MENTAL ILLNESSES AND BARRIERS TO SEEKING MENTAL HEALTH CARE IN THE VIETNAMESE COMMUNITY IN AUSTIN, TEXAS FROM THE PERSPECTIVES OF COMMUNITY LEADERS AND PROVIDERS

Presented by Anh Ly

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I intend to submit a copy of my Health Science Scholars thesis to the Texas ScholarWorks Repository. For more information on the TSW, please visit https://repositories.lib.utexas.edu/.

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ABSTRACT

Vietnamese Americans are often grouped into the model minority category; however, national demographics show that Vietnamese Americans may experience greater disadvantages compared to other Asian-American groups. Furthermore, Vietnamese Americans have a unique immigration history due to many seeking refuge from the Vietnam War. A history of fleeing war and attempting to adapt to a new culture in the United States have greatly influenced Vietnamese Americans' way of life and mental health. Despite the rapid growth of the Vietnamese population in Austin, Texas, few studies have focused on this group in the city, especially in the context of mental health. In this study, I explored factors influencing Vietnamese Americans' mental illnesses and barriers to seeking mental health assistance in Austin, Texas. A total of 12 community leaders and providers who are familiar with the Vietnamese population in Austin were interviewed to gather diverse narratives of experiences within the community. The interviews were recorded, transcribed, then qualitatively analyzed for common themes. The findings from the study provide a summary of mental illnesses and mental health access in the Vietnamese community. More importantly, the findings bring attention to the critical need of culturally specific mental health resources that take into account factors discussed by the participants, such as Asian family dynamics and differences between western and eastern mental health ideologies. This study will help agencies and non-profit organizations establish appropriate mental health initiatives for the Vietnamese community in Austin, Texas.

Key words: Vietnamese Americans; mental health; Austin, Texas; barriers to care; immigrant health

I. INTRODUCTION

Although many studies have explored the barriers to health care facing the Asian population in the United States, very few have disaggregated the data to explore the barriers experienced by individual Asian ethnic groups. Studies focusing on Asians as a whole often fail to acknowledge the diversity within the population. Even citizens coming from the same Asian country may speak different dialects and have distinct cultural beliefs. These factors in turn lead to unique health experiences; thus, there is a need for more culturally specific research in health care.

I will focus on Vietnamese Americans in Austin, Texas. Asian is the fastest growing racial group in the United States (Jang, Park, Chiriboga, & Kim, 2017). Furthermore, Vietnamese Americans belong to the top four largest Asian ethnic groups living in the United States (Fancher, Ton, Le Meyer, Ho, & Paterniti, 2010). In Austin, specifically, the Asian population size has doubled every 12 years (City of Austin, 2016). Vietnamese alone makes up over 11% of the Asian population in Austin (U.S. Census Bureau, 2017a).

The migration and post-migration hardships of Vietnamese after the Vietnam War may shape individuals' mental well-being. Furthermore, being a more recent group of immigrants, resources may be less established for Vietnamese Americans. Additionally, Vietnamese Americans are often placed in the "model minority" group. Model minorities are assumed to be well-adjusted to life in the U.S. with high occupational and educational achievements (Sue, Sue, Sue, & Takeuchi, 1995). However, national demographics show Vietnamese Americans are more disadvantaged compared to their other Asian counterparts in various indicators, including education attainment, income, and English proficiency. These historical experiences, cultural expectations, and societal pressures together are reflected in the mental health of Vietnamese

Americans, their help-seeking behaviors, and the barriers they encounter. Most importantly, the topic of mental health needs further attention because there are a wide range of factors that may negatively influence the mental well-being of Asian Americans, yet studies have shown significant underutilization of mental health services among this population (Woo, 2017; Jang, 2016; Abe-Kim et al., 2007). Findings from the current revealed the barriers to seeking mental health care that may contribute to the low mental health service utilization by Vietnamese in Austin, Texas.

My objective was to provide a more nuanced and comprehensive overview of the mental health and the barriers to seeking mental health care experienced by the Vietnamese community. Specifically, the I explored common mental health diagnoses, mental health awareness, and barriers to mental health assistance of three age groups: 18-34, 35-60, and 60+ years old. Each age group has different narratives with varying immigration stories, societal roles, and acculturation that may serve as underlying factors for mental health outcomes. I also explored the availability of mental health resources for the Vietnamese community in Austin and community leaders' vision for future health initiatives. The culturally specific recommendations formulated based on the findings could be implemented to bridge the unmet mental health needs of the Vietnamese community in Austin, Texas.

II. BACKGROUND

II.I. Vietnamese Migration to the United States

The United States is home to the largest Vietnamese diaspora, followed by Australia and Canada (Migration Policy Institute, 2015). Today, many Vietnamese Americans settle in California; a large proportion of Vietnamese Americans also settle in Texas, Washington,

Florida, and Virginia (Migration Policy Institute, 2015). The first large wave of Vietnamese migration to the United States began before the Fall of Saigon in April of 1975 (Kim, 2006). Soon after the war was over, another wave of migration occurred when Vietnamese tried to flee the country by boat (Kim, 2006). The third wave of early immigrants to the United States consisted of former South Vietnamese government officials who were released from the war re-education camps (Kim, 2006). Many early Vietnamese migrants settled in the United States as refugees (Kim, 2006). Immigration after 1996 was mostly family-based (Migration Policy Institute, 2015). Having to leave their home country due to war and political oppression rather than pull factors such as economic opportunities, many early immigrants may be at greater risk for mental illness. Furthermore, the historical stress may perpetuate in the family, influencing the mental health of the family, including that of the younger generations (Maffini & Pham, 2016).

