MENTAL HEALTH PERCEPTIONS IN A VIETNAMESE AMERICAN COLLEGE STUDENT POPULATION

_____

A Thesis

Presented to

The Faculty of the Anthropology

Program in the Department of

Comparative Cultural Studies

University of Houston

_____

In Partial Fulfillment

Of the Requirements for the Degree of

Master of Arts

_____

By

Tieu-Nha Nguyen

August 2019

MENTAL HEALTH PERCEPTIONS IN A VIETNAMESE AMERICAN COLLEGE STUDENT POPULATION

_____

An Abstract of a Thesis

Presented to

The Faculty of the Anthropology

Program in the Department of

Comparative Cultural Studies

University of Houston

_____

In Partial Fulfillment

Of the Requirements for the Degree of

Master of Arts

_____

By

Tieu-Nha Nguyen

August 2019

ABSTRACT

This study explores the relationship between Vietnamese American culture and mental health perceptions. Previous research done in the Asian American community made strides in identifying cultural values that can hinder help-seeking and open dialogue. However, there has been little ethnographic research in the last ten years done on specific Asian populations like the Vietnamese. This research seeks to answer whether two noted barriers to psychological services still play a role: limited awareness of resources and stigma.

Semi-formal interviews and case studies were conducted on a college age population in Houston. I used content analysis to pull themes from texts of interviews. I identified cultural phrases and explanations of behavior by simplifying sentences from basic units of meanings, to codes, categories and themes. Together, interviews and participant observations of select individuals in both formal and informal settings yielded five themes: Family & Culture, Mental Illness, Stigma, Therapy, and Mental Health. These themes were discussed by comparing Vietnamese and non-Vietnamese participants' answers about mental health perception and resources accessed during periods of stress.

The results support the research that limited awareness of resources and stigma are barriers for help-seeking in all forms for Vietnamese American college students in this study. While more people talk about mental health, there are still cultural values such as resilience and propriety as well as generational incongruence between participants and their parents that limit openness in talking about mental illness.

Acknowledgements

To the professors and friends who cared enough about the topic and myself to spend time immersed in my own world as well, I cannot thank you enough for you time. Finishing a thesis is not something you can do on your own. You've made such a big difference in my life and I hope you understand how much you mean to me.

Professor Rasmussen, as my Chair, your advice went above and beyond. You guided me with a fine balance of compassion and sternness that I will always value and try to emulate in my own life. Thank you for teaching me how to think complexly about culture and translate that into my writing. I couldn't have done this without you and thank you again.

Professor Gordon, thank you for your support and the time you put in to making me a better anthropologist. You've always told your students to move beyond the classroom and go into the real world and make a difference. No need to worry; I'll always be looking for a new topic to study with a glass in hand. Cheers.

Thank you for your endless presence and advice, Dr. K. You were the rock in my life for so long. It took a lot of patience to be there every step of the way and to reassure me the many times I lost faith in myself. You're the best, and you can delete all those drafts in your storage now. To Freedom!

Justina Anazonwu, thank you for the edits. Thank you for the friendship. Really, just checking in throughout this process means the world to me. YOU mean the world to me! Kelsie Spears-Johnson, I'm glad we extended our friendship outside of UH. Your advice and ruthless questioning helped the proposal take shape. I'll be forever in your debt.

TABLE OF CONTENTS

LIST OF FIGURES AND TABLES

Dedication

Some things are better left untranslated.

Cảm ơn Bố Mẹ đã kiên nhẫn với con và tin tưởng vào trong đề tài này. Nói thật ra là con làm xong luận án không phải cho mình con mà để trả ơn phàn nào đó cho Bố Mẹ. Sau đây sẽ là giã từ vũ khí!

CHAPTER ONE: INTRODUCTION

Mental illness is a major cause of disability worldwide, affecting around 350 million people, according to several international organizations (UN SDG Report 2017, NIMH). Mental illnesses (or disorders) are defined as "any mental, behavioral or emotional disorder", resulting in impairment, interfering and limiting daily activities (NIMH). Some common diagnostic disorders include depression, anxiety, bipolar disorder, and phobias. The number of people diagnosed with a *mental illness* (MI) continues to rise (UN 2017).

Mental health experts attribute both biological (genetic, physiology) and environmental (infrastructural, lifestyle) causes to the development of mental illness (UN 2017). Different communities are unevenly impacted by institutional policies and cultural beliefs regarding illness and perception of treatments. While more people are seeking solutions on their own, cultural and economic barriers to proper information continue to hinder successful treatment (WHO, Mayo 2018). Informal networks like support groups and public health campaigns work to educate and reduce the stigma surrounding mental illness (WHO, OECD, Abduhrehman 2016)).

Research Topic

This researcher looked at mental health perceptions in young adult Vietnamese American college students in the city of Houston, Texas. Asian Americans (AA) as defined by Chu and Sue (2011) are Americans whose national origins comprise of groupings such Southeast Asia, East Asia and South Asia. Specific countries include: Cambodia, Laos, Vietnam, Thailand, China, Japan, the Koreas, the Philippines, and India. Asia as a grouping

is a political construct but neighboring countries have overlapping cultural values, beliefs, and orientations.

There is lower professional usage compared to the general population (28% versus 58%) (Chu and Sue 2011:3). Asian Americans are therefore less likely to be diagnosed with a mental illness, even though an estimated 4.5 to 11% of the population have one (Han and Pong 2015). They are also less likely to access or receive adequate treatment; those who receive initial treatment are more likely to have received involuntary treatment (Han and Pong 2015; Miller et. al 2011).

The literature shows that many Asian Americans in college tend to face greater pressure from family to perform well in school and work (Hunt and Eisenberg 2010). Instead of reaching out to professional help on campus, AA's prefer to locate help within their social network (Tanap 2018; Lee et. al 2009). This can simply mean companionship or seeking advice from family and friends. Researchers studying this population believe that culture influences perceptions of mental illness and how students negotiate help-seeking, especially the role of stigma regarding mental illness (Hunt and Eisenberg 2010; Pong 2015; Chu and Sue 2011).

Almost half of all lifetime cases of mood and anxiety disorders start at age 14 and increase to three-fourths by age 24 (Kessler and Ustun 2004). Adulthood is a critical period of development; this population has specific cultural and societal burdens that possibly contribute to long-term illnesses and disorders. College students face a lot of pressure to succeed (Hunt and Eisenberg 2010). For example, students have financial and academic burdens, and are expected to engage in social and organizational relationships within a demanding and intensive environment. These demands on their time can contribute to a

build-up of stress, and if students do not have the skills to manage these stressors, it can lead to the onset of a mental illness (Hunt and Eisenberg 2010).

The researcher shares a same culture and linguistic background as Vietnamese Americans, and this helped to narrow the scope of such a diverse group of cultures. The literature focuses on Asian America as a group because of shared political identity, and while this has brought awareness to important issues to this community the distinctions between the ethnic communities have been overlooked. *The researcher examined a Vietnamese American young adult population in college within Houston and their cultural understanding of and response to mental illness, while also focusing on how this relates to help-seeking in terms of resources accessed by this community.* This research hopes to contribute to ongoing studies related to mental illness and help-seeking, which predominantly revolve around *limited awareness of resources* and *stigma* (Hunt and Eisenberg 2010; Chu and Sue 2011).

Overview

This research hopes to add to the existing literature on mental illness on college campuses by identifying ways psychological services can appeal to both college and Vietnamese American students. Houston is a large and diverse city with several colleges and universities and therefore the city of choice for conducting this research. Houston represents a variety of cultural identities which are important when providing services to the student body, such as access to psychological services.

The relationship between ethnicity, education status and mental health perceptions were explored through an initial, anonymous survey asking demographic questions and

perceptions of available resources, as well as through participant observation, semi-structured interviews, and case studies. By understanding the dynamics and motivation through the lens of cultural values and now they inform *stigma* (if any) towards accessing various resources, the Houston community can be better advocates for mental health and individual preference. To the researcher's knowledge, there hasn't been specific studies of this focus in the United States in the last 10 years, so the researcher hopes to update the literature on how much of the beliefs regarding mental illness and help-seeking still hold true, at least for the population studied here.

CHAPTER TWO: LITERATURE REVIEW

Definition of Mental Health

Health in general is defined by the WHO (2013) as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" while a state of *mental* health consists of "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (UN 2017). Longitudinal studies on mental health state that well-being consists of: emotional and social support and companionship, physical safety, economic security, access to basic needs which include healthcare, sanitary facilities, education, political stability, and more (WHO Mental Health 2017; UN 2017).

Social markers like socio-economic status (income, health insurance), education level, cultural heritage and acculturation, stigma, gender, sex, age, and social network also affect mental health conception, illness, and treatment. Recent research has also studied technology and dependence on social media as a factor in the increasing mental illness across the globe (O'Keeffe 2011).

Mental Health in Cultural Contexts

Anthropologists also contend that mental health involves both real and perceived well-being within a culturally specific context (Kohrt 2015). Most of the definitions used in this study are Western-based diagnostic models, although different manifestations of stress within cultural contexts are researched and discussed, since not all conceptions of stress

adhere to the Western biomedical model (Hinton and Good 2015). There are numerous examples of local and culture-specific illnesses that share many of the same symptom clusters, and biomedical guidelines should only be a stepping point to a wider understanding of mental health and illness.

One of the most famous medical disputes is the tragic case of Lia Lee, a Hmong infant whose epileptic spells were interpreted by her parents as spirit possession, an honor to be host for powerful entities. Her doctors thought her symptoms needed to be treated while her family believed that she was special and that her seizures made her different and touched by the gods (Fadiman 2012). Her seizures were made worse by incorrect doses or total refusal to take medication her parents deemed dangerous.

Lia's parents dressed her in beautiful hand-woven traditional gowns and hired Hmong shamans to come and perform rituals for her good health. She was very spoiled and loved by many, but the medical professionals and her family had a bitter battle in the authority over treatment. In the end, the dispute put Lia in a permanent vegetative state. There was a lot of miscommunication and poor cultural translation between doctors and the Hmong community, over issues like the efficacies of certain medications and why CPS was eventually called on the family for negligence. The definitions of "healthy" and "sick" differed too much and cultural brokering was begun too late to find a middle ground.

While Anne Fadiman is a journalist, in the book she discussed the case with a medical anthropologist named Arthur Kleinman who said that a "model of mediation" rather than a "model of coercion" would have made things better. "You need to understand that as powerful an influence as the culture of the Hmong patient and her family is on this case, the culture of biomedicine is equally powerful" (Fadiman 2012: 261). While Western diagnostic

models are held to a very high standard of investigation, it is its own culture, as Kleinman says. Other models of viewing the world, what we tend to call traditional cultures, undoubtedly affect peoples' interpretation of the Western models they engage with, and which influence treatment as well.

Culture in Western Models

There have been critical developments in diagnostic approaches and on-the-ground interventions in health care systems that are informed both by psychological study and cultural observations (Kohrt 2016: 26; Whitely 2014). While diagnostic categories are important, local understandings of mental illness and treatment plans can vary. People perceive and experience mental distress in "local contexts", understanding mental illness within their own cultural constructs. The cause for their illness might be non-organic; the origin might be from social disruption rather than a chemical disruption. While symptoms can overlap between populations, diagnostic criteria for mental illness do not fit neatly in them, which the DSM-V seems to acknowledge (Hinton 2015:4).

One key concept related to non-organic causes is understood in medical anthropology as the *body/mind* relationship. The Cartesian concept of the mind and body as separate entities does not fit neatly with how other cultures define a person. For others, the relationship is a little more holistic; the body and mind form an intricate relationship. Culture affects how stress is interpreted through social meaning. This is important when asking people to recognize symptoms; for example, mental health can be expressed physically, through pain and bodily (somatic) sensations rather than measured in behavioral and

psychological changes, where "culture affects the *content* but not the process or structure of psychopathology" (Jenkins in Kleinman 1991).

Furthermore, the person (self) as a rational body, capable of making their own decisions and independent of society owe more to Western philosophy than being rooted in biological concepts. People might hold social relationships in high regard and incorporate friends and family when they're making decisions. Western categories of mental illness should incorporate the local contexts in which people express distress.

An example of a *culture-bound syndrome or illness* can be seen in anthropologist Kristin Yarris' work in Nicaragua. She interviewed families where the mothers were forced to find work outside of the country, sending regular income home but rarely being able to visit (Yarris in Kohrt 2016:126). It was easier for women to find work elsewhere, and they would leave their children with maternal parents. Grandparents handled the expenses, and fluctuations in money abroad would in turn affect the household. Children felt "emotionally suspended" between mothers' visits, alternating between joy and sadness when their mothers would leave again for work.

During Yarris' research she encountered culturally salient phrases like *tristeza* or "feeling sad", *sin ganas de hacer nada* or "having no desire to do anything", and *pensando mucho*, which means "overthinking". Symptoms were like anxiety, since family members were constantly worrying about separation and finances. Rumination was a key symptom for grandparents as well, serving as a focal point in conversation with friends and an annoying reminder of their situation. Interventions based on ethnographic interviews emphasized family-based solutions, such as creating a network of surrogate family members rather than taking medication. It took a more in-depth exploration of emotions, cultural expressions and

the larger dynamic forces of migration and finances to find some solutions for this specific community.

Prevalence and Understanding of MI

Mental illness continues to rise. Globally, one out of every two people will develop a mental illness in their lifetime (OECD). For developed nations, 5% of the population at any given time has a severe form, and 15% have a common illness like depression and anxiety. Half of all adults are diagnosed by age 14, and the likelihood of lifetime prevalence as well as comorbidity with other illnesses and disorders increase over a person's lifetime (Kessler and Ustun 2004).

Further, mental illness comes in many shapes and sizes. The most common illness is depression, affecting 300 million people worldwide (UN 2017). Those with depression are also more than 50% likely to be diagnosed with anxiety (ADAA 2018), which is also linked to cardiovascular disease and diabetes (UN 2017). Other common mental illnesses are bipolar disorder, ADHD, schizophrenia, mood and personality disorders, phobias, and dementia (Mayo 2018).

Mental Illness and Risk Factors

The National Institute of Mental Health divides mental illness into 2 categories: *any mental illness* (AMI) and *serious mental illness* (SMI). In the last year, 44.7 million Americans, which is 18.3% of the population, suffered from any mental, behavioral, or emotional disorder, and 10.4 million adults suffered from a serious illness, where the symptoms were debilitating and life-threatening (NIMH). Risk factors can be classified as a

combination of environmental disadvantages (social, cultural, economic) and biological predispositions.

Genetics plays a key role in human development, and like other physical diseases, a parent or a close relative with a mental illness means a higher chance of developing one themselves (DBSA 2018). Emotions have been shown to be differently processed in the brain between East Asians and Europeans. When shown the same stimuli evoking fear, the emotion was processed in different parts of the brain for each group. This supports theories of at least some synergism between biology and culture, since it's possible for more tolerance of some emotions over others, like fear (Hinton 2015).

Social and cultural risk factors for mental illness include: past trauma, personality, sexual identity, gender, other disorders (like PTSD, anxiety, eating disorders), chronic or serious illness, unequal social status, work load, and more (Mayo 2018; Levacque 2017). Those with a mild to moderate mental illness are two to three times less likely to be employed, mostly from stigma and persistent cultural views regarding psychological and pharmaceutical treatment (OECD).

Nature versus Nurture

Studies that show the flexibility between environment and biological factors include the Holocaust survivor study and Suomi's monkeys by Stanford (Dess 2001). The survivor study done by Rachel Yehuda and Linda Bierer looks at resilience to traumatic events in the children of Holocaust survivors in Ohio (2009). The now-adults in the generation after WW2 were able to endure catastrophic events, such as loss of job, house, high weather damage and threat to life, but were less resilient to interpersonal trauma, such as a loss of a family

member, meaning there are cultural beliefs that can shield people from certain stressors. In addition, preliminary tests in the study showed it is possible for pregnant women experiencing stress can affect the genetic expression for their children *in utero*.

Suomi's monkeys are part of the infamous experiment where macaque baby monkeys were taken from their mother and given hard, unresponsive wire "mothers" as substitutes for physical comfort. When the monkeys grew up, they became more likely to be antisocial and more prone to anger and violence. Blood tests revealed that cortisone levels were abnormal, meaning that the threshold for any kind of stress was low and that their response to stress was quick and easy to trigger. They did not have a healthy biological response to stress like the control monkeys who had a real macaque mother.

