisfaction, with questions about staff’s explanations of services, diagnoses and treatments, whether inpatient or outpatient treatments were more acceptable, and the patient’s willingness to use the same services in the future.

Results were that patients’ relatives were, on average, moderately satisfied with treatment. Patients expressed greater satisfaction with the special treatment unit for refugees than with mainstream services, where findings were not influenced by diagnostic differences or symptoms levels at the time patients responded. Further analyses controlling for multiple comparisons revealed that the extent of information provided and ease of negotiating changes in treatment were the most salient variables in distinguishing satisfaction levels across two types of treatment centers.

Patients’ fluency in English and the relatives’ level of education were inversely associated with satisfaction scores, suggesting that the greater ability of the patient and families to evaluate services, the less likely they were to express satisfaction with treatment. The authors posited that specialized mental health services for refugees may be more acceptable to refugee populations than mainstream counterparts, maybe due to better communication with patients and their families. Patients and families who are in a position to evaluate services fully are more likely to be critical of treatments offered. The authors not only address the microsystem by
including family and relatives, but also examine the mesosystem through inclusion of interactions of family, patients, and the mental health system.

In one of few exploratory studies using qualitative face to face interviews to gather in-depth information, Hampton et al. (2007) investigated perceptions of Mental Illness (MI) and rehabilitation services with 20 Chinese and 20 Vietnamese Americans. The researchers found the following major themes including (a) MI was a treatable disease that consisted of different types and varied from mild to severe; (b) the major cause of MI was stressful circumstances such as the Vietnam War and immigration; (c) MI was not positively perceived in the participants’ communities (sense of burden, damage family reputation, punishment for past wrongdoing); and (d) rehabilitation counseling services were virtually unknown to the participants, although some knew of mental health services.

The study reflects examination of the macrosystem through cultural aspects, in addition to the exosystem by examining influences of communities. Results indicated that participants tended to have a holistic view of health, distinguishing physical from mental, but tended to link two together thinking that physical caused mental concerns. Almost all Vietnamese participants, regardless of age or gender, talked about the Vietnam War and its impact on their lives. The importance of the chronosystem is evident in how the event of the Vietnam War has impacted Vietnamese participants regardless of age or gender.

Quantitative studies with college students. In one of the earliest studies found on Vietnamese Americans, Atkinson, Ponterotto, and Sanchez (1984) examined the attitudes of 63 Vietnamese and 52 Anglo-American college students in an Extended Opportunity Program and Services (EOPS) toward counseling. The authors found that Vietnamese refugees enrolled in EOPS have lower positive attitudes toward seeking professional psychological help, described
less identification of personal need for professional aid, less tolerance of mental health use
stigma, lower interpersonal openness towards problems, and lower confidence in the competence
of mental health professionals to help.

Vietnamese and Anglo-American students reported seeking help from a friend first, but
Vietnamese students ranked the oldest person in the community as high while Anglo-Americans
rated them as low. The study is important in examining Vietnamese Americans as a specific
group in their attitudes towards counseling. Because these are students that are being sampled,
this and other studies presented onward can be inclusive of the micro and mesosystem, as
Vietnamese American college students interact with the educational system.

Hoang (2011) conducted a correlational study to examine the relationship between
gender, stigma, enculturation, and attitudes toward seeking professional psychological help.
Data was collected from 130 (45 males, 93 females) Vietnamese American students attending a
large community college in the ethnic enclave of Orange County, CA. A large majority (94.9%)
were born in Vietnam and seven (5.1%) were born in the United States. Length of residency in
the United States ranged from less than one year to 45 years. Three independent variables are
gender, enculturation, and stigma. By including specific measurement of enculturation, the
authors incorporate examination of attitudes and ideologies of culture from the macrosystem.

Results indicated that individuals perceiving greater stigma for receiving psychological
help were more likely to endorse negative attitudes toward seeking professional psychological
help. Hoang (2011) also found a statistically significant relationship between gender,
enculturation and attitudes toward seeking professional psychological help.

Hom (1996) studied the value perspective of individualism-collectivism, acculturation,
and ethnicity in relation to counselor preferences and attitudes toward seeking counseling in 323
Asian American college students, 80 of which were Vietnamese. Similar to the previous study, inclusion of cultural variables indicates a macrosystem approach to examining help-seeking. The author found that more acculturated participants had more positive attitude towards counseling and were more likely to express preference for an Anglo-American counselor over an Asian-American. Lastly, regardless of acculturation or gender, participants preferred counselors with similar values to them over all other counselor characteristics. Females had more positive attitude towards counseling than males, individualistic students had less positive attitudes toward counseling, and collectivistic students had more positive attitudes towards counseling. Highly acculturated and bi-cultural students were more collectivistic than low acculturated students.

Researchers have also examined specific psychological distresses in the Vietnamese American population. Han and Lee (2011) surveyed 134 Vietnamese American students attending a public university in Northern California to examine the role of parental and peer attachment, intergenerational conflict, and perceived racial discrimination on depression. Inclusion of parental and peer relations indicates examination of the microsystem, while racial discrimination indicates an examination of mesosystem through the individual’s interactions with the outside world. The author found that higher levels of parental and peer attachment predicted lower depressive symptoms. The author also examined the meditational role of Sense of Coherence (SOC) on depressive symptoms. SOC is defined as a global orientation impacting perception and interpretation of external events in life as ordered, predictable, manageable, and meaningful. Han and Lee (2011) found that SOC partially mediated the effect of parental attachment on depressive symptoms and played a complete meditational role for perceived racial discrimination on depressive symptoms.
Lam (2007) examined whether sense of coherence mediated relationships between perceived racial discrimination and collective self-esteem to psychological distress depression and anxiety for 122 Vietnamese American college students. The author found that greater levels of perceived racial discrimination (PRD) were associated with a lessened sense of coherence (SOC), and higher levels of psychological distress. Lam (2007) stated that path analysis indicated SOC partially mediated the relationship of PRD to depression and also anxiety.

Higher levels of Collective Self-Esteem (CSE), or individual’s evaluation of one’s self-esteem derived from interaction with others, was associated with a stronger (SOC), resulting in association with lower depression and anxiety. SOC mediated the relationship between CSE and depression, and partial relationship between CSE and anxiety. Through an ecological lens, the authors examine larger macrosystem dynamics through cultural racial interactions, while addressing micro and mesosystem dynamics in participants’ interactions with the outside world.

The authors specifically noted the need for future studies to examine the role of effects of living in an ethnic enclave on these aspects. Both Lam (2007) and Han and Lee’s (2011) studies demonstrate the negative impact of PRD on mental health. Racial discrimination is an inherent cultural factor for consideration in working with Vietnamese Americans and these studies highlight the importance of examining cultural factors in mental health.

Chung, Bemak, and Wong (2000) examined psychosocial adjustment issues for 358 Vietnamese American college students in the Los Angeles and Orange Counties. The sample consisted of two groups of immigration from 1971 to 1985, with the first wave before 1976, and the second wave after. Findings indicated significant differences in levels of distress, social support, and acculturation between the two waves. The second wave reported more psychological distress, while the first wave reported greater acculturation and satisfaction with
social support than the second wave. Women reported more acculturation than men. There are limitations in this study including sampling and lack of examination of psychological distress.

Findings from this study are important in suggesting that there needs to be awareness and continued examination of intergroup and gender differences in refugee psychosocial adjustment in order to understand the importance of pre and postmigration issues, especially in regards to the importance of considering social support networks. The authors’ approach displays examination of microsystem and mesosystem aspects through inclusion of social supports, and macrosystem aspects through inclusion of acculturation.

**Quantitative studies with adolescents.** Research on Vietnamese adolescent mental health is expanding, with inclusion of caregiver considerations into research design. By including parents specifically in the research, these studies have focused on the microsystem in an adolescent’s world. Nguyen (2006) investigated the prevalence of behavioral and emotional symptoms among 71 Vietnamese American children ages 11 to 18 as reported by parents and based on self report in the ethnic enclave of Orange County, California. The author found that Vietnamese immigrant children exhibit significantly higher rates of behavioral and emotional problems than normative United States sample.

Results indicated that boys exhibited higher scores than girls on both externalizing and internalizing problems, but there was no relationship between age group with these problems. The author noted a significant relationship between the parent’s report and self-report. In regards to acculturation, results indicated a positive relationship between children’s acculturation level and parent and self-report of behavioral and emotional problems, while there was an inverse relationship when accounting for immigrant parents’ acculturation level. Additionally, the parent and child’s level of acculturation contributed to prediction of variance in child’s
externalizing problem scores. In addition to the microsystem, including acculturation examines the macrosystem dynamics for the child.

Nguyen (2008) examined the relationship between father’s levels of acculturation and parenting styles and relationships among self-esteem levels and depression scores of the adolescents by surveying 290 Vietnamese American adolescents 13 to 18 years old. By examining acculturation and including parents, the authors consider the macrosystem attitudes and ideologies of culture and microsystem family dynamics. Findings indicated that most of the adolescents perceived that their fathers have not acculturated to United States culture and still use a traditional authoritarian parenting style, irrespective of the amount of time living in the United States. In addition, results revealed that adolescents who perceived their fathers as practicing the authoritarian parenting style reported lesser levels of self-esteem and greater depression scores in contrast to those with who perceived their fathers as using the authoritative parenting style.

Another aspect explored is the impact of historical trauma in parents on Vietnamese American children. In Mai’s (2009) study, the author studied 37 Vietnamese refugee couples and their children, with 74 participants total recruited from Southern California, with adult children being male or female 16 or above. They were Vietnamese refugees or descendants of refugees, and either American born or no more than 3 years of age upon arrival in America. The researcher found low trauma symptomology, anxiety, and depression amongst both parents and children. Typically, they reported these symptoms as “not at all” and/or “a little”. Only two parents (5%) and no children scored above the clinical threshold for PTSD.

In addition, parents scored 29% on anxiety and 26% on depression above clinical thresholds, while children scored 5% on anxiety and 22% on depression. The total number of
trauma events parents reported correlated significantly and positively with their DSM trauma score. In regards to transmission of trauma, no correlation was found between parental trauma and children’s trauma; however, there was a correlation between parents' reported depression and children’s reported depression. Also, children’s perceptions of their parent’s depression were also related to children’s symptoms of trauma, anxiety, and depression.

Children whose families did not discuss trauma stories regularly reported less depression than those who did. Events of greatest impact for parents were loss of family, friends, and home while the trauma of escape was the most significant for the children. By including parents in sampling, the author consider the microsystem in an adolescents’ life, and by examining historical trauma the author highlights the chronosystem and how sociohistorical conditions can impact an adolescent.

Phinney and Ong (2002) investigated the relationship between adolescent and parent differences in the promotion of family obligation and adolescent life satisfaction of Vietnamese and European American families. Surveys were administered to 230 parents and adolescents, with 103 Vietnamese American families and 135 European American families. The researchers found adolescent and parent discrepancies strongly negatively predicted life satisfaction across both groups. The effect did not seem to be moderated by culture, but may suggest that more general processes influence life satisfaction perceptions. The authors, however, did not examine family conflict and reported not being able to determine whether conflict contributed to discrepancy. To some extent, the authors examine the microsystem of the family by including parents and the macrosystem by including culture.

Lam’s (2003) study evaluated an ecological model outlining culture, community, family, and individual contextual factors that influence psychological distress of Vietnamese American
adolescents. The author surveyed 152 Vietnamese American adolescents ages 14 to 18 in the ethnic enclave of Westminster, California regarding sense of self, acculturation, family functioning, social supports, and psychological distress. Hierarchal regression results indicated that support for the ecological model, with stress of living in a Vietnamese community and negative self-esteem significantly predicted levels of psychological distress.

Using path analysis, the author also found a negative indirect effect of bicultural identity on psychological distress. This was mediated, however, by the positive relationship between bicultural identity, cohesion and social support, and global self-esteem. Thus, participants who identified as bicultural had stronger family bonds and more social support from peers and relatives. They were more prone to higher self-esteem and less likely to have psychological distress. An analysis of covariance to investigate differences in acculturation types indicated that adolescents who considered themselves as bicultural reported markedly higher global self-esteem, sense of community, and level of peer support satisfaction.

In addition, those that also indicated assimilation reported themselves to be significantly less depressed, distressed, and anxious. Correlates with psychological distress were adverse neighborhood, discrimination, pro substance abuse attitudes, and traditional beliefs.

Several studies have also examined Vietnamese American adolescents in combination with another Southeast Asian American population, Cambodian Americans, due to a common refugee background (Boehnlein et al., 1995; Choi, He, & Harachi, 2008). Choi et al. (2008) examined Intergenerational Cultural Dissonance (ICD), parent-child conflict and bonding and youth problem behaviors in 164 Vietnamese American and 163 Cambodian American families with adolescents. The authors found that in both groups, ICD indirectly predicted problem behaviors by increasing parent-child conflict, which results in weakening parent-child bonding.
The youth reported that child-parent bonding can aid in buffering against conflict in both Vietnamese and Cambodian youth. Specifically with youths, if they reported cultural gaps with their parents, they also reported higher rates of fights and disagreements with parents. By examining ICD, the authors examine the microsystem by analyzing family relationships and the macrosystem by analyzing cultural dissonance as a main aspect. In this study and Nguyen et al.’s (2011) study with adults, the authors highlight useful information on the concept of ICD and the impact it can have on both help-seeking and parental relationships in youth.

Lim, Stormshak, and Falkenstein (2011) studied the extent to which identification with Vietnamese or Cambodian culture, peer relationships, and coping behaviors influenced substance use among 50 Vietnamese and 52 Cambodian American youths ages 12 to 18 years. They found that identification with culture of origin and coping behaviors moderated the relationship between deviant peer association and substance use. In other words, positive coping skills can buffer the detrimental influences of deviant peer association and substance abuse. Also, strong identification with culture of origin, especially general collectivistic tendencies of Southeast Asian culture, may serve as another protective factor. The authors examine peer relationships in the microsystem along with broader macrosystem cultural dynamics. This study is important in exploring protective factors towards mental illness, including the impact of culture, as research has primarily neglected examining protective factors (Vera & Conner, 2007).

**Qualitative and mixed methods studies with adolescents.** There have been studies with adolescents that use qualitative methodology or incorporate qualitative elements into methodology. Boehnlein et al. (1995) studied 107 patients at an Indochinese psychiatric clinic in Oregon with adolescent children from ages 12 to 18. Of this sample, 60 were Vietnamese American. Using a structured questionnaire, the authors examined types of problems described
by parents, which were categorized into aspects of communication, school performance, personal behaviors, social behaviors, and antisocial behaviors. The authors address examination of the microsystem by including parents and school dynamics into the study.

As the authors compared two different ethnic groups, they also examine the macrosystem in comparing different attitudes and ideologies of Vietnamese and Cambodian culture in the context of American mainstream culture. Vietnamese parents reported significantly more problem behaviors than Cambodian parents and more dissatisfaction with life in America. Both ethnic groups reported parents’ relationships with their adolescent children as a chief basis of concern and perceived this to be a major influence on the parents’ perception of their own health.

Few ethnic differences, however, were found between refugee groups in how patients perceived their problems. The study is innovative in that they conducted cross cultural research on phenomena not previously studied using what researchers reported as an ethnographic approach, but there are noted difficulties in interpretation of responses and analysis of data. For example, it seems only one Cambodian and one Vietnamese bilingual health care professional was used throughout the process, thus interpretation of responses and use of it in data analysis were not checked by others.

Nguyen and Cheung (2009) explored the impact of parenting styles as perceived by 313 Vietnamese American adolescents ages 13 to 17 in the ethnic enclave of Houston, Texas on their mental health. The study examines the microsystem of the family, specifically with parents. The authors originally aimed to compare styles between mothers and fathers, but 83% of participants chose to focus on their fathers in responses while filing out the Parental Authority Questionnaire.
Analysis of descriptive statistics indicated that mothers tended to have less education, lesser income, and a lesser acculturation score than fathers. In addition, adolescents’ responses reflected parallel perceptions that most parents, both fathers and mothers, practice a punishment-oriented authoritarian parenting style. Adolescents who indicated focus on their mothers in their responses tended to report greater self-esteem and a lower depression scores than those who focused on their father.

The survey also contained a section for qualitative comments in which the authors found common themes of: (1) communication between parents and adolescents; (2) criticism from parents; (3) affection and encouragement from parents; (4) parents’ granting freedom/autonomy to adolescents; (5) sacrifices parents made for the adolescents; and (6) openness of the parents.

**Qualitative and mixed methods studies of children in other countries.** Current research on Vietnamese Americans and mental health tapers off after the developmental period of adolescence, and not much is known about Vietnamese American children and mental health. However, there have been studies on Vietnamese immigrant populations focused on children’s mental health in other countries such as Australia and Norway. In Tran’s (2012) study, the author conducted a mixed qualitative and quantitative study on Vietnamese immigrant parents’ perceptions of parenting roles, child development, child health, illness, disability, and health service utilization in Brisbane, Australia. All participants were current clients of a community health center, over the age of 18, and had at least one child under the age of five.

In regards to mental health, Tran (2012) found that participants were less familiar with the role of psychologists and social workers because these roles are not existent in the Vietnamese health system. Participants preferred to seek the help of relatives and then their family doctor for child health related problems. When asked why they did not use particular
health services, most stated that they “never needed the service” or “do not know about them”, indicating a need for information on mental health professional services and outreach.

The author found that there is stigma towards disability and mental illness as compared to Western counterparts. For example, one participant cited Karma, attempted abortion, and taking oral contraceptives as causes of mental illness in children. Negative perceptions of mental illness also stemmed from beliefs that it is a manifestation of weakness of the mind, and that persons with mental illness cannot contribute to the collective good as others can, which is reflective of the Confucian philosophy of sacrificing individual needs for the overall good.

Amongst the Vietnamese participants, they also found that they were generally less satisfied with previous use of mainstream English speaking services. Through an ecological systems perspective, the authors address most of the systems. By including parents, the author includes the microsystem; by including participants’ interactions with various health workers the author incorporates the mesosystem; and including professionals such as social workers who may never interact with the actual child the author highlights the exosystem. On a macrosystem level, the author examines cultural differences in mental health beliefs.

In a qualitative study by McKelvey et al. (1999) examining Vietnamese parental perceptions of childhood mental illness in Australia, the authors randomly selected a cross-sectional sample of Vietnamese-origin children and adolescents aged 9 through 17. Structured interviews were conducted with a randomized sample of 283 Vietnamese parents. Parents were asked to pick from a list of thoughts, feeling, and behavior that they would consider symptoms of mental illness in a child.

Parents were also asked at what point in time would they seek help outside of the family for a child considered to be mentally ill, the professional(s) or agency(ies) they would ask for
help, knowledge of existing mental services, and belief about the causes of child mental illness. Vietnamese parents identified psychotic symptoms, disorientation, and suicidal thoughts and behavior as psychopathological. They identified biological/chemical imbalances, traumatic experiences, and metaphysical/spiritual imbalances as causes of childhood mental illness. Most participants encouraged Western-style treatment approaches, seeking help at the initial onset of symptoms, but knew very little of existing community mental health services for children. The authors incorporate microsystem and macrosystem elements by examining parental views of childhood mental illness and cultural aspects of their responses.

In Norway, Vaage, et al. (2011) studied Vietnamese refugee parents 23 years after immigration to investigate the long term effects of trauma, fleeing, and exile on children of refugees. A longitudinal prospective cohort of Vietnamese refugees including spouses and children born in Norway were recruited in 1982. Information was gathered from one or both parents at arrival in 1982 at time one, follow-up in 1985 at time two, and 23 years after arrival at time three. They found almost 40% of the families had at least one parent with a high probability for a mental health concern. A father diagnosed with PTSD increased the likelihood of a mental health concern in their offspring. Only 4% of the children ages 10 to 23 years were considered as prone to mental health concern. There was an association, however, between likelihood of mental health concern in children and in fathers at time three.

A significant adverse paternal predictor for the children’s mental health at time three was the father’s PTSD at arrival in Norway, while a positive predictor was the father’s participation in a Norwegian network 3 years after arrival. The authors examine the chronosystem by sampling after the major event of immigration in a refugee’s life then examining 23 years after, but also include the microsystem by including parents and children.
Evaluation of Available Research

In regards to the studies on the Vietnamese American population, children have rarely been included in the existing literature. The literature on all Vietnamese Americans predominantly uses quantitative methods to explore mental health, yet within the limitations noted weak or faulty measures, and the hesitancy in what salient variables may have been overlooked (Han & Lee, 2011; Lam, 2003; McKelvey et al., 1999; Ngo, 2005; Nguyen & Anderson, 2005; Silove et al., 1997; Vo, 2005). Several studies also noted the difficulties in language and translation of instruments (Luu et al., 2009; Nguyen & Anderson, 2005; Vo, 2005).