II.II. Unique Characteristics of Vietnamese Americans

Despite often being classified as one of the model minority groups, Vietnamese in general have lower education attainment and household income compared to their other Asian counterparts. According to the 2017 American Community 1-Year Estimates, over 1.8 million Vietnamese currently reside in the United States (U.S. Census Bureau, 2017d). Only 20.9% of Vietnamese 25 years and older hold a bachelor's degree and only 9.5% hold a graduate or professional degree (U.S. Census Bureau, 2017d). In comparison, as of 2017, 53.8% of Asians 25 years and older living in the United States hold a bachelor's degree and higher (U.S. Census Bureau, 2017b). The median household income for Vietnamese as of 2017 was $64,586 while that of Asians in general was $83,456 (U.S. Census Bureau, 2017d; U.S. Census Bureau, 2017b).

A large proportion of Vietnamese experience a language barrier living in the United States. In the United States, a limited English proficient (LEP) person is someone who speaks English less than "very well" (Batalova, 2015). Among those who are 5 years and older in Austin, Texas and speak Vietnamese at home, 47.15% speak English less than very well (U.S. Census Bureau, 2017c). The language barrier could contribute to the mental health inequalities experienced by the Vietnamese population. Unlike other objective medical diagnostics, many mental health-related assessments involve the patients accurately describing their feelings or symptoms. Inability to do so may leave the patients with untreated mental illness (Sentell, Shumway, & Snowden, 2007). Not only is it a moral obligation to provide linguistically appropriate mental health resources, it is also a federal mandate. According to Title VI of the U.S. Civil Rights Act of 1964, organizations that receive federal financial assistance, either directly or indirectly, must provide LEP persons with meaningful access to all services (U.S. Department of Health & Human Services, 2013). However, many LEP patients are not aware of this federal mandate (Patel, Firmender, & Snowden, 2013).

Even in the context of mental health, studies have shown that Vietnamese Americans may be at a greater risk for mental illness compared to other Asian groups. One study compared the levels of mental health symptoms of Vietnamese, Miens, Laotians, and Cambodians at a mental health agency in Seattle, Washington. The findings showed that Vietnamese had higher levels of psychotic symptoms and emotional distress compared to the other Southeast Asian groups (Kim, 2006).

II.III. Utilization of Mental Health Services

There is a great disparity between the use of mental health care among Asian Americans —including Vietnamese Americans — and other populations. A study using data from the National Latino and Asian American Study and the National Comorbidity Survey Replication found that only 8.6% of Asian Americans sought any mental health services compared to 17.9% of the general population (Abe-Kim et al., 2007). Another study conducted using data from the Los Angeles County's Department of Health Services, which is the second largest public health system in the United States, found that Asian Americans have significantly lower rates of mental health service use for schizophrenia, bipolar disorders, depression, anxiety, and intellectual disabilities, compared to Whites (Woo, 2017).

II.IV. Existing Studies on Vietnamese Mental Health in Austin, Texas

There are only two existing studies focusing on the mental health of Vietnamese Americans in Austin, Texas. One was a qualitative study conducted by the Asian American Resource Center, Inc. in 2014. There were 15 participants in the Vietnamese focus group (Cobalis, Varghese, & Chan, 2014). Vietnamese participants discussed the lack of resources to accommodate diverse languages, cultures, and ages. Participants also addressed distrust in primary care providers, as the participants believe that these providers do not have a good understanding of mental health topics. Another barrier participants discussed was generational conflict, which makes it difficult to address mental health problems in the family (Cobalis et al., 2014). Though the focus group focused on Vietnamese mental health, there are a few limitations to the study. The majority of the participants had an educational attainment above high school. Additionally, the majority of the participants think it is somewhat easy or very easy to

understand prescription information or other written information provided by the doctor (Cobalis et al., 2014). Thus, the sample from this study may not be representative of the diverse Vietnamese population in Austin, Texas. Lastly, the mental health discussion was generalized to focus on depression (Cobalis et al., 2014). Though depression may be a common mental illness, it is important to consider other diagnoses and their potential causes when examining the mental health of a population.

The second study was the Asian American Quality of Life Survey conducted in 2016. The survey was conducted in various Asian languages and had a total of 2,609 participants, 513 of whom were Vietnamese (Jang, 2016). Among the ratings for life satisfaction, Vietnamese were observed to have lower ratings compared to other groups, such as Filipino and Asian Indian (Jang, 2016). The study found that 54.6% of the Vietnamese participants had mental distress and 9.2% had a serious mental illness (Jang, 2016). More importantly, these percentages were higher than those of the overall sample and those of other Asian ethnic groups (Jang, 2016). In the overall sample, the prevalence of mental distress was 44.2% and the prevalence of serious mental illness was 6.1% (Jang, 2016). Despite the high prevalence of mental illness, a very small proportion of Vietnamese actually seek mental health assistance. Only 5.0% of Vietnamese seek professional assistance through a psychiatrist or a mental health provider, and only 15.7% reported that they saw a general medical provider in the past 12 months about a mental health problem (Jang, 2016). Another 4.2% of Vietnamese seek help through another source, such as a minister or priest (Jang, 2016).

