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Demographic, Contextual, and Cultural Barriers to Mental Healthcare Seeking Behavior in the United States Among Southeast Asian Women Refugees: A Systematic Review

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An abstract of
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Abstract

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By
Sandra K. DiVitale

Little is known about Southeast Asian refugees' American mental healthcare seeking behavior. Previous research has indicated that Southeast Asian refugees underutilize American mental healthcare services. However, the reasons for this underutilization are not fully understood. This systematic review examines the relationship between contextual, cultural, and demographic factors and their influence as barriers to accessing these services among Southeast Asian American refugees, especially women. An index search was conducted for peer-reviewed journals published from 1975 to 2019 using *PubMed, EMBRACE, Web of Science, PsychInfo*, and *Anthropology Plus* databases. This search was followed by manual handsearching and snowballing techniques to identify gray literature. Sixteen publications in total were included in the final analysis.

Results from the review suggest that Southeast Asian women refugees have more positive attitudes toward and willingness to use American mental healthcare than men. Women refugees' experiences of greater pre-migration and resettlement psychological distress are accredited for their motivation in having a more favorable view of American mental healthcare services. Review studies challenge previous research findings that Southeast Asian refugee underutilize these services. Findings suggest instead that American standards for minimally adequate mental healthcare do not meet the needs of Southeast Asian refugees when they do present for care. Southeast Asian women refugees who experienced domestic violence indicated a preference for community, peer-based support groups that provide instrumental learning and psychoeducation instead of seeking outside mental healthcare. Cultural barriers are found to be less influential through time than structural/contextual barriers such as continued extreme poverty with limited access to transportation and health insurance. Recommendations include multi-level interventions that address decreasing barriers to accessing American mental healthcare at the individual/family, community, and societal levels.

Keywords: refugees, American mental healthcare access, barriers to access, Southeast Asian, Cambodian, Vietnamese, Laotian, Hmong

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Dedication and Acknowledgements

Do not go where the path may lead, go instead where there is no path and leave a trail.

—Ralph Waldo Emerson

May this thesis help articulate "the pain of untreated intergenerational trauma in refugee families, . . . to the fear and pain of deportation" that Southeast Asian refugees face in the United States (Southeast Asia Resource Action Center [SEARAC], 2019, para. one). In so doing, I invite change in how we Americans provide increased access to adequate, culturally competent mental healthcare services, especially for Southeast Asian women refugees, to help hear their often-unheard voices.

Toward that effort, I would like to thank my patient and very helpful thesis committee with Dr. Rebecca Upton, committee chair, and Dr. Laurie Gaydos, my field advisor. Without their help, I would not have had this opportunity to serve Southeast Asian American women refugees differently.

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Select Abbreviations

AA	Asian American
CDC	Centers for Disease Control and Prevention
DSM-5	*Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*
DV	Domestic Violence; also referred to as Intimate Partner Violence
LEP	Limited English Proficiency
PD	Psychological Distress
PTSD	Post-Traumatic Stress Disorder
SEA	Southeast Asian
SEAA	Southeast Asian American
SIT	Social Identity Theory

SEARAC	Southeast Asia Resource Action Center
UNHCR	United Nations High Commission for Refugees
WHO	World Health Organization

Chapter One: Introduction

Background

Since 1975, over 3.1 million Southeast Asian (SEA) refugees have resettled in the U.S., making them the largest refugee group in U.S. history (Lee, 2016). SEA refugees have fled war-torn countries, exposure to which increases the likelihood of developing depression and Post-Traumatic Stress Disorder (PSTD; Bogic, Njoku, & Priebe, 2015; Miller & Rasmussen, 2017, April). Despite many having been in the U.S. for over 40 years, SEA refugees face further stress from the threat of possible deportation under the current U.S. political climate (Nguyen, 2017, March 16). Yet, little is known about SEA refugees living in the U.S. and their mental health seeking behaviors (Leong & Kalibatseva, 2011, March). Even less is known about the specific needs of SEA women refugees in this regard (Augsberger et al., 2015). For example, SEA refugee women have a largely unmet need for support in domestic violence situations for which they tend to not seek mental health services (Ho, Dinh, & Smith, 2017; Lee & Hadeed, 2009, April).