There are a few studies on Vietnamese Americans that have incorporated qualitative elements in an effort to discover new themes and overcome methodological concerns (Boehnlein et al., 1995; Hampton et al., 2007; McKelvey et al., 1999; Nguyen & Cheung, 2009; Silove et al., 1997; Tran, 2012). However, these studies use general qualitative methodology without much clarification on details of the approach. Also, existing research tends to look at detrimental factors that influence youth mental health and it would be useful to examine protective factors (Lim et al., 2011; Vera & Conner, 2007).

Starting with the literature on Vietnamese American adolescents and moving to Vietnamese children in other countries, there seems to be more inclusion of parental and caregiver perspectives in examining mental health. Also, studies on Vietnamese children in other countries have either been qualitative or mixed methods approaches. Due to the lack of literature on Vietnamese American children’s mental health, the literature review was broadened to include all ethnic minority children to examine how others have investigated the wider topic of children’s mental health. This is followed by a brief description of research on ethnic
Minority children’s mental health in other mental health fields and the need for research in counselor education.

Minority Children’s Mental Health

In the literature on the topic of minority children’s mental health, researchers have stressed the importance of examining culture and ethnicity specifically. In Samaan’s (2000) review of the literature on children’s mental health, the author examined race, ethnicity, and poverty and found that poverty and economic hardship are associated with psychological distress in ethnic minority children and adolescents. The author stressed the importance of examining cultural influences on the mental health of children. Although ethnic minority children face adverse psychological and behavioral problems because of their minority status, there may be protective factors that help buffer against stressors and further research on this is needed. The author introduced constructs for the influence of protective cultural factors that included social support, extended families, profound religiosity or spirituality, and maternal coping skills.

Cauce et al., (2002), discussed the importance of cultural and contextual influences on mental health seeking, introducing a help-seeking model that includes problem recognition, decision to seek help, and service selection. Specifically highlighted was the importance of the ecological systems influencing the individual, with emphasis on the culture and context in the macrosystem in the mental health of ethnic minority youth. The authors noted the impact of culture and context on each including how a problem is defined, whether help is sought, and where it is received, with a specific focus on ethnic group differences. They found that obtaining mental health services is oftentimes a last choice for ethnic minorities and once a problem is recognized, informal support such as extended family are often utilized first. They noted, however, that there is little research on what that process looks like. They also identified that
overall the literature on health seeking is incomplete, although studies suggest that culture and context play an important role in the process. Although not systematically investigated, there has been much conjecture on how cultural groups differ on basic questions such as what is considered to be a mental health problem. Although this is a conceptual article, the authors introduce a framework for researchers to develop studies that examine minority children’s mental health and service utilization. The following are quantitative studies on minority children’s mental health.

**Quantitative Studies.** In the literature review, several studies were found using the 1996-1997 Patterns of Youth Mental Health Care in Public Service (POC) Study. Youth involved were ages 6 to 17 who were receiving services in one of five public sectors of care including alcohol or drug, child welfare, mental health, juvenile justice, and school services with major emotional disturbance, with participants grouped into African American, Asian Pacific Islander, Latino, or non-Hispanic White (Yeh, Hough, McCabe, Lau, & Garland, 2004). In examining racial and ethnic patterns in parental beliefs about causes of child problems among a sample of 1,338 parents with children who have been identified to have mental health problems, Yeh et al. (2004) found that Asian Pacific Islander Americans (APIA) and Latino parents were less likely than were parents of non-Hispanic Whites to endorse etiologies stemming from physical causes, personality, and familial issues.

In a subsequent study, APIA and Latino youths were less likely to use specialty mental health services (Yeh, et al., 2005). They also found that parental beliefs regarding causes of child problems partially mediated the relationship between race and ethnicity with use of mental health service. Biopsychosocial beliefs of physical causes and trauma were associated with increased likelihood of mental health use, but surprisingly beliefs on sociological, spiritual, or
natural disharmonies did not demonstrate an influence. In both studies, the authors examine the microsystem by including parents in research design, the mesosystem by including examination of interaction with actual mental health service use, and macrosystem by including cultural aspects.

Garland et al. (2005) also examined racial and ethnic differences in a subsample of 1,256 youths ages six to 18 and their mental health service use in the POC study. Youth and caregivers were surveyed with measures of mental health service use, psychiatric diagnoses, functional impairment, caregiver strain, and parental depression. The authors found that Asian Americans had the lowest rates of mental health and outpatient service, and were half as likely as non-Hispanic Whites to receive any mental health or outpatient service. All service use was associated with parental report of caregiver strain. The authors examine microsystem aspects with inclusion of parents, in addition to the macrosystem by examining racial and ethnic differences in service use that might be attributed to culture.

Ho, Ye, McCabe and Hough (2007) examined parental cultural affiliation to mainstream American culture and an alternative culture as possible mediators of the relationship between race, ethnicity, and youth mental health service use. In a subsample of 1,364 youth ages six to 17 and their primary caregivers from the POC study, parental cultural affiliation was a partial mediator in relationship between race/ethnicity and mental health service use for Asian Pacific Islander. Asian Pacific Islanders were significantly less likely than non-Hispanic Whites to use mental health services, with parental affinity to alternative culture found to partially account for lower rates of use. Most studies have not examined contribution of caregivers to children’s mental health service utilization. This researchers examine parents which are part of the
microsystem but also focus on the macrosystem by honing in on culture, both American and alternative.

Montazer and Wheaton (2011) studied the impact of generation and country of origin on the mental health of children of immigrants ages 9 to 16. Using a sample of 837 families from the Toronto study of intact families, the authors demonstrated that generational differences in the mental health of children occur only in families from countries of origin at the lowest levels of economic development. For those originating from countries from the lowest levels of economic development, a mental health advantage in the first generation evolves to a disadvantage in the 2.5 generation (one foreign born and one native born parent) relative to third or later generational children.

Vietnam was placed in the lowest category of economic development, and thus later generations could evolve to a disadvantage based on application of these findings. Children from backgrounds characterized by higher economic development show no initial or eventual differences from the native born. As the researcher in this study examined economic processes that might not necessarily directly include the child, the authors address macro and exosystem dynamics in a child’s life. Also, inclusion of generational examinations is reflective of the chronosystem, with different generations experiencing varied patterning of environmental events and transitions.

There have also been studies both here and abroad that focus on minority children’s mental health with specific ethnic groups. To begin, there is specific research with other Asian American populations regarding children’s mental health and caregiver perspectives. Daley (2005) studied 40 Cambodian American children, ages 8 to 18, about their parents’ beliefs regarding the treatment of mental health problems using two hypothetical vignettes regarding
externalizing and internalizing problems. The study had a group of children and parents who had received services and a matched community sample.

The author found that clinic parents tended to view these problems as able to be helped as compared to community parents. Results also indicated that both parents and children overall endorsed mental health treatment. Also, children rated their parents as more helpful than parents rated themselves. The author in this study addresses the microsystem by sampling parents and extends to the mesosystem by examining interactions parents have had with mental health treatment services for their children.

Lowinger (2009) explored 157 Chinese American parents’ willingness to seek psychological help for their children’s emotional and behavioral problems from school. Using hypothetical vignettes also containing externalizing and internalizing problems, the author asked parents to pretend as if the children in the vignettes were their own. Results indicated that parents viewed the child as in need of immediate professional help.

Seeking help was not conditional upon the family first addressing the problem, the problems manifesting in the home, or the child’s school performance. Parents responded that children with externalizing problems were in greater need of immediate help than those with internalizing problems. The most preferred referral source was the school psychologist and the treatment of choice was psychological counseling. Ethnic matching was reported by parents to be unnecessary. This study has also focuses on the microsystem by sampling parents and mesosystem by examining interaction of parents with referral sources and treatment providers.

Lau and Takeuchi (2001) also examined the relationship between cultural factors, appraisal of child behavior problems, and help-seeking responses in 120 Chinese American parents of elementary school aged children. Using a hypothetical vignette, parents were asked
how they might respond if their children displayed the behavioral problems. The authors found that cultural value had an indirect effect on help-seeking intentions through impact on affective responding.

Results indicated that more traditional Chinese parents answered with greater feelings of shame to child behavior problems and less intentions to seek help. This seems to contradict the previous studies (Daley, 2005; Lau & Takeuchi, 2001) to reflect more negative attitudes towards mental health treatment, but still reflect some type of cultural impact. The researchers included parents to examine the microsystem and also specifically examine cultural factors reflective of macrosystem attitudes and ideologies.

Broadening to other racial groups, in a study by Lambert, Puig, Lyubansky, Rowan, and Winfrey (2001), the authors examined adult perspectives on behavior and emotional problems in African American children using two vignettes with internalizing and externalizing problems. The sample consisted of 43 parents of children ages 6 to 11, 53 of their teachers, and 115 clinicians that treat that population. Parents, teachers, and clinicians were found to differ on their ratings, with parents indicating externalizing problems as more serious.

Race was also found to have an effect on ratings, regardless of whether the person was a parent, teacher, or clinician. African American raters, irrespective of problem type, rated problems as significantly higher than and more likely to improve than their white peers. It is important to note that African American parents reported more seriousness with externalizing versus internalizing problems, and that this was a result of faulty childrearing.

The authors noted the need for further cultural examination behind why African American parents predominantly thought this. They proposed some speculation about how African American sociocultural norms could influence parents’ answers, such as collectivism in
which externalizing behaviors are visible actions that can affect the entire community. The authors address the micro, meso, and macrosystem by including the parents, various adult figures in the spheres of a child’s life, in addition to examining racial variables.

Mukolo and Heflinger (2010) examined differences in caregiver strain, barriers-to-care endorsement, and provider satisfaction among 175 rural and urban African American caregivers with children from four to 17 from one Southern state whose children received Medicaid sponsored mental health services. Results indicated that children exhibited clinical levels of externalizing and internalizing mental health symptoms and high levels of co-occurring physical health problems. Almost one quarter of the children were cared for by someone other than their biological parents. Almost all caregivers reported strain associated with children’s mental health problems, compromised personal health status, and high levels of depression. Family perceptions of barriers (such as concern about potential negative reactions of significant others) were most endorsed. Most caregivers were satisfied with their children’s mental health services, with lowest levels on the provider sensitivity subscale. By specifically examining not only parents but caregivers as well, the authors examine a broader embodiment of the microsystem in a child’s life.

Alegría et al. (2004) investigated factors reported by primary caregivers of Puerto Rican children, ages four to 18, about decisions whether to use mental health care for their children, interviewing a total of 1,885 caregiver and child dyads in Puerto Rico. Similar to Mukolo and Heflinger (2010), the authors examine a broader embodiment of the microsystem in a child’s life by including caregivers in general. The authors found three significant predictors of service use that included child’s level of impairment, parental concern, and child’s adversity in schoolwork performance. However, most children remained untreated, even those with a diagnosis. Also, in
regards to sector of care model in mental health versus school setting, the significant predictor is any disruptive disorder diagnosis.

Lambert et al. (1992) examined Jamaican and American adult perspectives on child psychopathology by specifically examining cultural factors. Adults sampled included 81 American and 47 Jamaican parents, 62 American and 55 Jamaican teachers, and 113 American and 47 Jamaican clinicians. The authors presented the participants with two vignettes, one with a child with overcontrolled problems such as fearfulness while the other vignette is of undercontrolled problems such as fighting. Through regression analysis, the authors found that education influenced certain ratings, but the most influential effect was culture. The authors noted that in order to avoid an ethnocentric vision of dysfunction, examination is needed of how child psychopathology is defined in other cultures such as Jamaican, in regards to behavior and how adults in society perceive that behavior. In this study, the authors examine adults as part of the microsystem in a child’s life and the specific dynamics in the macrosystem through cultural attitudes towards child psychopathology.

Thabet et al. (2006) investigated Palestinian mothers’ perceptions of child’s mental health problems and services among a group of 249 Palestinian refugee mothers with children under the age of 16. Using checklists, the mothers equally perceived emotional, behavioral, and psychotic symptoms as indicative of mental illness in childhood. Mothers perceived various causes of child mental concerns that included family problems, parental mental illness, and social adversity. A large proportion, 42.6%, had knowledge of local child mental health care and overall preferred Western modes of treatment over traditional types, with support for promoting mental health awareness. The authors examine the microsystem by focusing on mother’s
perceptions, in addition to the mesosystem by examining interactions with child mental health care.

**Qualitative and mixed methods studies.** An increasing number of studies are incorporating qualitative methodology to investigate cultural perspectives. Arcia et al. (2004) investigated Latina mothers’ mode of entry into services for their young children, four to 10 years old, with disruptive disorders. They interviewed 62 Cuban (63%), Puerto Rican (19%), and Dominican (18%) American first-time help seekers. Nineteen percent were girls and 81 percent were boys. They found four modes of entry: (a) coercion, (b) acceptance of offered referral, (c) responsive and resourceful help-seeking subsequent to school reports of behavior problems, and (d) a laborious and difficult path that was characteristic of 52% of the sample. Major barriers to services for the average help seeker were the interaction of maternal lack of competence and service characteristics.

Schools, maternal and child characteristics, and social network forces played significant roles for all mothers, but the final determinants of service entry differed by the mode of entry taken. Findings indicate that problem labeling is not an essential antecedent to service entry and that direct referrals might effectively shorten the help-seeking process. The authors noted the need for future research on the extent of effects of social network. The authors incorporate the microsystem in this study, but also note that a broadening to include social networks is needed to include meso and exosystem aspects.

In another study with Latina mothers, Vera and Conner (2007) examined Latina mothers’ perceptions of mental health and promotion. The authors used a narrative inquiry due to failure of existing literature to incorporate protective factors, interviewing 10 mothers of children 18 months to 12 years. They interviewed mothers as they often serve as “monitors” for children’s
mental and emotional needs. Mothers were 30 to 43 years old, with 6 Mexican immigrants, with the rest of the four either Argentinian, Puerto Rican, or multiracial.

The authors found that a theme in all 10 interviews was the interpersonal nature of mental health. The participants also expressed a belief in the connection between parent and child mental health, a belief that environmental influences promote mental health, and a belief that threats to mental health include divorce, drugs, conflict, neglect, illness, and abuse. Participants noted that acceptable ways of restoring mental health include formal and informal means, with trustworthiness of vital importance. None of the participants expressed concerns with quality of services, but half reported that the quantity and availability of resources could be improved.

Although this study had a smaller sample size than Arcia et al.’s (2004) study, their purpose was exploratory and more open-ended as they were looking for protective factors as well. The authors were also more descriptive in the narrative methodology used, as Arcia et al. (2004) described a general qualitative approach. Vera and Conner (2007) addressed establishing credibility and validity by describing strategies such as member-checking in a second follow-up interview and using secondary coders. Vera and Conner (2007) examined mothers and thus similarly focus on addressing the microsystem in a child’s life. Although different ethnic groups are sampled in both studies, little examination was given to macrosystem comparisons in cultural attitudes and ideologies.

In a qualitative study by dosReis et al. (2007), the authors examined how parents’ interpretations of their child’s disruptive or inattentive behaviors directed them to find medical care that resulted in a diagnosis of attention-deficit hyperactivity disorder (ADHD). Using a grounded theory approach, 26 participants were recruited from primary care, developmental and behavioral, and specialty mental health pediatric clinics to be interviewed by telephone using
semistructured protocol. Parents reported going through an extensive process before seeking treatment to identify their child’s problems. Parental conceptualization emerged as parents’ described their child’s behavior, situation explanation, description of how ADHD impacted their children, and how answers were sought. Parental reaction to the behavior and visualization of their child’s future showed their motivation to control the situation.

Four distinct patterns of process of coming to terms with their child’s ADHD, which included immediate resolution, pragmatic management, attributional ambivalence, and coerced conformance. Most participants were mothers and the goal of future research is to interview multiple informants who have different relationships with the child to obtain different views on mental health care. The authors outlined their data analysis congruent with grounded theory and noted attempts at establishing credibility including data triangulation, reflexivity, and peer-debriefing. The authors focus on the microsystem of parents, but also highlight mesosystem interactions with the outside world through examination of service use.

Studies in other countries regarding children’s mental health have emphasized the use of qualitative methodology in collecting data. For example, in the United Kingdom (UK), Dogra et al. (2005) examined the understanding of mental health by 15 Gujarati Hindu parents and 15 of their children ages 11 to 16. They explored this population’s understanding of the terms “mental health” and “mental illness” through the use of semistructured interviews, and subsequently used thematic analysis to identify three key themes. They found that in regards to understanding the terms mental health and illness, there was confusion between the two concepts.

They also found confusion in both parents and youth on the causes of mental health problems, with stress and anxiety given as main causes. Lastly, they found sociocultural factors in these families which led to reluctance to discuss concerns outside of the family. Results
indicated that neither young people nor their parents had a consistent understanding of mental health or mental illness, confusing this with the term of learning disability. The authors specifically noted that in order to progress in appropriate service planning and development, more work needs to done on establishing a joint comprehension of key terms such as mental health and illness. The researchers focus on the microsystem by including parents, along with the macrosystem through examination of cultural understanding of children’s mental health and illness.

In a subsequent study, Dogra et al. (2007) explored Gujarati families’ perspective of service provision for mental health problems and how service could improve to effectively meet their needs. They noted that other studies on use of child mental health services have found differential rates of use by minority ethnic children including Punjabi Muslims of Pakistani descent (Roberts & Cawthorpe, 1995), Asian (Hackett, Hackett, & Taylor, 1991), and South Asian (Daryanani, Hindley, Evans, Fahy & Turk, 1991).

The authors conducted semi-structured qualitative interviews with 15 parents and 15 young people ages 11 to 16. The authors found, that overall quality of service appeared more important than its responsiveness to culture or ethnicity for both young people and their parents. Sources for help include specialist mental health professionals, health visitors, counselors, hypnotists, and peers/friends. Parents wanted services to be safe, to be confidential, to be with competent staff they could communicate with, and to be with staff of the same language.

The authors noted that future research should address service questions in diverse population groups, defined from an ethnic and cultural perspective and examine which barriers apply to which population (i.e. stigma). This study was similar to the previous study because the authors address the micro and macrosystem, but extends to include meso and exosystems.
because the authors examine actual service use and the interactions with care professionals.

Examining interactions with various spheres concerning a child’s mental health, whether directly involving the child or not, sheds some new information on the needs of this population. In these innovative studies, Dogra et al. (2005; 2007) have attempted to examine the root foundation of mental health conceptualization in Gujarati minority population and follow how that impacts seeking help and service use holistically.

Bradby et al. (2007) investigated British Asian families and their use of child and adolescent mental health services (CAMHS). Using qualitative methodology, the authors used focus groups followed by semi-structured interviews with 35 adults who identified themselves as Asian and had children. In the second phase of the study, seven service users of CAMHS and health care professionals were interviewed, along with five caregivers of potential service users. In the focus groups, the researchers found that stigma and fear of gossip were barriers to using CAMHS. They found that users of CAMHS desired minimizing stigma that they endured by emphasizing that mental illness was not madness and could be overcome.

Families with children with complex emotional and behavioral problems stated that discrimination by health, education, and social care personnel amplified their child’s struggles. They found that those with severe and chronic mental illness endured culturally inappropriate services. The authors examine the microsystem of a child’s life, but also extend to incorporate the meso and exosystem by including health care professionals and examining interactions amongst families and care providers.

Walker (2001) conducted a secondary analysis of qualitative and quantitative data regarding caregiver views on cultural appropriateness of children mental health services from a sample of 286 children receiving services for severe emotional and behavioral disorders. Results
indicated that caregivers find the child’s culture as integral in service planning and delivery and that providers are only partly successful in culturally appropriate service delivery. Analyses showed that minority caregivers were more likely to describe providers’ failure to work with community and ethnic values, with highly significant effects on overall satisfaction.

Themes from caregivers’ accounts also cautioned against viewing minority cultures as homogenous, calling for a cognitive match on top of ethnic match, as ethnic matching does not necessitate effective treatment. Cognitive match means a shared understanding between clients and providers on aspects of mental health provision. Another theme is dissatisfaction related to differences in ideas about parenting, especially discipline in caregivers. In this study, Walker has examines the microsystem, mesosystem, and macrosystem by reviewing information on caregivers, interactions with child mental health care, and the cultural dynamics that occur.