On the other hand, the monkeys who were taken away from their biological mother and given over to an adoptive mother did not grow up to have the same antisocial behaviors as those who only received a wire mother. They were able to live and grow up quite "well-adjusted", according to researchers. Both studies show how environment affects genetic factors and vice versa. Stress response is a confluence of many factors.

Common Disorders

While a variety of personality and mood disorders exist, depression and anxiety deserve some mention here. People are most commonly diagnosed with these two, and they tend to co-occur during a person's lifetime (ADAA 2018). They were also frequently brought up during interviews. While not every participant has been professionally evaluated and diagnosed, many discussed their symptoms. In general, the researcher avoided using these terms and talked about symptoms in terms of "stress" rather than through diagnostic terms.

Depression

Depression is characterized by two or more weeks of "a persistent feeling of sadness and loss of interest in everyday activities" (Mayo 2018). There are also feelings of emptiness, hopelessness, a decrease in energy, appetite, excessive thoughts of past failures and of death and suicide; some people have unexplained physical problems as well. People can have "sub-syndromal depression", which means they have four or less of the symptoms; early diagnosis and treatment of mild to moderate forms of depression prevents major depressive disorder (MDD) from developing.

Depression, along with anxiety, often develop in late teens and early twenties, though adolescents and older people can also develop them. They can co-occur with other diseases such as diabetes, heart disease, cancer, and Parkinson's. While there are psychotherapeutic and pharmaceutical treatments available, help is often delayed on average a decade, when negative thoughts and behaviors set in and become harder to correct (OECD 2018). Reasons for not seeking help are that the issue isn't considered serious, people don't know about mental illness and symptoms, and they had stigmatized psychotherapy and counseling.

Risk factors for depression include: personal and family history, genetics, life changes, trauma, stress, and debilitating illness. Overwhelming stress leads to extended periods of negative mood disorders, which negatively affects physical health and contributes to a weakened immune system. If not corrected, this can lead to a shorter life span and suicide.

Anxiety

Anxiety disorders consist of: general anxiety disorder (GAD), panic disorder, social anxiety, PTSD and phobia disorder. GAD is the most common form of anxiety disorder. 19.1% of the US population has anxiety, the most common mental illness in the US. 22.8% of those diagnosed had a serious form of anxiety (NIMH 2018). Symptoms include being restless, easily fatigued, difficulty concentrating, being irritable, high muscle tension, sleep apnea and constant worrying.

Globally, 1 in 13 people suffer from anxiety, and 75% of depression and anxiety diagnoses are untreated in developing countries (ADAA 2018). Risk factors include: personality, being female, having few economic resources, being divorced or widowed, and a family history of anxiety. There is constant fear of the next episode, and there is constant feeling of being out of control.

Current Treatments

Research has increasingly emphasized environmental/social factors as being risks mental illness. A lack of awareness of mental illnesses and its symptoms along with stigma exacerbate the illness over time and increase the chances of having another mental or chronic disorder. Mental health professionals call for more funding, resources, and increases in targeted research to better understand perceptions of mental health and holistic and less expensive treatment options, like medication and therapy (Hunt and Eisenberg 2010).

Advocacy groups recommend complementary lifestyle treatments, such as practicing yoga, tai chi, meditation, regular exercise, and eating a healthy diet (ADBA; NIMH; NAMI). Other treatments like massage therapy and hypnotherapy are available, although not enough large-scale research has been done on efficacy. Lifestyle treatments have increased in

popularity in the last ten years, with 10.1% of the US population having done some form of yoga in the last year, 8% meditation, and 3% adopting healthier diets (NCCIH).

Antidepressants, antianxiety medication, and antipsychotics act on different hormonal processes in the body to resolve chemical imbalances in mood and anxiety disorders (NIMH). Depending on personal history and genetics, psychiatrists can decide which medication is better suited for each individual. Medication can improve multiple disorders or used to augment treatment for different MI‘s. As with all other medications, pharmaceutical treatment comes with risk.

Finally, psychotherapy has been proven to help change negative thoughts and behavioral patterns in patients. Cognitive Behavioral Therapy (CBT) is especially useful for people with depression and anxiety. This type of therapy teaches people how to identify and change emotions, thoughts and behavior, and giving them the ability to track such emotions, plan a different way of thinking and coping with stress, and provides supportive counseling and interactive planning to consciously change behavior and thought.

CHAPTER THREE: POPULATION OF INTEREST

Anthropology studies phenomena in qualitative and quantitative ways, which helps to understand both cultural consensus and the lived experience. The researcher's background as a Vietnamese American student can add an insider perspective and provide deeper insight.

The relationship between the US college-age population and mental distress has been studied for some time, but it is only recently that specific populations, such as lateral (departmental) and vertical (undergraduate vs. PhD) distinctions have been studied (El-Gouroy 2012; Levecque et.al 2017). Other intersectional studies have been done on ethnicity, substance use, trauma and other social and environmental factors that affect mental health (Chu and Sue 2011; Buchanan 2012; CCMH 2017).

While this research emphasizes depression and anxiety because of its frequency in statistics and interviews conducted, (ADAA 2018; UN 2017), other disorders were discussed by participants as well. The unique pressures from cultural identity (Vietnamese American) and a rite of passage and all its ideas of success deserve more research.

Young Adults

The young adult population can range from 18 years of age to the early 30's, and some key similarities affect this broad group. They face low financial stability, less knowledge of mental health, and are more likely to develop a range of disorders, such as depression, psychosis and social phobia (Kessler and Ustun 2004). Anxiety has a 30.4% diagnosis rate between the ages of 18 to 29, and depression (major depressive disorder and

dysthymia, a mild form) has a 17.1% diagnosis rate in the same age range (Kessler and Ustun 2004).

Most of the diagnoses occur during this time, although this is an underestimation given that people in this age range are less likely to report embarrassing behavior such as emotional problems. Perceived stress negatively affected "Quality of Life" in a range of contexts, such as social relationships, physical, psychological and environmental settings (Seo 2018). Disorders are likely to occur at a time when health service use is at its lowest, from self-stigma and lack of awareness of resources (Wright 2011: 500).

College Students

During the researcher's time in school, it seems like almost everyone has personal experience with depression or anxiety, often self-diagnosed. The facts seem to support anecdotal evidence. U.S. college students have high rates of depression and anxiety; 1 in 6 have some mental illness, with some having depression and anxiety (ACHA 2017). Schools can't keep up with the demand for psychological services (Hunt and Eisenberg 2010), and students have a difficult time finishing the treatment plan or locating long-term help outside of campus.

MI affects many aspects of performance and productivity, undermining the college experience. Research has shown that college students report high anxiety and depression after their first semester at school (ACHA 2017). Common stressors include pressure to achieve high grades, work-home balance, relationship stressors, socioeconomic background, racial inequality and sexual violence (Hunt and Eisenberg 2010). Sleep deprivation, anxiety, and being more prone to high-risk activities, are all results of being in an academic

environment with many responsibilities that create pressure to succeed. They are at higher risk of stressors during college and can have health problems that continue beyond their education.

College Students and Help-Seeking

According to research, only 24% of students diagnosed with depression sought help (Hunt and Eisenberg 2010). Although the number of students who use on-campus services have increased, they are prone to early drop-out, usually after six sessions (Hunt and Eisenberg 2010; CCMH Report 2017). They also seek help at lower rates than the non-college adults, even though the rates of mental illness are the same in both populations and psychological services on campus are relatively affordable (Kim et. al 2015:14). Directors of psychological services cite insufficient resources, and issues connecting students to long-term support off-campus (Hunt and Eisenberg 2010).

A WHO analysis found that many do not receive treatment until on average a little over a decade (Kessler and Ustun 2004). Young adults are then more likely to develop a co-occurring mood or obsessive disorder and physical illnesses, decreasing overall health. Mental health professionals advocate for a better mode of delivery, better early screening on campus, and proactive outreach to dispel myths about mental illness (such as only crazy and weak people develop a mental disorder) and increase awareness of resources (Buchanan 2012).

Vietnamese in the United States

Vietnamese Americans (VA) migrated to the United States later than other Asian American ethnic groups, with most arriving from 1975 and onward in waves. After temporary settlements spread across the US, many drifted towards urban centers such as San Jose, Los Angeles and Houston. After escaping war, Vietnamese in America settled into their respective cities, found work, raised their family and built permanent immigrant communities.

Vietnamese Americans of this generation tend to suffer from PTSD, depression and mood disorders from combat trauma and forced migration. While VAs tend to avoid professional help, many in the first generation to the US have recognizable symptoms, such as mood swings, anger fits, and prolonged sadness, a part of the healing process and negotiating their lives between two identities. Vietnamese refugees to America in the 1980's had gastrointestinal complaints in addition to psychological symptoms (Jenkins in Kleinman 1991). Migration is still occurring to the United States, so the amount of time here is important to consider when interviewing students.

Vietnamese and Mental Illness

The literature discusses specific mental health challenges that Asian Americans (AA) face and calls for more intersectional research (Han and Pong 2015). Like their research, participants in this study spoke about transmitted cultural beliefs such as distant parental figures, respect for anyone older, and to continue with the mindset of "keeping one's head down and pushing through". While none of the students believed in the "old way of thinking" of karma (nhân quả), traditional cultural values related to interpersonal relationships

continue, stigmatizing loss of emotional control and children avoiding being open or seeking advice from parents.

Traditional Views

However, this doesn't mean that Vietnamese culture brushes off mental health and illness entirely. While uncontrollable emotions might be viewed as lack of decorum and disrespect for others (Gustafsson 2009:15; Pong 2015), first-generation Vietnamese might explain severe mental illness (*tâm thần*) as fate (*nghiệp*) or karmic in nature, as retribution for past wrongs. Traditions from the old country to alleviating problems include a "mounted ascension of the spirits" by a medium ("lên đồng") to find the spiritual origins of an illness or kowtowing at a temple and making a financial offering in exchange for godly help (Gustafsson 2009:80).

Back in Vietnam people who were different, like those with severe mood and psychological disorders, were tolerated. It was something that happened to the family because of "past wrongdoings". However, in the US, psychotherapy's function and purpose is a mystery to most of the older generation who are not familar with psychology, and this makes it difficult for parents to relate to their children about mood, emotion, and stress.

Many cite their parents' lack of biomedical understanding as part of the reason why they don't discuss stress and seeking professional help with their parents. At least in this research, none of the Vietnamese American participants cited spiritual healing as a source of help. Even college students in Vietnam do not prefer spiritual counseling. Instead they seek professional help at 68.7%, support from family and friends at 73.7%, and traditional healer/alternative medicine at 7.5% (Kamimura et. al 2018).

Important Cultural Conceptions

Like Asian Americans, Vietnamese Americans tend to hold cultural values like interdependency and family-centered values (collectivism) and tend to face pressure from family to succeed in school and work (Chu and Sue 2011). Mental illness is not identified by name or simply not talked about (Lee et. al 2009) and cultural values tend to value self-control over emotions. Help tends to be sought within the social network rather than with outsiders (Pong 2015; Han et. al 2015). Students believe their parents will simply say to "push through" just like they did when they came to the US, rather than share with others. "Saving face" means keeping problems within the family, and it is considered shameful (*làm mất mặt*), or a loss of face, to tell strangers like counselors about things such as mental distress, financial problems, interpersonal conflict, etc. (Kim and Omizo 2003). "*Xấu hổ*" doesn't just mean shame, but dishonor for your family too.

Vietnamese Americans believe mental illness is a sign of weakness, from the individual's lack of emotional discipline to the family's failure to help (Fancher 2009:264). The older generation also believe mental illness may come from having a bad personality or is caused by incurring bad karma from previous misdeeds (Fancher 2009). Another common explanation is that mental illnesses tend to work themselves out and people should handle problems on their own (Nguyen et. al 2011; Schraufnagel et. al 2006).

There might also be mistrust of authorities of medicine. Psychiatric help is not well understood and so is mistrusted and viewed as quack science; others view it as an inappropriate way to solve problems (Fancher 2009:64; Nguyen and Anderson 2005). Misunderstanding of biomedicine can occur, and some perceive antidepressants and

medication as harmful to smaller Vietnamese bodies because of stronger side effects (Fancher 2009:265).

Generation Gap

Specifically, Asian Americans tend to suffer from *generational acculturation gaps* (Miller et. al 2001). *Acculturation* is the process of adjusting to a new social, linguistic and cultural environment that is dissimilar to one's own culture of origin (Claudat 2016). *Acculturative stress* is the psychological impact of adapting to a new culture. Vietnamese Americans who acculturate at faster rates than their parents (hence generational) have more family-related conflict and stress (Nguyen et. al 2011). They have different values, beliefs about the self, which are related to school performance, obedience and duties to family, and in general problems in trying to balance two cultures at once (Lee et. al 2009).

Young adults are more acculturated and tend to deviate from traditional beliefs. They are less likely to talk to their parents about psychological help, since they consider asking for such help as shameful (Nguyen et. al 2011), unnecessary (Nguyen and Anderson 2005), and shows a lack of confidence in the family to care for the individual. There is also an emphasis on not accepting failure. This could make it more difficult to relay problems with parental figures, since it causes parents to worry and feel like they failed their children as well.

Currently there is inconclusive evidence that acculturation necessarily leads to a more willingness to use the services, as there are complex factors that affect help seeking, and acculturation needs more multidimensional study (Nguyen and Anderson 2005). Overall, mental health services are underutilized (Spencer 2010; Augsberger 2015) and

underdiagnosed (Chu and Sue 2011; Pong 2015). Mental illness is therefore stigmatized to a large degree in the AA community.

Other Considerations

They are also more likely to face structural barriers compared to the general population. Vietnamese Americans are socioeconomically more vulnerable than their other Asian American counterparts. They are less acculturated, less aware of resources, and less able to access ethnically-similar resources. Mental health also could simply not be a priority among activities (Nguyen and Anderson 2005). In that study, Vietnamese Americans prioritized physical health over interpersonal harmony, with mental health coming in last.

Among those who are open to accessing such services, there are worries about language barriers, culturally insensitive providers, and costs (Han 2011:66; Spencer 2010). Statistically, when Asian Americans encounter treatment, their symptoms are severe and mental health services were only accessed as a last resource (Schraufnagel et. Al 2006:28). And when access is equalized by insurance and cost, there are still other barriers for minority populations like stigma, language and cultural conceptions of treatment.

Asian American College Students and Help Seeking

There is not much literature on Vietnamese American college students, and most of the statistics are based on Asian American students. In a study done on college students in Vietnam, students said they perceived an increase in diagnosis over the last twenty years and comes to the same conclusions as the Asian American studies (Kamimura et. al 2018). The major causes of developing depression and anxiety are from life stressors and chemical

imbalances. The students are more likely to seek help from friends and family over self-help. Mental illness is still stigmatized in the population and is associated with reduced help-seeking.

The literature on Asian Americans looks at acculturation as positively correlated to help-seeking, reaching levels of Euro-Americans in the 3rd generation (Pong 2015). Those with more acculturative stress have poorer mental health and tend to seek help more (Miller et. al 2011). So even those who are more acculturated and are open to psychological help face social barriers. The lack of knowledge and discussion at home about mental illness leads to difficulties understanding and finding professional psychological support. When Asian Americans do access counseling, it is usually involuntary admission.

Most of the barriers for help-seeking stem from a general lack of mental health knowledge and misunderstanding of mental health advice. Interviews with Asian American college students indicate that there are salient topics related to culture that should be considered in treatment, such as acculturation, discussing how acculturative stress manifests, generational status, and identifying possible social support systems (Miller et. al 2011).

Help-Seeking and Stigma in VA Community

Stigma is defined as any "characteristic that is considered disadvantageous and biased against you in a negative way" (Mayo 2018). Discrimination because of mental illness can lead to fewer opportunities at work or housing, refusal to be covered by health insurance, belief that you won't succeed, and social isolation. It also prevents successful outreach by mental health professionals and lay people because of mistrust or fear of ostracization, and skepticism by government officials, policy makers and donors to the cause (Kohrt 2016: 26).

But does this population truly carry different prejudices than the general population? What we know and what we assume might not be accurate, at least over time. A social worker who works in a psychiatrist's office explained that for her patients the underusage is not from stigma but a lack of awareness of the resources they have; she emphasized that what stops youths from seeking help is more perceived financial than cultural or linguistic barriers (Chinh Tran, personal communication). Even though it's an anecdote, there is reason to question whether culture negatively affects help-seeking, or if other factors are at work.