Through the present study, I explored potential barriers that may explain low utilization of mental health services in the Vietnamese population. In the Asian American Quality of Life Survey, approximately 6.5% of Vietnamese reported that they experienced an unmet mental

health care need (Jang, 2016). However, this number could be underreported, as many may not be aware that they have a mental health need or refuse to acknowledge that they have a need on the survey. The Asian American Quality of Life Survey revealed significant cultural stigma associated with mental health and also misconceptions about mental health. For example, 34.3% of Vietnamese view depression as a sign of personal weakness and 18.2% believe that they would be a disappointment to their family if they were to have depression (Jang, 2016). Additionally, 38.0% of Vietnamese believe that antidepressant medicines are addictive (Jang, 2016). In this study, my objective was to incorporate qualitative observations from key informants, who have worked with a large number of Vietnamese Americans, to explore the cultural and systematic barriers that may help explain some of the quantitative statistics from the Asian American Quality of Life Survey.

III. METHODOLOGY

III.I Semi-structured Interviews

The study was classified as *exempt from review* by the University of Texas at Austin Institutional Review Board. The primary researcher identified the first round of contacts based on prior knowledge of representatives that work for organizations supporting the Vietnamese American or the Asian American community in Austin. Some of these contacts then referred the researcher to other points of contact that may be interested in participating in the study. The participants were emailed about the study then scheduled for an interview. Participants needed to be at least 18 years or older and have worked with the Vietnamese American community. There were no racial or ethnic background criteria for the participants. A total of 12 semi-structured interviews were conducted. The participants consisted of 2 medical professionals, 2 therapists, 3

representatives from non-profit organizations, 1 representative from a major mental health institution, 1 community health worker, and 3 employees from the University of Texas at Austin.

On average, interviews lasted approximately 30 minutes. The interviews were conducted via phone or at public locations, such as community center and coffee shop, as requested by the participants. All interviews were conducted in English. Data saturation was reached after 12 interviews, as common themes began to repeat.

In the interviews, the subjects were prompted to discuss prominent mental illnesses observed in the community, potential causes of such illnesses, the community's knowledge of mental health, and barriers to help-seeking observed in Vietnamese in the 18-34, 35-60, or 60+ age groups. Furthermore, the participants were asked to evaluate the amount of mental health resources available and recommend future programs or initiatives to help bridge the unmet needs. Examples of the interview questions asked are as follows: What are the prominent mental illnesses experienced by the [age group]? What are the factors leading to these illnesses? What are the barriers to seeking mental health assistance experienced by [age group]? Describe the Vietnamese population's knowledge of mental health and mental health resources. There were 15 questions in the interview guide; however, participants had the option to not answer questions that they did not know the answer.

In this study, a *first-generation immigrant* is defined as someone who was born in Vietnam, then immigrated to the United States. A *second-generation immigrant* is someone who is born in the United States to at least one parent who was born in Vietnam.

III.II. Data Analysis

All 12 interviews were included in the analysis. All interviews were audio-recorded and

transcribed verbatim by the researcher. The interviews were first read in their entirety. The interview responses were then analyzed by question. For each question, the primary researcher reviewed responses from all the participants and qualitatively identified common themes among them. The process was repeated for all of the questions. No coding software was used.

IV. RESULTS

IV.I Overview of Qualitative Results

The results from the interviews are reported below based on the main categories of the interview questions: mental illnesses and contributing factors, mental health awareness and barriers to mental health care, generational difference and health seeking behaviors, availability of mental health resources in Austin, and participants' vision for future mental health initiatives.

IV.II. Prominent Mental Illnesses and Contributing Factors

For the 18-34 age group, participants observed high prevalence of depression and anxiety among Vietnamese in the community. Participants also mentioned early onset of other mental illnesses, such as bipolar disorder and borderline personality disorder in this age group. The most common contributing factors to depression and anxiety as cited by participants were academic stress, familial pressure, and societal pressure. In addition to the pressure of performing well in school, participants mentioned that Vietnamese students may be pressured to pursue certain career paths that their parents believe are successful and stabilizing. Participant 2 shared an example of the career pressure experienced by many young Vietnamese-American adults.

"…when you look to some kids that are doing well to graduate from high school, now

they are thinking about 'well my parents want me to be a doctor but I don't want to.'" - Participant 2

Participant 7 expressed a similar observation regarding academic pressure.

"...they are mostly pressured to go to college and you know that anxiety to succeed, to graduate, to get a degree in which you might or might not like..." -Participant 7

Furthermore, the challenge is exacerbated when individuals find it difficult to discuss these challenges with family members. Participants acknowledged that young Vietnamese Americans may be afraid to disappoint their families; furthermore, participants mentioned that intergenerational differences between the parents and young adults may make it more difficult for young Vietnamese Americans to have mental health-related discussions. Participant 8 shared her encounter with clients who have had concerns regarding family expectations.

"...I've definitely had clients who had very deep depression because they felt like they were disappointing [their] parents, they were not living up to their parents' expectation or they felt like their parents didn't understand them, and they had to I guess like, made a lot of sacrifices that contribute to their happiness." -Participant 8

For the 35-60 age group, participants again identified depression as a common mental diagnosis. Participants referenced career and family-related stress as a contributing factor to the onset of depression in this group. Career and family-related stress can result from conditions

such as job insecurity, unstable marriage, and also intergenerational conflicts with the youths in the household. Participant 10 referenced some of these factors below. Other participants also mentioned conflict between expected economic opportunities in the United States and the reality. Participant 2 elaborated on this factor. Post-traumatic stress disorder (PTSD) and schizophrenia onset also surfaced in the discussion.