**Evaluation of Available Research**

Through examining the literature on Vietnamese Americans, little research is inclusive of Vietnamese children 12 and under, especially with Vietnamese American children. The literature review was then expanded to include ethnic minority children and mental health. Specific attention was given to methodologies used in examining minority children’s mental health due to the continued confusion on what variables to focus on, reliance on quantitative methodology, and the uncertainty regarding existing measures in examining Vietnamese Americans’ mental health. There is a mix of both quantitative and qualitative methodologies. However, similar concerns were found in the quantitatively focused studies that were reported in the Vietnamese American literature review, with an addition of how the use of vignettes could apply to actual help-seeking behavior (Daley, 2005; Lau & Takeuchi, 2001; Lowinger, 2009).

Research in other countries such as Britain and Australia have been inclusive of
qualitative and mixed methods (Bradby et al., 2007; Dogra et al., 2007; Dogra et al., 2005) and most qualitative studies in the United States with minority populations cited the exploratory nature of their research to justify use of qualitative methods (Arcia et al., 2004; dosReis et al., 2007; Vera & Conner, 2007). In conclusion, due to the exploratory nature of researching the population of Vietnamese American children, a qualitative approach is needed in order to discover what needs to be examined more closely on the overlooked topic of minority children’s mental health. Several researchers have advocated for the appropriateness of qualitative research in studying multicultural issues and counseling (Merchant & Dupuy, 1996).

The Current Study

As mentioned earlier in Chapter One, research in other fields have promoted and conducted studies on working with ethnic minority children with an emphasis on examining culture. Although the literature is too vast to include in the scope of this literature review, some examples include fields such as social work (Johnson, et al., 2004), psychology (Tucker, 2002), and psychiatry (Nguyen et al., 2007; Minnis et al., 2003) and the impact on service utilization. Vietnamese Americans were highlighted specifically in other fields on attitudes toward children with disabilities (Saenz et al., 2001).

Despite the advocacy and continued growth on researching minority children’s mental health in other fields, counselors continue to need more research and training on working with youth in general. The counseling professional lacks preparation, professional development, and research focused on mental health practice with youth (Mellin & Pertuit, 2009). It is imperative that counselors respond to the crisis in children’s mental health and clarify the role of the counseling profession (Mellin, 2009).
As reflected by this literature review, research has focused on Vietnamese American adults, adolescents, college students, and Vietnamese children in other Western countries. In addition, most studies involving children’s mental health in general focus on the microsystem (Qin et al., 2011). Many of the studies reviewed cited difficulties with normative methods in exploring Vietnamese Americans mental health and other ethnic minority children and their families. Many of the studies used psychometric scales, operationalized variables, and predefined constructs are all reflective of normative methods (Lee & Tracey, 2005).

This qualitative study was built on existing research in the following ways. First, is probably one of the few exploratory studies to focus on the mental health of Vietnamese American children 12 and under. Second, a clinical sample was included that highlighted important mesosystem dynamics as the microsystem of the family interacts with mental health care. Third, this study helps to capture cultural perspectives of Vietnamese American families towards children’s mental using their own words through qualitative exploration, and highlighted avenues for further exploration and overcoming some of the problems associated with normative approaches typical of quantitative methods.
Chapter 3: METHODOLOGY

Researcher Lens

In order to comprehensively explain the methodology underlying this study, I identify and discuss the worldviews of research that guided my study. First I describe social constructivism and follow with how critical theory supplemented this worldview in my study.

The worldview that guided my investigation is social constructivism (Hays & Singh, 2011). Social constructivists believe that there is no “universal truth” and that there are multiple contextual realities constructed by people (Hays & Singh, 2011; Patton, 2002). Constructivists argue that reality about counseling phenomena are subjective, with researcher and participant having biases that are entrenched in different cultural experiences and identities (Hays & Singh, 2011). For example, I acknowledge that having been born and raised in the United States, I have a conception of mental health that is heavily influenced by American culture.

However, I have interacted with and may encounter Vietnamese Americans whose mental health conceptions and experiences are heavily influenced by Vietnamese cultural norms. I have seen differences in conceptions of mental health in Vietnamese Americans that include what causes mental health to deteriorate and how Vietnamese Americans describe mental health. To illustrate, many have described metaphysical and spiritual impacts on their mental health stemming from Buddhist, Taoist, and Confucian philosophies. They have also noted specific stressful circumstances such as immigration or the Vietnam War as major causes of mental health deterioration. When describing psychological discomfort, physical terms are used as there is more familiarity with physical and medical illness in Vietnamese culture. Researchers have reported findings that support what I have observed (Hampton et al., 2007; Leung, Cheung, & Cheung, 2010; McKelvey et al., 1999).
With this approach, I sought to construct knowledge by examining participants’ social interactions influenced by cultural, historical and political processes (Hays & Singh, 2011) such as Vietnamese culture, immigration, and repercussions of the Vietnam War. I sought to examine how these interactions influence their lives and construction of knowledge (Creswell, 2007; Hays & Singh, 2011; Patton, 2002), specifically in regards to mental health concerns among children. Although there has been research on Vietnamese Americans’ perceptions of mental health, the particular knowledge examined here is Vietnamese American children’s mental health.

Researchers should understand the philosophy of science parameters that are the conceptual roots underlying the search for knowledge (Ponterotto, 2005), especially when selecting and designing a research approach (Creswell, Hanson, Clark Plano, & Morales, 2007). In order to describe social constructivism thoroughly, I apply the philosophies of science in research paradigms and traditions that help develop scientific inquiry in qualitative research. They are ontology, epistemology, axiology, rhetoric, and methodology (Hays & Singh, 2011). I define each term and describe how these manifest in the social constructivist paradigm.

Hays and Singh (2011) provide succinct definitions of ontology, epistemology, axiology, and rhetoric. Ontology is the nature of reality or degree to which universal truth is sought about particular constructs and processes in qualitative research. In social constructivism, this means that multiple realities of a phenomenon exist. Thus as a social constructivist researcher, I interviewed several participants for extensive periods of time to seek the multiple meanings of Vietnamese American family members’ perceptions of children’s mental health (Ponterotto, 2005).

Epistemology, otherwise known as knowledge construction, is defined as the process of knowing, or degree to which knowledge is believed to be constructed by the research process in
general or particularly in the context of the researcher participant relationship. In social constructivism, this means that knowledge is co-constructed between researcher and participants. Thus, as I interviewed participants, our dynamic interaction constructed knowledge (Ponterotto, 2005) and was integral to capturing and describing what it was like for a Vietnamese American mother to raise a child with a mental health concern. As I examined the stories, I integrated my knowledge as a person from Vietnamese American culture who has worked as a counselor and researcher in the community to interpret their descriptions, highlighting facets of Vietnamese cultural perspective infused in the descriptions.

Axiology involves the role of the researcher’s values and assumptions in inquiry, and how these influence research questions and design. This also includes examining the values of participants and research setting (Ponterotto, 2005). Specific to this investigation, I approached this study relating my values and personal experiences regarding children’s mental health to the researcher-participant collaborative relationship. In the rhetoric or dissemination of findings and qualitative data presentation, social constructivists believe that the data presented is primarily reflective of the participants’ voices and comprehensively describes the roles of researcher and research setting in understanding the research problem. For example in this research report, findings are presented in the first-person and personalized.

Methodology is how the terms mentioned above overlap to influence research design, to determine what is researched and how it is researched. Social constructivists believe this is largely collaborative between researcher and participants with naturalistic inquiry. In my approach to this study, I conducted face to face interviews in settings that were part of the participants’ world including their homes and community settings (Ponterotto, 2005).
Another worldview that guided my investigation is critical theory, an extension of social constructivism (Hays & Singh, 2011). Critical theory is concerned with how inequality and oppression mold people’s experiences and understandings of the world. Specifically, critical theory is concerned with issues of power and justice and how economy, race, class, gender, ideologies, discourses, education, religion, other institutions, and cultural dynamics interact to build a social structure (Fay, 1987; Morrow & Brown, 1994). This theory is important in that research is not just conducted to study and understand, but extends to critique and transform society (Patton, 2002). My aim with this research was to critique established social norms and helped counseling research to include diverse experiences, knowledge and thinking. In extending critical theory to action, I hope to catalyze social action through awareness and advocacy to benefit those without power (Morrow & Brown, 1994; Patton, 2002).

Critical theory is especially important in exploring the concept of mental health, a label created arbitrarily and used frequently, yet lacking a unifying definition (Santos, 1997). I used critical theory to unravel roots of the problem, framed within theory of society and culture (Santos, 1997). Instead of accepting the term mental health at face value, I applied critical theory to the concept of mental health to explore the problematic lack of definition. A critical theory to explore the concept of mental health should also include a “theory of the subject” and of subjective experience (Santos, 1997). In application to this study, I examined the subject of mental health, specifically with children, and the subjective experiences of Vietnamese American mothers concerning their children’s mental health.

There are different forms of critical theory such as critical race, feminism and queer theory (Glesne, 2011; McLeod, 2011; Parker & Lynn, 2002; Patton, 2002). Critical race theory focuses on how racism is entrenched in society and that race is socially constructed to identify
and classify people, with emphasis on examining how social and political manifestations of power work to include or exclude people of color (Glesne, 2011; Parker & Lynn, 2002). The feminist paradigm focuses on gender as an organizing principle in the design, process, and reporting of findings (Glesne, 2011). Queer theory emphasizes how sexual orientation impacts participant experiences of phenomena and how oppression such as heteronormativity, the perspective that heterosexuality is the norm, influences those experiences (Glesne, 2011). Since critical race, queer, and feminism theory are focused on specific oppressions, I applied critical theory broadly because it is considered to be the most influential of the paradigms, with the largest focus (Hays & Singh, 2011). I strived to acknowledge the intersectionality, (Glesne, 2011) or simultaneous identities of race, class, culture, sexual preference, and gender oppressions (Trahan, 2011), that arose for participants in the study, and I designed the study with critical theory broadly to be inclusive.

Similar to social constructivism, to thoroughly describe critical theory, I applied the philosophies of science within critical theory. The ontology is that reality is subjective and may be influenced by oppressive experiences (Hays & Singh, 2011); thus as a critical researcher I used interviews working under the assumption that Vietnamese American children were not receiving adequate mental health services due to differential oppressive power dynamics (Ponterotto, 2005).

Epistemology in critical theory is that knowledge is co-constructed between the researcher and participants (Hays & Singh, 2011), where I worked collaboratively with participants to help empower them to seek improved children’s mental health services (Ponterotto, 2005). For example, for an interview where I gained a more thorough picture of
what services participants have been exposed to, I referred them to more appropriate services that serve the Vietnamese American community.

Axiology for critical theory is that a researcher’s values are instrumental in acknowledging social injustice and promoting change (Hays & Singh, 2011) and in this study I acknowledged from the beginning that I expected results to document some level of discrepancy with Vietnamese American mother’ conceptions of children’s mental health and experiences of mental health service usage, and results are used in a way to advocate for improved access and services (Ponterotto, 2005).

Rhetoric for critical theorists is that participants’ voices are central to reporting findings (Hays & Singh, 2011), and thus I placed emphasis that results are presented in the first person, personalized, and utilized the participants’ own words (Ponterotto, 2005). The research design within critical theory methodology seeks to minimize the exploitative processes in qualitative inquiry by using appropriate data collection methods and considering how results may affect social experiences of participants (Hays & Singh, 2011). For example, I used interviews as a data collection to minimize the exploitative process in two ways. The first is by empowering participants to use their own words to describe their experiences, without imposing pre-defined words that they must use. The second is overcoming translational difficulties through instant verbal clarification during interviews and follow up after interviews so that participants are not misunderstood.

**Research Design**

Out of the qualitative studies concerned with minority children and their family’s perceptions of mental health, researchers have tended to use a general thematic or content analysis approach (Daley, 2005; Bradby et al., 2007; Dogra et al., 2005; Dogra et al., 2007).
General thematic or content analysis approaches typically involve reading the transcripts along with any field notes and coding key terms, themes, and issues, followed by some form of summarization (Miles & Huberman, 1994). Specifically with content analysis, the researcher counts the number of times a particular topic arises and little attention is paid to meaning, and should not be considered qualitative research (McLeod, 2011). A multiple case study design was used in researching Vietnamese American families by interviewing mothers of children with mental health problems. In the following section, I will describe the multiple case study design infused with phenomenological aspects and expand on my reasoning for why it was used for this study.

**Multiple Case Study Design.** In this research, I used a multiple case study approach to explore Vietnamese American mother’s perceptions of children’s mental health. A multiple case study design was used, as it is the preferable strategy when descriptive or explanatory questions are being posed, when the investigator does not have control over occurrences, and if the focus is on a current phenomenon within some context on the reality of life (Yin, 2003; Yin, 2012). Also exploratory “what” questions with the goal of developing important propositions for future inquiry can also use case study design (Yin, 2003). The following is an explanation of why a multiple case study design was utilized due to how the study fits into these criteria.

**Why Multiple Case Study Design.** The current study utilized a multiple case study research approach because it is aimed at acquiring an understanding of another’s experiences accurately and capturing reflections of experience of the phenomenon that the participant has experienced (Creswell, 2007). The current study meets the three main criteria for case study design. The first is that in this study, the three main research questions center around exploring what Vietnamese Americans perceptions of children’s mental health are, how they address
concerns, and what their experiences are like and were a good fit for multiple case study design. The main research questions are centered around how questions that are explanatory and what questions that can be explanatory and exploratory regarding children’s mental health services that are a good fit for multiple case study design.

Secondly, as the investigator I did not have control over the actual behavioral events being studied, as the perceptions and experiences of the participants had already occurred and were gathered through interviews. A highlight of case study research is utilizing evidence such as interviews (Yin, 2012). Interviewing is one of the most important data collection strategies in qualitative research because the researcher can gather in-person, in-depth information, using participants’ own words while strengthening the research relationship (Suzuki, Ahluwalia, Arora, & Mattis, 2007). The interviews aid in gathering meaning from experiences (Suzuki et al., 2007), a major goal in the design of this study as I sought to understand the cultural meanings.

Another benefit of interviews is that issues over language and translational difficulties can be minimized. There is a lack of conceptually equivalent terms in the mental health field that fully translate from English to Vietnamese. For example, there is no exact translation of the word “counselor” or “therapist” into the Vietnamese language, with the closest conceptualization being a psychiatrist. However, psychiatrist is translated as “bác sĩ tâm thần”, which literally means “mental doctor.” (Kaplan & Huynh, 2008). Thus, some Vietnamese Americans use this term mistakenly to identify a mental health professional. I utilized the interviews as a bilingual researcher to help bridge the gap between the lack of equivalent terms through verbal explanation and clarification. An additional benefit in the emphasis on interview data is to understand meaning and cross-generational interactions with non-English speaking adults or limited English speaking adults, as this effects parenting practices to how information is
conveyed by their children (Ash, 2004). English speaking children often act as intermediaries for their adult parents, but when the adult can communicate directly to the researcher in their native language, more trust and rich information can be gathered (Ash, 2004). Thus, as a bilingual researcher I was able to gather information that is more candid and descriptive.

Using interviews in the multiple case study design helped in capturing inter-ethnic differences and cultural context. By using interviews, I attempted to understand the experiences of each participant, and then search for collective perspectives across all participants. For example, in Hampton et al.’s (2007) qualitative study with Chinese and Vietnamese Americans on perceptions of mental illness and rehabilitation services, all of the Vietnamese participants mentioned the impact of the Vietnam War on mental health regardless of age or gender, but described the impact of the war in different ways. Older generations described the direct impact of war on their mental health, while younger generations who did not experience the war described adjustment difficulties to American language and lifestyle due to their family’s immigration to the United States.

The intent in the current study was to capture aspects such as acculturation and ethnic and racial identity development of participants’ that may have been neglected by previous studies on Vietnamese Americans. These are major aspects that can highlight individual differences for people within an ethnic minority group such as Asian Americans along with subgroups within (Leong & Chou, 1994; Kim & Omizo, 2006).

Thirdly, multiple case study design is a good fit for examining current phenomenon within the context on the reality of life examined, or real world context (Yin, 2012). In this study, the phenomenon is that of Vietnamese American mothers with children who were experiencing mental health issues and their perspectives on children’s mental health. Although I
was not able to utilize phenomenology as the main approach, I was able to incorporate aspects of phenomenology through multiple case study design by focusing on the context of real-life phenomena (Yin, 2012) occurring for these mothers and using this as an empowering research process, as participants are encouraged to collaborate with the researcher throughout (Hays & Singh, 2011). The phenomenological approach stresses the importance of interviews, starting with a semistructured format that can steer towards a more unstructured format as the emphasis is on participants’ as storytellers rather than respondents (Eatough & Smith, 2008). Participants are empowered as experts in describing their experiences and the meaning derived from those experiences, a process that can have therapeutic benefits. Especially in this study, I had participants that have experienced, to some extent, adversity from the Vietnam war and subsequent immigration, and empowerment during the research process has helped by providing participants a forum for discussing and reflecting.

In designing this research, I needed an approach that could help me embrace the multiple roles that I had with participants and the topic to be studied. Personally, I identify myself as Vietnamese American and as someone that was raised in the heart of the Vietnamese American community. I am the daughter of two Vietnamese immigrants, both identifying as refugees who had to flee Vietnam following the war. Professionally, I have worked with and studied this population for a significant part of my life, and plan on continuing to do so.

As I study Vietnamese American families, I acknowledge that it is impossible to set aside all of my experience, both personal and professional, that may influence the research in a biased way. I integrated the personal insights of myself as researcher conducting the research and interacting with participants while collaborating to learn about the phenomena under investigation (Patton, 2002).
I also utilized reflexivity infused throughout the process. Reflexivity is the process of critical reflection on the self in research as instrument (Denzin & Lincoln, 2005). This involves introspection on personal experiences of topic under investigation, awareness of relationship with research participants, self-consciousness around how research is written, and critical analysis of one’s identity as representative of a particular social group (McLeod, 2011). Multiple selves are brought into the field, but also created in the field. These “selves” include the research-based self, brought self composed of historical, social and personal viewpoints, and the situationally created self (Denzin & Lincoln, 2005). I reflected and wrote about the aspects throughout the research process. My goal was not complete objectivity, but to be honest and candid throughout the research process so that readers can make decisions about how my experiences influenced the research.

**Research Questions**

**Research Question 1:** What are the cultural values and beliefs of Vietnamese American families on children’s mental health?

**Research Question 2:** What mental health concerns is a/are Vietnamese American child(ren) facing, and what do their families think impacts their child(ren)’s mental health both positive and negatively?

**Research Question 3:** How do Vietnamese American families address mental health concerns for their children, and what were their experiences like?

**Participants**

Case study design can be based on one case or unit of analysis, but can contain more than a single case (Yin, 2012). In this study, I aimed to recruit a sample size of five children and their families, but due to difficulties in participants willing to participate, I ended up with 4
participants that included all mothers. Each mother is considered a unit of analysis. Family structure in a Vietnamese American family may look different due to mass immigration, thus definitions of family “family” have shifted and expanded (Kibria, 1993). In this study, family included others such as friends, or distant relatives who form ties of fictive kinship to replace relations by blood (Kibria, 1993).

Participants were four Vietnamese American mothers currently with children (ages 3 to 12) residing in California. There could have been one child or multiple children in the family that are 12 and under. At least one adult was interviewed who ensured that the child received mental health treatment and who also aided in making key mental health decisions, with the rationale that this family member had a more thorough understanding of the child’s treatment. To attain this sample, I used purposeful sampling since I sought to explore the perceptions of a particular group of individuals and used a multiple case study research design. Purposeful sampling refers to selecting cases that fit the criteria for the topic being studied and choosing information-rich cases to gather in depth information (Patton, 2002). I chose this method of sampling because I wanted to maximize on the richness of the data gathered from participants as they pertain to the topic under investigation.

**Methods of recruitment**

I contacted key informants working with the Vietnamese American community in Southern California and recruited through networking with local agencies, organizations, religious institutions, and businesses that work with Vietnamese American families. I arranged with key informants to make announcements of the study at public forums, meetings, and presentations to families, along on Vietnamese American radio and television. Key informants are individuals that are highly informed, accessible, and can give sponsorship to information that
may not be readily available to the researcher (Creswell, 2007). Key informants were also given letters to distribute and families were directed to contact the primary investigator if interested in participating in the study. Letters were provided in hardcopy and electronic form. Recruitment letters were also used as advertisement to be posted at various locations where Vietnamese American families would interact.

Using a snowball approach or referral sampling (Penrod, Preston, Cain, & Starks, 2003), families that contacted the primary investigator were asked if they would know of other families that would be interested in participating. If they did not know of other families interested, participants were given the recruitment letter to forward to those families. Chain referral sampling can be used for hard to reach minority populations dealing with sensitive topics, while minimizing bias, maintaining privacy, and confidentiality (Penrod et al., 2003). Families were asked to contact me by phone or e-mail.