Two challenges have been identified from previous research concerning SEA refugees living in the U.S. in terms of seeking U.S.-based, mental health services. These include: 1) underutilization services at rates of up to three times that of Caucasians, and 2) premature termination of mental health services at significantly higher rates than Caucasians (U.S. Department of Health and Human Services [DHHS], 2001). This thesis focuses specifically on examining the demographic, contextual, and cultural barriers that impact the underutilization of these services by SEA refugees living in the U.S.

Problem Statement

There is a need to understand the relationship between barriers among SEA women refugees living in the U.S. and their mental healthcare seeking behavior following resettlement.

Purpose Statement

The purpose of this thesis is to understand the relationship between barriers among SEA refugee women living in the U.S. and their mental healthcare seeking behavior following resettlement in order to facilitate usage of these critical services. This thesis examines the contextual, cultural, and demographic barriers that impact the underutilization of these services among SEA women refugees living in the U.S. The following sections within this chapter serve as background information on countries of origin as well as the reasons and conditions under which SEA migrated to the U.S. Thereafter, this thesis identifies limitations and gaps in current research about the contextual/structural, cultural, and demographic factors and their interactions, laying the foundation for the development of more effective interventions intended to increase Southeast Asian American (SEAA) women refugee engagement in American mental healthcare services.

Research Objectives

1) Identify how SEAA refugee characteristics as gender, ethnicity, and culture influence help-seeking behaviors for American mental healthcare services,

2) Identify what other contextual/structural, cultural, and demographic variables impede SEAA women refugees from accessing American mental healthcare,

3) Identify the strongest predictor barrier variable for each of the three SEAA ethnic groups, blocking their engagement in and underutilization of American mental healthcare services,

4) Examine whether the research assumption that increased acculturation leads to increased U.S. mental healthcare seeking behavior holds true for SEAA refugees,

5) Identify current interventions intended to decrease barriers to accessing American mental healthcare in SEAA refugees, and

6) Propose future interventions to decrease barriers to access for American mental healthcare for SEAA refugees.

An Overview: SEAA Refugee Countries of Origin

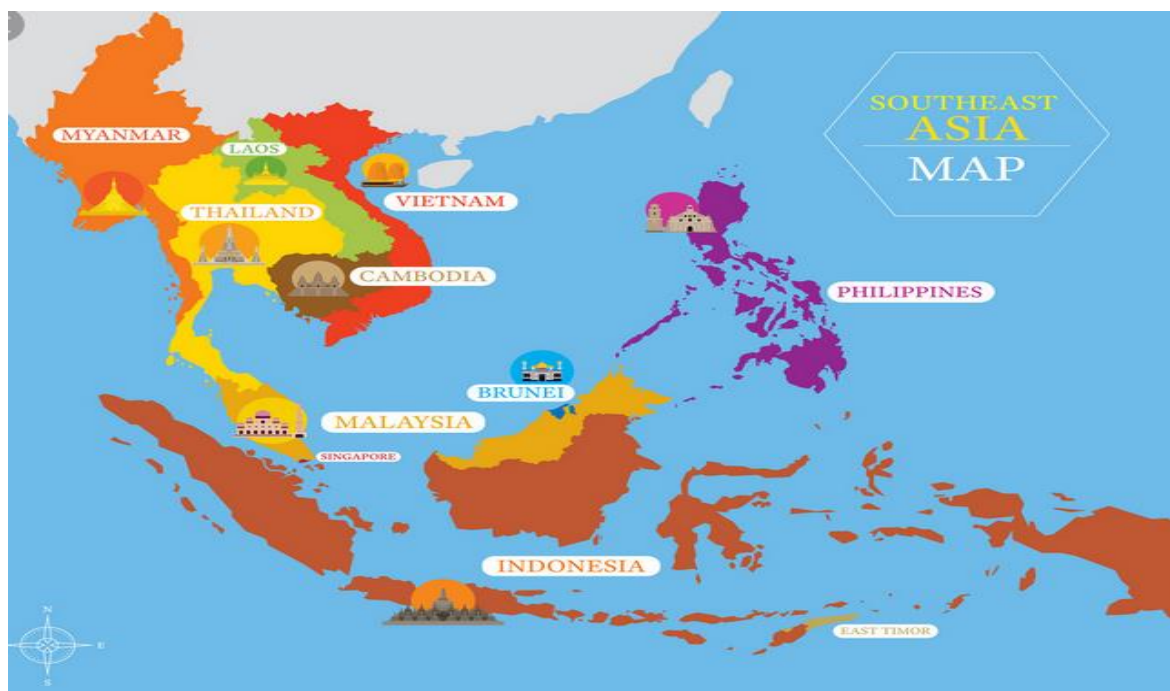
Despite the fact that Asian Americans (AAs) comprise up to 40 different cultural subgroups, they are often viewed as a single group. Therefore, the mental health needs specific to Asian refugee subgroups such as SEAAs are often overlooked (Hsu et al., 2004). While Southeast Asia is made up of 11 different countries (see Figure 1.1), research studies and professional organizations such as the Southeast Asia Resource Action Center (SEARAC) use the term Southeast Asia to refer solely to those originating from Cambodia, Laos, and Vietnam (Ngo & Lee, 2007, December; Uba, 1992, September-October). To ensure consistency, this thesis limits findings to these three SEA countries.