"Vietnamese, yeah, at least from what I know, they tend to have problems with marriage, family life, and they tend to have problems more with raising kids." -Participant 10

"They think once they come to the USA, they will be able to make a lot of money to support their family, but in reality they don't. They have no skillset, the language barrier, there's a lot of other barriers in their real lives, so they get really depressed." -Participant 2

For Vietnamese seniors, who are above 60 years old, participants mentioned depression and PTSD as common mental diagnoses. Since the Vietnamese diaspora is fairly recent, nearly all individuals in this group experienced the hardships of migration, some as refugees, others as family-based immigrants. Many also lived through the Vietnam War period. These historical factors play a significant role in mental health outcomes of this population. Participants further referenced difficulty communicating with families, loneliness, and loss of loved ones as factors that could influence the mental health of the Vietnamese senior population. Participant 8 discussed some of these factors below. A few participants also mentioned common mental illnesses such as Alzheimer's disease, dementia, and schizophrenia and contributing factors, such as genetics, social life, and environmental factors.

"…a lot of senior citizens that move here, they are very lonely. Like they come here with their family, but they're bound to the house, they can't go anywhere because they can't drive, they don't speak the language, they're just stuck so I think that…depression is one of the biggest things." -Participant 8

IV.III. Mental Health Awareness and Barriers to Mental Health Care

Lack of mental health awareness is a barrier to mental health care. Mental health awareness depends on a multitude of factors, including an individual's level of education and acculturation to the culture here in the United States. In general, participants noticed that there is a correlation between age and level of awareness. Those in the younger age groups are more likely to be aware and familiar with the concept of mental health compared to the elders.

Intergenerational and cultural differences were mentioned as contributing factors to the negative mental wellness of the young adult population (18-34 years old). However, these factors can also act as barriers to help-seeking. Many people in the 18-34 age group are also in denial about their mental health. Participants mentioned that these individuals may be ashamed to seek mental health assistance. Many Vietnamese families put great emphasis on family values and pride; thus, having a mental illness may be viewed as shameful and seeking mental health assistance would devalue the family "face" and the sacrifices made by the older adults in the family. Participant 5 explained how one may hide their mental illness to protect the family pride.

"… the Asian culture, Vietnamese culture, we're very connected to the community and people talk and so there's a fear of like things getting out, and like things coming back to your

family, so there's the hiding from the family and also wanting to protect family…" -Participant 5

There is an overlap of mental health barriers experienced by the two older age groups. Similar to the first age group, cultural values and shame were mentioned as potential barriers. Participants also mentioned how mainstream mental health care approaches in the United States contradict with Vietnamese cultural values. Participant 8 shared her experience with clients who have encountered this barrier. Some participants also mentioned language, transportation, and cost as additional barriers for the older age groups.

"I've had clients tell me that therapists have straight up told them that 'the way you parent, the way you live your life is wrong' so the whole cultural piece [and] language piece is huge." –Participant 8

IV.IV. Generational Difference and Help-Seeking Behaviors

Similar to the responses received for the question regarding mental health awareness, many participants acknowledge that factors such as total time living in the United States and acculturation are significant predictors of one's awareness about mental health. Participants did not mention differences regarding mental illnesses between first and second generations; however, many agreed that there may be additional barriers to seeking mental health care for first-generation immigrants. Participants mentioned barriers encountered by first-generation immigrants such as language, access to technology, unfamiliarity with western mental health ideology, and less exposure to mental health resources. Participant 4 discussed how these factors affect access to mental health care.

"You're in the U.S., so if you're first-generation U.S. citizen or immigrant, then it would be a little bit more difficult to access services due to language proficiency. It also has an issue of familiarity with mental health concepts that's tied to western concepts." -Participant 4

IV.V. Vietnamese Community's Knowledge of Mental Health and Availability of Mental Health Resources in Austin, Texas

Responses varied when asked about the Vietnamese's knowledge of mental health and the existence of mental health resources. However, many participants believed that there is limited knowledge about mental health in the Vietnamese population overall due to different cultural approaches to mental health. Participant 11 discussed how the concept of mental health is very foreign to some Vietnamese individuals.

"So almost zero [knowledge about mental health] because there is also this mentality of, you know, just kinda working through it without thinking you have an issue….So they don't think that mental health issues exist at all and they just think that it's something you work through like everything else in their lives…" -Participant 11

All of the participants expressed concern that mental health resources available in Austin, Texas are not enough to accommodate the growing Vietnamese population. Many mentioned there is a lack of culturally and linguistically appropriate resources, targeting specific Asian ethnic groups. Some participants also mentioned that there are very few mental health specialists who are Vietnamese in the Austin area. Participant 4 shared her concern for the inadequate number of Vietnamese mental health specialists. A few participants noted that the Vietnamese

community is working together to support its members, but there is still a lack of emphasis on mental health and also lack of support from other institutions. Participant 8 acknowledged the work of the internal community but also noted the need for additional mental health support.