Despite the methods used to recruit, only four mothers participated in the study. Numerous other fields have noted the difficulties in recruiting ethnic minorities in mental health research and there is little published literature on practical measures to include minorities (Rugkása & Canvin, 2011). Difficulties were present in this study and may be tied to the stigma regarding admission of mental health treatment, concerns regarding being a minority, concerns regarding anonymity, believing participation should involve incentives, or any combination of these aspects. However, these are conjectures and not specifically examined in this study.

**Inclusion/Exclusion**

Criteria for inclusion was based on ethnicity and the presence of children under age 12 in the family. Specifically, I recruited participants who are part of a Vietnamese American family with at least one child ages 3 to 12 who has used or is utilizing mental health services. An adult
of Vietnamese descent needed to be the legal guardian of at least one child of Vietnamese descent to compose the minimum of a family unit for consideration in this study. Participants could have included one or both parents or other custodial caregivers. Beyond that, families could have included multiple generations and additional participants could have included various extended adult family members (grandparents, aunts, cousins, uncles, religious figures, etc.) that can be male or female. For the study, a pool of four mothers met the sampling criteria and were invited to participate. The focus was on families that have had clinical exposure to mental health services. Clinical exposure is operationally defined for this study as families who have child(ren) that have either had experience with professional mental health services or who are currently in treatment.

My criterion for exclusion was Vietnamese American families without at least one child between ages 3 and 12 years old and/or who have not had child(ren) who have accessed professional mental health services. The rationale behind this decision was to focus on families, especially members that help make key decisions and ensures that that treatment occurs in raising children 12 and under in a clinical population.

**Procedures**

There were two primary types of data that were collected to inform this study. These included interviewing and journaling. All interviews were audio-recorded with prior consent from participants, using two digital recorders. An audio-recorded journal entry was also done before and after each interview.

**Data collection.** The procedures for data collection are outlined in the three key steps. Firstly, to recruit participants, I gave electronic and hardcopy versions of recruitment letters in both English and Vietnamese to key informants in the following locations: California community
agencies, organizations, religious institutions, and businesses that served a significant number of Vietnamese Americans. Upon obtaining permission, I posted recruitment flyers or letters at these locations. I also employed referral sampling if I had trouble recruiting Vietnamese American families. In this case, participants may know others who meet the criteria of the study and that are also information rich cases (Patton, 2002). A family who knew of another family that may be interested was given recruitment letters to forward. In addition, upon obtaining permission from key informants, I made announcements at public meetings, forums, and presentations, along with announcements on Vietnamese American radio and television to recruit participants. Attendees were given recruitment letters as well.

Subsequently, when a family contacted me, I scheduled a pre-screening meeting with potential participants to explain the study and sign forms. I explained that I will interview the adult family members and caregivers of Vietnamese American children. They were informed that interviews are audiorecorded. I let participants know that participation was voluntary and they could withdraw from the study at any time. I explained the potential risks and benefits from participation, confidentiality, and limits to confidentiality. I described to participants the confidential handling of information after the interviews and how anonymity was going to be maintained throughout the process (Gibbs, 2007). Forms included informed consent and release of information in both English and Vietnamese. After all questions were answered and forms signed, I scheduled the participant for their interview.

Lastly, before meeting with each participant, I wrote an entry in my reflexive journal to capture any biases, subjectivity, and value-laden perspective along with thoughts on methodology (Glesne, 2011). When I first met with each participant for the first interview, I had them complete a demographic questionnaire (see Appendix D), then proceed with the interview.
Because I conducted a qualitative study using qualitative methods, I attained perceptions by conducting individual semistructured interviews with each adult participant, using an interview protocol (see Appendix C) that served as a lenient guide (Hays & Singh, 2011).

Semistructured interviews are noted to be more culturally appropriate and inclusive of participants’ voice (Hays & Singh, 2011). Each participant had an initial interview, with one participant needing to have a follow up interview. Interviews were between 60 to 90 minutes and conducted in locations based on participants’ choice. All interviews were audio recorded using two recorders and no participants denied audiorecording. I used an interview protocol to conduct the semistructured interviews. Semistructured interviews are guided, open-ended communication meetings and interview protocols are written conversational guides that have the main questions to steer the interview process (Rubin & Rubin, 2005). Because I used a semistructured approach, I used my interview protocol sparingly. For example, I started with broad main questions that encourage participants to describe their lived experiences about the specific phenomena and what it meant to them (Rubin & Rubin, 2005). While I began each semistructured interview with the same broad main questions, the other follow-up questions and probes I used during each interview were modified depending on the participants and other factors that impacted the interview (Rubin & Rubin, 2005). Depending on the language preference of the participants, I conducted the interview in English, Vietnamese or both. Following each interview, I summarized, made a memo, and added a follow-up entry into my reflexive journal.

These initial questions were used to guide the semistructured interviews. They are followed in parentheses by the specific research questions that were addressed.

1. Tell me about your child.
2. What are your child(ren)’s mental health concerns and how did you find out about them?  
   (R1 and R2)
3. Describe how you went about deciding to seek mental health services for your child.  
   (R3)
4. Did this process involve talking to others? If so, with whom and why? (R3)
5. How did you seek help and with whom? (R3)
6. What have your experiences with mental health services been like? Overall, is there 
   anything that you would have done differently and what would that be? (R3)
7. How would you define mental health? (R2)
8. What are your views on mental health, especially regarding your child(ren)? How do you 
   think those views that you just described were influenced by your Vietnamese 
   background? (R1 and R2)
9. What do you think impacts child(ren)’s mental health? (R2)

Follow up questions were be used to increase depth of participant responses and clarify 
responses. (See Appendix C titled Interview and Research Questions.)

Data Analysis

Interviews were audiorecorded then subsequently transcribed. The interviews were in 
both English and Vietnamese, so transcripts and excerpts may contain both languages. 
Vietnamese language use was italicized, followed by English translation in parentheses. 
Transcripts contained both languages throughout the body and also within sentences as 
caregivers switched languages between Vietnamese and English (Ash, 2004). I utilized the 
process of back-translation (Willig & Stainton-Rogers, 2008) to ensure the accuracy of 
translation of texts. This process involves the following steps: (1) I translated Vietnamese
language usage in the interviews from Vietnamese to English; (2) a Vietnamese-American peer translated the text back to Vietnamese; and (3) this back-translated version was compared to the original version, and adjustments were made until both are conceptually similar. Emphasis was placed on conceptual equivalence (Willig & Stainton-Rogers, 2008) to ensure that the meanings are captured as accurately as possible in the translation from one language to another.

Data analysis was performed consistent with multiple case study design (Yin, 2012) with phenomenological aspects (Creswell, 2007; Hays & Wood, 2011; McLeod, 2011; Wertz, et al., 2011), noted in the following key phases. Qualitative analysis transforms data into findings, and although there are guidelines there is no precise formula for that transformation process (Patton, 2002). To help understand the process, data analysis is listed here in phases but does not necessarily need to go in this order as I view data analysis as a fluid and nonlinear process, that can be adapted based on the purpose of the research.

In the first phase, there were two parts. In the first part, I began with a full reflection and description of my own experiences that influence the phenomenon studied (Creswell, 2007). In the second part, I incorporated memos, journaling, and summarizations that I have recorded throughout the process.

In the second phase, I read transcripts for a sense of the whole (Wertz et al., 2011). This was done in order to conduct a holistic analysis for each individual case and a description of the case was developed (Yin, 2012).

In the third phase, I utilized horizontalization, where I reviewed the interview transcripts, highlighting verbatim “significant statements”, sentences or quotes that provide an understanding of how the phenomenon was experienced by participants (Creswell, 2007). By doing so, I identified meaning units to the experience under investigation that can lead to productive
analytic reflection that can answer the research question (Hays & Wood, 2011; Wertz, et al., 2011). Using open coding, I took the data and segmented them into categories of information (Corbin & Strauss, 2008)

In the fourth phase, I incorporated qualitative content analysis (Graneheim & Lundman, 2004) to aid in generating themes from the transcripts. From the meaning units, key phrases within the units were extracted to create condensed meaning units (see Table 1). Next, an interpretation of the underlying meaning of the condensed text was made, labeled through coding, and then categorized according to themes emerging from the data (Graneheim & Lundman, 2004). Coding during this phase was axial, in which the categories from open coding related to central phenomenon category (Corbin & Strauss, 2008). Utilizing a constant comparative method, I concurrently coded and analyzed data in order to develop concepts while continually comparing specific incidents, refining concepts, identifying their properties, discovering relationships to one another, and incorporating them into a comprehensible descriptive model (Corbin & Strauss, 2008).

In the fifth phase, I searched for connections across emergent themes both within and across each case through cross-case analysis (Yin, 2012), then related and clustered meaning units to describe the context of the case (Creswell, 2007). I used peer-debriefing and member-checking to enhance trustworthiness during this step. I asked participants to read through the synthesis of data into these themes and confirmed whether it actually captured the meaning for them. Peer-debriefing and member-checking will be explained in a later section on trustworthiness.

In the sixth phase, themes from within and across each of the cases were described, along with assertions or interpretations of the meaning of the cases (Creswell, 2007; Yin, 2012)
experienced through influence of context or setting (Creswell, 2007). Moustakas (1994 in Creswell, 2007) noted that the researcher can also write about their own experiences, contexts, and situations that have influenced their experiences, and I reflected on any additional personal statements not captured at the beginning during this time. Lastly, I reported the “lessons learned” from these cases (Creswell, 2007) through implications for counselors and future research.

**Researcher Focus**

Throughout the research process, my intent was to capture the lived experiences and meaning for the participants in the study through their own descriptions, while being mindful of the uniqueness of each individual case. Through this research, participants were able to use their own words and voice, and my focus was to have the data honor their depictions. I also acknowledge that as the researcher, I bring in biases both conscious and unconscious. This study was with a community with which I closely identify, and this holds significant implications for the research. I was also a primary instrument in the data collection and analysis (Hays & Singh, 2011). For these reasons, I focused on being as candid as possible in disclosing myself as a researcher and instrument so that consumers of the research can make their own decisions about any biases that I may have. I aligned my research closely with heuristic inquiry and reflexive writing to achieve this. The primary goal was to capture participants’ experiences and meaning making, while fully disclosing continued reflexivity to inform the process and outcomes of inquiry.

**Trustworthiness**

Trustworthiness is of vital importance to qualitative research in establishing the quality of the research outside of the parameters of quantitative research (Givens, 2008; Lincoln & Guba,
Trustworthiness is established through the criteria of transferability, credibility, dependability and confirmability versus quantitative terms of external validity, internal validity, reliability and objectivity (Creswell, 2007; Patton, 2002). I will define the criteria and follow with specific strategies used to enhance trustworthiness.

Transferability is providing enough information about research and findings so that consumers can make decisions about how applicable the research is to the context of their work (Lincoln & Guba, 1985; Morrow, 2005). Thus, I provided sufficient information about myself as the research instrument, the research context, processes, participants, and researcher–participant relationships to allow readers to apply the findings to his or her context (Morrow, 2005).

Credibility is the “believability” of the study, with major criteria for whether conclusions make sense (Lincoln & Guba, 1985; Morrow, 2005). In practice, this can be illustrated by prolonged engagement, persistent observation, reflexivity, member-checking and peer-debriefing (Morrow, 2005). Dependability is the consistency of study findings across various times and researchers (Lincoln & Guba, 1985; Morrow, 2005). This can be enhanced through a comprehensive audit trail and report of research structure so that the study can be repeated (Morrow, 2005). Confirmability refers to ensuring that interpretations and conclusions match the data (Lincoln & Guba, 1985; Morrow, 2005). A key illustration of confirmability, similar to dependability, can be the examination of the audit trail by an independent reviewer to verify the research process and interpretations are consistent with the actual data (Morrow, 2005). The following are strategies that I used to enhance the criteria of trustworthiness. I will describe the application of each strategy of audit trail, member-checking, peer-debriefing, the authority and expertise of the researcher, and triangulation respectively.
Throughout the study, an audit trail consisting of a comprehensive collection of documentations regarding all of facets of the research was kept (Givens, 2008). To provide a comprehensive audit trail, I provided a detailed chronology of events, processes, and thinking, influences on data collection and analysis, emerging themes, categories and models, and analytic memos (Morrow, 2005). This included a reflexive journal kept by me with notes about data collection and memos generated during data analysis. Transcripts are part of the audit trail, both un-translated and translated texts along with a description of the translation process. All documents in data analysis, including initial noting, emergent themes, clustering and description of the meaning making process, were part of the audit trail.

Member-checking involves the researcher soliciting viewpoints from the participants on the credibility of the findings and interpretations. This also aided in verification to ensure that the data truly represented the essence of what actually occurred and that analysis was derived from the findings (Givens, 2008; Patton, 2002). Member-checking can be done by asking each participant to read a synthesis of their transcribed narratives and give me feedback. I checked with individual members. Feedback was given informally through conversations, or formally during follow-up interviews. Participants confirmed whether the analysis and themes were representative of their lived experiences.

My authority and expertise as the researcher aided in establishing credibility. I brought my experience as a person that identifies as Vietnamese American. Thus, I have insider cultural knowledge of the population with which I am working. This aspect helped me establish rapport with the population, as I had access to cultural knowledge and can communicate in the Vietnamese language. I also have educational and professional experience in the field. I studied
counseling children in both my masters and doctoral program, and I have worked in the community as a child counselor with this specific population.

Peer-debriefing or checking is a validation strategy employed in this study. External check of the research through peer-debriefing sessions in which the peer debriefer keeps the researcher honest by asking hard questions about methods, meanings, and interpretations (Creswell, 2007). This is also an opportunity for catharsis by sympathetically listening for feelings. I processed this research with a Vietnamese American peer, who is also a Vietnamese American counselor educator who has worked with children. The peer aided in auditing and verifying assessment of clustering of data.

Triangulation is the use of multiple and varied sources, methods, researchers, and theories to provide substantiating evidence to illuminate a theme or perspective (Creswell, 2007). The strategy of triangulation is beneficial because it provides diverse ways of examining the same phenomena and also adds to confidence in conclusions drawn from the findings (Patton, 2002). There are several types of triangulation (Creswell, 2007; Patton, 2002) and the following is a description of the types that were used in this study.

Data triangulation involves cross-checking and comparing the consistency of information gathered through different means, across various time frames, and varieties of situations (Patton, 2002). This study involved data from interviews, researcher reflection of interviews, literature and theory review, and thorough consultation with other researchers. Data was collected from interviews, which were audio-recorded. I kept a reflexive journal, field notes, and memos throughout the process that aided to substantiate the evidence.

Investigator triangulation involves the use of multiple investigators in the research (Patton, 2002). I was the primary investigator in this research. However, I was supported by a
Vietnamese American counselor educator who has worked with children and audited my work. I also had a Vietnamese American peer who aided in the translation process from Vietnamese to English. I also collaborated with the dissertation chair, the methodologist on the committee, and a qualitative dissertation analysis consultant.

Theory triangulation is the use of multiple perspectives to theoretical schema in examining the same data (Patton, 2002). As part of the literature review, I conducted a review of the historical context of Vietnamese American history and research regarding children’s mental health. Experts from the field of child mental health were used for consultation throughout the study. This included a Vietnamese American counselor with training and experience counseling children and dissertation committee members knowledgeable in the field of children’s mental health.
<table>
<thead>
<tr>
<th>Participant, Line # (Verbatim from Transcript)</th>
<th>Meaning Unit (Description close to the text)</th>
<th>Interpretation</th>
<th>Category</th>
<th>Theme(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thao, 443. For Vietnamese people, when they need mental health services, it is something different [for them]. A crazy person is not normal and goes to see mental health.</td>
<td>Shame and stigma towards mental illness creates a different perception of mental health services</td>
<td>Overcoming shame and stigma to obtain mental health services and maintain pride</td>
<td>Pride or Sự Kiêu Hãnh</td>
<td>Beliefs and Values</td>
</tr>
<tr>
<td>Lillian, 573, They, no, at first they still think that I was being overprotective, that they don’t think my son is that severe, or that he’s autistic, he should be fine.</td>
<td>Family influence on outlook on child’s mental health</td>
<td>Considering family’s outlook on child’s mental health</td>
<td>Collectiveness</td>
<td>Beliefs and Values</td>
</tr>
<tr>
<td>Clara, 106, The diagnosis. And then he has learning disability, uh developmental delays. Speech, reading and writing, probably reading, Which effects everything else.</td>
<td>Belief and relations in causes for mental health disorder</td>
<td>Actively learning and finding causes for impacts of mental disorders</td>
<td>Developmental</td>
<td>Problems</td>
</tr>
<tr>
<td>Thao, 492, When I went in, the people would ask, ‘What happened to her? How is she doing things? What behaviors does she have?’ I needed help from them so I described what</td>
<td>Description of initial entrance into services and the need for gathering of information from professional helping</td>
<td>Permitting access to information about child and justifying with need for help</td>
<td>Assessment</td>
<td>Approaches</td>
</tr>
</tbody>
</table>
behaviors she has regarding temperament, and what she couldn’t do such as when she went to school, she would not listen, get irritable, and would hit her peers.

**Huong, 928,** So the person teaching explained to me that before, my husband and I would fight all time. So when we went to this class about anger management for one year. The people would explain to us that if you are angry, then you lose effectiveness. It is best to not to get angry and instead change to gentle communication and it works more than getting angry. So I used that to apply [in talking] with all people or my child and it works more.

**Huong, 1413,** Now the doctor had declared that my child has this illness and [I wondered] why is the school denying it. I didn’t sign the paperwork too, so the nurse had to contact the doctor to find out about that issue. Now they are quiet.

| Note: Adapted from Graneheim & Lundeman, 2004 |
|-----------------------------------------------|---------------------------------|---------------------------------|---------------------------------|
| **education** to address mother’s mental health concerns to aid with child’s treatment | **Importance of seeking help through education for parent’s own mental health concerns to help with child’s mental health concerns** | **Education** | **Approaches** |

| Resistance from school professionals and using advocacy | Combatting resistance from school with advocacy can be effective | **Negative** | **Experiences** |
Chapter 4: FINDINGS

This study aimed to understand how Vietnamese American families view children’s mental health and the experiences and cultural beliefs that have influenced their perceptions. A qualitative research approach using strategies from multiple case study research design with phenomenological aspects were used for this investigation. Purposeful sampling was employed and included four Vietnamese American mothers that have utilized mental health services for eight children between 2 to 12 years old. This chapter presents the findings that emerged from in-depth interviews with the four mothers.

The first part of the chapter presents a capsule summary of the four Vietnamese American mothers interviewed. The capsule summary of their unique experiences provides a basic context for better understanding their individual viewpoints. Names of the participants, their children, and relatives have been changed using pseudo-names in order to preserve anonymity and maintain confidentiality of the information shared.

Participants’ Profiles

Participants in this study consisted of four female Vietnamese Americans, all mothers of at least one child under age 12 who have accessed and utilized mental health services. Two of the mothers reported high school as their highest education level, one reported elementary school and the other as a standard college degree. When the interviews were conducted, all three of the mothers reported at least part-time employment, while one reported staying at home to watch the children. All four mothers were born in Vietnam, but immigrated at different ages. Two of the participants immigrated as children, while the other two participants immigrated as adults after the age of 18. Two of the participants reported English as their current primary language, while the other two reported Vietnamese as their first language. On average, participants’ ages ranged
from 37 to 43 years old. Refer to Table 2 for an overview of participant profiles. More detailed information on each participant is presented below.

**Thao.** She is a primarily Vietnamese speaking 43 year old mother who immigrated to the United States 14 years ago when she was 19. She is currently a homemaker and focuses on taking care of her children. Thao has a 14 year old son, an 11 year old daughter, a nine year old son, and a seven year old son and she has accessed mental health services for all three children. She noticed that her nine year old son was “different” with regard to behaviors, socialization, and independent living skills. She took him to the medical doctor, who simply stated that he was developmentally delayed and made no further recommendation. She also noticed similar symptoms in her younger seven year old son. Later, Thao viewed a California television show on autism and services available. Upon calling the number from the show and obtaining more information, she moved her family from Nebraska to California to access services. She reported that her sons received Applied Behavioral Analysis (ABA) services, family counseling and individual counseling. Thao’s other two children also accessed mental health services through a community mental health clinic for adjustment and depression due to family conflict related to their brothers’ severe autism. She has accessed individual, family, and group services for herself, and reported that her husband has also utilized individual counseling.