Studies done with Vietnamese Americans show that they tend to stigmatize being overtly expressive. Public displays of anger and sadness for instance means unhappiness with the self and the family, since the self is an extension of the immediate social network (Ting and Hwang 2009). It shows that the family has failed to help the individual resolve their problems. This also extends to help seeking as well; going to a counselor is bringing the family out to the public to see and judge. It is also a sign of weakness to seek help from an outsider (Nguyen 2005:215). The correct hierarchy is to solve problems within the family first and then seek an outsider, and even then, it would be priests, Buddhist monks, or spiritual specialists.

The students' values and beliefs do not include any class of spiritual leaders, but stigmatization of public displays of emotion still exist, which is frequently mentioned by participants in this study. How does this taboo on emotion affect help-seeking, and if so, how can the community address these barriers? Medical anthropologist Arthur Kleinman talks about the problems with cultural competency (being able to understand different cultures and its impacts on health), such as overemphasizing cultural values as the main cause of an illness and overlooking other wider social effects on mental health (Kleinman 2006). This

researcher hopes that these anthropologically-informed interviews can help the psychology and Anthropology community to better flesh out connections between behavior, beliefs and actions taken. This research further adds to the literature on minority and college-age students and their relationship with mental illness as a medical construct and as a lived experience.

CHAPTER FOUR: THEORETICAL FRAMEWORK AND METHODOLOGY

Theoretical Orientation

Roy D'Andrade's work in cognitive anthropology talks about the need to study *values*, as they are key to understanding people's motivation (2008). What kinds of values, motives, and ideas of importance do people hold and how do they affect behavior? In our case, how do values have cultural significance? Values also explain how people negotiate responsibility in different areas of their lives, what they believe and what is important to their "life career", or attainment of goals. There are many factors that people consider when performing any action, and it is no different when considering seeking help. Values orient activity, and studying what people value and mediate, such as between family, success, personal/societal attainment, and social relationships can help explain behaviors.

In addition, critical medical anthropology (CMA) informs this research. CMA is the approach to studying health that emphasizes economic and political impacts of health, and how biomedicine affects health and disease (Winkelman 2009:305). This perspective challenges medicine as also having its own values and having some subjectivity. We should constantly reevaluate our work and find holistic solutions that combine the social, psychological, and biological realms. Science also operates within historical, political and economic to influence health, access to healthcare and disparities between populations (Winkelman 2009:14). Symptoms, disease and illness are culturally relative, and the goal is to resist applying biomedicine to all situations, since beliefs, behaviors, and attitudes are not universal but very much situational.

Both backgrounds served to receive data with an open mind, knowing that health, disease and illness are social and cultural constructs and that there are many causes and solutions for mental illness that do not neatly fit into so-called Western, or biomedical categories. Asian American college students approach mental health and illness in different ways. The historical, socioeconomic backgrounds contribute to unique stressors that are studied here.

Anthropology's Role

Outreach is naturally a cultural arena (Kohrt 2015:28). Anthropology can contribute to mental health research in two ways. The first is understanding the varieties of mental health. Cultures have their own definitions for abnormal and normal behavior and thoughts and have culturally specific social responses to those behaviors (Winkelman 2009:206). Anthropology can bridge the gap between different cultural concepts and also negotiate between biological universality and cultural uniqueness of human experiences (Winkelman 208).

The second way Anthropology can contribute to mental health initiatives is finding solutions to mental health crises in culturally sensitive and productive ways. For example, anthropologist Arthur Kleinman's eight questions asks subjects to name and explain illness on their terms, framing illness not as a medical condition but also as social suffering. Because health is both real and perceived, understanding how people comprehend, express and discuss mental illness is important to finding effective and accessible solutions.

Concepts like self, body, mind, health need to be challenged because they are viewed differently worldwide, unlike prevalent Western thought (Hinton 2015: 24). While avoiding

representing culture as a unitary whole, we can understand people's perspectives, such as those in this present study. With solid data and locally compatible solutions, Anthropology can help better understand social and cultural dynamics that affect understanding and views on treatment, and better connect people to informed and viable solutions.

Methodology

This section will describe this survey and interview methodologies, planning and logistics. Data was collected in semi-structured interviews and guided conversations. Case studies consisted of interviews and participant observation during informal settings, such as study sessions or for lunch. Schema theory analysis is laid out in addition to the motivational/value theory that is the foundation for analyzing the relationship between behavior, reasoning and significant cultural values. In addition, the data is supplement with sentence analysis and organization, and frequency and context of words used.

The survey battery and the in-person questionnaire were approved by the University of Houston Institutional Review Board on November 30, 2018, study STUDY00001325. Data collection began on January 21, 2019 and ended on April 20, 2019. According to the NIH IRB Human Subject Research guidelines, all the participants were promised anonymity. The survey was created and sent through an application on Google called Survey. It can receive responses without any personal information. The participants were promised a $5 Starbucks gift card if they chose to continue with the in-person interview, with a chance to win an additional $30 gift card during the final raffle. This study was self-funded, and expenses incurred were budgeted out of the researcher's personal account.

Survey

The survey link was given out on January 21st, 2019 at the beginning of the Spring semester through organizations with a substantial number of Asian American students. Therefore, the survey link was sent out in waves, and responses came in as participants submitted their surveys. The target recipients were Houston undergraduate and graduate students, both male and female from the following institutions: UH, UH-D and HCC. Most of the students were enrolled in the College of Pharmacy, Nutrition, and Biology within their respective universities.

Total number of respondents for the survey, N =60, out of which, 57 were from UH, 1 was from UH-D, 1 from the University of St. Thomas, and 1 from HCC. The attrition rate for the online survey was 0. Total number of respondents for in-person interview, N = 24, is included in survey numbers. The survey was also encouraged by students in their respective schools.

The last question on the survey asked respondents to provide an email address if they wanted an in-person interview. The researcher contacted and scheduled interviews based on mutual availability and preferred location of the students. 10 of the students were from the College of Pharmacy. The rest were 2 UH undergraduate students (UG), 1 UHD UG, 1 HCC, and 1 Lone Star student. Study population contained 13 female students and 3 male students.

Interviews

The researcher contacted interested participants for the formal interview. The researcher provided her own transportation and was flexible with time. Interviews took place in various study rooms on UH's main campus as well as at subjects' houses at their

convenience; this also provided them quiet and privacy. All interviews were conducted in English, although some Vietnamese terms were sparingly used in three interviews; they were transcribed and noted by the researcher. Although terms were used in English, the context of the interviews allowed the researcher to approximate the Vietnamese terms for frequently used words.

According to the Human Subject Research guidelines SOP 502a, all the interviewees signed the consent and waiver forms. They were verbally reminded that the interview will be recorded in its entirety and they had the right to end it at any time, and this would not be held against them in any manner.

The recordings were done on the researcher's phone through an in-phone service called "Audio Recorder" and the option of "Interview Format", where both ends of the cell phone functioned as microphones for quality sound. As indicated in IRB template 503, this data was kept private and only the researcher had access to the passcode on the cell phone.

The interviews were converted from audio to text through an online service called Temi.com. This occurred between March 5th, 2019 to May 2nd, 2019. The audio files were first downloaded to the researcher's home laptop. It was then uploaded to the researcher's Google Drive and then onto Temi.com. The interviews were transcribed, and a week was required for minor corrections. Only the researcher had access to the data and the laptop password as well as the Google Drive passwords.

The website Temi.com offered this service for a small fee, also incurred by the researcher. The transcription service also timestamped the conversation, which made it easy to reference during analysis. Since there were only two speakers during an interview, the names were left as "Speaker 1" and "Speaker 2" on the printed interview.

Most interviews lasted approximately 40 minutes. The gift cards were given to each participation after the interview ended. Some participants initially refused the gift card, stating they only wanted to contribute to the topic. Most students left telling the researcher to email them with additional questions should she have them.

Interview Methodology

There are three different techniques used to analyze qualitative data: content analysis, key word analysis, and cross-narrative analysis. These are summarized below.

Sentence analysis breaks down long interviews into smaller units of meaning for grouping into similar ideas, beliefs, themes. Complete sentences start out as "units". When condensed into shorter phrases, they become "codes". Codes help to simplify and connect the larger units. Codes are grouped together based on topic to form categories that answer questions like, who, what, where, and why. Categories are grouped together to answer questions such as by what means, why, how, and in what way. These become the themes that can explain behavior. They can be cultural truths, values and schema that motivate behavior. Erlingsson and Bryzseiwicz (2017) applied sentence analyses to interviews done with patient dissatisfaction in an African hospital, and the researcher has chosen to do the same.

Cross-narrative analysis simply compares categories and themes between individuals. The method chosen by the researcher reflects work done by Naomi Quinn on variations of the story "La Llorona" (Text Analysis in Wutich 2015), which entails fusing qualitative data, which highlights much depth, along with quantitative data, which establishes patterns across people, population, to make attempts at validating cultural beliefs. Here the researcher chose to look at frequency of concepts within a case and between cases as well as differences

between them, doing simple calculations using Microsoft Word and logging in numbers in Excel, while also documenting the specific instances and the context around the concept when they were used.

The researcher combined categories into one Master List sheet. The researcher also divided participants answers into Vietnamese (V) Responses and Non-Vietnamese (NV) for closer analyses. Comparing and contrasting between populations through text make recognizing distinctions easier. Since this is a small study population, it cannot be established that all Vietnamese Americans adhere or understand the same cultural models, but that specifically, Vietnamese American college students are *likely* to have the same cultural explanatory models as the ones in this research.

Keyword analysis studies words looked at how they were used in context and if it adhered to the cultural model. Quinn's analysis of metaphors in marriage using keywords and Rodney's study on bilingual Japanese spatial ordering of emotion were used to uncover some cultural models, and the researcher chose to do the same.

Case Studies

Case studies allowed the researcher to gauge participants' stress levels throughout the semester. The frequency of interaction also increased rapport with the researcher and more honest discussions took place. Not all interviews were formal and recorded, but during study sessions they were able to share about school, family and stress. They all had something special to contribute in terms of unique stories and their perspectives on mental health for themselves and a conscious awareness in others too.

Case selection was done after data collection was completed. After interviews concluded, each participant was coded with either 3 letters (E, F and J) (and a single number

0-9) for labelling during analysis and keeping up with Human Subject Research guidelines. This keeps the participants' identities anonymous and made referencing them easier during analysis and discussion. Also, interviews were written as page number of the printed version. For example, 2:4 is the second interview, 14th page.

A brief summary of the three case studies (all pseudonyms) are given here:

Stevie is a female Asian American (non-Vietnamese) who has OCD, anxiety and depression. She is currently in graduate school. She sought help at CAPS and continues to take medication. She is an active part of mental health education in the wider Houston community, as well as at her college and at CAPS.

Tamara is a female Vietnamese American who has anxiety issues in the past. She recently started getting panic attacks, and went to therapy, although she has since gotten them under control. She says she doesn't have a lot of "emotional intelligence" and has a hard time processing her emotions in the present.

Derrick is a male Vietnamese American who does not have any identifiable mental illness. Mental health is not something discussed in the home, and he came with no understanding of it. His inability to conceptualize and empathize with what people in his life are going through, his gender, and his thoughtfulness made him a right inclusion to the case study collection.

Challenges of the Research

There was some difficulty recruiting participants for this topic. Out of 60 survey responses there were 24 requests for interviews, and 16 confirmed participants. Out of those

16, there were 3 male subjects. The time constraints on participants limited interviews. The researcher was only able to do so because of her flexible schedule and ability to get transportation to campus and sometimes to homes whenever participants had some free time. While Anthropological methodology states that 15 participants are enough for qualitative interviews, it would have been more fruitful to have a higher total count for both Vietnamese and non-Vietnamese for quantitative methods like non-parametric data. Hopefully future studies will include this type of analysis.

Limited resources include lack of incentive for greater recruitment. All gift cards were paid for out of pocket, and while some students rejected the gift card given at the end of the interview, their explanation after it ended was that it was something they wanted to do and wanted to contribute to research. Therefore, the research might have attracted people interested in the subject and willingness to discuss a potentially sensitive topic.

It would have helped to recruit more students in a wider range of fields as well, gender, colleges, for a more balanced subject group. The male students interviewed had a different perspective regarding mental health, so with more males recruited those topics could've been explored more. More non-parametric analysis of the data was not able to be done. Also, while open-ended interviewing styles allow the conversation to go where it may, with the time constraints on participants, not all topics were able to be covered. In the future, the researcher could do better to request more time from the subjects and draw the conversation back to the questions at hand.

Finally, there was not enough interviews done with mental health professionals for comparison. It would have been would have been helpful to have done long-term interviews with this group as well to discuss the professional perspective on Asian and Vietnamese

American underutilization of services. Although it was not the purpose of the study, supplemental interviews can only bolster the data; hopefully this angle can be noted for future research.

CHAPTER FIVE: RESULTS

This section will cover the initial survey data, compare the hypotheses with the interview data, and finally dive into the themes that came up during content analysis. Case studies and keyword analyses are interspersed to elaborate on culturally salient themes.

Initial Survey

The survey was sent out through Google Survey Form on January 21st and closed on March 2, 2019. The purpose of the survey was to lay out the research and find students to continue with the in-person interview. No demographic data was collected. The last question allowed participants to submit their email addresses. The researcher received 60 anonymous responses, 24 email addresses, and 16 total students who completed at least one in-person interview.

The initial data for responses is below:

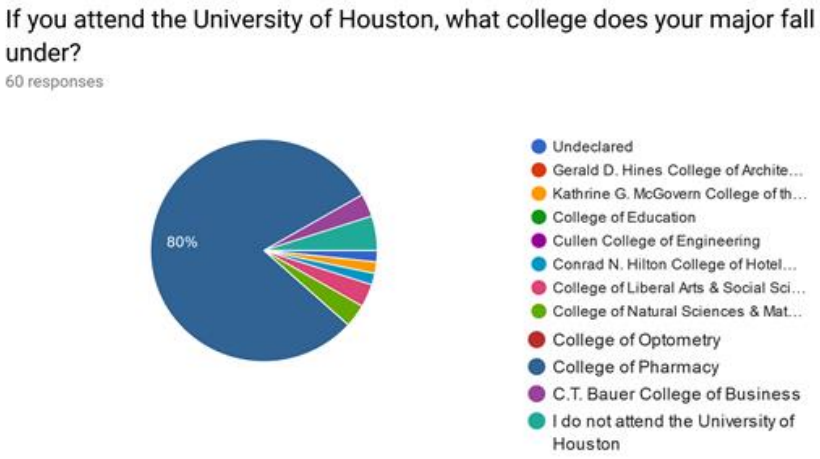

Figure 1. Distribution of Respondents from Colleges and Universities in the Greater-Houston area

The chart below shows the distribution of the survey N=60. The students who completed the survey represented higher education institutions in Houston. The sample most represented were students enrolled in graduate studies within these institutions. The second most indicated that they were seniors in college. Age was unfortunately not considered, because this researcher considered rank in school a more valid indicator of stress and mental health awareness (more time spent in school, more chances of academic and life experience).

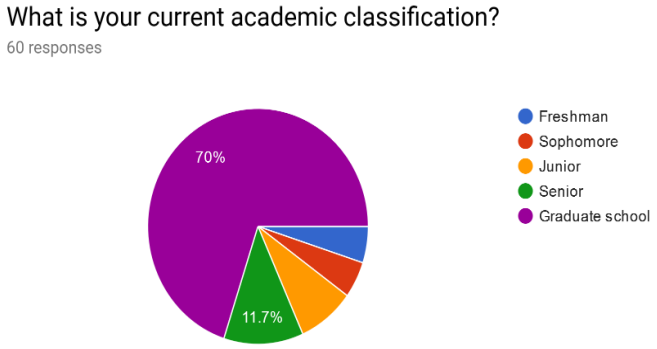

Figure 2. Distribution of Respondents' Academic Classification

The academic classifications were about the same for the interviews, as shown below:

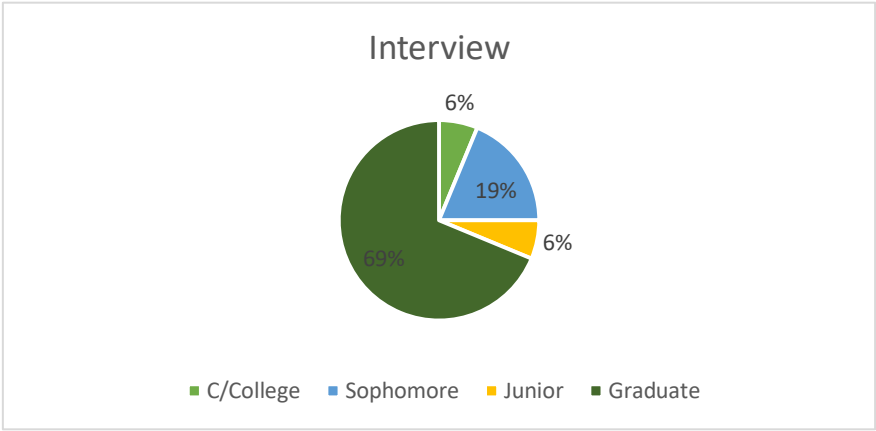

Figure 3. Distribution of Respondents' who agreed to the in-person interview(s)

When asked about self-care and exercise, most indicated that they took partake in cardio fitness at 46.7%, mindfulness at 36.7%, weight-lifting and meditation each at 23.3%, followed by practicing yoga at 21.7%. A small percentage of those polled seemed to indicate that praying, journaling, counseling, shopping, etc. are activities done for self-care.