"I know there's a dearth of mental health specialists within the Vietnamese and Vietnamese-American community. There's probably like 6 that I can conjure up, which is not exactly the best number for a growing population." -Participant 4

"I think the Vietnamese community works really hard to try to provide support for people, but I think because there is a lack of understanding and information, there isn't a lot of support for people dealing with mental illness." -Participant 8

IV.VI. Participants' Recommendations for Future Initiatives

Participants suggested that there is a need for culturally specific health education and outreach focusing on mental health in the city. Participant 2 stressed the need to de-stigmatize mental health in the community.

"… We need to lead them step by step to understand [that] this (mental illness) is just like when you have diabetes, like when you have high blood pressure. It's nothing different than those diseases, you know, nothing to be ashamed of." -Participant 2

Additionally, participants emphasized the need for health professionals that can communicate with their patients in Vietnamese and also health professionals that understand the

underlying cultural beliefs about mental health and mental illness. Participant 4 mentioned this specific need for culturally competent mental health practitioners.

"You've got to have practitioners that understand eastern philosophy of mental health, and you just need to have it about community. You've got to have programs that can mobilize these underserved communities, and not just get things translated." -Participant 4

One participant called for more culturally competent resources at the university level, such as career service counseling for Asian-American students. There was also a call for distribution of resources where Asian Americans, including Vietnamese Americans, are geographically concentrated for easier access. Participant 1 expressed his concern about the location of resources.

"Even if Austin is the most liberal place you've ever been, it's a very southern, segregated, city so all the Asian Americans are pretty much up North [Austin], and are we investing up North?"-Participant 1

V. DISCUSSION

I found that academic stress and familial pressure as the most common contributors to mental illness in Vietnamese-American young adults. Many first-generation immigrants came to the United States to flee the war-torn country, or were sponsored to the United States through family reunification. Though some first-generation immigrants had the opportunity to continue to pursue higher education in the United States, others may have had to enter the workforce to support their family. Thus, it is then up to the next generation to pursue higher education and

seize the academic and economic opportunities that the previous generation did not have. Some immigrant parents are familiar with the academic system in the United States, but there are also some immigrant families that have never had anyone enroll in college. Thus, this leaves many young Vietnamese young adults, especially who are first-generation college attendees, to navigate the higher education system with minimal family assistance. Adapting to the college environment is a difficult transition for every student; however, many Vietnamese-American students navigate this challenge without any familial support.

Furthermore, Vietnamese-American parents may also place additional pressure on the students by demanding them to pursue certain career paths that they believe will provide high and stable economic returns, though these career paths may or may not align with the student's passion. As Pumariega and colleagues reasoned, these academic and economic expectations may be a way for first-generation immigrants to justify their sacrifices, such as moving to a foreign country and persisting through the hardships along the way (Pumariega, Rothe, & Pumariega, 2005). The familial pressure, although it may be unintentional, exerts a burden on the younger Vietnamese, which could lead to negative implications for both their mental health and their educational performance. Additionally, Vietnamese Americans, along with other Asian Americans, are often grouped in the "model minority" category and assumed to all have high achievements with no challenges (Han & Lee, 2011). This assumption can lead to a lack of resources provided by higher education institutions or government agencies targeting Asian-American and Vietnamese-American young adults. The lack of resources only exacerbates the burden on these Vietnamese young adults.

Another finding was that intergenerational conflicts have negative influence on the mental health of Vietnamese-American young adults. Although it is normal to expect some

conflicts between parents and young adult children in the family, intergenerational conflicts in immigrant families involves cultural clashes, since the immigrant parents may still hold on to the values and beliefs from Vietnam, whereas the young adult children are more adapted to the U.S. mainstream culture (Choi, He, & Harachi, 2008). This type of conflict is referred to as intergenerational cultural dissonance (Choi et al., 2008). The tension within the family could impede open communication between parents and the children, which could have significant mental health implications. As a result, children may choose to withhold their concerns regarding mental health since they are not able to openly share their thoughts due to clashes in family beliefs. There may even be a clash in mental health ideology between the generations. For instance, Nguyen and colleagues have asserted that any expression of distress, such as irritability, by the children, may be perceived as if the children are being disrespectful to the parents; thus, the challenges experienced by the young adults are invalidated (Nguyen, Kim, Weiss, Ngo, & Lau, 2018). Familial pressure combining with family conflicts due to cultural differences can exacerbate the stress experienced by Vietnamese young adults.

For the 35-60 age group, participants cited depression as a common mental diagnosis. Similar to other working-age adults, life stressors, such as work-related pressure and familial roles, can contribute to poor mental well-being. However, there are two additional distinct factors that may influence the mental health of Vietnamese who are in the 35 to 60 year range. These factors are intergenerational conflicts and acculturation. Though many studies often focus on intergenerational conflicts from the perspectives of the younger generation, it is important to note that cultural clashes between the generations also have negative mental health implications on the older generation. Many Vietnamese immigrants also find it difficult to adapt to a new culture with values and beliefs that are completely different from theirs. Furthermore, since a

large proportion of Vietnamese in Austin are limited English proficient (U.S. Census Bureau, 2017c), many may experience challenges at the workplace, or obtaining jobs and other services. Additionally, these Vietnamese immigrants may have held a higher position at the workplace and in society back in Vietnam; thus, it was a shock to transition to lower conditions of living as an immigrant in a foreign country. These chronic adaptation challenges certainly serve as contributing factors to poor mental well-being.