**Lillian.** She is an English speaking 43 year old mother and immigrated to the United States when she was nine years old. She works as a financial manager. Lillian has a nine year old daughter, an 11 year old son, and a 12 year old son who have all accessed mental health services. All of her children were referred by their pediatrician after consistent issues with tantrums, perseveration, sensory issues, self-harm, and speech delays. They were diagnosed at varying points on the autism spectrum, with her eldest displaying the most severe symptoms.
Lillian’s children received services beginning at around two years old, including in home and at facility ABA services through the regional center and school district. She reported that her youngest two children have been discharged from services due to significant improvement and early intervention, and that her eldest son is currently still receiving low level follow up services (i.e. brief in-class intervention).

**Huong.** She is a primarily Vietnamese speaking 37 year old mother who immigrated to the US 14 years ago at age 12. She works as a manicurist at a nail salon. Huong has four children, and her second child, a seven year old son, has accessed mental health services. He was originally referred by his school due to symptoms of defiance, hyperactivity, impulsivity, tantrums, and sensitivity to sound. Her son was diagnosed with Autism and Attention Deficit Hyperactivity Disorder (ADHD) by a psychiatrist and received medication and in school support services. He is currently in the process of obtaining individual counseling services. Huong reported that she had accessed group counseling and educational classes to aid in dealing with her son’s illness.

**Clara.** She is an English speaking 38 year old mother, who immigrated to the United States when she was four years old. She graduated from high school and currently works as a home health aide, providing caretaking and transportation for youth and elderly with disabilities. She is divorced and raising two sons, ages 10 and 11, who have both accessed mental health services. Her younger son was diagnosed at age seven with Attention Deficit Disorder (ADD), learning disorders with reading and writing, and speech and developmental delays. Clara reported that she first had concerns for her younger son when he had difficulties with eye contact, would not respond to his name, mumbled and repeated hand movements. She first learned of concerns through his teacher and sought the help of a medical doctor. Clara’s younger
son has received both individual counseling sessions for a period of three years at least one time a week and participated in group therapy to aid with socialization. He has been on medication for two years, trying various medications including Metadate, Zoloft, Ritalin, Adderall, and Strattera. Clara also reported that the older brother was diagnosed with ADHD and has participated in counseling. The older brother exhibits similar inattentive symptoms as his younger brother, but the older brother is more vocal and able to express himself using words. He also received medication and Clara noted improvement within two weeks. This was in comparison to the two or three months for the younger brother to show improvement. Clara reported that she also sought counseling for her own mental health concerns, citing the stress of parenting two children with mental health disorders as one of the reasons she sought services for herself.
Table 2

**Summary Profile of the Vietnamese American Mothers and Their Children**

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Current Age</th>
<th>Years in US</th>
<th>Current Marital Status</th>
<th>Primary Language</th>
<th>Description of Children in Family (age in parentheses)</th>
<th>Mental Health Diagnosis</th>
<th>Mental Health Services Utilized</th>
<th>Length of Time Utilized Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thao</td>
<td>43</td>
<td>15</td>
<td>Married</td>
<td>Vietnamese</td>
<td>Son (14), Daughter (11), Son (9), Son (7) who have all used MH Services</td>
<td>Autism, Adjustment and Depression</td>
<td>Applied Behavioral Analysis (ABA), Counseling (Individual, Family and group)</td>
<td>2010 to present</td>
</tr>
<tr>
<td>Lillian</td>
<td>43</td>
<td>34</td>
<td>Married</td>
<td>English</td>
<td>Son (12), Son (11), Daughter (9) who have all used MH services</td>
<td>Autism Spectrum</td>
<td>ABA, Individual and group therapy</td>
<td>2004 to present; younger 2 siblings discharged before starting school</td>
</tr>
<tr>
<td>Huong</td>
<td>37</td>
<td>15</td>
<td>Married</td>
<td>Vietnamese</td>
<td>Son (7) who used MH services, 3 siblings (2 to 4)</td>
<td>Attention Deficit Hyperactivity Disorder (ADHD)</td>
<td>Medication, Individual and group counseling, Psychoeducational classes</td>
<td>2012 to present</td>
</tr>
<tr>
<td>Clara</td>
<td>38</td>
<td>33</td>
<td>Divorced</td>
<td>English</td>
<td>Son (10), Son (11)</td>
<td>ADHD</td>
<td>Medication, individual and group counseling</td>
<td>2010 to present</td>
</tr>
</tbody>
</table>
Primary Findings

This section summarizes Vietnamese American mothers’ lived experiences accepting and coping with their children’s mental health related issues and subsequently accessing and utilizing mental health services for their children. The main theme that was related to the participants’ concerns and struggles were how participants were facing the conflicting realities of mental health issues. From these themes were derived four main subthemes. The first subtheme includes culturally grounded beliefs and values. The second subtheme is problems that drive seeking help, which includes categories of intrapersonal and interpersonal problems. The third subtheme is factors that impact mental health, which includes psychological and biological factors. The fourth subtheme is different approaches to treatment and counseling, that includes methods and attitudes categories. The last subtheme is reflecting back on experiences with counseling through self-empowerment advocacy, with categories that include positive and negative experiences (see Table 3).
### Table 3

**Content Analysis Theme Chart**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Facing the conflicting realities of mental health issues</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subtheme (s)</strong></td>
<td>Culturally grounded beliefs and values</td>
</tr>
<tr>
<td><strong>Categories</strong></td>
<td>Intrapersonal</td>
</tr>
<tr>
<td>Codes</td>
<td>Collectiveness</td>
</tr>
</tbody>
</table>
Facing the Conflicting Realities of Mental Health Issues

Across participants, the primary theme emerging from the data was how deeply participants struggled with the sometimes conflicting values and beliefs of Vietnamese and American culture as they faced the reality and subsequently sought help for their children with mental health concerns. These struggles seemed to reside primarily around their understandings of the origins of mental illness, decision-making about whether and how to seek services for their children, and preferences and expectations for counseling. Lillian indicated her initial reaction was,

Oh, I started crying. Yeah, it was hard. It was really hard. You know, because it hits you like that and then you, you wonder, okay you’re about to have another one (child). You know, what’s going on? What’s going to happen?

Lillian illustrated the struggle with accepting her child’s mental illness, and worrying about the future of her other child. Subsequently, Lillian’s in-laws responded in the following manner.

We would go to my cousin’s house, and my in-laws’ house, and my um, nephew and niece’s birthday party. And when the family started gathering to cut the cake, to sing, he would go find a closet and cry, because it was too much for him. Okay? And I think that that’s when my family noticed there was something wrong. So I, I had, even my family, I had mentioned that. And you know what they said? [The family said] oh he’s fine! You know, your husband was like that when he was young. He didn’t talk ‘til he was five! And look at him now, he is fine! And I thought, oh okay whatever. I’m going to do what I want with my kids. I’m not going to just say that they’ll grow out of it. I did pursue [help].
A second mother, Clara, reported how her relatives responded: “Oh, oh, they didn’t like it. No, they didn’t like it because, um, is there something wrong with me? Yeah and you know I guess that’s normal.” She described the negative reaction from her family, and how she attempted to overcome her internal struggle by rationalizing that her family was reacting normally.

How the mother’s responded to their internal struggles and juggling their cultural beliefs/values/norms and their personal values and responsibility for their child/children was a critical factor in the mothers either advocating aggressively or not advocating aggressively for their children/child. The influence of culturally ground beliefs and values represents an umbrella subtheme that includes four related codes.

**Category**: Cultural Beliefs and Values

**Code 1**: Collectiveness: focus on promoting selflessness and putting the family, which could be both immediate and extended, and community needs ahead of individual needs

**Code 2**: Pride or Sự Kiêu Hạnh: feeling of deep pleasure or satisfaction derived from one’s own achievements or those one is closely associated

**Code 3**: Respect or Sự Kính Trọng: sense of deference or esteem to authority, usually elders in the family and the community

**Code 4**: Acculturation: process of integrating cultural beliefs and values from another group

**Cultural Beliefs and Values.** For the four participating mothers in this study, their Vietnamese values and beliefs played a significant role in the understanding of mental health in general, as well as the particulars of their children’s mental problems. These cultural values and beliefs impacted the identification of mental illness and decisions about whether to seek
Four major codes emerged from the data that connected to participants’ cultural values. The codes included collectiveness, pride, respect, and acculturation. Participants’ beliefs related to their children’s mental health were also identified. Value, as defined in the study, is what a person finds important and tries to emphasize in his or her life and a belief is a conclusion on something based a person’s knowledge or experience.

**Collectiveness.** All four participants included a collectivistic view towards seeking help for their children’s mental health challenges. Vietnamese cultural values focus on promoting selflessness and putting the family, which could be both immediate and extended, and community needs ahead of individual needs. Individual needs can include those of the both child or the mother’s. Collectiveness was expressed in participants’ family piety (hiếu) and emphasis on obtaining family members’ input, especially elders, on making important decisions that could impact the family unit as a whole. A collectivistic approach was present in all major family decisions, including treatment of their children’s illnesses. Lillian explained: “And I think that that’s when my family noticed there was something wrong. So I had, even my family had mentioned that.” This participant illustrates how family input on an identified problem verified her perception of her child, whether or not they agreed on how to proceed.

Another participant, Thao commented: “The family was broken, and relatives were afraid.” In most cases, final decisions were made by the mothers in this study regarding their children’s education and psychological treatment, but not until going through a process in which family discussions and family members’ opinions were heard. Despite fear or differing viewpoints regarding their child’s mental health, the four mothers still expressed some type of consultation with their family.
For example, Lillian reflected on her child’s mental health and family involvement when she noted: “They, no, at first they still think that I was being overprotective, that they don’t think my son is that severe, or that he’s autistic, he should be fine.” Similar statements by participants indicated that in all four cases there was consultation and discussion with extended family members regarding the child’s mental health related issues. Within this Vietnamese collectiveness concept there was not uniform agreement regarding the next steps to take to address the issue. It was also evident that in all four cases the child’s mother made the decision.

**Pride or Sự Kiêu Hãnh.** Another important Vietnamese value expressed by participants was family pride, and, for the most part, it was related to dignity not only for themselves, but their entire family. Pride can be described as a feeling of deep pleasure or satisfaction derived from one’s own achievements or those one is closely associated with. Thao explained:

> [Vietnamese parents] Don’t want to look and admit that their children are sick. Their children need help and will not admit it. They say that their children are beautiful, just like that. They are like [their families], but this is not right.

This participant acknowledged the importance of family pride in the Vietnamese culture, but she also noticed negative consequences when this pride interferes with critical decisions such as their children’s health and well-being. Parents, for example, might resist taking their children to treatment because such action would admit that something might be wrong with their children and help is needed.

Participants explained that for most Vietnamese families, the underlying perception is that a mentally ill child is a reflection of faults in the family. Furthermore, Huong said: “God is love and so the life of family is still steady. I try to find every way for my child to be happy, to be better, and to love his siblings” In Huong’s description of her family, she displayed a sense of
pride because as a family they were able to thrive despite the challenges of having a child with mental illness.

All four mothers indicated extreme difficulty acknowledging and communicating their children’s mental health needs with family members and other people in their Vietnamese community. For example, Clara noted: “It was harder, because I did not tell my sisters. My older ones and cause then they would think I am crazy or [something].” Based on this strong sense of family pride, participants expressed the need to avoid shame, or “losing face” (mắt mạt), through fear of stigmatization or labeling because of their children’s mental health problems. Shame can be a painful feeling usually connected to the idea that one has done something improper, and the four participants wanted to avoid this feeling not only for themselves, but also for their children and families.

The shame in this study was related to participants’ children mental health diagnosis and how being “labeled” with a mental disorder negatively impacted the children and families often by being stigmatized from their own Vietnamese community. Clara reflected: “It will be on their records for life that they have a mental illness. And that was a big issue. It was a major conflict [in the family].” Thao also expressed concern, and said: “For Vietnamese people, when they need mental health services, it is something different [for them]. A crazy person is not normal and goes to see mental health.” She added in regards to her child: “It is very difficult. Oftentimes, I don’t dare to tell others so they don’t know.”

**Respect or Sự Kinh Trọng.** In this study, respect was indicated as a major value for the participants. They related it to a sense of deference or esteem to authority, usually elders in the family and the community. They explained the significance of prior generations’ opinions and traditions on their own decisions. Most participants expressed respect to their elders’
Vietnamese parenting styles that included obedience, and when needed, punishment. They also recognized, however, the values from the Western world when approaching their children’s needs and mental health problems. Huong reflected further on how strict Vietnamese parenting practices are oftentimes very difficult to apply to a child and be effective. For example, in regards to her own mother, Huong explained:

My family is not educated. My mother teaches the children very well, but in the old fashioned way. Kids that are normal listen to her, but children like my son, do not listen. Vietnamese [people] always place children [like my son] as undisciplined. They can’t teach them because they don’t listen. They use a whipping stick to hit them, but they don’t observe and research on their children.

Huong’s statement illustrates the respect for traditional Vietnamese parenting and how such a restrictive way of education and/or communication might be difficult to apply to children like her own son who suffered from a mental illness. She emphasized the importance of observing and understanding the child’s needs as she has learned in the United States, and how traditional forms of corporal punishment do not work with children with mental illness. Thao reflected on how her own childhood affected her parenting:

For Vietnamese people our children are number one. We worry about them, but they have to suffer like we do. My dad was strict, very strict. So I rebelled, talked back, but I still suffered. It I not right, that I had to suffer, I don’t make my children suffer like that.

Thao described her upbringing with a strict authoritarian father and how it was a common cultural practice to have children suffer and be punished. She also indicated her attempt to break the family cycle and use her ways of parenting with her children in which suffering was excluded
and empowerment included. She stated: “They have the right to choose for themselves, we can’t force them, can’t force them anymore, so I think that if I only say no, I am not helping.” The participants strived to respect prior generations’ opinions and traditions, but also to integrate new cultural values and beliefs from the American culture through acculturation.

**Acculturation.** Acculturation was expressed throughout the process, as participants struggled with integrating what was learned from their own upbringing in a Vietnamese family with new values and traditions learned in the United States. Acculturation can be described as the process of integrating cultural beliefs and values from another group. Huong described the difference in having a Vietnamese background and living in America when she stated: “We grew up in Vietnam, but I have two ways of living now [reference to the United States]. From when I was small to then coming and growing up here [to the United States], the environments are different.” Huong described the differences between how she was raised in Vietnam and living in the United States. Clara also expressed the differences when she stated: “The Asian community because the new generation can’t, um the old generation can’t, they don’t associate. There is such a huge gap in traditions and culture and um the lifestyle.” She highlighted the generation gap and stated that to in order to address the gap, she would “want to know more and learn more to help them (her children).” Huong also explained: “From Vietnam, we only apply some parts. Life was hard. Kids had to listen to adults. Because of this sickness [for my child] is different, right is right, wrong is wrong regardless of where it [treatment practices] comes from.” Huong explained the differences, and claiming that she will use whatever treatment practice is right for her child, regardless of whether it is from Vietnamese or American culture.

Huong illustrated what the other participants realized; that they had to do things differently from their Vietnamese culture to address their children’s mental illness in the United
States and admit when things from Vietnamese culture did not work. Thao explained her acculturation process:

Each one [Vietnam and United States] has unique differences of its own. So I see that, I see that whatever Vietnamese culture uses, that matches with our children’s needs I keep. Then what is American and is not right, I try to explain to my children.

All mothers in the study used aspects from the two cultures they found appropriate for their children, and discarded those that were not productive or were perceived to be negative contributors to their children’s well-being. Because of the participants’ openness and willingness to learn new things in the United States, they were able to better access and utilize mental health services. One of the participants, Lillian, reflected:

I’m afraid that there are families out there at home, you know, moms that are not so familiar with the language. Not familiar with the services. They’re going to miss early interventions. And by missing out on these early interventions, it’s going to be much harder for their kids to develop.

The cultural values and beliefs of the parents in this study provided a basis for which the participants viewed children’s mental health. As a system, the parents juggled integrating Vietnamese cultural norms and Western cultural norms in which they were raising their children. Through the process of acculturation, participants in this study tried to incorporate the best of both cultures and made decisions regarding education and treatment that could benefit their children’s mental health and social well-being. The cultural values and beliefs of collectiveness, pride, and respect were what they tried to incorporate through acculturation into seeking help for their children’s mental health. These cultural values and beliefs became the foundation with which the mothers in this study found the motivation and drive to seek help for their children.
Problems That Drive Seeking Help. The process of seeking helping was motivated by driving forces for the mothers. Thus, data gathered in this study sought to understand the driving forces for treatment through what the mothers considered impacted their children’s mental health and challenges for their children. The mothers described these driving forces through themes of what problems their children were facing. In regards to the main mental health problems expressed by mothers, the mothers in the study indicated concerns that were grouped into categories of intrapersonal or interpersonal issues affecting their children.

Subtheme: Problems That Drive Seeking Help

Category 1: Intrapersonal: relates to a child’s self, including attitudes and self-esteem

Category 2: Interpersonal: relates to child’s relations with others

Problems are what the mother’s considered were the mental health concerns that their children were dealing with. The mothers described this through intrapersonal concerns of self-esteem, cognitive functioning, and developmental delays.

Intrapersonal Issues. Intrapersonal issues for the mothers relates to a child’s self, including attitudes and self-esteem. When mothers were asked what they thought were their major concerns regarding their children’s mental illness, they described concepts such as self-esteem, developmental, and cognitive functioning as intrapersonal problems. Self-esteem could be defined as the realistic respect for or favorable impression of oneself. Lillian expressed concerns regarding her son’s self-esteem.

I said to myself, I’m going to be very careful and I will keep helping him, so that he’ll have good self-esteem. That will pull him through. No matter what other kids will say to him, because kids are just being kids. If he is not strong enough, I’m afraid that it will impact him.
Lillian stated how she wants to foster a positive self-esteem in her son. Huong stated similarly: “So I have to research on ways to help, ways to make him happy, to attend and gather at school around him and not regret his illness so he can feel good about himself.” Low self-esteem can be a problem, especially for a child with a mental health illness, and building resiliency to face adverse situations with peers through improved self-esteem can aid in alleviating the negative impact.

In addition, concerns regarding their children’s appropriate development of cognitive functioning or ability to acquire and retain knowledge were also expressed by the four participating mothers. Thao expressed concern in regards to her daughter, she said: “She is weak in her education. It is usually about her English class, so I go [to the school] when I see something wrong. I can ask for help immediately.”

Clara, another participant, reported: “[my son] has a learning disability. Developmental delays in speech, reading, and writing. It effects everything else.” Also, Thao described how she agreed with her doctor about her son’s developmental delays, and stated: “The doctor said [that my son] had developmental delays and I thought the same as the doctor.” Thao further elaborated on the specific concerns, and reported: “Before he went to this school, my son did not know how to talk at all. He couldn’t say mom or dad, and even wore diapers.” All four participants described various aspects of developmental delays and how these were manifested in their children. Concerns regarding cognitive functioning often served as a catalyst for participants’ motivation to quickly seek help.

**Interpersonal Issues.** In this study, these types of issues were related to the relations between the participants’ children and the mothers, as well as others, such as siblings, other family members, and school peers. Participants expressed concerns regarding their children’s
lack of communication, potential physical harm to themselves or others, and poor socialization skills. Communication can be described as the ability to give or interchange thoughts, feelings, and information by writing or speaking. Clara noted: “I guess because [my son] couldn’t speak, he couldn’t translate his emotions into words. So then, he got more aggressive and we ended up having to get him a therapist.” She also stated: “I got worried, he wouldn’t have eye contact. He wouldn’t respond to his name. Then he wasn’t mumbling or repeating after his brother. Mainly a lot of screaming and just a lot of hand movement.”

Another participant, Thao also noted difficulties in communicating with her children. She explained:

So when we talk I don’t understand my children [sometimes], and if I ramble, my children don’t like it. They only want me to say yes or no only. If I ask them: When will you come home? Tomorrow what will you do at school? How many friends do you have? [They don’t like it]. I need counseling too, so I can learn about mental health and how to talk to my children.

Communication problems, both on the part of the children and their interaction with their parents and others influenced the mothers’ decisions to seek treatment for their children. This situation would also impact the delivery of treatment and sometimes counseling for participants themselves, as in Thao’s case. Huong also reported on the importance of addressing communication issues impacted the delivery of her own counseling, where she learned to “not get angry, change to sweet [words] and it works more. So I used that to apply to all people, or my child so it works more.”

Regarding potential harm to themselves or others, mothers were concerned for their children’s safety as well as the safety of others. Clara asked herself:
What will happen if they don’t have the tools to manage [with situations]? And they become a menace to society and then it comes back upon me as bad parenting to begin with. I don’t want that. I want them to be responsible and to be aware of their own actions. I [want them to recognize] their emotions and what they are capable of doing with them.