According to this diagram, 96.8% chose exercise (cardio fitness, yoga, Pilates, weightlifting, gym, and neighborhood walk) as part of their self-care and health routine. 68.5% chose non-exercise individual activities as part of their daily care routine (Music and video gaming, praying, gratitude journaling, shopping, face sheet masks), while 71.7% chose some form of mindfulness, meditation and/or yoga as part of their health routine.

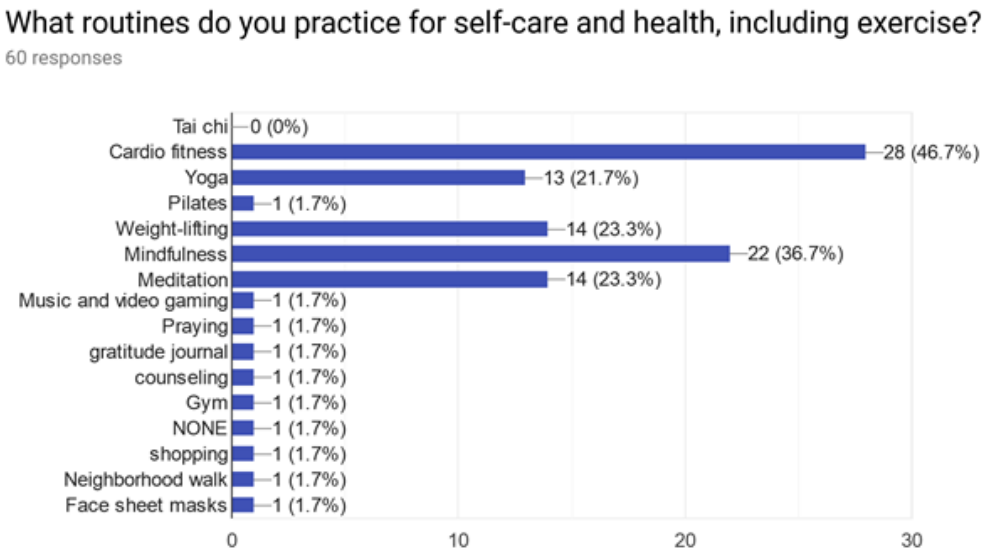

Figure 4. Responses for self-care among college students in the greater-Houston area

Only one person said receiving counseling was part of their self-care routine. Interviews showed the same patterns when it comes to self-care and stress-relief activities. It

is not common to seek counseling; reasons given were the high cost, the cultural mismatch with therapists, and desire to handle it without external help. Most people do not consider therapy for these reasons and want to look at other resources more readily at hand and understood before seeking help, usually when it's more urgent.

Analysis

This section will summarize similarities and differences between the populations and seek to answer the main questions discussed in this research:

Issue 1: Vietnamese lack awareness of resources on campus.

Issue 2: Vietnamese tend to use personal networks before seeking professional health support.

Issue 3: Stigma still plays a role in actively seeking professional support.

Population: Vietnamese and Non-Vietnamese

6 out of the 10 Vietnamese (V) were "second generation", meaning they were born in the United States. While there are some research indicating language barrier as part of the lack of mental health discussion in the Asian American community (Chu and Sue 2011), more specifically participants cited the cultural incongruency, lack of correct vocabulary to express the complex processes of mental illness and stress. The traditional explanations like karma (*nhân quả*) or spiritual possession (*ma nhập*) do not exist in this group, nor do their parents adhere to these beliefs, according to the conversations.

The Non-Vietnamese (NV) group were evenly divided. 3 of them are Hispanic Americans, 3 Asian Americans. Although they were not from the same ethnic group, they

had similar qualities such as experience with psychotherapy and as an immigrant second generation. Therefore, they are controlled for some things, such as level of acculturation and positive attitude towards mental health support and therapy, in addition to being more open about their own struggles.

Similarities and Differences

Again, the NV group seemed more open to therapy, which might be skewed in this research because most of them have had contact with psychological services and generally have good things to say about it, unlike the V group. In addition, they didn't mention mental illness as a stigmatized topic to the degree that Vietnamese did. Their parents were mostly confused about counseling services and how it worked. For Vietnamese they thought of stigma in terms of "what would people think", and that services were only for people with extreme behavioral problems, which doesn't include themselves.

Vietnamese tended to talk about their behavioral problems as "lacking control". They couldn't get their thoughts under control, were preoccupied with them throughout the day during other activities and felt some shame (*xấu hổ*) for not being able to restrain their emotions. For NV, symptoms were more physiological, such as anxiety attacks with rapid heartbeats and restlessness, rather than cyclical thoughts and such. It doesn't mean NV group did not have the same uncontrolled thoughts, but it was not mentioned as frequently as the V group. It could be that Vietnamese culturally value emotional restraint and emphasize showing restraint for both themselves to "save face" for their family.

Also, quite a few female participants complained not just of panic attacks, but loss of sleep or oversleep. While these aren't always a sign of mental distress, many brought up the

fact that sometimes they overthink so much that it interferes with their ability to go to sleep and stay asleep. This is an overlap of psychological and biological symptoms of stress.

Hypotheses

How does the subject population for this study articulate or modify current national studies done on mental health perception and access to resources?

For Vietnamese Americans, it appears that this study is representative of some of the general theories of behavior. The first hypothesis tested in this thesis is that college students are not aware of resources. All participants were aware that resources exist, but most do not understand the process, unless they have accessed them in the past (3/10).

In addition, national studies say that Asian Americans only seek help when it's critical. This is generally agreed upon. The mental health professional in this study said that out of hundreds of people who have entered their psychiatric facility, only 3 or 4 were Asian American. For the five Asian Americans who received psychological services either on campus or in private facilities, two were admitted involuntarily, and three only sought help when they had a major depressive or psychotic episode.

For the Vietnamese Americans in this research, 9 out of 10 said that they will get help when they feel their condition is bad. While they talk about having negative behaviors they dislike, such as lying in bed for long periods of time, uncontrolled behaviors and thoughts like feeling upset, preoccupation that affects daily activities, and unpredictable panic attacks, they're doing "well" or "okay" now and have been trying to work things out on their own. Solutions include self-reflecting, exercising and lifestyle changes, distancing oneself from the issue and focus on relaxing activities.

There was no mention of consulting with a spiritual leader or using traditional medicine to alleviate stress. It could be that Vietnamese students did not want to admit that they still use local healers because the public tends to outwardly consider them as "backward practices". Or it could be the participants were not particularly religious and therefore do not use religion and spiritual practices as a resource.

Is the population aware of resources?

Individuals in school for more than three years are aware of resources on campus. They know the gist of how mental health (CAPS) services on campus works and the steps to get help, but do not fully understand other alternative sources such as walk-in screenings (Let's Talk) to the formal psychological resource at CAPS, nor do they know how the process works. They do hear their professors reference services in the syllabus at the beginning of the semester.

As much as the Vietnamese group say they do not need nor access any professional resource, many of them do not stigmatize it and said they do refer friends who are struggling with academics or interpersonal relationships to CAPS. In sum, only those who have gone through the process understand the costs, processes and what to expect if they find themselves in need of these resources in the future.

What kinds of resources did they access in response to stress?

Both groups have access to the same type of resources, but the Vietnamese group predominantly tried to solve it on their own, with 53% of solutions offered self-administered, while non-Vietnamese suggested working on their issues on their own 29% of all

suggestions. Vietnamese suggested going to a friend 26.5% of total suggestions, and non-Vietnamese suggested friends 24.5% of the time. Vietnamese suggested going to family versus therapy at 2% versus 4%, and non-Vietnamese suggested going to family at 7% versus 12% for therapy. One wouldn't talk to friends but try to resolve it on their own at all costs.

There are a variety of ways people access resources during stressful periods. People usually try to handle it on their own, either by working through the issue or preoccupying themselves with other activities. People who don't like to rely to others tend to relax and "chill out", a period of time in which they take a break from social interactions to be alone and temporarily step away from obligations, and to recollect their thoughts.

Others take a more active approach, like practicing self-control and time management to avoid getting overwhelmed; they also exercise and try to be less serious all the time. Two people mentioned praying, but the majority do not reference religion in any way. This could be that in public settings, one is taught to avoid topics such as politics and religion. However, given the sensitivity and openness about discussing mental health for both parties, it could also be that most of those interviewed are not religious and do not resort to prayer for comfort.

The second most accessed resource is friends. Most Vietnamese wanted to talk to a friend who is going through the same things them, which leaves out their family, friends outside of school, and therapist. The reason Vietnamese don't access their parents could be that since their parents expect them to be independent, returning to their parents for advice presents two problems. The first is that their parents can't understand what they're going through and therefore be unable to help. The second would be that students see it as a sign of shame (*xấu hổ*) because they were not able to take care of their issues themselves.

The third resource would be therapy for Vietnamese. They recommend it for others, although not directly for themselves. They said that therapists didn't know them and their personality, and it was better talking to someone who could relate to them, rather than just help them solve their problems. They tend to consider family important but distant and unable to relate to them on this topic, and therefore unable to help them. Even if they don't access therapy, they mentioned it and talked about it with less negativity than about family; the generation before them appears to be inaccessible for discussion.

For non-Vietnamese, family came third and therapy came last on the list. It was important for non-Vietnamese to talk to someone they can trust, to hold them accountable to be open about how they feel and to have a good support group. While they didn't have ongoing discussions, their parents and siblings were able to share stories of their own struggles. For Vietnamese no mention of talking about this topic with siblings came up.

What is stigma's role?

Stigma still plays a role, but it is not entirely the stigmatization of mental illness but rather the cultural values of resilience and independence. For **resilience** (*chiệu đựng* or being able to handle pressure), it is taught that you must be strong and work hard. This work ethic is part of the immigrant philosophy, and it is not just part of Vietnamese Americans but for all the first-generation Americans.

However, **independence (***tự lập*) is a trait that is learned for Vietnamese children. Their parents couldn't help them in schoolwork, and so had to learn everything on their own. Their parents simply didn't have time for them growing up, and so participants had to figure out how to live in American society, navigate higher education and financial aid, and

networking amongst their peers. It seemed as if their parents provided housing, food, clothing and some financial support, but not emotional support. It could be parents wanting the best of both worlds, want children to be independent but also desiring the traditional level of obedience. These two traits were interwoven in the interviews, and it came up in every conversation with the Vietnamese group.

Only Vietnamese talked about their current views on mental illness in a negative way. They said that therapy is for "crazy" people, and they of course weren't crazy. Even so, they both said therapy is still an option for them only if they have academic problems, not if they had mental health problems. Another participant made a joke about "not being in the psychological books" and is "sane".

A participant who was hospitalized stated that when they were in the intensive care unit for suicidal thoughts, they were still able to walk to the canteen and back. They referred to the psychotic wing as "the crazier unit", since they couldn't leave and had to be under highly supervised care. This was how they stigmatized mental illness in the past.

It could also be that the interviews were formal and not the appropriate place to make jokes about mental illness. Words like crazy or insane were used only to demonstrate what the participants felt other people in society think about mental illness. Since the participants were mostly in graduate school studied the physical sciences, they are educated in the behavioral and biological aspects of mental illness and do not use those terms.

Culturally Salient Themes

Causes

We now understand that mental health is a combination of environmental and genetic factors. Environment can have a greater effect than genetics and v.v., which is not to include individual predisposition and physical health. The popular phrase is that genetics is the template and the environment that one is born into shapes health, personality, and such.

One of the Vietnamese participants has bipolar disorder (F2). They are in pharmacy school and says that for some disease states such as mental health disorders, "sometimes you can quote unquote can be born with it because you already have a genetic deficiency for it", and environmental triggers can cause a hormonal imbalance and lead to "onset for other things you've never had experienced before" (4). They are implying that some disorders are inherent while others are "learned" from the environment.

When asked about the dynamics of environment and biology on mental health participants answered that it was both. Participant F9 said that in order to get your mental health under control, "you need to meet it halfway", meaning that although it can be genetic, it also requires initiative to take care of yourself (14). More than half of participants said that one of the biggest environmental triggers is "transition periods". "Going to a new place on your own…obviously that's scary and that's new" (F9:12).

J5 said that the first time they felt overwhelmed was "in pharmacy school"; it was the first time they were away from family. During this period of moving between home and school, they also went through a breakup (3). Another student explains that "every transition period is rough on me… I don't know why, it just triggers my anxiety", such as going from 8^{th} to 9^{th} grade, high school to college, and college to graduate school (J8:2).

Other factors discussed were related to commitment to family and school. Since the researcher used her personal network to find participants, most students were from one

graduate program in UH. It is a time-consuming program which requires a lot of organizational participation in addition to the high workload expected of students. It is an intense program, (J5), which in turn causes a lot of conflict with family.

Families don't understand the time commitments which J5 explains 'People not understanding in this kind of vigorous program, I don't have as much time" and therefore cannot attend events and hang out at home. E1 specifies that family "sometimes…just don't approve the participation of me in organization(s)… can you just study and that's enough?" (5). It is not the obligation to perform duties at home, but more of an obligation for spending time with family in a leisurely sense.

Someone else said that there are the chemical imbalances in my brain, while others used the words hormonal imbalance, signaling that there's a genetic and biological effect that lays foundation for the person's health. However, most of the answers to "what causes you stress" were environmental factors, namely family duties, school commitments, and transition periods.

Culture and Family

One of the main causes of stress for both groups came from family. 6 out of 10 Vietnamese lived at home and 4 out of 6 non-Vietnamese did. Those who lived at home talked about some version of the family unit, with one or two parents and siblings. None talked about living with grandparents, so the family unit most likely consists of parents and brothers and sisters. Even though culture and family are intertwined, it helpful in separating them at the beginning of analysis because personal family dynamics could sometimes be quite different than when participants mentioned "culture" in a larger sense, whether it is

Vietnamese or Hispanic culture, or American culture when comparing them against their family behavior and values.

Tamara talked about how the ethic of hard work, “I guess an Asian trait”, made her feel like she always had to be doing something. When she was feeling sad or anxious, she didn’t know the words to express how she was feeling to her mom. It was especially hard since she felt obligated to help her mom with her daily activities, like shopping and running errands with her, which cut down the time she had in a day to study. Duty was taught when she was young, and it became a natural habit even though she doesn’t have much time now.

Her mother sometimes forgets how packed her schedule is for school. Since her mom doesn’t drive and instead takes the bus, Tamara feels obligated to take her mother where she needs to go if she has free time. Her mother sometimes asks to go to three or four different places during a trip, which frustrates her sometimes. “I could’ve been home by now, I could have done this lecture already. And then I feel bad. " It's hard when she has a lot of time-consuming activities at school, in addition to helping her mom out when she can.

Vietnamese

When specifically asked, Vietnamese culture is more different compared to American culture than other cultures here in the US. Namely, it is East Asians who tend to have a higher degree of strictness in terms of parenting (F9-9). All 10 of the Vietnamese participants stated multiple times that they do not talk to their parents about mental health, for various reasons related to culture.

One reason for the disconnect is that their parents came here and were also transitioning. It was “Vietnamese culture”; our parents “went through their own struggles

too", such as "going to a new country and learning the language and everything" (J9-6). They worked and came home, to provide for their children, and sometimes had to take care of themselves with no help. Their "parents had to fight for themselves" and do not fully understand or have time to talk to their children about much more than necessities. It is a duty to their parents to take care of themselves.

Conflicts tend to relate to parental expectations. Because of the generational barriers, the first generation here (the parents) were for the most part unable to go to school and have a fuller knowledge and background of the sciences on topics such as stress and the body. In addition, they retain some key cultural traits that influence how they behave towards their children and want their children to behave as well.

Even the vocabulary might be hard to translate. When Tamara was asked if she talks to her mom about mental health, she says, "No, I don't know how to talk to her about it. I don't know the words for it. I tell her I'm stressed, and I can't even explain that…" She had to explain how she felt to her dad and he was able to relay it to her mom. Her mother now understands for the most part and tries to ease back on asking her to take her places.