Many research studies and professional organizations limit their focus to those coming from Cambodia, Laos, and Vietnam because of their shared historical and political experience. Specifically, SEAs came to the U.S. as refugees resulting from the American occupation during the Vietnam War. This forced exodus makes SEAs unique to other AA groups, because the majority of SEAs came to the U.S. as refugees, not immigrants (Portes & Rumbaut, 1996; Uba, 1994). Prior to 1975 when the first wave of SEAs began to arrive, discriminatory U.S. immigration policies under the 1790 Naturalization Law limited entry to only Caucasians. In fact, from 1924 to 1950s, Asian immigration was completely banned (Shibusawa, 2019). Therefore, the

SEA influx is mainly a recent migration within the last 50 years or less since the end of the Vietnam War.

This thesis postulates that any meaningful, culturally competent intervention addressing barriers to mental health utilization must be based upon a familiarization of this subgroup's stressors arising from their unique historical, cultural, and political contexts. This includes an understanding of their shared experience of war, frequent resettlement in camps in neighboring countries, migration to the U.S., and acculturation (Nguyen, 2014, April). Previous research showed that SEAAs are at increased risk for the development of psychiatric disorders due to their spectrum of experiences from leaving their native countries, memories of exposure to combat that likely included the witnessing of the deaths of relatives and others, and being interned in concentration camps (Abueg & Chun, 1996). Prevalence of psychiatric disorders in SEAAs is discussed in Chapter Two.

Figure 1.1 ***Map of Eleven Southeast Asian Countries***



Source: VectorStock (2019). *Southeast Asia map*. Retrieved from http://vectorstock.com/15738463

SEA History of Migration to the U.S.

Overview. As mentioned above, the development and implementation of meaningful, culturally competent interventions must be based upon a greater understanding of the historical context of SEAs' forced migration to the U.S. This context is especially important for those involved with community out research needed to address domestic violence (DV) and intergenerational trauma which have become increasingly important issues within SEA communities resettled in the U.S.

Overall, the flight of SEA refugees to the U.S. took place across three different waves (Davis, 2000). While most SEAs faced common pre-migration stressors, those fleeing each of the three respective countries had their own specific hardships which are therefore detailed separately as follows.

Vietnamese Refugees. The first wave from 1975 to 1979 was composed of approximately 125,00 Vietnamese educated elite, professionals, and those who had worked with the U.S. military or South Vietnamese government. This refugee subpopulation had the advantage of migrating in family units through U.S.-sponsored evacuations by sea or aircraft (Abueg & Chun, 1996). Those who migrated during the second wave from 1979 to 1980 were made up of two distinctly different groups. The first group was made up of family members of those who had fled during the first wave, while the second was mostly from rural areas with less educated backgrounds than their predecessors (Ngo & Lee, 2007, December).