Thao also commented, “[my daughter] would say that she dropped the papers and a friend stepped on them, but he did not apologize. And she didn’t wait for him to say sorry and she hit him.” Furthermore, Huong reflected on his son’s mental condition and said:

[My son’s] illness is a psychiatric disorder. Sometimes he is sad and sometimes happy. He is not normal, in some activities he is aggressive. He is different from his other normal siblings. He is hyperactive and does whatever he likes or wants, and no one can control or stop him.

Huong also highlighted not only fear of physical harm to others by her son, but also to self-inflict harm. For example she described when her son had to go to the hospital after he shoved foreign objects into his nose and ears:

I was very scared rushing Ervin to the ER. It normally happens on the weekend. My mother called me at 8 pm and said, ‘he has a nose and ears problem and you should come home to take him to the ER.’ They tied him before removing the foreign objects, and I cried and embraced him for four, five hours. I beg him ‘please stay still and bear the pain so that the doctor can work on you.’ Sometimes if he is bleeding and crying, and I embrace him and cry. I [always] try to comfort him so that he stops crying.

Clara also highlighted this concern when she commented:
A lot of kids are killing themselves because they can’t go to their parents to talk about what is going on. Oh my God, I don’t want that. I want to have a relationship with my kids, where I know [about] any issues that arise.

Physical harm was described by all participants in different ways, whether it was the concerns of current or future possibility for harm. The data indicates that children’s potential physical harm was a major contributing factor in the decision to seek help for their children.

Lastly, all four participants expressed concern regarding the socialization of their children. Socialization is a continuing process whereby an individual acquires a personal identity and learns the norms, values, behavior, and social skills appropriate to his or her social position. Lillian explained: “I try to encourage him. I want him to just develop on his own. I don’t want to go out and find him friends and force him, because I want friends to come to him and like him. And I want them to play with him.” Clara also stated her wish for her son to work on his social skills. She said: “[I want him] to know how to interact, demonstrate his emotions, and socialize.”

Difficulty with socialization was expressed by all participants as a concern, and it reflected the collectivistic value of Vietnamese culture, and the importance of social interaction and input. This was especially important for the four mothers in the study to be able to aid their children, as they grow up in two cultures and develop their self-identity. As mothers described what mental health problems their children faced, they also expressed what they thought were factors contributing to their children’s mental health.
Factors Thought to Impact Mental Health. Participants described factors that they considered to impact their children’s mental health when racing the conflicting realities of mental health issues for their children. They reflected and expressed their opinions on the factors through biological and psychological factors, affecting their children’s mental illness.

Subtheme: Factors Thought to Impact Mental Health

Category 1: Biological factors: genetics and physical manifestations of mental illness

Category 2: Psychological factors: Pertaining to the mind or mental phenomena

Biological Factors. The four participating mothers gave different reasons and hypothesized about both biological and psychological factors influencing or contributing to their children’s mental health condition. Biological influences included genetics and physical manifestations of mental illness. Biological influences expressed by the participants included genetics, prenatal care, and family hereditary transmission. For example, prenatal care was of concern when Huong expressed: “When I was pregnant, I was sad and I think that this effected Ervin’s nerves afterwards.” Direct links were made between her prenatal care and the effects on her son’s psychological state. Huong used the word “nerves” to describe this as there was lack of an equivalent word in Vietnamese. Clara thought that the paternal side of her child’s family was related to mental illness. She explained: “Mental issues and stuff like that, that’s real in every family. It’s not on my side but his dad’s side.” Lillian expressed both genetics and prenatal care circumstances as effecting her child’s mental health condition. She commented: Mental health, I don’t know, probably [related to] raising the fetus inside the mom? I mean, taking care of the baby before he was born. In my situation, it is hereditary. I think that no matter how good I did raising this fetus, it couldn’t be helped.
Lillian thought that despite all her care during the prenatal stage, her son would have been mentally ill due to genetics from her husband’s side of the family.

**Psychological Factors.** In addition to biological factors, the participants also expressed psychological factors, pertaining to the mind or mental phenomena that influenced their children’s mental state. Psychological factors described by all the participants were stress and conflict. Stress was seen by the participants as strain or worry in the child or the people surrounding the child, including them. Thao noted stress in her daughter, and explained: “She didn’t want to see. Every time she saw her brother, she would bow her head, so that is why she didn’t talk very much. My situation was very difficult; I had to go get mental health help.”

Stress is a part of the human condition, but it is how the stress is dealt with that needs to be examined. For Thao, her daughter’s avoidance of having a mentally ill brother warranted Thao to search for help. Another type of stress described in this study was related to parental stress, such as when Lillian noted: “I have been crying at home by myself. My husband works nights. He couldn’t soothe himself [son]. I didn’t know how to soothe.” She reported: “With that in mind I knew that I needed help [to soothe my son].” Stress can be difficult when coping mechanisms are not effective; this can drive parents to seek help, such as Lillian’s case. Thao also described familial stress and stated:

So little brother is like this [mentally ill], older brother is like that [mentally ill] and at that time older [mentally ill] brother would hit his younger sister. The situation for the family would change forward, change backward, change houses, change all over the place, and we would worry about caring for the kids.
Parental stress, evident in Thao’s description, can also be overwhelming as parents attempt to manage and adjust to changes in the family. Familial stress was also reported by Thao to be present for all family members as they adjusted to change within the family system.

Similar to stress, conflict with others was seen as impacting participants’ children’s well-being and themselves. Conflict was described by participants in terms of a fight, battle or struggle due to discord of action or feeling having occurred. One of the participants, Lillian, explained:

I was taking him by pushing the stroller when another baby stroller came by. He raised his hand straight and slapped the other person’s child. So the child’s mother naturally, as a mother, saw another boy hit her child so she hit my child.

For most of the participants, behaviors such as aggression caused conflict with others and they needed to seek services to deal with those behaviors in order to minimize and also understand how to resolve the conflict. Additionally, some participants expressed how family conflicts impacted their children’s mental health. For example, Huong described a marital conflict and said: “At that time, my husband and I had problems. Things that were not happy, we ended up always crying. I think that that influenced the problems with my child.” Familial conflict was also seen as impacting Clara’s life, she said: “It’s hard because I’m divorced. The thing is like even with our [disagreements], we had to work together to seek medical [attention] concerning the kids.” Clara described a conflict derived from her divorce and how her family has been stable but conflicted with her ex-husband due to cultural differences.

These research findings indicate how Vietnamese cultural beliefs and values such as collectiveness, pride, respect, and family piety permeate into what participants believed Vietnamese American children were facing as mental health concerns and what impacts their
children’s mental health. Mental health concerns identified by the participants for their children revolved around fostering a positive self, and bringing that self to the forefront in the interaction with others. The biological and psychological aspects described by participants as impacting their children’s mental health also include facets of family influence and the importance of social group interaction. Participants expressed that children were influenced by factors related to biological, psychological, as well as by the interaction with others. Psychological impacts included stress and conflict. Biological impacts included genetics and prenatal care circumstances. The importance of the participants expressing both intrapersonal and interpersonal issues aided in the understanding of what they believed were problems affecting their children’s mental health condition.

**Different Approaches to Treatment and Counseling.** As the mother’s continued to face the conflicting realities of mental health issues through accessing and utilizing services to address their children’s mental health concerns, they described methods utilized and their attitude in following through. Families’ approaches and attitudes towards their children’s mental health and its challenges are described. There were two categories of methods used and personal attitude that include six related codes:

**Subtheme: Different Approaches to Treatment and Counseling**

**Category 1: Primary methods are what specific and strategic things were done to address mental health concerns**

**Category 2: Primary attitudes are the manner, orientation, feeling, position, etc., with regard to mental health treatment**

**Primary Methods.** A method represents a way of doing something in a very strategic way. Mothers in this study described three main methods that enabled them to access the system
to meet the needs of their children including assessment/counseling, education, and networking.

**Assessment and Seeking Counseling.** Apparent in participants’ descriptions was their use of initial information based on their children’s assessment and final diagnosis. Assessment is the appraisal of a person’s mental health with a full gathering of history. Lillian commented on her experience with her son’s first assessment. She said:

> Before they put you into any services, they make you go through so many different tests, and questionnaires! I remember, yeah a lot of tests and questionnaires. They want to make sure that you are fit and you are right for them.

Lillian was also able to acknowledge the importance of assessment prior to determine an appropriate treatment for her son. However, not all participants were pleased with this first experience. Some of them expressed frustration with the assessment process, such as Huong. She stated:

> They made me find out, by all [forceful] ways, to meet that doctor. At that time I did not want to find out [the diagnosis]. But they kept making me go to meetings at that program and with that doctor. I went and waited for the doctor and had an examination. The doctor diagnosed the child with that illness. We went home and the school did not accept it [the diagnosis] and called me. I got angry because why did you make me go [to the doctor in the first place]?

Thao described what assessment involved in her experiences and said:

> When I went in, the people would ask, ‘What happened to her? How is she doing things? What behaviors does she have?’ I needed help from them so I described what behaviors she has regarding temperament, and what she couldn’t do such as when she went to school, she would not listen, get irritable, and would hit her peers.
She described some of the questions that she was asked to answer and how she answered them. Although participants varied in their perceptions of what assessment was like for them, Thao’s description of her experience captured what many of the participants recognized in assessment, that it was a needed part of the process to get help for their children.

After their children’s psychological assessment and diagnosis of mental illness, participants searched for mental health services for their children, including counseling. All participants described utilizing counseling as part of their treatment. They needed this professional guidance from a trained mental health professional in psychological problems. Participants described various forms of counseling including individual, group, and in home counseling. Clara described how her son engaged in both individual and group therapy and how being involved in a group changed his perspective regarding his own mental health concerns. She explained:

“He had individual therapy and then group therapy. With the group therapy, it was with other kids, so then he can know how to interact, demonstrate his emotions, and socialize.” She further went on to describe how group treatment aided in helping him connect with other children that had a diagnosis and felt less alone. She said:

For him he was fine. His group therapy was harder to get in than the individual therapy. But once he got into the group therapy, there was more progress from there. And I guess he started associating that he had what other kids had. I guess he was, he felt that it was okay.

Thao reported on her use of counseling to aid in her children’s treatment: “For me own self, I need counseling too. So I can learn about mental health and how to talk my children.”
The participants shed light on how accessing multiple forms of counseling helped their children. Thao noted what she observed as her child’s counselor’s approach to counseling. She explained: “She is very dedicated. She would meet with him, come to the house, observe the family’s situation and play with him. This went on for almost a year and half.” Thao also described how her child’s counselor worked with her, and said:

The counselors said that I have to put out 10 to 15 minutes to talk to my children, such as on the way to school or picking them up. Ask them what they ate today? I think that I didn’t do any of that. Just simple things like that I had not done for my children.

This participant’s narrative shows how important the counselor’s approach was in treating their children. The mother valued the modeling that the counselor did to educate her, and she was receptive to observing and learning from this modeling. This helped to develop trust between the counselor and mother. There was a general trust in the counselor to aid her to address mental concerns and learning ways from a professional.

Clara noted on why there was a lack of a counseling profession in the Vietnamese community, and noted: “In the Vietnamese culture you can’t talk about your emotions. You can’t talk about your feelings. You can’t do that stuff.” As the mothers interacted with the counselors, there was a safe environment created between the counselor, child and mother in the therapeutic relationship.

Lillian stated: “So I think just working closely with your counselor and find someone that you trust, and they will guide you through, you know.” This working relationship and modeling led to the mothers’ education on how deal with their children and aided them with fostering development of coping skills.
Education. Participants also expressed that education was an important component of how to approach their children’s mental health challenges. Education is the act or process of imparting or acquiring general knowledge, developing the powers of reasoning and judgment, and generally of preparing oneself or others intellectually. Seeking education meant that participants were in an active process of acquiring knowledge. For example, Thao stated that:

I don’t know how to explain it, but we are mothers. We understand our children the most. We always have to study and learn first. Then we teach it to our children. Only mothers can teach their children. I learn from the teachers of my children, then teach my children that is my personality in how I do things.

She also noted the necessity of education for herself, stating: “So mothers have to learn and question first. Then we teach our children. We always have to follow closely the teachers, so that we can learn and question them with other parents together.” Huong explained how classes helped her to address her concerns, she reflected:

So the person teaching explained to me that before, my husband and I would fight all time. So when we went to this class about anger management for one year. The people would explain to us that if you are angry, then you lose effectiveness. It is best to not to get angry and instead change to gentle communication and it works more than getting angry. So I used that to apply [in talking] with all people or my child and it works more.

She elaborated further on the application of education by stating: “Now we go home and talk gently to our children. We see everything differently now than in the past before going to the class. I used that [information from class] to apply to my life.” As they learned new things that differed from Vietnamese culture, they also learned new ways to deal with their children’s
mental illness that were not part of their knowledge. In addition to working with the counselors and utilizing the modeling by the counselors, the mothers also used networking and information gathering through avenues such as technology to educate themselves.

**Networking.** The participants also expressed the importance of networking that aided them in working with their children. Networking is a supportive system of sharing information and services among individuals and groups having a common interest. Lillian, who turned to her spirituality for support and stated: “But I think it’s part of us, being a Catholic and you have a very strong will. And you believe in God.” Huong noted the importance of friends, and stated: “During that time, I met my friends who told me about a special program for children with development disorders. I registered him with a school district that put him in the program.” Thao also noted that peers who have accessed mental health services were sources of support. She stated:

> When I don’t know, then I ask. There are other mothers that are very knowledgeable, who show us. They are thorough with their guidance, support each other. I can call them on the phone and if I need help with anything, they are always ready.

Overall, participants’ descriptions depict a wide range of support networks and highlight the underlying collectiveness in Vietnamese culture. Reaching out and seeking group input can be seen as naturally engrained in the participants, and was reflected in the way that they approached their children’s mental health illness.

A part of networking was the access of information through the internet. Clara stated: “I have to search on the internet because it took us a long time for the doctor to have the approval.” So she used the internet as a source of information while she waited for results. Lillian expressed using the internet immediately after finding out about her son’s diagnosis, and said:
“That night, oh my God, I went on the internet and I started.” Also, she used the internet to follow up on referrals. She explained: “When I heard about this program [for autism], I did some research, you know. I went online and researched and say, ‘Oh my God. The services are great.’ I should take advantage of it.” When needing more immediate information, the participants described using technology to gather more information.

Participants also expressed how important it was for them to be advocates for their children and network to find services. Advocacy is the act of pleading for, supporting, or recommending for another. Lillian described: “I am an advocate, they’re so young. Without, me they’re not going to get that service. When I said to myself, ‘If I am the only person that could help, I, I’ve got to go for it. I’m going to do it.” Thao also stated: “Children show behaviors that then I started to work for his care, I asked for that service for him to learn” and “I called and saw that if I wanted to care for my children. I had to look for myself.”

Participants also expressed the impact of previous or current interaction with mental health services from other family members, whether it be the parents themselves or having several children with mental health concerns to aid in building a network for future services. For example, Huong had experience with her eldest child and was able to utilize mental health services with her other children. She commented:

With my eldest child, I didn’t know where to start asking for services or how to help my child. So the younger ones I had more experience, so later on with more children then I have a little more experience. But back then I only had the first child, so I didn’t know anything. Now there should be a requirement to announce to parents at the schools, to parents with just their first child that don’t know [about services].
Huong described how previous mental health usage aided in networking so that she could access services for her younger children. She is also stating that it is important to network to reach parents trying to get mental treatment for their child for the first time. Also, Lillian described her previous experience and how helpful it was by stating: “So my younger kids, will follow through, because I was already in the program of helping my eldest child through. So that helps a lot.” Clara expressed that she valued therapy because of her own experience, stating: “It’s really good. I myself had to go through therapy for a while.”

**Primary Attitudes.** In describing methods used by participants to address their children’s mental health, it is important to explain participants’ attitudes towards them and how families contributed and supported their children’s socio-emotional well-being. Participants described their attitudes or the manner, orientation, feeling, position, etc., with which they viewed their children’s mental health treatment. Overall, participants were willing and open to trying new things through an acculturation process of integrating Vietnamese and American culture. Participants’ attitudes towards mental health in general, and their children’s mental illness specifically, were important elements in their understanding and impact to their children’s well-being. Their attitudes toward treatment included their openness, self-reflection, and resourcefulness.

**Openness.** Openness meant that participants were willing to apply concepts and skills learned in treatment to other settings. Openness encompassed the ability and motivation to share and try new things. Lillian embodied her openness, stating:

So they [the children] learn it, they see it. So all that was done in therapy, I also did it at home too. So I tried to buy the toys that they use in therapy, to do it at home so that I can enhance it.
Huong also asserted that openness to apply skills in the home increased the effect of treatment and stated: “So we need to go home and use this [therapy] like that and it will work more.” Participants understood the importance of generalizing skills and techniques learned in treatment and adopted this attitude in order to increase the effectiveness of treatment for their children.

Connected to their will to reach for help and try new things, the four participants expressed the need for openness when attempting to address their children’s mental health. Clara noted that: “If your way is not working, you have to be open-minded and find another way because one of your children could die because of it.” Also, Lillian expressed the need for openness to share experiences, stating: “To me, I’ll share. I’ll say, ‘Oh yeah, my sons are diagnosed.” In addition, participants also observed how other parents are not open. Huong commented: “I was able to go into this program so I was able to understand and find out a lot from other people, there are also people that don’t try to understand.” In looking towards the future, there was an expression of openness, described by Thao: “I will continue going on. I will go if there is anything I can ask for, study about, so that the children can get programs to help them.”

Participants were open to test and try procedures and techniques new to them in their children’s journey to improvement and possible recovery. For example, Clara expressed:

The meds, it just took a long time to get to the right one. It took almost two years. First of all, it was because he was on the Metadate. And that didn’t work. The doctor said that with the medications, it takes within 2 to 3 months to see the results.

Also, Thao expressed her willingness to experiment in counseling, by stating:

It [counseling] was very fun, and it was because I was able to learn and ask. There are things that are so new that I didn’t know about. When I talk with my son, I used
words that are not right. If I used [English] words that are too simple, then it is not accurate. When I ask questions, the meaning will be different. So I would ask [my counselor] to fix it so I would say it right.

*Self-Reflection.* Another important attitude found in the four participants is self-reflection. All of the participants demonstrated the ability to critically think about themselves and the challenging situation facing their children. Clara commented:

As Asians, you know, we don’t deal with mental illness. We don’t. That’s life, move on. I realized that wasn’t the way it was supposed to be. Because that’s not following the issue and I need to get that mentality out of me.

Participants also self-reflected on what they thought were the right ways to help their children. One participant, Lillian, explained: “It’s okay. I had to do it at the moment. At the time, it was the right thing to do, so I had to do it.” Participating in this study itself was an act of self-reflection. Self-reflection was also part of their counseling experiences, and the participants displayed the capacity to be able to do this, which may have helped them to maximize their possibilities and effectively face many challenges.

*Resourcefulness.* Participants expressed resourcefulness in obtaining services for their children despite the obstacles presented for them. They were able to skillfully and innovatively deal with their children’s mental health concerns. Despite a lack of information and not knowing where to start seeking help, all of the participants were able to obtain treatment for their children. For example, Lillian stated: “You know, I’ve asked about the program, and I said, this is going to help my kids. I did pursue the program. And so I think it took a while for it to start because I had to look.” Huong noted:
When my child has a problem then I want to research to help my child, and I don’t want my child to be like that and leave them like that. So I let my child have it and that’s why I have to try to research to help my child to be like other normal children.

Thao illustrated resourcefulness when she reported:

They let him in the school and said that he had autism, but I didn’t know what that was at all. After that I saw on TV about autism, that children show behaviors. Then I started to work for his care. I asked for that service for him to learn. When I saw that my children were like that, then I went to ask at all sorts of places.

She moved her family to another state to access services, and described: “So I saw on Vietnamese television that this was autism, and that in Orange County California that they have developed something that can help guide me. So I moved from Nebraska to here.” Being resourceful meant that if obstacles arose, the participants made changes and adjustments to address the obstacles. This also reflected their experiences with acculturation and needing to make changes and adjustments in integrating culture. Having examined how the participants addressed mental health concerns for their children, it is important to describe what their experiences were like in order to identify how services can be improved.

**Reflections Back: Experiences with Counseling in Self-Empowerment & Advocacy.**

As participants reflected back on facing the conflicting realities of mental health issues and their experiences, they described both positive and negative aspects of their experiences. Although the participants shared negative aspects of their experiences, overall they expressed self-empowerment and a sense of advocacy that they accessed services. Self-empowerment and advocacy manifested in what positive aspects they were able to gain from seeking treatment for
their children. All four participants expressed the subtheme on reflection of experiences with counseling through positive and negative categories.