In addition to other common mental illnesses experienced by seniors, PTSD was emphasized as a common mental illness experienced by the senior Vietnamese population. The high prevalence of PTSD can be explained by the hardships living through and escaping the Vietnam War. Many came to the United States as refugees during or after the war. In addition to experiencing the terror during the Vietnam War, many also stayed in refugee camps for an extended period of time (Kim, 2006).

Participants also attributed the cause of poor mental health of older Vietnamese in Austin, Texas to the lack of autonomy. As mentioned by Pumariega and colleagues, lack of cultural flexibility and isolation are common factors contributing to poor mental health in older Asian Americans (Pumariega et al., 2005). Many of the seniors are homebound and depend on their children for assistance; thus, they may be lonely and feel isolated from the rest of society. It is important to acknowledge that, although there are some Vietnamese senior programs in Austin, there are many barriers to accessing these programs. Many seniors may not be aware of the programs' existence or may not have the transportation available to participate in the activities. Although there are some ride services available in addition to public transportation, Vietnamese seniors who are limited English proficient may not be able to register for these ride services, or navigate the city public transportation system. Even if language assistance is available, they may

not be aware of the process to request assistance. Furthermore, public transportation stops around Austin may not be within walking distance to certain neighborhoods; therefore, using public transportation is not an option for many seniors. It is important to note that lack of transportation not only hinders Vietnamese seniors from participating in social programs; it also prevents them from accessing health care services.

Barriers to mental health care varied for each group; however, the culture component appears to affect individuals across the age spectrum. As described above, intergenerational conflicts in the context of cultural ideology may prevent Vietnamese youths from discussing mental health with their families. Another common cultural barrier experienced among all age groups is stigma associated with mental illness. A mental health study from New Orleans showed that many Vietnamese perceive mental illness as being "crazy," and refer to people with mental illness as abnormal (Do, Pham, Wallick, & Nastasi, 2014). Similar to other Asians, Vietnamese also value emotional self-control, which emphasizes the ability to internalize and have complete control over stress and suffering, as opposed to sharing concerns with others (Kim & Omizo, 2003). This value, however, conflicts with the western approach to mental health treatment, which emphasizes open discussions of mental problems (Kim & Omizo, 2003). As described earlier, language and transportation are factors that contribute to social isolation in the community; these factors may also interfere with efforts to seek mental health treatment from medical or mental health facilities. Though barriers to mental health care may depend on one's level of acculturation and societal or familial support, first-generation immigrants may be more vulnerable to challenges such as unfamiliarity with mental health, a lack of English proficiency, and lacking transportation.

Though participants' perceptions of mental health awareness in the Vietnamese

community varied, these community leaders and providers collectively agreed that there is a lack of culturally specific mental health support for the growing Vietnamese population in Austin, Texas. A few participants referenced the Asian Family Support Services of Austin (AFSSA) as an existing organization in Austin whose works accommodate various Asian cultures and languages. However, AFSSA's mission is to specifically support Asian clients who experience domestic violence, sexual assault, or human trafficking ("AFSSA – Asian Family Support Services of Austin," n.d.). There is not any other organization catering to the Asian community that focuses on general areas of mental health.

One may argue that there are mental health organizations and institutions in Austin that the Asian community can seek assistance from. However, there are accessibility factors that may influence a Vietnamese or Asian client's willingness and ability to seek assistance. These factors include cultural competency, language accommodation, and cultural representation. These mental health institutions may have very few specialists that can understand and acknowledge clients' perceptions of mental health from an eastern perspective. A study exploring effective methods of discussing depression with Vietnamese-American patients showed that Vietnamese patients value treatment efforts that acknowledge their cultural beliefs and try to incorporate these beliefs into the explanation of illness and treatment (Fancher et al., 2010). Another component to consider is language accessibility. A study examining access to mental health treatment by English proficiency showed that only 11% of Asians/Pacific Islanders who do not speak English receive services when they expressed a need, compared to 56% of Asians/Pacific Islanders who could speak English. The researchers also emphasized that having access to mental health treatment does not always constitute high quality of care for individuals with a language barrier (Sentell et al., 2007). The Asian American Quality of Life Survey showed that

61.5% of Vietnamese in Austin prefer to seek counseling from someone with their own ethnic background (Jang, 2016). Since a large proportion of Vietnamese prefer to seek help from a Vietnamese specialist, they may not be inclined to seek professional help if there is a lack of representation at mental health institutions. Concerns from the participants of the current study justify a need for more diverse resources in Texas and specifically in the City of Austin.

VI. RECOMMENDATIONS

I present the following recommendations, building upon the participants' recommendations presented in the Results section. The recommendations fall under three broader goals: improve health care practices, improve mental health education and outreach, and advance the next generation of health care leaders.