The first trait is being "**closed off**", mentioned by 9 participants. F9 states that "some families might consider it frivolous to talk about mental health" or even "sharing about your life" (5). Parents don't openly discuss their feelings, and emotional wellness is simply "not touched upon" (F9-4). F2 specifically states that "I feel like within the Asian community you don't hear about people like, going, and like, we've been dealing with that for so long" (6). Even her Hispanic friends can still talk to their parents and even if they aren't Americanized: "they still are very understanding and like they would do anything for their kid or whatever. Like I mean my parents like moved to Vietnam, like they did that for me, but it seems like

that's all they did" (3). It's an issue Vietnamese Americans have dealt with on their own, and mental health tends to be avoided outside the family unit as well. Back in the "old country", parents were the providers and siblings took care of themselves. Parents were to be respected and not approached for comfort.

F3 says that when he sees his mom, mental health isn't discussed because he doesn't see her often and so that time is spent talking about "festive" stuff instead (8). E8's parents are "very emotionally distant, so they don't think that anything may or could be wrong in maybe me or like my siblings' problems" (7). Even if families do talk about everyday life, the topic of mental health is avoided. J9 said that in a medical class "they said Asians in general just don't talk about their mental health" (18).

It could also be parents do not have the educational background in the sciences specifically, so it is hard to talk about mental health when parents lack the understanding of concepts and vocabulary to talk to their children. J6 is a mental health professional, and they notice the distinction between themselves and their parents. Their parents have no reason to tell their business to others, so the fact they can't talk about it is because they can't conceptualize it (J6-6). "Back in Vietnam people just, everyone was struggling to survive", so they have no similar experience as those who grew up here with a different understanding of stress and how it can influence physical health.

"They know it's there, they just don't know what to do with it… because she doesn't understand …it's not because she's dumb or anything, it's just she's just wasn't given all the knowledge for her to understand what diabetes is" (6), which was the example E3 gave when talking about biological mechanisms. If their mom couldn't understand how diabetes works, it would be harder for her to understand bipolar disorder, which they have. Vietnamese

students spoke of "science" almost as a different language, with its own belief system on how the world works, and it only gets specialized the greater one continues with school. Most of the students interviewed were graduate level (11/16) and are in a program of specialized medicine on campus. Simply learning the vocabulary as fluent English speakers can be overwhelming at times. It is a bigger barrier to communication when there are two different cultures and languages spoken.

The second trait related to culture is "**resilience**" (chiệu đựng), with 6 people talking about this. E1 says that parents and family taught them to be strong, and capable. E3 says that they had to learn everything on their own, and that if they could do it, E3 can too. J9 mirrors this: "So they probably felt like, if they could go through that, I could go through something like this, I'll be fine" (6). E3 says that their parents taught them resilience. "And it applies to everything we do, even our emotions with our disease states" (5). Parents are expecting their children to be able to do well, since they themselves survived such things as war, famine, and culture shock.

The third trait is "**pressure**", or "strictness" which 5 people mentioned. Parents want children to do well academically. F9's parents did not like it when they wanted to not pursue a science degree: "I don't think I've talked to them specifically about mental health…I've talked to them about things like not pursuing a career in the sciences and that was, that was also, so I feel like that was a very comparable situation" in terms of being poorly received (5). "It doesn't matter if you're 18 or not" (E3-1), parents continue to lecture, telling children to "do this, or do that" (E1-3). These traits listed above show how beliefs are passed on.

Duty to parents is so congruent with reality Vietnamese don't recognize that their relationship to their parents can be different than anyone else's, and the pressure to succeed

becomes second nature as well. When asked why she thinks people don't get help, Tamara replied, "Usually people struggle, and they don't reach out academically because no one wants to be like, 'Hey I'm failing'… you're failing, you're stupid is what it's tied to. But it doesn't necessarily mean you're stupid". She tells her classmates that help is always extended outside the classroom too, in case they need help.

Non-Vietnamese

It is instructive to see how a diverse pool of participants compares to Vietnamese participants for salient topics such as life experience and thoughts on mental health. This section will briefly cover culture's influence on mental health and then family values and behavior regarding the same topic.

NV directly discuss parents' high expectations for success, and often use comparison to pressure their children to do well. F1 states that while their mom is easy-going, their dad is the strict one who is hard on them, expecting from a young age A's instead of B's. E2 and J8 have parents who wanted them to do well in school and be present for family activities and responsibilities. These include playing piano and micromanaging school study schedules and taking care of family who recently came to the US. For J4, their mother compares them to successful older siblings who took finished school on time, and the tendency to compare has been passed down to the participant.

J8's mom actually was the one who noticed their hallucinations and wanted them to go to see a therapist and psychiatrist. Their mom would also check in often with them during transitional periods because she knew that J8 had issues during these times. J8 describes their mom as "more liberal compared to most Asian parents" and that she's "not traditional" (2),

implying that most Asian parents are not very open to therapy and discussing mental health issues. This is true for most of the participants, so J8's parent is a rare exception in understanding and welcoming of therapy.

Even with J5's parents' science background and career in medicine, the participant stated that "with Indians, I don't think it's necessarily acknowledged as a thing you should go get help for" (4). It is resolved at home or alone. F7 also mentioned that when they were institutionalized after their suicide attempt, their mom was afraid that people would "talk bad" about them. So, while sometimes therapy has evolved over time into something acceptable for some students and parents, parents don't quite understand the language of science. This was addressed in the Vietnamese as lack of "conceptual" understanding (J6), of the process of mental illness on the body, such as the receptors (E3).

4 out of the 6 NV talked about their family's ongoing struggles with mental health and behaviors. E2 inherited their parents' stubbornness, while F7 feels like maybe their compulsive counting was inherited since their mother has been doing the same since their childhood. F7's father also had depression before he moved to the States and their sister had a suicide attempt when she was younger, in addition to occasional panic attacks. J4's family had a traumatic experience in childhood, and many of their aunts and uncles developed substance abuse as they grew up. E1 said they had a "dysfunctional childhood". Mental illness is briefly mentioned and not discussed at length for NV.

At the beginning of their symptoms, this group said their parents spoke of mental illness as "non-existent", with F7's parents calling it a "phase", a period of intense sadness and confusion everyone goes through at some point in their lives. Others had no idea what to do when their daughter "sleeps all day", "why doesn't she get up and do something?" (F1).

Suicide attempts and crying spells were also kept away from their family until they had to say something. Reasons given were that they didn't want to worry their parents and that they simply wouldn't understand the severity of it; parents either think their children are lazy or that their symptoms weren't as bad as they thought.

Two participants' parents made them go to therapy. For those who also had developed symptoms such as depression, anxiety, or panic attacks, their parents now encourage them to go and are open about it. The sole person whose parents do not acknowledge mental illness such as depression or anxiety does encourage that person to go to try it, but still believes that depression is ultimately a "disease of luxury" that only spoiled children in wealthy countries experience.

For the rest, their parents know about the symptoms, although they don't quite understand. They encourage their children to visit specialists, like therapists and psychiatrists. They would sometimes ask the participant for advice, feeling like the participant, because of their experience, is now approachable.

Keyword: Parents/Generation

Table 1. Parent/Generation

Phrases Used	**Total**	**V**	**NV**	**M**
"don't talk about mental illness"	8	7	1	2
"can't relate"/"don't understand"	9	7	2	3
"didn't want them to know"	10	4	6	1
"emotionally distant"	4	4	0	0
cultural barriers/different culture	15	12	3	1

"conflict"	2	2	0	0
Total	48	36	12	7

These words are important when they are used frequently. They contain ideas about culture, like Quinn's study on financial metaphors when people discuss marriages (2009). While she says metaphors aren't the best at explaining the complexities of culture it can help us partially understand how people view mental health, whether in a negative or positive light. It can also help audiences to relate to the individuals more when they come across a commonly understood metaphor.

As stated before, parents are not always seen in a positive light when talking about mental health. Even though their parents care for them, they just don't know how to go about it. Most of the participants say their parents can't relate to them because of cultural barriers. These barriers mentioned include language, stressors from work and school responsibilities, outside stressors, socializing and networking, and expectations of self and society.

Parents are "distant", often in "conflict", and have a "barrier" between them and their children. Out of 15 mentions for the "barrier/different culture" category, 6 said there was a dead space between them and their parents; one person called it a "wall", and what they have with their parents is an "emotional scar, burden, border… I don't know what to call it" (J1-2), and that "because of that rough pass it's hard for both of us to get back on track" (4) and resolve the childhood trauma. This relates to Vietnamese parents being "closed off" from their children. There are conversational bridges that are hard to cross, so their children avoid even bringing it up.

Stigma

According to Stevie, stigma is the wrong word to use. “Prejudice is a better word; stigma is evil, prejudice is less negative connotation, not understanding” (16). Participants feel like they still must hide their symptoms, sometimes out of fear of being judged, but also because they feel like people won’t understand them. F7 continues by saying that “people are embarrassed, not so much others are mocking them (2:15). It’s partly self-stigma in addition to thinking that people around them won’t be able to help or understand.

Table 2. Reasons for not Seeking Help

Reasons/Excuses	**Frequency**	**Vietnamese**	**NV**
Shame/Hide	13	7	6
Ignorant/ don’t know what to do	6	6	0
It means you're weak	9	6	3
Resilience	16	8	8
Other solutions first	8	5	3
Denial	8	6	3
Find good service	7	4	3
Not as bad	8	3	5
Total	76	45	31

Stigma exists for participants, but in general both groups stated that they just didn't want to be vulnerable with a stranger and would rather tell people close to them. The stigma came from believing people will think they're weak and vulnerable. Also, being resilient and strong is a trait found in both groups; although Vietnamese had a cultural explanation for it, the NV group also had similar beliefs about appearing tough and the need to push through. It could be that all participants have at least one parent not born in the US and are considered first-generation immigrants, and resilience in America is a shared cultural value for success.

Vietnamese

Vietnamese believe that their parents won't understand them, so they don't even bring it up: "How do you bring up mental health, and talk about something so heavy (laughs)? (J9-17). E8 says that "my parents are very emotionally distant. They don't think anything may or could be wrong in my siblings" (7). When Derrick was still living with his parents, they found marijuana in his room. When they asked him why he replied, "I had mentioned something along the lines of I feel sad and that didn't make the conversation any better".

Even though he knows his parents love him, they don't understand what school is like here now and it is hard to communicate how he is feeling. Participants felt it was better just to keep it to themselves and solve their issues on their own. There is too much to explain and it seems like there is not enough patience nor time to elaborate, not to mention culturally alien subjects like relationships, the importance of extracurricular activity, and finding one's passion outside of school.

Other reasons they hide it is because they are ashamed of losing control, being vulnerable and weak. E3 says it's not so much karma "but there's definitely a shame (*xấu hổ*) component that's attached to it" (5) when talking about needing help. People would tell you, "What's wrong with you? Why do you need to be on these drugs? Why do you need to see a therapist?" (5) and not understanding what the treatments are for. The shame lies in "**propriety**" or *bình tỉnh,* a cultural value also mentioned in Gustafsson's work on spirit possession in Vietnamese. It is a moral failure for Vietnamese because it is essentially a disturbance of the family network and a failure of the family to take care of their member.

E8 told the researcher that "Asians are more liberal here than other Asian countries…here you're taught to express yourself, how else can you get what you want if you don't speak up and say anything?" (7). E8 is implying that Americans tend to talk about how they're feeling in general, that way they can be truthful to others around them and get what they want out of relationships and work, among other fields, while Asian and Vietnamese Americans tend to keep their heads down and do not outwardly express their feelings.

This also connects to phrase that "it's not that bad". E3 says that there's "this idea that that's never going to happen to me, so you distance yourself from it. You don't realize the severity… but in general you don't want people to know about it" (E3-9). In part it is denial and thinking oneself as invincible. Regarding himself, Derrick said that maybe he's a good liar. "I don't want to go to CAPS because maybe I feel like it's not that bad and I just want to pretend like I'm normal or something".

J6 says some of their patients deny it until they are discharged from the hospital. J9 only received treatment involuntarily. They told themselves, "Ehh, I'm fine but I got to that

point" (1). For some it wasn't just cultural stigma towards seeking help, but an unawareness of symptoms and their severity until they couldn't function.

Non-Vietnamese

NV talked about how things aren't as bad as one thinks. Some common explanations are, "it's just a phase", and "I don't have those symptoms anymore". It's just a part of life and something that you go through (J4). In general, they deny any problems and believe that they should handle things on your own first.

When asked about where they drew the line between self-help and going to counseling, people could not give a clear explanation. As someone who was in the same situation, F7 said that "people think they can handle it on their own. You do not handle asthma on your own" (18). Participants who have experience with mental illness and/or counseling likened panic attacks to asthma attacks. They say that people and medical education are starting to take mental illnesses seriously as much as physical illnesses. Hopefully in the future people will go to counseling like they would for a physical exam.

No one wants to be vulnerable. "They know the number (for campus counseling) now, they're just scared to go… and admitting that there's something wrong. No one wants to be sick" (F-7: 2:13). This group also mentioned that gossip makes talking about mental health hard. Stevie was accused of looking for attention and making a big scene when they were talking about their story of mental health in public.

Most of the people in this group have gone to therapy and have positive things to say. Some reasons mentioned for initially avoiding counseling is difficulty finding a therapist who understands their culture and figuring out medication. It is hard to find a therapist, and

participants indicated that finding someone from the same cultural background would be very helpful to people. Cultural congruency again must also be tempered, since not all people from the same culture share the same values.

Misconception

The way some Vietnamese talked about mental health is interesting. There is still a line between different mental states. Even though one participant had a mental breakdown and only wanted to hurt themselves, they still had to be cuffed and taken by police officers for their and the public's safety. The division between physical harm and mental disorder still exists. Someone else said people told them that people with bipolarism are violent, "but most people don't do that…but that's the image that people have".

It's not just being violent, but unstable. People who have experienced or work with mental health patients shared about misunderstandings they've seen. "They think I'll flip a switch and start yelling at them, then **flip a switch** and be super happy… that freaks people out honestly, but that's the perception they already have of mental illness". Someone else said that when people come to their facility to seek treatment, they think everyone goes there and receives treatment where it's like a "**looney bin** where you like strap them up; that's what they expect". Patients don't think chemical dependency is something that needs treating, even though most people use chemicals to mask behavior or psychological distress (Maté 2010). People don't understand the variety of ways mental illness can manifest, nor the actual similarities and differences between them.

"It's either you're completely crazy or you're suicidal its either, at least that's what they always think; I'm not bouncing off the wall… but if it happens to you, it can happen to

us too". Only **crazy or suicidal** people need help, meaning since they can still function and perform daily activities, it means they're well and don't need counseling services.

People tend to combine symptoms of all mental illnesses and aren't at all familiar with the physiological processes for any of them. For example, J4 thought that thought that depression can lead to schizophrenia. While there is overlap, it's usually the diagnosis and symptoms of schizophrenia that causes depression from personal stigma, side effects of medication, and overlap of symptoms, not the other way around (Conus, et. al:2010). E1 had a friend in high school who was diagnosed with depression. They were unaware of it because their friend was usually happy and cheerful, meaning that their friend did not behave like a depressed person should have.

TV also plays a role in misrepresenting episodes. One person gave the example of seizures. People "don't know any other view other than the one. For seizures, not all of them are convulsing on the floor. but that's what everyone assumes a seizure is" (E3-6). Mental disorders are usually portrayed in only one way and for many people that's their sole encounter with it: "it is possible some people can [mistake] schizo (schizophrenia) as depression because sometimes that does happen. It's a part of it. But, um, I can kind of see how people could [mistake] everything as one thing. Um, because of how like TV and whatnot has it" (J6-7).

To sum, "at least I'm not bipolar". Even though there's more awareness, there still "more empathy towards… I feel like towards depression and anxiety versus like someone who [is] considered like psychotic or they're crazy. They can take care of their own kind of thing" (F7-17). There is the false association of all mental illnesses with violent behaviors, which is not true. Since people also confuse counseling and institutionalization, and only

crazy people need those types of service, people tend to avoid counseling because they are afraid people will think they're crazy or unstable.

Mental illness is still considered a burden for people. Even for someone who cares for you, like Derrick did with his girlfriend, it can be a daunting task. She described her disassociation when she's driving, and it really scared him. "I don't know what to do when she tells me she's done it (cutting herself) besides just to stop". He can't imagine how people feel when they're in that situation. It is an extra weight to worry about someone else, if they'll act out or behave violently. Mental health education will have to continue to address these misrepresentations.