Subtheme 1: Reflections Back on Experiences with Counseling

Category 1: Positive aspects of experiences of their children’s mental health treatment

Category 2: Negative aspects of experiences of their children’s mental health treatment

Positive Experiences. Positive subthemes described included helpfulness, improvement, and relationship building. The following is a description on the participants’ meanings on the positive subtheme and its categories. Thao noted the helpfulness of both individual and group counseling:

At the beginning of group counseling, I would go by myself, just me and the mental health person. But after, the mental health person would gather all the parents to sit and talk with each other, tell our situation, how our children are, and what do we need. [They would ask,] ‘When you deal with your children like that, is it okay?’ So we bring that out and share with each other. We guide each other and it’s very effective. That really helped me a lot.

Lillian also noted: “I thought I saw that it helps him and I put him in. You know, and so that’s how I felt. You know and I, I wish that other would, would feel the same way.” Beyond her own perception that treatment was helpful, she extends the hope that others will try and find treatment for their children helpful as well.

In addition to feeling that treatment was helpful, participants also expressed witnessing improvement. Improvement can be described as going into a more desirable condition. Lillian noted how improved her son is: “But he, he’s better. He’s, you know, I think his social skills has
developed, um, tremendously, um, in the last few years.” Thao expressed improvement for the entire family by stating:

Understanding with my child, me as a mother in the family, my husband too. He had to go to mental health services, and he got better, knowing how to deal with the children and know why our family is like that. My family really needed mental health services.

She further elaborated improvement throughout the family, describing that there were “changes in my entire family also, not only for children and me, but the entire family.”

Relationship building, or enhancement of emotional connection, was expressed by the participants. The experience of relationship building in the counseling experience was expressed by Huong, who stated: “I want to have a relationship with my kids with any issues that arise, or mental issues.” Thao exemplified how the counselor aided in her relationship building, by stating:

Because I didn’t know why I said that, so I asked [my counselor], and [my counselor] said it correctly. Before I would talk to my son, I would ask the counselor to see if what I said was right. Do I need to fix anything back? So the counselors would say fix this, and whatever it was they would aid to fix it again.

She reported results such as:

I know ways to talk to my children. My children know how to talk to me. When we see that the two of us are starting to not understand each other, we slowly sit down and gently talk with each other. They don’t understand me as I say something, so I would get the dictionary and ask my child what words to use. So my kids can help me.
These examples show the desire of parents to enhance the relationship with their children but finding it difficult at the beginning. Findings from this study show that the four participants found that treatment aided in enhancing family relationships.

**Negative Experiences.** Negative experiences described by these mothers included difficult, needing evidence or proof, time constraints, and resistance. The self-empowerment and advocacy of these mothers is displayed by the fact that despite these negative aspects, the mothers overcame them and continued services for their children. Difficulties can be seen as hard to deal with and not easily done. For example, Thao became teary and reflected: “That is hard, my situation was happening and I was having a problem that was burdensome”. Lillian had difficulties with dealing as she gave birth to more children, reporting that: “I started crying. It was hard. It was really hard. Because it hits you like that and then you wonder, you’re about to have another one. What’s going on? What’s going to happen?” Huong described how difficult it was for the school to accept her son’s assessment and diagnosis to start treatment, stating:

Now the doctor had declared that my child has this illness and [I wondered] why is the school denying it. I didn’t sign the paperwork too, so the nurse had to contact the doctor to find out about that issue. Now they are quiet.

Participants also expressed an overall need for evidence or proof regarding diagnosis and treatment. For example, Clara noted that with her family: “I could say they need proof. I think they need something that is tangible. But then I don’t know why because they are so superstitious.” Lillian also noted that other families needed evidence or proof of her child’s mental illness, stating: “So I think that’s probably the barrier, that you have to set it for other families to see it [mental health treatment], right? So that, that they might reach out more.”
Indicative in these descriptions is the need for proof and evidence from not only family members, but also those outside of the family.

The constraints of time were described by all participants. Huong, reported that: “I can’t be there all the time for them” and noted her limit in always being there for her children. Lillian stated: “I didn’t have the time and it [counseling] was too much time for me with my kids.” Thao remembered: “Well sometimes at the office I don’t have enough time.” Treatment can be a time consuming process and despite the difficulties in finding the time for their children’s mental health services, the mothers in the study were able to somehow prioritize and make time.

All the participants described resistance from their families and resistance manifested in many forms. Although they were not resistant, they could see how other parents could be resistant. For example, Clara described resistance from her ex-husband: “He [ex-husband] wasn’t on board at all. I guess cause, his girlfriend thought that why is [Clara], putting the kids on meds, seeking a therapist and psychiatrist, and going through all these therapies.” She also described resistance from her older sisters when she stated: “My older sisters, said no he is not (mentally ill)”.

Lillian also reported resistance from her family. She remembered them saying: “You know what they said? “Oh he’s fine! You know, your husband was like that when he was young. He didn’t talk ‘til he was five! And look at him now, he is fine!” Participants also described how other parents can be resistant to seeking treatment for their children. For example, Huong stated: I have problems paying attention to my children a lot. There are mothers who only know to work. They know that their child can’t talk and have these symptoms [from mental illness] like this, but they don’t want to find out more. I was able to go into this
program, so I was able to find out more. There are also people that don’t try to understand.

Thao also described empathizing with resistant parents and stated: “I can understand that parents don’t dare bring their children, don’t want to look and admit that their child is sick. Their child has things that need help, they will not admit it.” Despite the resistance experienced from various sources, the participants in the study continued with their children’s mental health treatment. Some participants were even able to empathize with parents that may be resistant and reasons why they may be resistant.
Chapter 5: DISCUSSION and IMPLICATIONS

The aim of this qualitative study was to understand how Vietnamese American families cope with their children’s mental illnesses and utilize mental health services, specifically how culture influences mental health service utilization. Research has indicated a lack of knowledge, understanding, and professional preparation of counseling professionals regarding children’s mental health problems from culturally and linguistically diverse backgrounds (Mellin & Pertuit, 2009; Thompson & Henderson, 2007). A greater knowledge regarding cultural influences and preparation for counselors is needed to help bridge cultural gaps and integrate techniques and methods to more adequately address the mental health needs of diverse children and their families (Thompson & Henderson, 2007).

Other disciplines in the social sciences have promoted and conducted empirical studies (Johnson, Davis, & Williams, 2004; Minnis et al., 2003; Nguyen, et al., 2007; Tucker, 2002) on working with ethnic minority children, noting a specific emphasis on examining the influence of culture. The counseling profession, however, has limited empirical knowledge regarding service utilization by Vietnamese Americans. As the population of Vietnamese American children in the United States continues to grow (Nguyen et al., 2011), and as Vietnamese children and families continue to encounter unique mental health concerns (Pyke, 2000; Leung, et al., 1997; Thai, 2002), the counseling profession must develop a greater knowledge and understanding of the Vietnamese culture to aid in addressing the mental health problems of this population.

For organizational purposes, this chapter is divided into three sections. In the first section, findings are summarized and discussed in relation to prior literature reviewed in Chapter Two. The second section discusses both theoretical and practical implications for counselors and mental health professionals providing services for ethnic minority children with mental health
problems, in particular, children with a Vietnamese background. Implications presented are based on the connection between research findings and the conceptual framework for this study, the Ecological system theory. Finally, the last section provides suggestions for future research.

**Discussion of Study Findings within the Context of Previous Literature**

Research findings from this study indicate that cultural beliefs and values impact Vietnamese American decisions to address children’s mental health concerns. The influence of their cultural beliefs and values appeared to be deeply present in how they accessed and utilized mental health services for their children. There seemed to be a distinct parallel between their acculturation process of integrating Vietnamese and American values and beliefs and integrating newfound methods/strategies and attitudes to address their children’s mental health related issues. The families involved in the study were particularly consistent, persistent, and determined to follow through with treatment and counseling services. This determination was evidenced in how they spoke of their experiences in utilizing mental health services. The participants demonstrated resilience in addressing their children’s mental health concerns, possibly fostered by previous experiences in coping with adversity and sociocultural challenges.

In addition, the findings indicate that it is important to understand what Vietnamese American families consider to be as relevant factors influencing and impacting their children’s mental health. The participants described psychological factors such as stress and conflict. In addition to psychological factors, the mothers also indicated biological factors that they believed influenced their children’s mental health such as genetics, family hereditary transmission, and prenatal care. This is consistent with what Dogra et al., 2007 found in their study with ethnic minority Gujarati children, and that assumptions should not be made about the mental health knowledge or beliefs of prospective clients and their families.
It is also important to consider what Vietnamese American families believe are concerns that would warrant seeking assistance, with consideration to their family and cultural background. In this study, participants described limited knowledge about children’s mental health and the process for accessing treatment and services. This is aligned with previous research on how minorities may differ in understandings about mental illness and treatment due, in part, to services historically available to them in their country of origin (Algeria, et al., 2010; Cauce et al., 2002).

In addition, there may also be differences in beliefs about what a counselor can do to help children experiencing mental health needs (Algeria, et al., 2010; Cauce et al., 2002). For example, Thao and Huong would often describe educational aspects involved in their counselor’s interactions with their child, but had difficulty distinguishing that this was not a counselor’s main role. Thao described her son’s male counselor role who “took him and see if he could get additional tutoring, very dedicated, very improved, and then he would go and ask for those teachers, then wait for him to finish with tutoring.” This may be due to the participants lacking a frame of reference outside of education for the services provided by mental health professionals and contextual and cultural influences may not have a frame of reference for the mental health profession.

Participants in this study described the impact of contextual and cultural influences when they described how they were raising their children in the United States, but needing to integrate their Vietnamese cultural background. The contextual influences include their children being born and raised in the context of the United States, but having parents from a Vietnamese cultural background. This is consistent with what previous literature emphasizing the importance of cultural and contextual influences (Cauce et al., 2002).
Findings in this study are also consistent with what McKelvey et al. (1999) found regarding Vietnamese Americans’ perceptions of biological causation of mental illness and the parent’s limited knowledge and understanding of existing community mental health services. McKelvey et al. (1999) in their study of Vietnamese Australian children’s mental health, found that over 78% of the parents indicated some type of biological causation for mental illness in children, along with over half indicating some type of genetic hereditary influence. The participants in this study all noted some type of biological causation when discussing the factors that have influenced their children, including genetics, prenatal care, and family hereditary transmission. All four study participants also expressed their struggles in seeking information and services for their children’s mental illness. Some, such as Lillian and Huong, lacked adequate information on their children’s mental health diagnosis and where to go for treatment. Others, such as Thao, struggled with finding culturally sensitive services in her area of residence and had to move to an area in California where he culturally sensitive services were available.

In regard to the need for culturally relevant interventions reflective of individual acculturation processes, this study supports past research that noted the importance of Asian American children’s acculturation and ethnic identity on their mental health (Lopez et al., 2011; Qin et al., 2011). There is a need to examine parental and family acculturation and its impact on children’s mental health (Lopez et al., 2011; Qin et al., 2011). Although the acculturation process for children was not examined, the mothers’ description of their acculturation processes for seeking and acquiring help for their children’s mental health problems was highlighted in relation to their children’s treatment. For example, Thao described “Learning, anything that is Vietnamese that is good we keep, and anything that is not good we discard. Americans whatever is good we take, following me that is what I think.” Thao’s example depicts the process of
acculturation, picking and choosing what worked for them in their learning of mental health problems and treatment, and how they dealt with their struggles. She further noted how she dealt with the discrepancies in culture by having stated:

Each one [Vietnam and United States] has unique differences of its own. So I see that, I see that whatever Vietnamese culture uses, that matches with our children’s needs I keep. Then what is American and is not right, I try to explain to my children.

The mothers in the study were all highly involved in their children’s treatment, and their Vietnamese cultural background was also manifested in how they approached help and treatment for their children. Walker (2001) interviewed caregivers and discovered that knowledge of their children’s culture was integral in service planning and delivery. Walker (2001) found that providers of mental health services, however, are only partly successful in mental health service delivery due to their limited knowledge of the children’s culture.

Hampton and colleagues (2007) noted how Vietnamese Americans believed that mental illness would damage the family reputation and was not positively perceived in the participants’ communities. Findings in this study support this trend. The participating mothers expressed the desire to follow their families’ wishes and maintain pride without jeopardizing the mental health services provided to their children with mental illness. This study also supports Hampton and colleagues (2007) findings on how a positive community perception was important to Vietnamese Americans.

Two other relevant studies about Vietnamese American families are related to punishment and authoritarian parenting styles (Nguyen & Cheung, 2009). These family aspects are prevalent in the Vietnamese culture and oftentimes cause conflict between parents and children (Nguyen et al., 2011). In this study, participants addressed punishment and authority
when they explained their own upbringing in Vietnam. Although they indicated the importance of respect to elders, they described differences in their parenting styles and the parenting styles of their parents.

Findings indicate that despite both positive and negative perceptions of treatment, participants still engaged and continued with treatment. Few studies have included a clinical sample (Mai, 2009) of those who have or are currently using mental health services. Rather, studies have examined treatment preferences rather than actual service utilization (McKelvey et al., 1999). Important in the participants’ narratives is drawing on the positive strengths that they exhibited in their approach, attitude and perceptions of treatment. For example, one of the subcategories in attitude towards treatment included openness. Nguyen and Anderson (2005) found in their study that Vietnamese Americans who have a greater inclination to disclose and be open are more positive in their attitudes towards pursuing mental health services. By focusing on positive strengths, the counseling profession can begin to understand how to foster strength and resiliency in working with Vietnamese American children and their families so that they may have the best treatment outcome and maintain it.

Implications for Practice

This section delineates both theoretical and practical implications for the field of counseling and mental health to respond to the unique needs of Vietnamese American families with children with mental illness. Thus, an interpretation of the dissertation findings is provided based on the guiding research questions and retrospective examination of the theoretical framework presented in Chapter 2. Practical implications delineate applications of new insights derived from this study and the connection with the Ecological Systems Theory (EST) in order to
address significant problems concerning Vietnamese Americans and the pursuit of quality and culturally sensitive services in mental health.

**Ecological Systems Theory (EST).** Cauce et al., (2002) specifically called for the use of the EST in examining minority children’s mental health. This includes the microsystem, mesosystem, exosystem, macrosystem, and chronosystem. They also discussed the importance of cultural and contextual influences on seeking mental health treatment.

**Microsystem.** In this study, microsystems were described by participants through descriptions of family, peers, mental health services, and school systems that surrounded their children. The patterns, activities, roles and interpersonal relations were important. Special focus was reflected in the mothers’ descriptions of themselves and their families in relation to their child(ren). These four mothers were the key decision makers in their children’s treatments. Children are minors and the access and consent for treatment are embedded in the microsystem, especially with their direct caregivers. It is interesting to note that out of the recruitment process, only mothers came forward to participate in the study. In the description of the mothers, they seemed to play a primary role in their children’s treatment as contrasted with others in the family, especially the fathers. This may tie closely to gender (Morrow & Brown, 1994) in critical theory and how role divisions are made within the family, with mothers seen as the primary caregivers for the children in Vietnamese culture (Kaplan & Huynh, 2008).

Practical implications are that outreach and treatment should consider the microsystem as a critical part of treating a Vietnamese American child. Outreach is needed within the microsystems that surround the child in order to engage the family in mental health services, and given the representation of females in this study that counselors may find particular success engaging mothers. Mothers in this study also described some degree of involvement with the
school system, so an important strategy to consider is outreach through the schools. For example, sending Vietnamese American service providers or those familiar working with this population to the school could be a strategy. Also having families that have already used mental health services reach out and provide perspective to potential service users could also be helpful. Families that have not accessed mental health services but need them, may also benefit from having exemplars of those children that have been treated successfully in order to access services for their own children. During treatment, it could also important to include these microsystems as part of the assessment process and how treatment is delivered, as they seem to be an integral part in the child’s life. Counselors can use ecomapping, which is a tool that can be used to encourage discussion in counseling by charting out in a visual representation the various levels of individual, family, and community resources (Ungar, 2010). Other strategies that counselors can use include giving clear information to Vietnamese American families on their children’s mental health treatment and providing time for the family to ask questions. In addition, counselors can also engage the families through constant collaboration and inclusion of the family in the assessment and treatment process. Counselors can also approach treatment with a child not only through the immediate family, but through extended family and other support networks as collectivism is an important part of Vietnamese culture.

**Mesosystem.** In this study, the mothers described the mesosystem, or interaction of two or more settings, and their children’s interactions with the outside world. Mesosystem was described as interactions between family and school, family and peers, and mental health services and family. The participants described these interactions, and this reflects the level of involvement the mothers in this study have in other microsystems involved in their children’s lives. It is important to note how these interactions came about and developed and how these
interactions impacted seeking mental health treatment and usage for Vietnamese American children. For example, all of the participants identified some type of interaction with the school system while in the process of access mental health services for their children. Huong described the difficulties with initial assessment with the school, and Thao described constant interaction with the school to check on her child’s performance. In Huong’s case, the interactions with the school during assessment were a major barrier to access treatment as the school staff could not agree on her son’s diagnosis. The barriers that may present depending on the point of access for these children, such as the school, can impact access to services if there is a tension between school and family in the mesosystem. Thus it is important for counselors to address this through strategies that foster communication and collaboration amongst interactions in the mesosystem. Specific strategies for accomplishing this include providing information and referral materials in Vietnamese and English, targeting specific doctors’ offices that see Vietnamese American children, and schools that have Vietnamese American children enrolled to collaborate.

Practical implications for counselors when examining the mesosystem, are the importance for counselors to acknowledge the various interactions between multiple settings and that counselors should do more to engage in interactions with these other settings to develop effective treatment. As mentioned previously, counselors can provide more outreach to school staff and families at the school, and facilitate positive collaboration with school staff and the families of children that are being considered for treatment. Out of these interactions expressed in the study, the core concept seems to be how the family’s interactions with outside systems effect the child’s mental health treatment. Another avenue for point of access described by the mothers was through health services such as primary care doctors, and similar outreach, engagement and collaboration with primary care doctors can aid Vietnamese American families.
Mainly, counselors should be aware of the interactions among different microsystems in a Vietnamese American child’s life, and how to aid in fostering communication and collaboration amongst those microsystems to provide mental health services. Specific strategies for accomplishing this include asking the families how they heard of services, and accessing those places for distributing language specific flyers with information regarding services and making connections with personnel, especially any Vietnamese speaking personnel to foster referrals and collaboration.

**Exosystem.** The mothers described settings that do not involve child but indirectly affected the child. For example Thao described the influence of mass media, when she saw a television show on her son’s mental illness and decided to contact to access services. Huong also described the influence of friends who had accessed special services for their children, and how she sought services after.

Important strategies that counselors can use from this is to take into consideration the importance of settings that do not include the child, but are expressed by families as part of how they seek information and make decisions. Strategies that counselors can use is outreach and engagement through mass media, by providing information and allowing for answering of questions on Vietnamese broadcasting networks. Also, information provided at local churches, temples and social gatherings where caretakers converge can aid in spreading information and knowledge. The information that is important to provide through any of these public forums includes what mental health concerns are diagnosed, how mental health concerns can be treated, and where they can go to access treatment.

**Macrosystem.** The mothers described the culture and subcultural attitudes, belief systems, and ideologies of their Vietnamese cultural background and the struggle to integrate
those learned from American culture. Two specific macrosystems were described by all participants, their Vietnamese culture and the American culture. Macrosystems are rarely examined, but in this study, cultural aspects were directly derived from participants’ voices. The mothers described their strong ties to Vietnamese cultural beliefs of collectivism, pride, and respect. However, they also expressed difficulties in understanding and balancing different facets of American culture, specifically how mental health treatment is provided in the United States. Therefore the mothers described their struggles with integrating their Vietnamese beliefs and values into mental health treatment for their children, and how acculturation played into how they addressed their children’s mental health. In having awareness of this struggle, counselors can find out ways to aid these families in their integration process.

Specific recommendations for counselors include seeking to explore and more completely understand the cultural attitudes, belief systems and ideologies of a child’s Vietnamese heritage and examine how they are being integrated by the child and the child’s family into their lives in America. Counselors can do this by asking open ended questions throughout the process about the family’s Vietnamese heritage and any struggles that they have experienced living in America. Another way to aid families is to provide them with some type of context that they are not alone in their struggles with integration, whether it is through written resources or actually connecting with other families experiencing the same struggles, aiding Vietnamese American families in normalizing their experiences without minimizing their struggles can be helpful. Findings also indicate the contextual and cultural influences that are present while working with a Vietnamese child and their family, and counselors need to explore ways to foster integration of Vietnamese cultural background into treatment. Concrete
applications such as family therapy using open dialogue and facilitation of communication can aid in this process.