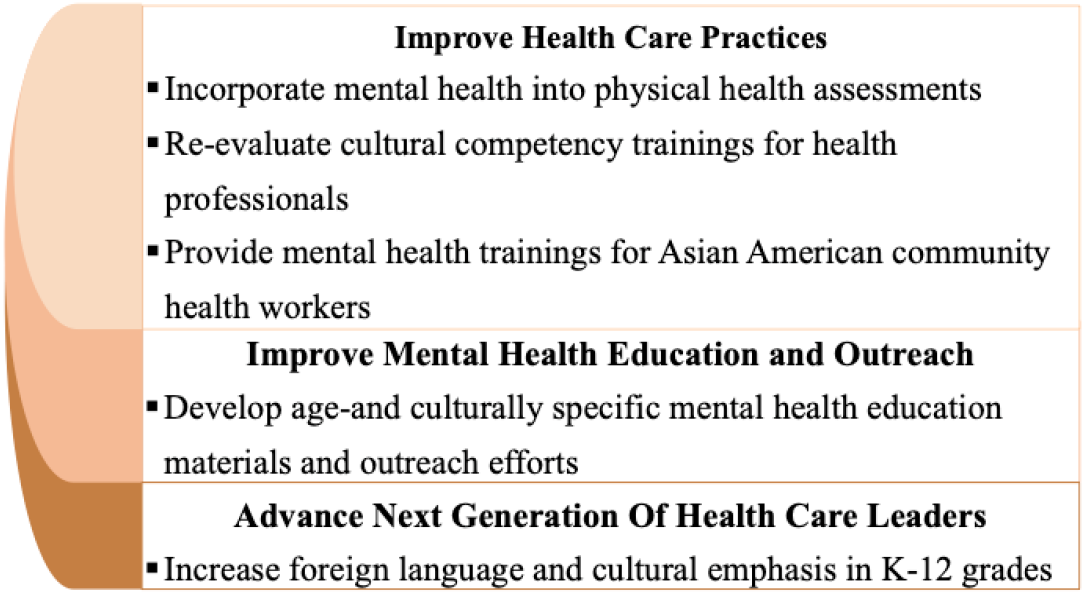

Figure 1: Recommendations to help bridge the mental health care needs in Austin, Texas

VI.I Incorporate Mental Health Into Physical Health Assessments

Many Vietnamese tend to seek mental health assistance from their primary care provider

(Jang, 2016). There is also greater stigma associated with mental health care compared with physical health care (Woo, 2017). As a result, physical health assessments may be the place where mental illnesses are first discovered. Many community health screenings still only focus on physical health outcomes. Those who do not have access to a primary care provider may depend on these screenings as their main health care resource. Thus, these screenings should include questions to identify potential mental health problems. Furthermore, primary care offices should include mental health-related questions in the visit questionnaire, if such initiative does not already exist at the office.

As mentioned by the participants, many Vietnamese may not know that what they are experiencing is classified as a mental illness. They may view the symptoms of depression as something that is part of life and that there is no cure for such feelings. Incorporating mental health into physical health assessments would help de-stigmatize mental health and also help reduce the untreated cases of mental illness.

VI.II. Further Research To Re-Evaluate Cultural Competency Trainings For Health Professionals

As Austin is becoming more diverse, there is a need for health care institutions to re-evaluate cultural competency trainings and the effectiveness of these trainings. There should be further research to document the types of cultural competency trainings, if any, provided by health-related organizations, both governmental and non-profits. Medical students, mental health specialist and trainees, and staff at mental institutions should understand the difference in mental health ideologies held by westerners and individuals coming from other parts of the world. As a few participants mentioned, these health professionals need to be able to see complex cultural

difference, such as the Asian family dynamic, as a cultural uniqueness rather than suggesting that their clients need to aim for a different family and lifestyle that resemble the western model.

VI.III. Provide Mental Health Training for Asian American Community Health Workers

Community health workers are members of the community where they serve, sharing common identities, such as ethnicity, language, and even life experiences (U.S. Department of Health & Human Services, 2007). Community health workers provide community members with culturally and linguistically appropriate health education, connect them to health resources, and also give them informal counseling (U.S. Department of Health & Human Services, 2007). There is a need to provide community health workers with mental health trainings. Since the community health workers share the same cultural beliefs as their clients, they may be able to reduce the stigma associated with mental illnesses. Furthermore, mental health trainings will allow community health workers to detect early warning signs of mental illness and make timely referrals for treatment. A pilot promotora (Latino community health worker) intervention program for immigrant Latinas in North Carolina found significant decrease in depressive symptoms and levels of perceived stress among the program participants (Tran et al., 2014). The pilot program also resulted in a positive increase in attitude towards depressive treatment and perceived social support (Tran et al., 2014).

VI.IV. Establish Age-and Culturally Specific Mental Health Outreach Efforts

As mentioned by the participants, there is a critical need for mental health outreach efforts that focus on the Vietnamese community and acknowledge the community's cultural assumptions about mental illnesses. However, there is also a need to develop health education

materials and outreach efforts that target specific age groups within the Vietnamese community, since each Vietnamese age group has very different societal and familial factors that could influence their mental health, as shown in the results of this study. The outreach effort can first begin with public locations where a certain age group tends to gather. Furthermore, the health education material will need to reference topics that are familiar to the Vietnamese community, such as work-related stress for the working age group and academic stress for the young adults, rather than focusing directly on mental health topics, such as depression or anxiety without the familiar context.

For instance, to promote mental well-being in the Vietnamese senior population, public health workers and mental health institution representatives may need to visit locations where the seniors may gather, such as the Austin Vietnamese Senior Center or Gus Garcia Recreational Center, to distribute or present materials that introduce the community to mental health and mental illness in Vietnamese. Additionally, for the Vietnamese senior population, these materials may need to focus on ways to address issues that are familiar with the community, such as loneliness.