Mental Illness

Table 3. Description of Mental Illness

Mental Illness	**Frequency**	**Vietnamese**	**NV**
Diagnosis	6	3	3
Stigma	4	3	1
School Contributions	8	5	3
Obligation to Parents	15	9	6
Work	1	3	1
Loss of Emotional Control	24	18	7
Isolated Self	10	8	2
Didn't Realize It Was Happening	11	8	3

To be accurate, unless stated directly to the researcher that the participant has been diagnosed and described the treatment process, the researcher does not assume an illness. Out of 16 students, 3 NV out of 6 have been diagnosed and receive treatment, receive medication, or had therapy; one does not receive treatment anymore, while 3 out of 10 V students have formally been diagnosed and receive treatment, medication and/or therapy.

This section can read like the explanation section, which is understandable given that social factors are the main reason mentioned as stress-inducing. However, this section will discuss official diagnoses and what led up to the manifestation of symptoms. While the stressors remained the same (school, work, family and friends), the way both groups realized they weren't doing okay are different.

The behaviors for both populations were generally the same, although the V population talked about physical manifestations of stress less, even though there were more than twice as many Vietnamese as Non-Vietnamese. Also, the NV group only mentioned withdrawing from others twice, while there were eleven mentions by the V group of self-imposed isolation.

The NV group made more mentions of physiological symptoms, such as heart racing and anxiousness. In general, psychological symptoms were more predominant for both, while physical symptoms accounted for much less in the V group than the NV group. It could be related to how Vietnamese conceptualize emotions, as something to be controlled. Since emotional control/restraint is valued, they remember when moments when they were unable to show restraint.

Table 4. Types of Behavior Mentioned

Mentions	**Frequency**	**V**	**NV**
Mental + Physical Behaviors	89	42	47
Mental Behaviors	59	29	30
Physical Behaviors	30	13	17
Despondent/blank/lose will to live	12	5	7
Uncontrolled thoughts	33	22	11
Preoccupation	7	3	4
Hyperactive behavior	20	8	12
Keep to self	13	11	2

Vietnamese

The Vietnamese group seemed to have more symptoms related to preoccupation, coming up 18 times. Seven of the mentions came from those with official diagnoses. They were unable to control the thoughts and were unable to realize that their mental health was declining before a major event happened, such as a panic attack.

In the interviews, most of the Vietnamese participants said that their parents were emotionally distant and were only the financial providers in their lives. They usually didn't discuss such "frivolous things" such as personal stress and problems. They were more likely to isolate themselves, such as physically hide, keep emotions and their problems to themselves and not sharing them with parents. This goes back to the cultural value of propriety (*bình tỉnh*) which means to keep calm, keeping a level head and not causing a disturbance. If they had to be upset, they would rather be alone.

It is hard when emotions aren't discussed in the home. J5 talks about how the lessons their parents taught them about doing things on your own affected their understanding of mental health: "I think it's kind of the culture and the way we were raised; we have to learn… and that translates into our emotional states" (5). F2 continues in the same vein when they say, "I don't have the emotional intelligence, so I don't realize it… it builds up and I get stressed and don't know what to do" (2/13).

Whether in academia, society, or with emotional awareness, it's mostly self-taught, and in general Vietnamese Americans perceive that they don't receive affection and emotional knowledge from their parents to effectively deal with uncomfortable changes in emotion. F2 could only relay part of their frustrations to their mom by explaining their situation to their dad, while others required a full emotional breakdown for their parents to offer emotional support, albeit limited (J1).

For the Vietnamese group, participants talked about states of mind, such as being sad, upset, nervous, angry, or tired. These were common terms they used to describe themselves during periods of stress. They usually did not refer to physiological symptoms. They did however used methods of distancing when it came to stress, such as "isolation", "staying in bed", "keeping to self" and "not going to parents" for help.

The few times physiological symptoms were mentioned were when they were describing anxiety attacks or sudden bursts into tears. It is interesting that even when asked about what they've gone through during stressful periods, the Vietnamese group broadly generalized their behaviors and did not talk about the physical toll of stress on the body. Again, it is possible that because emotional restraint is valued, there is greater focus on psychological symptoms (seen as a loss of restraint) rather than physical symptoms.

Non-Vietnamese

All three of those diagnosed have two or more illnesses, with depression and anxiety co-occurring. While it is likely that they were in denial that there was something unhealthy about their loss of emotional restraint, they always knew that what they were feeling was abnormal. Unlike Vietnamese students, they understood what was going on when they were experiencing the irritability, loss of feeling, and uncontrollable thoughts that characterizes their respective illnesses.

They also isolated themselves, but not as much. At the current moment they do not keep emotions inside if they can help it. The only person to mentioned keeping emotions to themselves is J8, who feels antisocial during periods of transition, such as going to a new school or starting a new semester (2). It's possible that since they've been diagnosed in the past, they are less likely to hide symptoms. They know to talk to others when it gets bad and have a close group of friends to either talk them through their situation or get their minds off the problem.

NV group discussed more physiological symptoms in depth, mainly because most of this group experienced a greater range of illnesses outside of depression and anxiety (OCD, psychosis). This group discussed reckless behavior they've done, including substance abuse and drug abuse. During periods of stress they can feel their bodies tensing up, shaking, racing of the heart, adrenaline, and more people in this group mentioned crying.

They did not keep to themselves as much as the V group, mentioning withdrawing only twice, even though this group also had symptoms of feeling despondent without the will to live, they didn't talk about separating themselves from their close ones. This might be an indication that at least for these students, they are more likely to keep others in the loop and

do not resort to isolation when they're not feeling emotionally well. They aren't always expected to keep it to themselves and handle it themselves.

Again, a possible reason for less emphasis on distancing is because more people in this group have been diagnosed with a mental illness. Four people have undergone treatment and received diagnosis, while two are on medication. It could be that the seriousness of what they've gone through means that they're more likely to have surrounding support and an understanding community of people they can rely on.

Keyword: Time

The way that people discuss time is important, and it depends on context. Time is a precious and limited resource. It can be spent doing something bad, like spending a lot of time feeling bad about yourself (F7-1, J4-18) or doing nothing (F2-5). If F2 wakes up late, she is demotivated to head to school because she started off her day with not enough time to get ready. For F7, she spent so much time being depressed before seeking help that she is making up for that poorly spent time by educating classmates on resources and improving her own mood. J-4 when discussing what her parents think about mental illness, she says that most people spend their time feeling bad about themselves instead of doing something. When she was younger, J4's mom "didn't have time to feel sorry for ourselves" (J4-5). The generation after her spend their time unwisely worrying about things that ultimately won't help them succeed.

Table 5. Time

Phrase Used	**Frequency**	**Vietnamese**	**NV**

"don't have much time"	12	8	4
"things take time"	5	3	2
"give up time"	4	3	1
"long time to get help"	5	3	2
"invasion of time"/time-consuming	6	5	1
"stressed all the time"	10	7	3
"spend time"	7	5	2
"free time" vs "school time"	7	5	2
Total	52	39	17

It can also be used in good ways, such as being productive, and doing what you want. Time is precious in that can be invaded or used unwisely and must be protected. One way it can be wasted is by talking about mental health to parents, so that if too much time is gone without changing mindsets and therefore not being productive, efforts are abandoned because it's not "worth it" anymore.

It requires dedication and careful management, since you must dedicate time to studying (J4-1). In addition, it can also be dedicated by being created. It's not the real creation of time, but the allotment of time, carved out and managed to be spent doing something productive and spent wisely.

All these terms were used when talking to college students. Time is a precious resource. The amount of time between tests, exams in school, in addition to balancing it with personal, self-interested time is limited. It's this balancing act that causes a lot of stress for the participants. They either "don't have the time" or "can't find the time" to do things. They can't fulfill parental obligations and expectations (E4-2) or spending it with friends who are

not in school or do not understand the participants' other obligations (E1-4). When they do have the time, they like to spend it wisely, engaging in a relaxing activity (E2-2).

The burden of responsibility related to family obligations found in the Vietnamese American students creates pressure and added stress on figuring out how to balance organizational and academic expectations and taking care of family by "being present" or spending quality time with them. More than half of the mentions for "time" related to not having enough time to fulfill all obligations.

Because it's a limited resource, time must be carefully managed. Depending on how well you allot the time, such as dedicating a lot of it to studying, you also need to allot some time for self-care (F1) The second most context for time is using it to "giving yourself more time", and "finding time" to care for yourself and unburden yourselves from the usual responsibilities (E2-13;E3-2), because if you burn out, what good is it going to do for you and your grades and everyone else in your lives?" (E8-6).

Therapy

Only 6 out of 16 students have gone to therapy. Outside therapy is separate from CAPS as a school service. Many students had misconceptions about the process and it's best to address it here in a special section as well. Another form of therapy mentioned is dog therapy, where schools bring dogs to campus during exam week, so students can come pet the dogs and relax.

Also, there are movies shown by CAPS related to mental health, and Let's Talk, an informal service offered by CAPS where students can come talk to a psychologist one-on-one at designated places across campus like an introduction session. Most students were not

aware of these services. Breathing and meditation as therapeutic practices are also included in this section. In the initial survey, students mentioned practicing mindfulness, meditation or yoga. Even though they identified these as health practices, they seem to consider them a more physical than spiritual activity, and do not think of them explicitly as stress-relieving.

Stevie is a mental health advocate at school and in the Houston community. She sought help at CAPS and said it was hard at first to get to a counselor back then, since service was offered on a first-come-first-serve basis. Now that she and the Student Government Association (SGA) on campus advocated for more funding for therapists and a streamlining of the counseling process, it has been much easier for students to receive services.

She is not shy about telling people she takes medications. Even though she hasn't been to see her counselor for a few years, she says she's functioning well on her medications. The goal is not to be happy, the goal is to function. She reminds her patients that those are their "functioning pills", not happy pills. She feels like the more people know about it and talk about it, the less stigma there will be about behaviors and less shame in seeking help.

Vietnamese

3 Vietnamese have gone to therapy. They heard about CAPS as a service during orientation week before school starts. "My professors always mention CAPS in class, and they say it's a great service" (J7-7). Those who have gone encourage their friends and family to go as well, as it is a great service. In general, Vietnamese know that the services are there, since those who haven't gone have suggested CAPS to friends and actively encourages them

to go. Most have tried breathing and meditation, but do not use it and don't think it's a good fit.

Non-Vietnamese

NV had more positive things to say about therapy sessions. Most of them have gone to some form of therapy and liked it. J5 says that therapy offers you a "new viewpoint" where a stranger tells you something you didn't hear before… something you didn't want to hear, or you need to", and counselors are there to give a new perspective on things people are going through (5). F1 is grateful that their counselor checks in on them if they skipped class or if they recently had a difficult therapy session. NV said that even though they might not use the breathing and meditation exercises all the time, they know that is helpful (J5-7).

Problems

Both groups faced the same problems and there wasn't a noticeable difference in the reasons given for not seeking therapy. The reasons ranged from practical to personal. All of them mentioned resistance to seeking therapy, including personally not needing it yet, or that their parents don't think it's necessary.

Practical reasons include finding a good counselor. 4 out of the 6 who have gone said that they didn't connect with the counselor they met, not always because of culture but more of the generational gap; F2 said that "she was okay. I didn't really like connect with her. Little out of touch? She seemed sweet. Yeah. Like an old generation lady" (15).

For Stevie the problem was with the dosage. About a week after she started taking her antipsychotics, she noticed the negative thoughts getting worse. She had two near-suicide

attempts, where she almost physically acted on her impulse. She considers them suicide attempts because she was so close. In her words, “I say near, it’s like, it was like, climbing up a building and standing on the ledge and thinking you’re going to, about to jump but you didn’t. So, I say near attempt, even though, it’s like an attempt”. She was hospitalized and went from CAPS to a private facility. Therapy takes some getting used to, from sharing personal details with “a stranger” to figuring out medication. It is not an overnight solution, and one reason why people might be scared to start this kind of treatment.

Another reason that participants gave for not going to therapy was that it hard to find time. Since 11 out of 16 were in graduate school, the high-volume workload really limited the time they had to locate and work with a counselor. Since CAPS is offered from 8 to 5pm from Monday to Friday, some students are unable to find a time in their busy day to dedicate to mental health support. J5 notes the irony of being in the medical field: “It’s hard to find time in your schedule but you’re telling patients in retail you need to find time” (8) and J8 says that “because school ends so late and you have to eat dinner and do your schoolwork and then go to sleep, there’s not much time for focusing on your mental health” (4).

Many participants didn’t know how to access therapy on campus, which can make starting the process daunting. When asked about “Let’s Talk” sessions or the Suicide Hotline, most didn’t know about the additional program or how it works. The only person who did is Stevie because she’s also had to use it as well as an advocate for mental health awareness. One person thought that CAPS offered a texting service. They do not, and students must call in to the Services front desk to schedule an appointment. Misconceptions about mental health services also extend to what goes on in therapy. F2 didn’t know initial screening sessions are recorded for quality and safety purposes.

Regarding therapy, more Vietnamese said that they don't need it at this point in their lives, they don't need it yet, or that it's not that serious (J1). For both groups they said it was hard to open to a stranger. "It's hard for me to listen to someone's advice that I don't know" (J7-7). E2 says that "Personally… I have a hard time (of) sharing things…with people I don't know and opening up and admitting to things that I probably admit only to myself" (11). The stigma is still there. The negative terms used for "mental illness", such as looney bin and flip a switch are still common. These were mentioned above in the Stigma section.

Other Solutions

Table 6. Solutions-Not Therapy

Solutions	**Frequency**	**Vietnamese**	**NV**
Others: Friends	34	23	14
Others: Family	7	2	4
Self	63	46	17
Therapy	14	4	7
Other resources	26	11	15

Vietnamese

Self-solutions include reflecting about things in life, changing behaviors like learning self-control or keeping track of time/balancing work, school and home. Other forms of self-care include watching TV shows and movies, putting some distance between obligations and

to others sometimes, relaxing and letting go of things out of their control, being less serious, and finding a hobby.

Others brought up the numerous organizations on campus that help with educating students about what mental health is and how to seek help from campus. In addition, F9 suggests that if people take time to learn about other cultures and other people's experiences, they will focus less on their little bubble and relax a little.

Non-Vietnamese

Students in general still prefer going to friends to relieve stress (Han et. al 2015; Hunt and Eisenberg 2010). While Vietnamese predominantly prefer accessing resources that can be done on their own first (self-reflection, stress-relieving hobbies), NV were more evenly divided between resources they used, such as therapy (since they do have the track record of going in this group) and utilizing family as a resource, although not by much. In the literature, Vietnamese are less likely to seek out family for advice or support, and this is supported by this research.

Therapy includes both medication and counselors on campus. No one has their own outside counselor that they utilize (although price wasn't mentioned much, it is $5 for a session with CAPS at a much more reasonable price). Most go to the counselor in their graduate program only in extreme cases, since they have a lot of obligations at school and work.

Mental Health

Depending on how the conversation started off, the question "When do you feel mentally healthy? What does it consist of?" posed a problem for many. It is not something that some of them are aware of. Sometimes it was answered at the beginning, but most were able to give a more detailed response at the end of the interview after time thinking about the topic. One individual said that, "I don't really think about it like that", when asked about what point they felt satisfied with their life (F3-3). They said they are generally relaxed and do not stress out as much as others. In their words, "I guess under the psychiatric book, I'm good… I'm mentally sound" (3).

For the rest, they had specific answers for what behaviors are considered mentally healthy. These include being able to function and being able to reflect on what happens throughout the day and maintaining a healthy perspective on their issues, taking a step back when needed, not overthinking, and in general being conscious in the moment and making decisions with a clear mind (E1).

Table 7. What is Mental Health?

Mental Health	**frequency**	**Vietnamese**	**NV**
statements on mental health	67	40	27
able to function/balance/clarity	23	12	9
changing behavior/thoughts	25	14	11
other people	4	3	1
other	15	11	21

When asked how they're doing now, most participants said they were doing better. If they ever need anything, they will reach out (although that remains to be seen). One participant told the researcher that even though they have anxiety attacks once a month, they feel like it is controlled and that it is not serious enough for the counselor to help them with it (F2-13). F7, the mental health advocate, stated that even one attack is too much. No one with consistent asthma attacks would think that they have it under control. Vietnamese in particular still deny the severity of their physical symptoms, but in general both groups know that physical and psychological symptoms have lasting impacts on health.