**Chronosystem.** All of the participants exhibited aspects of the chronosystem: socio-historical conditions, environmental events, and transitions over the life course. The participants briefly described the socio-historical conditions of immigration to escape from war or declining economic conditions in Vietnam. If not for these conditions, the participants probably would not be in the United States, and their children might not have existed or would have been born in Vietnam. Because these conditions did exist, all of the participants emigrated from Vietnam and came to the US at different stages in their lives and had to adjust to living and raising their children in a different environment. Previous literature has cited the effects of the Vietnam War and displacement, and the lasting mental health concerns of the immigrants (Ida & Yang, 2003; Kaplan & Huynh, 2008). Intergenerational transmission of psychological concerns has also been noted in the literature (Wiese, 2010).

Implications for counselors can include a thorough psychosocial history of the Vietnamese American child being treated, to include the immigration history and mental health history of family members, both immediate and extended. Counselors can use this information to examine how this has impacted a child’s mental health to aid in conceptualization and treatment planning. Most of the mothers described their own mental health needs and treatment, and implications for future research could examine how parental or caregiver mental health can be related to children’s mental health based on the unique chronosystem for Vietnamese American families. Counselors can also be aware of the mental health needs of caregivers, who often due to the lack of knowledge of mental health services have gone untreated themselves. Counselors can make appropriate referrals for parents and caregiver to enhance treatment for the
Vietnamese American child. Further exploration in longitudinal studies could shed light on the continued transitions and effects of mental health treatment over the life course for these Vietnamese American children and their families.

*Integrative model for Vietnamese Americans (Lam, 2005).* All participants described how they were in the process of acculturation and described their ethnic identity. Although a specific measure of how and where participants were in the process was not examined, participants described engagement in the process by the way they integrated aspects of Vietnamese and American culture. The model highlights their children’s acculturation and how the mothers’ acculturation may affect their children as the mothers were key in what cultural aspects the children were exposed to in the way the mother’s parent their children.

Ethnic identity was a key component in this study. All of the mothers identified as Vietnamese American, while their children were either full Vietnamese or were of Vietnamese descent.

Connected with acculturation and ethnic identity, all of the participants expressed concepts from the integrated model, including living in an ethnic enclave and expressing their mental health beliefs. Participants such as Thao described moving her family from another state so that she could live in an ethnic enclave and receive services in Vietnamese. It is important to acknowledge that all of the participants described living in or near the ethnic enclave of Orange County, and may have had more exposure to use services and greater likelihood to use services as ethnic specific services are available. Mental health beliefs are part of the integrated model and were a key part of this study, as the second research question directly gathered participants descriptions of what they considered to impact their children’s mental health and what problems they think their children are facing.
**Strengths of the Study**

The mothers in this study have provided in-depth perspectives regarding their lived experiences of accessing mental health services for their children, something that has been missing from the counseling research. Specific strengths of the study include: researcher proximity with the study, use of participants’ voices and meanings, and trustworthiness. The sample of four Vietnamese American mothers provides an important contribution to the counseling knowledge base. This study provides the counseling field, comprised of counselor educators, counseling researchers and practitioners with the intersection of two distinct but related experiences. These are the experiences of Vietnamese American mothers and mothers of children with mental health concerns. Both populations have been neglected in the counseling literature.

**Researcher proximity.** My role as the researcher and close geographical proximity with the study location has enabled me to be immersed in the contextual parameters experienced by the interviewees. As I examined the interview transcripts, I attempted to bracket (set aside my presuppositions) my personal knowledge, beliefs, and presuppositions so that the voices of the participants emerged (Gearing, 2004). As I am a native of the Vietnamese American community in Orange County, and also work as a counselor serving this specific population, I have direct knowledge and experience with Vietnamese culture. This direct experience has enabled me to relate, build rapport and more deeply understand the culture of this community as I have progressed through this research. I have learned to provide mental health treatment to this community as I have progressed through my professional work experiences. This has aided me in engaging and understanding where the participants are coming from in terms of seeking mental health services for their children.
Use of participants’ voices. A strength is that participants’ direct comments were used to generate the themes. Primary in the study was the use of participants’ voices and meanings. Clarification was provided on confusing aspects, but the participants descriptions were at the forefront of the findings. Two of the participants were primarily Vietnamese speaking, so I was able to clarify on language use as there were certain terms that were difficult to express in English.

Trustworthiness. Additional strengths of the study are the establishment of trustworthiness through the use of an auditor and member checking with participants to examine accuracy of the information gathered. Using an auditor of Vietnamese background and who is a counselor educator helped in establishing trustworthiness. She was able to objectively examine the data but understand the concepts expressed due to her cultural background. Her background in mental health and cultural aspects helped shed additional light on what may be engrained in the data. Member checking with each of the participants individually aided in verifying whether the narratives and my reductions of the narrative correctly reflected what the participants were expressing during post interview session.

Limitations or Research Boundaries of the Study

This study had several research boundaries (Miles & Huberman, 1994) that need to be discussed. Research boundaries include a lack of the children’s perspective, sample representation, limited transferability, the inferential nature of qualitative data collection, and lack of prolonged engagement.

Lack of children’s perspective. A major limitation in this study is the lack of capturing the children’s perspectives. All of the data were gathered vicariously through the mothers, and more rich insight may be gathered directly from the children themselves who are the center of
this study. Although I was able to meet two of Thao’s children and all of Lillian’s children, I met them briefl
ly as they were playing or being treated. I did not have any direct contact with Huong or Clara’s children.

**Researcher bias.** Researcher bias may also be present in the research. Although I tried to be as reflexive and candid as I could regarding my own thoughts and feelings during the study, I may hold my own biases and presuppositions regarding this topic. I hold my own biases both as professional working within this community and, also biases as a person coming from this cultural background. Biases as a professional include my own opinion on treatment approaches and what I think is the most effective way to work with these families. Having come from a difficult background myself, there were times where I wish that my family had accessed mental health services for me. I may have brought this countertransference into how I interviewed the families, wishing that my family members had been able to access treatment for their children.

**Limited transferability.** Since only four participants, specifically mothers, were recruited for the study, there is limited transferability from this study due to limited sample representation. However, many questions have arisen from this study to explore in future research and this can serve as a platform in beginning to understand Vietnamese American children and their mental health. For example, why were mothers the ones to step forward for the study and what would the inclusion of the fathers or other male caregivers be like?

**Inferential nature of qualitative study.** Another boundary is that the nature of qualitative work is inferential. Data collection was gathered through interviews and inferences made by me on the interpretation of the data. I addressed this by being as candid and reflexive as I can about my interpretations of the data and I tried my best to present the data so that reader may draw their own conclusions.
Social desirability. Participants may have expressed social desirability, or the inclination of participants to respond in a manner to be favorably viewed. There may be situations where participants tried to answer favorably to me as they saw me as representing the mental health system, knowing that I work in the field. Thus participants may not want to offend or shed negative light on their own experiences. This may have to do with deference to authority figures and those in a professional capacity and the desire to be socially appropriate. The mothers in the study may have been more likely to defer to me than mothers from other ethnic backgrounds because they may have seen me as their bridge to a culture and service that they are still trying to become familiar with.

Lack of Extended Engagement. Lastly, participants were interviewed at one point in time following the usage of mental health services for their children. The only participant that was interviewed for a second time was Thao, due to needing follow up on her other children who I had not known had received mental health services. Information was gathered on reflections back on what the process was like for participants, not when they were actually going through the process of seeking assistance. Prolonged engagement can aid with establishing credibility (Morrow 2005), such as interviewing participants before, during and after receiving mental health services for their children. As a result of prolonged engagement over an extended period of time, the mothers would have been able to talk about how becoming familiar has helped them in becoming even more knowledgeable and stronger advocates for sharing within the community on mental health services.

Recommendations for Future Research

This study highlighted areas not previously addressed in the literature with a population that has often been overlooked in past research. This may foster future research to examine areas
related to Vietnamese American children’s mental health. Four future areas of research are recommended.

First, the counseling profession is encouraged to complete additional research studies on Vietnamese families that focus on parenting and other caregivers of children with mental health problems. Due to the fact that only mothers were interviewed during this study, it would be beneficial to conduct further studies with fathers or other caregivers to gain further information on the perspectives of others in the family that care for the Vietnamese American child. This can aid counselors in gaining a more complete understanding of cultural impacts. Research methods that could be especially helpful with this exploratory research could include qualitative research methods that include phenomenological and narrative research. Further survey research with mothers could be helpful with extending from the current research study.

Second, further studies are needed to give "voice" to children with mental illness from diverse cultural and linguistic backgrounds, including Asian American in general and Vietnamese Americans in particular. Based on the literature review of this study and the nature of this study itself, much of the previous research conducted on ethnic minority children’s mental health in the past has focused on the perspectives of parents and caregivers. Future studies that include the children’s perspective in the research can be helpful with understanding the perspective of the children directly receiving services. Future studies can be approached with narrative interviews and also possible observation to aid in trustworthiness of the data.

Third, more studies are needed related to the ecological system theory and its different components to create effective and culturally sensitive practical-intervention models for children with mental illness and their families. The findings in the study indicate the interplay of culture and context throughout the different systems in the ecological model. The ecological model aids
counselors and researchers in conceptualization of culture and context (Cauce et al., 2002) and can aid in treatment and research. Future research could be designed through a variety of ways such as integration of the ecological systems model as a lens for the literature review, a way to frame findings, or conceptualization of implications for practice and research through social network analysis and critical ethnography.

Lastly, future longitudinal studies following participants and their children over an extended period of time can be helpful. The findings from this study focused on capturing the experiences of the mothers after they had already sought services for their children. Although they reflected back on their experiences, research and prolonged engagement with the mothers throughout the process would aid in capturing a more complete narrative of their experiences. Especially helpful would be studies that begin during the help seeking process for participants and can follow the family as they navigate through entrance into mental health treatment followed by the process of mental health treatment. Furthermore, research on outcomes of mental health treatment would also be helpful, using a mixed methods approach to capture both qualitative and quantitative aspects of the experiences of Vietnamese American families.

An important aspect to consider in carrying out future research is the use of cultural brokers to aid in overcoming stigma, specifically in participating in research. One definition states that cultural brokering is the act of bridging, linking, or mediating between groups or persons of different cultural backgrounds for the purpose of reducing conflict or producing change (Jezewski & Sotnik, 2005). A cultural broker is defined as a go-between, one who advocates on behalf of another individual or group (Jezewski & Sotnik, 2005). Although I share the same culture as the participants and live in the same community, I utilized what could be considered as cultural brokers who work in the mental health settings that these families are
exposed to. These mental health service providers acted as links to the participants and aided in building rapport to set up the interviews. Research on insider and outsider status in studies note the complexity in power and positionality (Merriam, Johnson-Bailey, Lee, Kee, Ntseane, & Muhamad, 2001). For example, although I am an insider because I am from the same culture, I also am an outsider as I do not provide service to the participants, have a different education and seen as a researcher in a different position of power.

Final Thoughts

Based on findings in this study, it appears that there was a lack of or limited understanding among the participants about the mental health and educational services for their children, but were able to overcome their challenges through self-empowerment and advocacy. Major impacts described by the participants on mental health service utilization for their children were cultural differences and lack of or misinformation. For example, Lillian highlighted the lack of information by stating that “So I’m afraid that could be a reason why a lot of people are not getting the service or approach the service because they don’t know it’s available.” In regards to cultural differences, Clara reported on the cultural differences in counseling and how “Vietnamese culture you can’t talk about your emotions, you can’t talk about your feelings. You can’t do that stuff.” As a counselor, I think that in the process of engagement and continued rapport, it would be important for me to acknowledge the resilience of these mothers despite the many challenges of navigating two different cultures, the Vietnamese and the American. Interventions would be based on their strengths in order to foster self-awareness and resourcefulness, as well as empower them. I learned specifically to (1) outreach by understanding what conception of mental health and treatment is, (2) foster engagement in the counseling process through acknowledgement of cultural integration and the acculturation
process, (3) aid in maintenance of treatment progress by focusing on parental strengths and resilience in overcoming obstacles in treatment to support their children’s continued progress.

Children are a vulnerable population in our society, yet they are also the key to the future. Thus the greatest legacy we can provide for future generations is to invest in improving how we do things now. The following is a quote from a beloved television personality in American culture that captures the importance of investing in our future through our children. "One of the greatest dignities of humankind is that each successive generation is invested in the welfare of each new generation." -Mr. Rogers, children’s TV personality. As we become a diverse and multicultural nation, it is especially important for counselors to engage in improving engagement and mental health service delivery for the dynamic population of America. This can through future research and improving counseling practices to reflect the changes we face.
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APPENDIX A

Recruitment Letter/E-mail

Hello,

You are being asked to participate in a study examining Vietnamese American families’ perceptions of children’s mental health. This study is being conducted for research purposes. This study will consist of a questionnaire and interview that will last 60-90 minutes, with follow up interviews on an as needed basis.

To be included in the study, you must be an adult who is part of a Vietnamese American family with a child between the ages of 3 to 12 years old who has or is currently using mental health services.

The interviews will be audio recorded, and stored in a password-protected file by the primary investigator. Upon completion of the study, the recordings will be destroyed.

If you are willing to participate or have any questions, please contact Nancy Hieu Nguyen by calling (714)726-4691 or email at nhn111@psu.edu. Or, if you know any other families who fit the eligibility criteria, I would greatly appreciate if you could forward this message to them.

Sincerely,
Nancy Hieu Nguyen, M.S.
Doctoral Candidate, Counselor Education and Supervision
The Pennsylvania State University
APPENDIX B

Informed Consent Form for Social Science Research

Title of Project: Vietnamese American Families’ Perceptions of Children’s Mental Health

Principal Investigator(s): Nancy Hieu Nguyen, P.O. Box 60452 Irvine, CA 92602
Phone: (714) 726-4691, email: nhn111@psu.edu

Advisor: Dr. Elizabeth Mellin, 114 Ritenour Building University Park, PA 16802
Phone: (814) 863-2414, email: eam20@psu.edu

1. **Purpose of the Study:** The purpose of this research study is to better understand how Vietnamese American families’ perceive children’s mental health. By attaining such information about Vietnamese American families’ perception of children’s mental health, it is hoped that future inquiry into access, outreach, service delivery, and treatment outcomes can occur.

2. **Procedures to be followed:**
   You will be asked to complete a demographic questionnaire. Then an interview that will last 60-90 minutes, with the possibility of a follow up interview if needed. Interviews will be audio-recorded. You can choose not to answer certain questions.

3. **Benefits:** The benefits to you include sharing your experiences of mental health services for your child(ren); sharing your perspective on what children’s mental health means; and contributing to a large-university research project.

   The benefits to society include helping to add to existing research about counseling with Vietnamese American children and families. In doing so, it may help in providing culturally responsive services to Vietnamese American children and families.

4. **Duration/Time:** Each interview will last 60-90 minutes, with the possibility of a follow up interview if needed.

5. **Statement of Confidentiality:** Your participation in this research is confidential. No personally identifiable information will be shared with others as a result of your participation. Only the primary investigator will have access to the interview audio/video recordings. All electronic files containing data will be password protected and only the primary investigator will have access to these files. In the event of a publications or presentations resulting from this research, no personally identifiable information will be revealed. Pseudonyms will be used upon presentation of the research.

6. **Right to Ask Questions:** Please contact Nancy Hieu Nguyen at nhn111@psu.edu and/or phone at (714)726-4691 with questions, complaints or concerns about this research.

7. **Voluntary Participation:** Your decision to be in this research is voluntary. You can stop at any time. You do not have to answer any questions you do not want to answer. Refusal to take part in or withdrawing from this study will involve no penalty or loss of benefits you would receive otherwise.

You must be 18 years of age or older to consent to take part in this research study. If you agree to take part in this research study and the information outlined above, please initial the appropriate line below then sign your name and indicate the date. You will be given a copy of this consent form for your records.
Please initial one option below:

_______ I am willing to participate and be audio recorded. I realize that these recordings may be used in research presentations. I also permit my data to be kept securely stored until 2016.
Exceptions: ________________________________________________________

_______ I am willing to participate and be audio recorded BUT I would not like my recordings to be used in research presentations. I also permit my data to be kept securely stored until 2016.

**Future Research**
In the event that we uncover significant findings and wish to engage with more specific research related to counseling with Vietnamese American families, may we contact you in the future?

☐ Yes, here is my contact information: _____________________________________________________
☐ No, please do not contact me in the event of future research participation.

**9. Signature of consent**– If you agree to the information noted above, please sign your name. You will be given a copy of this form for your records.

_____________________________________________________________________________________

Participant Signature  Date

_____________________________________________________________________________________

Signature of Principal Investigator / Person Obtaining Consent  Date
APPENDIX C

Interview and Research Questions

Research Question 1 (R1): “Research Question 1: “What are the cultural values and beliefs of Vietnamese American families on children’s mental health?”

Research Question 2 (R2): “What mental health concerns is a/are Vietnamese American child(ren) facing, and what do their families think impacts their child(ren)’s mental health both positively and negatively?”

Research Question 3 (R3): “How do Vietnamese American families address mental health concerns for their children, and what were their experiences like?”

1. Tell me about your child.

2. What are your child(ren)’s mental health concerns and how did you find out about them? (R1 and R2)

3. Describe how you went about deciding to seek mental health services for your child. (R3)

4. Did this process involve talking to others? If so, with whom and why? (R3)

5. How did you seek help and with whom? (R3)

6. What have your experiences with mental health services been like? Overall, is there anything that you would have done differently and what would that be? (R3)

7. How would you define mental health? (R2)

8. What are your views on mental health, especially regarding your child(ren)? How do you think those views that you just described were influenced by your Vietnamese background? (R1 and R2)

9. What do you think impacts child(ren)’s mental health? (R2)

Follow up questions will be used to increase depth of participant responses and clarify responses.
APPENDIX D

Demographic Form

Participant Demographic Questionnaire

Please answer the following questions regarding yourself and the child prior to the interview. You will be contacted if the researcher needs to clarify/follow-up on any information you provide. Please make sure to check only one answer and write as clearly as possible. Any identifying information will be kept confidential and this questionnaire will be stored in a locked file cabinet with the other information collected during this study.

Participant ID# (given after confirmation of interview): ______

Participant pseudonym to use for confidentiality (first name only): __________________________

Relationship to child receiving mental health services: ________________________________

Sex (check one): O Male O Female

Date of Birth (day/month/year): ______________________________

Years of residence in the United States ________________________________

Location of Residence (City and State) ________________________________

If immigrated from Vietnam, year of immigration: ______________________________

Primary Language: ________________________________

Religious/Spiritual Orientation (please indicate if none): ________________________________

Sexual Orientation: ________________________________

Disabilities (example: physical limitations, chronic illness): ________________________________

Highest Education level obtained (check one): O Graduate professional training O Standard college/university O Partial college training O High school graduate or GED O Partial high school O Junior high school O Elementary school

Occupation ________________________________

Income (check one): O Less than 20,000 O 20,000-39,000 O 40,000-59,000 O 60,000-79,000 O 80,000-99,000 O Over 100,000
Child’s Information

Date of birth (day/month/year): ____________________________________________________

Place of birth: ____________________________________________________

Sex (check one): O Male O Female

Residence (City, State): ____________________________________________________

Grade level: ______________________________________________________________

Disabilities (i.e.: physical limitations, chronic illness): ______________________________

Siblings: ______________________________________________________________________

Child’s Family Structure (check one): O Married biological parents O Married adoptive parents
O Kinship care O Foster family O Group home O Step family O Residential O Same sex parents
(mothers) O Same sex parents (fathers) Other _________________

Presenting problem(s): _________________________________________________________

Source of referral: ______________________________________________________________

Diagnosis: ____________________________________________________________________

Treatment provided by: _________________________________________________________

Type(s) of treatment (i.e.: individual, play, family therapy, medication) and duration:

_____________________________________________________________________________

_____________________________________________________________________________

Any additional information:

_____________________________________________________________________________

_____________________________________________________________________________
Vita of Nancy Hieu Nguyen

Education

Ph.D., Counselor Education & Supervision, Pennsylvania State University, August 2014 (anticipated)
M.S., Counseling, California State University Fullerton, January 2008
B.S., Magna Cum Laude Human Services, Criminal Justice Minor, California State University Fullerton, May 2005

Publications


International and National Presentations


Teaching Experience: Courses Taught/Co-Taught

Leadership In The Helping Professions (California State University, Fullerton), Spring 2012
Family Counseling (Pennsylvania State University), Spring 2011
Child Counseling (Pennsylvania State University), Summer 2010