VI.V. Increase Mental Health Education In Middle And High School

It is critical that youths are introduced to the concept of mental health at an early age. A systematic review of mental health programs in U.S. schools showed that these programs overall led to improved knowledge of mental health in students; some programs also showed improvement in attitudes toward mental health and help-seeking behaviors among students (Salerno, 2016). Similar to how sex education is incorporated into the classroom curriculum, there is a need for mental health education in middle and high school. This will help de-

stigmatize the concept of mental health in young students, especially those whose family may be unfamiliar with the concept of mental health. Furthermore, sending mental health education materials home with the students may also help introduce parents to the concept of mental health, which may encourage them to address any mental illnesses experienced by their children at an earlier stage.

VI.VI. Increase Foreign Language And Culture Emphasis in School

There is a need to expand language and culture programs at the elementary and middle school levels. There are foreign language programs available through community organizations and religious institutions for young students, but these programs require students to participate on the weekend. Providing language and culture programs, possibly though an after-school programs for elementary and middle school students, could draw more interest from both the students and the parents. Though it is not possible to provide programs for every language, it may be possible to start with an after-school program that focuses on the two most-spoken foreign languages in Austin. Early culture and language programs will help preserve and expand the diversity of Austin.

Furthermore, there is a need to expand foreign language and culture courses to focus on eastern culture at the high school level. For example, high school students could benefit from an Asian-American culture course; this will help Asian-American students to better understand their own cultural backgrounds and other students to be aware of cultural practices that are very different from western culture. The expansion of language and culture programs in school curricula will help foster the next generation of diverse leaders, including health care leaders, who will be able to provide culturally and linguistically appropriate services.

VII. LIMITATIONS

VII.I. Language Barrier Among Participants

Language was a main limitation to the current study. Since the study was conducted in English, the pool of participants was limited to only community leaders and providers who could provide insights in English. However, there may be active community leaders and organizers at Vietnamese churches and temples who may not be able to participate in an English study. Furthermore, some of the participants were not very fluent in English so the perspectives they provided may not have been as descriptive as they could have been, had the study been conducted in Vietnamese. Another aspect of the language barrier relates to the medical terminology used. Though the study used very little jargon, many participants were unfamiliar with mental health vocabulary. Some participants were very fluent in conversational English, yet they may not have been familiar with terms such as "depression" and "schizophrenia."

VII.II. Familiarity With Mental Health Experienced By Vietnamese

Since mental illnesses are considered as taboos, many community members may not share their mental health concerns with others. Thus, the perspectives provided by the community leaders may have only been a very small subset of all the mental health obstacles experienced by the community. Additionally, since there is a low use of formal mental health resources, a few providers reported not having extensive contact with Vietnamese clients specifically. Therefore, what they provided may have been generalizations of what they observed from Vietnamese Americans and also other Asian Americans.

VII.III. Diversity of Participants

Although the study included medical and mental health professionals, no primary care providers were interviewed. As found in the Asian American Quality of Life Survey, Vietnamese Americans in Austin tend to report to their primary care providers if they have a mental health problem (Jang, 2016). Thus, family medicine doctors may have been able to provide diverse and unique observations regarding the local community's experience with mental health. Furthermore, the study did not include perspectives from faith-based leaders. Results from a Southern California study conducted in 2012 showed unique mental health perspectives from Vietnamese American Buddhists (H. T. Nguyen, Yamada, & Dinh, 2012). Religious leaders may have been able to speak about the association between mental illness and spirituality. Furthermore, since the participants were recruited based on the researcher's knowledge of existing organizations that support the Vietnamese community, then through snowball sampling, there may be more key informants in the community that were not contacted for the study.

VII.IV. Positionality Statement

I would also like to acknowledge my experience as a Vietnamese American living in the Austin community. I immigrated to the United States when I was 11 years old and have been living in Austin, Texas since then. Being a Vietnamese American who is a member of the Austin community may have influenced how the participants responded to my study compared to if a person of a different race or ethnicity were to conduct the interviews.

VIII. CONCLUSION

My results from the current study confirmed that there is a wide range of cultural,

historical, and social factors that may negatively influence the mental well-being of Vietnamese Americans. More importantly, the results also emphasize the plethora of barriers to mental health care experienced by the Vietnamese community in Austin, Texas. Findings from the current study also challenge the widely held model minority myth.

Participants from the study collectively shared a concern for lack of mental health resources in the city that accommodate the cultural differences of Vietnamese Americans compared to the western culture. The Asian American Quality of Life Survey showed the low utilization of mental health services among Asian Americans, including Vietnamese Americans, in Austin, Texas. The results from the current study stress that low utilization does not constitute low need for mental health resources. Thus, this study highlighted the underlying barriers that may hinder Vietnamese Americans and other Asian Americans in the city from seeking professional mental health care.

The testimonials from the Vietnamese leaders and providers call for further initiatives to dedicate resources to bridge mental health care disparity in racial and ethnic groups. Furthermore, it is important to conduct further disaggregated research for specific ethnic groups and allocate resources accordingly, since research that focuses on Asian Americans as a whole fails to reveal the challenges of more disadvantaged ethnic groups. The recommendations from this study include short-and long-term solutions that will help alleviate some barriers to mental health care experienced by the Vietnamese community, and potentially other Asian communities in Austin. Implementing educational and outreach efforts to inform the community about mental illness at earlier stages will prevent the overburdening of the health care system in the future, especially with the rapid population growth in Austin.

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