Vietnamese

While the NV group had more positive affirmations and examples of mental health, the Vietnamese group had a lot of "don't" statements, 9 of the 40 which are about avoiding certain behaviors, such as not needing medication, not letting emotions take over, and not stressing out too much.

There was also emphasis on being able to function *on your own*. Mental health means you are at peace with your problems and can go about your daily activities without being bogged down by uncontrolled thoughts and the desire to hide and stay in bed. Mental health is basic hygiene, according to J6. Also, Vietnamese were the only group to bring up being happy. NV group made no mention of the feeling of happiness, but even said that the purpose of mental health is not to be happy, to function. "I tell my patients who call it happy pills that it's not that, it's your function pills" (F7-13) and that "it's not the goal of mental health and depression… I think they just want to be functional" (16).

The Vietnamese group said that if you're happy being who you are and doing what you love and being happy that mental health is starting to be destigmatized in their age group. Happiness is a goal for most of the people in this group, unlike NV group, who believe that what most of those who have depression or anxiety is to return to some form of normal and do what they have to do.

Most Vietnamese are doing well and at a "good place". As most of the interviews were done midway through the year, schedules and exams were ramping up. The population said they were happy and have good friends to go to if anything were to go wrong. They were comfortable enough. Two stated that they don't need therapy at this moment. They emphasized if they ever need it, they will go to CAPS on campus. While some talked about having monthly panic attacks and others about sleepless nights, most Vietnamese do not conceptualize these as a problem, but as something everyone has. They continue to be resilient and do not feel the need to seek help.

Others were working on improving good habits, such as being more open with others, changing bad sleeping patterns, and quitting coffee. For Derrick, he said he brings up the conversation with the researcher when he's talking to other people about mental health and has been more open in talking about it with other friends and classmates. Instead of keeping his thoughts to himself, he tries to share what he's thinking about and reflecting on his actions and behaviors. He says it'll just take time before he is able to understand what people who experience mental illness are going through.

Non-Vietnamese

As stated before, being mentally healthy is being able to consciously make decisions in the moment and do the right thing. “Knowing right from wrong” stems from having a clear mind (J4). Being in control of thoughts, being self-aware and having a mindset were connected to activities they wanted to do more of, such as enjoying daily things, working out, and being okay and at peace and not overthinking things.

Also, not feeling shame and forgiving yourself for doing certain things or feeling a certain way was also important. It’s not that you don’t slip up from time to time, but that it is part of the learning process. For example, F7 says that their suicidal thoughts aren’t gone, but they’re quiet now. When asked to discuss stigma’s role in deterring seeking help, they said, “Umm…sorry, it’s tough to put myself back into that mindset back then to where I am now, where I see it [now], you know, just get help” (2:15).

For NV they were saying that it’s gotten better for them and they’re at a good place. They’re more open now to talking to people about it. They aren’t ashamed to seek help anymore, since they are now mostly familiar with the process and understand the purpose of counseling and have more options to choose from. It could be that the non-Vietnamese group encountered therapy more frequently and they had parents who were more open with them about mental health and therapy. Since more of them have gone through therapy, their parents are more familiar and willing to discuss such “heavy topics”, unlike the Vietnamese group. These differences require future research with parents.

Table 8. How Are You Doing Now?

Now	**Frequency**	**Vietnamese**	**NV**
Doing Better	16	11	8

Will Get Help/Reach Out if Needed	11	7	4
More to Work On	6	4	2
Other	10	3	4
Total Statements	43	25	18

Gender

There were two standout points that male students talked about, but the female didn't. All the men (3) had this to say about mental health (some variation): it's hard to imagine how depression or like anxiety feels, like I can barely imagine (J6-6). F3 says "According to the psychiatric book; I'm not crazy" and J7, the male case study, says "I'm in a realm where I keep getting explained the same thing and I just don't get it" (1).

It's hard to say whether they really felt stressed. This researcher observed that most males were relaxed and willing to talk about stressors, but it seems like they weren't always preoccupied with them. Whether or not males are generally more laid-back, less prone to overthinking, or if these males happened to be selected for this research and are more laid back than usual, is worth noting it down for further research.

J7 says "I'm always going to talk to someone about it. I'll think of different pathways first and ask someone close, present the info and ask them what I should do… I'm starting to listen to advice, finding better people who are further along (in life)" (3).

F3 often "let[s] things go as they are, you can't please everybody" (2:6). J6 doesn't let it reach that point because of his job: "Don't bottle it up because I work with people who do that; and I see what happens to them; and it's not healthy" (5). All three men don't go to therapy or consider it as an option because they have solutions such as letting things go and

resolving it right away. They don't have to talk to a friend or family about their issues, but they don't allow for it to preoccupy them throughout their day.

Women tend to seek help at a greater rate than men in the national data (Asian American) and across the board, but for these three, they seem to be well-adjusted to the stresses in life. All three are undergraduates, so this might play a role in them feeling like they don't need therapy. There is generally less stress at this level than the high volume of schoolwork and networking responsibilities at the graduate level for most of the women. All the men are Vietnamese, and even though they have the same issues with distant parental figures, they didn't talk much about resilience and propriety as something they did.

CHAPTER SIX: CONCLUSION

Concluding Analysis and Broader Significance

Questions Raised

There were a few interesting points that came up in analysis and will be useful for future research. Parents are the authority figure for participants without a lot of conversation. For many of those interviewed, there was an uneasiness with parents, where they knew parents were wise and experienced, but they couldn't really connect with parents on a deeper level when it comes to advice and honest discussions about stress and how to solve it. It was interesting that parents had high expectations for students while not really offering advice beyond general directives, like stay in school, do well, push through. Do parents feel the same way? What are some ways parents might view some topics as related to mental health, but their children do not?

Both groups mentioned not wanting to be a bother to friends and therapists, even though their function is to help people. While non-Vietnamese participants had family they could go to, Vietnamese felt like they were a burden to others and chose to take care of things themselves. Even so, both were hesitant about talking to this researcher for fear of burdening a stranger with their struggles. Could this be a more important deciding factor in avoiding going to external resources for help, rather than other cultural values such as resilience and high value placed on emotional restraint?

People could have different values than their self-identified cultural values. It's possible even though students identified as Vietnamese, or Hispanic or Indian, they are free to adapt to their American heritage as well. It is possible fear of burdening others, rather than

explicitly talking about being *independent* is an American value, shared as the culture they live in now. These are questions for more complex research on acculturation, rather than strict self-identification of culture.

Religion was also not mentioned much in the research. Students also said traditional practices and medicines were not practiced in their homes. It could seem that students are shy about this topic, or it could be that religion is not an important sphere of culture, at least in the older ways it was understood, as rituals, prayer, sites of worship and infusion of practices in daily life. The researcher believes that in part students are more spiritual than religious, rather than being devoid of religion; it has instead transformed itself into something new. Whatever it's role in culture now, this topic will require further study.

Concluding Remarks

Asian American is too broad of a term. Even though Asians as a monolith have similarities in culture, food, language, values, there are still some nuance, such as stressors and family dynamics. For Vietnamese their parents came to the US for a better life. The process of assimilation is uneven for both generations, and the idea of cultural incongruency is valid in this study.

The acculturation gap theory is upheld in this research, that there are different values held by both generations about the beliefs about the self, relating to school performance, duties related to the family (Lee et. al 2009). Even if the Vietnamese students tried to talk to their parents, they were unable to effectively communicate what they were feeling, in terms of stress, depression, anxiety, and emotional dysfunction.

Another way that the acculturation gap appeared is the dichotomy between traditional beliefs and Western beliefs. Vietnamese parents believed their children are just sad or worry too much. It is something within their control, so their children can handle it on their own with no need for outside help.

The Western diagnostic model medicalizes emotions (another debate in itself) and categorizes these behaviors as treatable symptoms and illnesses. Most parents do not think of prolonged uncontrollable thoughts and emotions as something that can be cured by talking out problems with a counselor or taking medication with it. Problems are simply pushed passed and overcome. Conceptually Western medicine is much different from traditional beliefs on emotion, stress and health.

These differences play out in help seeking, namely that students don't know how to express their symptoms in ways their parents can understand, which leads to disconnect. While Vietnamese parents might view the body and mind as one, they don't view emotion as something that can get out of hand. The mismatch in what health *is*, and how to treat it, makes it hard for students to discuss and negotiate with their parents the different ways to treat mood disorders, itself a Western medical concept.

Parents don't even talk about stress or mental illness and don't share experiences they might have. E8 said that even her parents don't talk about that anymore. F2 said that it might be like that, but now it is not about karma but more the shame of "losing face" that is still attached to mental illness. Vietnamese students in this generation, or at least in this research, do not talk about old conceptions of mental illness as a mark of shame and bad karma from past wrongdoings as Nguyen and Anderson say (2005). They also do not talk about seeking

spiritual leaders or seek shamans. Only two NV mentioned prayer as a personal source of comfort rather than a ritualized external experience.

Participants would rather go to their social network, namely their friends in the same class or age range, since they are the most relatable. After friends come family; for the Vietnamese group, they would rather go seek counseling than consult with their parents, since it is harder to convey their concepts and because their parents cannot relate to what they are going through. For some, their parents might be supportive but wouldn't know how to help them and bringing their problems to their parents' attention would make them worry and do more harm than good.

Also, language proficiency or being bilingual does not affect openness with parents. Out of the 10 who are fluent in their native language and speak predominantly in Vietnamese with their parents, only 3 talk to their parents about mental health and illness sometimes or when needed. Parents do not understand the terms or how academia and American society functions; they cannot fathom how time-consuming school is, or how thoughts can become so uncontrolled. In a way, the participants said such behaviors have just been normalized in their parents' generation, so they are not aware that it is a problem.

Mostly, Vietnamese internalize their stressors as their fault, a lack of emotional control and failure. While this research cannot say whether mental illness is underdiagnosed, it very much underutilized in this study population. In addition, this research mirrors Nguyen and Anderson's conclusions that there is not enough evidence that acculturation leads to a greater willingness to use services.

The complex factors that affect help seeking are not just cultural values of resilience but also inability in recognizing the severity of stress. For Vietnamese participants there was

a contradiction in their behavior. On one hand parents expect resilience and independence when it comes to school. Yet for students, they learned how to navigate American society on their own, as their parents were ignorant of things such as socialization and behavioral norms. Learning emotional discipline never went beyond parents' directives.

This is one of the conflicts that result from uenven acculturation between generations of "new" immigrants. Children are expected to be obedient yet also take care of themselves and make their own decisions, which can differ from what their parents expect them to behave. More multidimensional research is needed on acculturation (2005).

People were ignorant overall of the real process and additional resources at hand for little to no cost. Only one person was aware of the informal "Let's Talk" session hosted by CAPS every day of the business week. But even so, according to WHO it is wise to let people choose how they want to access help. "appropriate to give people agency with resources available", because resistance to treatment won't help the problem go away if there's no initiative on the part of the recipient.

Therefore, Hunt and Eisenberg (2010) and Chu and Sue's (2011) theory of limited awareness of resources and stigma holds true for this study. This research delves into more detail about what stigma consists of, which are *resilience* where seeking help would make students feel vulnerable, and stigma as being more along the lines of *ignorance*, the belief that counseling and therapy are only for severe mental illnesses.

Broader Implications

In sum, culture is a fluid colletion of ideas, beliefs, practices that are followed selectively by people. It is also unevenly followed and transferred by those in different

generations, especially when placed in an even more socially complex and culturally diverse place such as Houston. It would be unfair to say a value is simply Vietnamese or American. It would be more accurate to say a "value-as-what", meaning what behaviors are included in this value, and what is expected of people who adhere to this value. For example, resilience for Vietnamese participants is not just tolerating stress, but also pushing through and having control over one's emotions. Resilience is partly dignified silence as well.

Acculturation is too complex to be nailed down to a few cultural values. Individuals also have preference, and like those in this study, practical reasons also limit them from seeking help such as time constraints on activities to personal finances as well. Also, education is its own culture, and Science has its own rules, values and behaviors. What is its roles in creating values and how does it dominate conversations on health and beliefs of how the world works? Science is not a distant amoral construction but one that is shaped by people in privileged places. Parents of students who couldn't have a formal education in the United States are left out of the conversation. It is possible that solutions will include educating parents so they can also understand the ways stress works and their role in their children's lives, and what they can do to help.

Future Directions

While this work is a solid contribution to existing research, there is more to be done. Having counselors on campus with similar backgrounds or those who understand cultural values and expectations for Vietnamese American students can help. Participants said they wanted direct and specific instructions, not just someone to listen to them. Therapists discuss emotional states rather than giving them practical advice. It could be that the purpose and

goals are not addressed at the beginning of therapy sessions, and the practice to asking students what they want from therapy can be added to sessions early on.

Only two Vietnamese participants made distinctions between mental illnesses. When asked what the difference between the term for depression "*trầm cảm*", you can stay at home, but "*tâm thần*", the catch all term for mental illness, means you require hospitalization; at this point you have "extreme behavior" (E1:7) Another who was talking about their bipolar disorder said that people stereotype it as violent and overall extreme behavior, unable to control oneself. The distinctions between mental illness that second-generation Vietnamese Americans make, and if this is something that exists cross-culturally, would be a fruitful topic to explore in future research.

Students said their parents do not know what is required of them at school and work, and do not bring up mental health and illness. It could be that parents don't know the Vietnamese diagnostic terms either, or that they don't believe it exists. It would be helpful to interview multiple generations to see how values and knowledge change over time. Also, Hong et. al.'s work with Asian Americans and acculturation (2011) says that the second generation might need different styles of counseling, such as finding time to divide between their values, American values, and Asian values (2011:355). Talking to parents and even grandparents can help verify cultural values and views on mental health. In any case, interventions can include parents and understanding generational differences can help with being more inclusive of parents who continue to play a financial and personal role for the students.

In addition, theories for Vietnamese mental health conception discussed "karma", or the intergenerational transmission of "bad luck" which can manifest as health or personal

problems, seem absent in this population. When it was forced into conversation it was quickly shot down as it is something that people do not believe anymore. Therefore, it can also be useful to interview multiple generations of the same family to see if this belief is eliminated completely in the 1st generation or in the more Americanized Vietnamese Americans, and if it affects the parents' conceptualization of mental health as a perceived failure on *their* part.

APPENDIX

Interview and Survey Questions

Open-Ended Interview

What does mental health mean to you? When do you feel mentally healthy?

If you were to talk to your parents or close adults about stresses that have developed in your life, how do they typically respond?

When you are under distress, how likely would you consider going to the CAPS resource center on campus?

What other mental health services do you know are provided on campus?

Survey Questions

1. What is your GPA range?
- 0-1.99
- 2.0-2.99
- 3.0-3.75
- 3.75-4.0

2. What is the main language spoken in your family/at home?

3. What is the length of time you have lived in the US?

- I was born in the US
- 0-5 years
- 5-10 years
- 10+ years
- Don't know/Prefer not to answer

4. Do you know anyone who is suffering or has suffered from depression and/or anxiety?

- Yes
- No
- Don't know/Prefer not to answer

5. Do you know anyone who has sought out behavioral therapy for depression and/or anxiety?

- Yes
- No
- Don't know/Prefer not to answer

6. Do you know anyone who is currently or has been on medication for depression and/or anxiety?

- Yes
- No
- Don't know/Prefer not to answer

7. What routines do you practice for self-care and health, including exercise?

- Tai chi
- Cardio fitness
- Yoga
- Pilates
- Weight-lifting
- Mindfulness
- Meditation
- Other :_____

8. What is your age range?

- 18-21
- 22-25
- 26-31

9. What is your preferred gender?

- Female
- Male
- Transgender Female
- Transgender male
- Gender fluid
- Agender
- Prefer not to say
- Other: _____

10. What types of insurance coverage do you currently have?

- Optical
- Dental
- Primary Care
- Other : _____
- Don't know/Prefer not to answer

11. What is your current employment status?

- Full-time student
- Employed part-time
- Employed full-time
- Not employed but seeking

12. What is your academic classification?

- Freshman
- Sophomore
- Junior
- Senior
- Post-baccalaureate
- Graduate

13. If you are a student at UH, what college would your major fall under?

- Gerald D. Hines College of Architecture and Design
- Kathrine G. McGovern College of the Arts
- C.T. Bauer College of Business
- College of Education
- Cullen College of Engineering
- Honors College
- Conrad N. Hilton College of Hotel and Restaurant Management
- UH Law Center
- College of Liberal Arts & Social Sciences
- College of Natural Sciences & Mathematics
- College of Nursing
- College of Optometry
- College of Pharmacy
- Graduate College of Social Work

- College of Technology
- Graduate School
- Hobby School of Public Affairs
- None of the above/Not a student at UH

14. If you are not a student at UH, what is your major? Please answer below.

15. What is your religious affiliation?

- Agnostic
- Atheism
- Christianity
- Catholicism
- Buddhism
- Islam
- Judaism
- Spiritual, not Religious
- Other: _____

16. What is your relationship status?

- Single
- In a Relationship
- Married
- Divorced
- Widowed Separated
- Other: _____
- Prefer not to answer

17. If you have any questions, suggestions or concerns, please discuss them below:

18. If you would be willing to participate in the longer interview, please enter your email below. You will be part of the discussion on mental health in the Vietnamese American community and open the conversation to those at your campuses. In addition, you will get a chance to participate in a raffle for a $30 Starbucks gift card. Thank you for your participation!

Email:

UNIVERSITY of HOUSTON
A CARNEGIE-DESIGNATED TIER ONE PUBLIC RESEARCH UNIVERSITY

Consent to Take Part in a Human Research Study

Title of research study: **Mental Health Perceptions and Help Seeking in Vietnamese Americans College Students**

Investigator: Tieu-Nha Nguyen as part of thesis conducted under the supervision of Dr. Anjali Kanojia

Why am I being invited to take part in a research study?

We invite you to take part in a research study because of your potential contributions to understanding mental health perceptions in the Vietnamese American adult student population and potentially connecting mental health resources to this historically underserved group.

What should I know about a research study?

- Someone will explain this research study to you.
- Whether or not you take part is up to you.
- You can choose not to take part.
- You can agree to take part and later change your mind.
- Your decision will not be held against you.
- You can ask all the questions you want before you decide and can ask questions at any time during the study.

Why is this research being done?

The purpose of this study is to understand how Vietnamese American college students understand mental health, and how it affects help-seeking strategies. The investigator seeks to establish (if any) the relationship between culture, mental health, and whether stigma plays a part in the underusage of mental health services found on campuses in the greater Houston area.

How long will the research last?

We expect that you will be in this research study for no more than an hour, unless subject will be willing to continue discussion in other less formal settings. The initial study will consist of an anonymous online survey where participants can choose to have a short, 30-minute open-ended interview consisting of interview questions, but length will ultimately depend on the interaction between PI and the subject.

If the subject so chooses to extend the conversation into informal meetings, those occasions will be decided and documented between PI and subject(s), which can consist of informal discussions, roundtable with friends and colleagues, participant observation at study sessions, all with documented formal consent from all parties present.

How many people will be studied?

We expect to enroll about 50 people in this research study.

What happens if I say yes, I want to be in this research?

There will be one official meeting between PI and subject, date mutually agreed by both parties.

A demographic, general survey will be sent online before the meeting and are anonymous, unless the subject chooses to discuss the results at the meeting. Attached to the end of interview questions of the survey will be a contact form, so that if the subject wishes to be a part of the in-person interview, they will be able to get in touch with and schedule next meeting with the PI.

The official in-person interview will consist of longer and open-ended questions concerning the topic of mental health and stigma.

The research will take place in 252A in McElhinney or another space chosen by both the PI and subject for maximum comfortability and ease of travel. It will be a public space, unless the meeting is taking place on an online service, such as Skype.

For the interview portion, they will answer to the best of their abilities as well, with the absolute right to not answer or end the interview when they feel they need to do so.

This research study includes the following component(s) where we plan to audio record you as the research subject:

- € I agree to be audio recorded during the research study.
  - € I agree that the audio recordings can be used in publication/presentations.
  - € I do not agree that the audio recordings can be used in publication/presentations.
- € I do not agree to be audio recorded during the research study.

The subject may still participate if they do not agree to be audio recorded.

What happens if I do not want to be in this research?

You can choose not to take part in the research and it will not be held against you. Choosing not to take part will involve no penalty or loss of benefit to which you are otherwise entitled.

If you are a student, a decision to take part or not, or to withdraw from the research will have no effect on your grades or standing with the University of Houston.

What happens if I say yes, but I change my mind later?

You can leave the research at any time and it will not be held against you. No explanations are required for your request to leave the research to be approved.

If you decide to leave the research, contact the investigator so that the investigator can cease communications in a timely manner, so that no further contacts will arise.

If you stop being in the research, already collected data will not be removed from the study record. At the competition of the research, private identifiable information and initial data collected will be destroyed.

Is there any way being in this study could be bad for me?

There are no foreseeable risks related to the procedures conducted as part of this study. If you choose to take part and undergo a negative event you feel is related to the study, please inform your study team.

However, some psychological risks might occur. Discussing personal views of mental health and possible experiences related to mental health, illness, and stigma surrounding these topics might cause undue stress and triggers. The subject can at any time choose to end the research process related to their interview, and not incur any further risks. Resources are at hand to help the subject.

Will I get anything for being in this study?

All those who have completed the interview will receive a $5 gift card to Starbucks.

Will being in this study help me in any way?

There are no known benefits to you from your taking part in this research. However, possible benefits to others include helping add to the literature on mental health, illness, and stigma on college campuses nationwide.

What happens to the information collected for the research?

Efforts will be made to limit the use and disclosure of your personal information, including research study and medical records, to people who have a need to review this information. Each subject's name will be paired with a code number, which will appear on all written study materials. The list pairing the subject's name to the assigned code number will be kept separate from these materials. We cannot promise complete secrecy. Organizations that may inspect and copy your information include the IRB and other representatives of this organization, as well as collaborating institutions and federal agencies that oversee human subjects research. This research uses or discloses Protected Health Information as defined by the Health Insurance Portability and Accountability Act (HIPAA), and you will be asked to sign an additional document to authorize the use of this information.

We may publish the results of this research. However, unless otherwise detailed in this document, we will keep your name and other identifying information confidential.

What else do I need to know?

For subjects interested about their data after analysis, they will be able to have a copy of their audio recording.

Who can I talk to?

If you have questions, concerns, or complaints, or think the research has hurt you, you should talk to the research team at ttnguyen145@uh.edu or contact the Anthropology department at (713) 743-3987 .

This research has been reviewed and approved by the University of Houston Institutional Review Board (IRB). You may also talk to them at (713) 743-9204 or cphs@central.uh.edu if:

- Your questions, concerns, or complaints are not being answered by the research team.
    - You cannot reach the research team.
    - You want to talk to someone besides the research team.
    - You have questions about your rights as a research subject.
    - You want to get information or provide input about this research.

Signature Block for Capable Adult

Your signature documents your consent to take part in this research.

Signature of subject	Date
Printed name of subject	
Signature of person obtaining consent	Date
Printed name of person obtaining consent	

My signature below documents that the information in the consent document and any other written information was accurately explained to, and apparently understood by, the subject, and that consent was freely given by the subject.

Signature of witness to consent process	Date
Printed name of person witnessing consent process	

In the future, our research team may be interested in contacting you for other research studies we undertake, or to conduct a follow-up study to this one. ***There is never any obligation to take part in additional research.*** Do we have permission to contact you to provide additional information?

- € Yes
- € No

BIBLIOGRAPHY

Abduhrehman, R., et. al. “Working with Refugees from Syria and Surrounding Middle East Countries: Practical tips from Cultural and Psychological Perspectives.” *Public Mental Health Initiative.* 2016.

ACHA. “National College Health Assessment: Undergraduate Group”. ACHA-NCHA. 2017.

ADAA. “Facts and Statistics”. *ADAA.org,* 5 August 2018, https://adaa.org/about-adaa/press-room/facts-statistics.

Augsberger, Astraea, Yeung, Albert, Dougher, Meaghan, and Hahm, Hyeouk Chris. "Factors Influencing the Underutilization of Mental Health Services Among Asian American Women with a History of Depression and Suicide". BMC Health Services Research, 15, 1, 2015.

Buchanan, Jenna L. “Prevention of Depression in the College Student Population: A Review of the Literature. *Archives of Psychiatric Nursing*, 26,1, 2012.

CCMH. “Center for Collegiate Mental Health: Annual Report”. Penn State. 2017.

Claudat, Kimberly, White, Emily K., and Warren, Cortney S. "Acculturative Stress, Self-Esteem, and Eating Pathology in Latina and Asian American Female College Students". *Journal of Clinical Psychology*, 72, 1, 2016.

Chu, Joyce and Sue, Stanley. “Asian American Mental Health: What We Know and What We Don't Know”. *Online Readings in Psychology and Culture*, 3,1, 2011.

Conus, Philippe, Abdel, Baki, Amal, Harrigan, Susy, Lambert, Martin, and McGorry, Patrick D., and Berk, Michael “Premorbid and Outcome Correlates of First Episode Mania with Psychosis: Is a Distinction Between Schizoaffective and Bipolar-I Disorder Valid in the Early Phase of Psychotic Disorders?”. *Journal of Affective Disorders*, 126, 1-2, 2010.

D’Andrade, Roy. *A Study of Personal and Cultural Values: American, Japanese, and Vietnamese*. Palgrave Macmillan. 2008.

DBSA. “Depression”. DBSA, 5 August 2018, https://secure2.convio.net/dabsa/site/SPageServer/?pagename=education_depression.

Department of Economics and Social Affairs. “The Sustainable Development Goals Report 2017.” United Nations. 2017.

Dess, Nancy K. “The Nature of Monkeys and Mothering”. PsychologyToday, 6 April 2019, https://www.psychologytoday.com/us/articles/200105/the-nature-monkeys-and-mothering.

Erlingsson, Christen, and Bryzseiwicz, Petra. “A hands-on guide to doing content analysis”. *African Journal of Emergency Medicine*, 7, 2017.

Fadiman, Anne. *The Spirit Catches You and You Fall Down*. Farrar, Straus, and Giroux, 2012.

Fancher, Tonya L., Ton, Hendry, Meyer, Oanh Le, Ho, Thuan, and Paterniti, Debora A. “Discussing Depression with Vietnamese American Patients”. Journal of Immigrant Minority Health, 12, 2010.

Gustafsson, Mai Lan. *War and Shadows: The Haunting of Vietnam*. Cornell University, 2009.

Han, Meekyung and Pong, Helen. "Mental Health Help-Seeking Behaviors Among Asian American Community College Students: The Effects of Stigma, Cultural Barriers, and Acculturation." Journal of College Student Development, 46,1,2015.

Han, Meekyung, Cao, Lien, Anton, Karen. “Exploring the Role of Ethnic Media and the Community Readiness to Combat Stigma Attached to Mental Illness Among Vietnamese Immigrants: The Pilot Project *Tam An* (Inner Peace in Vietnamese)”. Community Mental Health Journal, 70, 2015.

Hinton, E. Devon, and Good, Byron J., eds. *Culture and PTSD: Trauma in the Global and Historical Perspective*. University of Pennsylvania Press, 2015.

Hunt, Justin and Eisenberg, Daniel. “Mental Health Problems and Help-Seeking Behavior Among College Students.” *Journal of Adolescent Health*, 46,1, 2010.

Jenkins, J. H., Kleinman, A., & Good, B. J. “Cross-cultural studies of depression.” In J. Becker & A. Kleinman, eds. *Psychosocial aspects of depression.* Lawrence Erlbaum, Inc. 1991.

Kim, H.J., Park, E, Storr, CL, Tran K. and Juon, H.S. Depression among Asian-American Adults in the Community: Systematic Review and Meta-Analysis. PLoSONE, 10(6): e0127760.doi:10.1371/ journal.pone.0127760. 2015.

Kleinman, Arthur and Benson, Peter. "Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It". PLoS Med, 3, 10, 2006.

Kessler, Ronald C., and Ustun, T. Bedirhan. “The World Mental Health (WMH) Survey Initiative Version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI). *International Journal of Methods in Psychiatric Research*, 13, 2, 2004.

Kamimura, Akiko, Trinh, Ha N., Mitch, Johansen, Hurley, Jazmine, Pye, Mu, Sin, Kay, and Nguyen, Hanh. “Perceptions of Mental Health and Mental Health Services Among College Students in Vietnam and the United States”. Asian Journal of Psychiatry, 37, 1, 2018.

Kim, Bryan S.K., and Omizo, Michael M. "Asian Cultural Values, Attitudes Toward Seeking Professional Psychological Help, and Willingness to See a Counselor". The Counseling Psychologist, 31, 3, 2003.

Kohrt, Brandon A. and Mendenhall, Emily, eds. *Global Mental Health: Anthropological Perspectives*. Taylor & Francis, 2015.

Levecque, Katia, Anseel, Frederik, et. al. “Work organization and mental health problems in PhD students”. *Research Policy*, 46, 2017.

Lee Sunmin, Juon, Hee-Soon, Martinez, Genevieve, Hsu, Chiehwen E., Robinson, E. Stephanie, Bawa, Julie and Ma, Grace X. "Model Minority at Risk: Expressed Needs of Mental Health by Asian American Young Adults". *Journal of Community Health*, 34, 1, 2009.

“Mental health: Overcoming the Stigma of Mental Illness.” *Mayo Clinic,* 14 August 2018, https://www.mayoclinic.org/diseases-conditions/mental-illness/in-depth/mental-health/art-20046477.

Miller, Matthew J., Yang, Minji, Hui, Kayi, Choi, Na-Yeun, and Lim, Robert H. "Acculturation, Enculturation, and Asian American College Students' Mental Health and Attitudes Toward Seeking Professional Psychological Help". *Journal of Counseling Psychology*, 58, 3, 2011.

NCCIH. "Anxiety at a Glance." NIH, 5 August 2018, https://nccih.nih.gov/health/anxiety/at-a-glance.

NIMH. “Mental Illness”. *NIH*, 5 August 2018, https://www.nimh.nih.gov/health/statistics/mental-illness.shtml.

Nguyen, Peter Viet, Leung, Patrick, and Cheung, Monit. “Bridging Help-Seeking Options to Vietnamese Americans with Parent-Child Conflict and Depressive Symptoms”. Children and Youth Services Review, 33, 1, 2011.

Maté, Gabor. *In the Realm of Hungry Ghosts: Close Encounters with Addiction.* North Atlantic Books, 2010.

“Mental Health Systems in OECD Countries.” OECD, 14 August 2018, http://www.oecd.org/els/health-systems/mental-health-systems.htm.

O'Keeffe, Gwenn Schurgin, Clarke-Pearson, Kathleen and CCM. "The Impact of Social Media on Children, Adolescents, and Families." Pediatrics, 2011.

Pong, Helen and Han, Meekong. "Mental Health Help-Seeking Behaviors Among Asian American Community College Students: The Effect of Stigma, Cultural Barriers, and Acculturation". *Journal of College Student Development*, 56, 1, 2015.

Schraufnagel, Trevor J. Wagner, Amy W., Miranda, Jeanne, Roy-Byrne, Peter P. "Treating Minority Patients with Depression and Anxiety: What Does the Evidence Tell Us?" General Hospital Psychiatry, 28, 1, 2006.

Tanap, Ryan. "Why Asian-Americans and Pacific Islanders Don't go to Therapy." *NAMI*, 2 August 2018, https://www.nami.org/Blogs/NAMI-Blog/July-2018/Why-Asian-Americans-and-Pacific-Islanders-Don-t-go.

Ting, Julia Y., and Hwang, Wei-Chin. Cultural Influences on Help-seeking Attitudes in Asian American Students. *American Journal of Orthopsychiatry,* 79,1, 2009.

Tran, Chinh. Personal communication. March 2017.

World Health Organization. "Depression." *WHO*, February 2017, http://www.who.int/mediacentre/factsheets/fs369/en/. Accessed 8 November 2017.

World Health Organization. "Mental Health Action Plan 2013-2020." WHO Document Production Services, Inc. 2013.

Wutich, Amber, Ryan, Gery, and Russell Bernard, H. "Text Analysis". In Bernard, Russell, H. and Gravlee, Clarence C. *Handbook of Methods in Cultural Anthropology, 2nd ed.* Rowman and Littlefield, 2015.

Whitely, Rob. "Beyond Critique: Rethinking Roles for the Anthropology of Mental Health". *Cultural Medical Psychiatry*, 38, 1, 2014.

Winkelman, Michael. *Culture and Health: Applying Medical Anthropology*. Jossey Bass, 2009.

Wright, Annemarie, Jorm, Anthony F., Mackinnon, Andrew J. "Labeling of Mental Disorders and Stigma in Young People". Social Science and Medicine, 73, 2011.

Yehuda, Rachel and Bierer Linda M. "Relevance of Epigenetics to PTSD: Implications for the DSM-V". *J Trauma Stress, 22, 5, 2009.*