The latter group are often called the boat people due to their escape on tiny fishing boats (Abueg & Chun, 1996). The boat people endured severe trauma with approximately half of the more than 200,000 refugees dying at sea in their overcrowded and unseaworthy vessels (Mollica, 1994). Additionally, 80% of their boats were assaulted by pirates from Thailand, Malaysia, and

the Philippines, averaging three waves of assaults from each (Fox et al., 1995). Because this thesis focuses also on the mental health concerns of women refugees, it is important to note that these attacks included vicious sexual assaults on the female Vietnamese passengers, the severity of which most Vietnamese women may never divulge (Kleinman, 1990). These assaults violated, shamed, and stigmatized not only these women but also their family members (Mollica, Wyshak, & Lavelle, 1987; see the section on “Theoretical Framework: Social Identity Theory” for further explanation for implications of shame and stigma for the individual, families, and communities).

Cambodian Refugees. The toll of the Khmer Rouge Regime (1975-1979) on Cambodians was horrific. Mortality estimates range from one to three million Cambodians during this time out of a total national population of seven million (Chan, 2004). Cambodians died from a combination of disease, starvation, and/or torture and execution, often targeting Buddhist monks and the educated elite (Kinzie, 1989). Executions, forced family separations, and work camp assignments were common place as the Khmer Rouge Regime pushed for the creation of a Marxist, agrarian culture emulating that of Mao Tse Tung’s Cultural Revolution. The objective of these sweeping changes was to wipe out any signs of Western influence (Abueg & Chun, 1996). Specifically, work camp environments, intended to re-educate the masses, were characterized by imposed hard labor, torture, beatings, disease, and starvation. Executions were also common in the work camps (1996).

In 1979, the Vietnamese invaded Cambodia, causing Cambodians to flood into Thailand by foot after which they resettled principally into the U.S., France, or Australia (Kinzie, Boehnlein, & Sack, 1998). Subsequently, these Cambodian refugees formed part of the third wave of SEAs into the U.S., beginning in 1982.

Laotian Refugees. The Laotian, Hmong, and Iu Mien ethnic groups in Laos had a pre-migration experience similar to the Cambodians and Vietnamese with one major exception. The Laotians, especially the Hmong, were recruited by the U.S. Central Intelligence Agency to fight the American secret war, a spin-off of the Vietnam War. The objective was to create another means by which the Americans could subvert communist forces in both Vietnam and Laos. When the Vietnam War ended, the Laotians who fought for the U.S. military expected the same safe U.S.-sponsored evacuation efforts provided the Vietnamese who had likewise worked with the U.S. military (Quincy, 1995).

However, that never happened. Hmong and other Laotians who fought for the Americans were left stranded, becoming targets for the subsequent regime. This regime was established in Laos in 1979 by Pathet Lao as a Marxist government with the aid of the Vietnamese (Quincy, 1995). One-third of the Hmong people perished during the Vietnam War. Many more died in the concentration labor camps under the Pathet Lao regime's rule. Thousands of Laotians were able to escape this regime, going by foot into Thailand (Tatman, 2004). Once reaching Thailand, they were largely detained in refugee camps (Abueg & Chun, 1996).

Laotian background is also unique among the SEAA refugees. Laotians came from diverse backgrounds with different social, economic and educational levels. The Hmong and Iu Mien people were more rooted in "tribal, agrarian, and preliterate societies located in the mountainous regions of Laos" (Abueg & Chung, 1996, p. 293). Further-more, given they were denied a safe, U.S.-sponsored evaluation at the end of the Vietnam War, in post-migration they maintain a sense of mistrust of and betrayal by the U.S. government (Dinh, 2009). That sense of mistrust and betrayal combines with other factors to contribute to the Laotians underutilization of American mental health-care services in resettlement (2009).

Laotians comprised part of the third wave of SEA refugees into the U.S., beginning in 1982 (Davis, 2000; Ngo & Lee, 2007, December). As recently as 2010, Hmong refugees resettled in Minnesota, forced out from the closure of the Wat Tham Krobok refugee camp in Thailand (Thao, Leite, & Atella, 2010, June).

Current Migration Patterns within the U.S. Today, the SEA refugee community in the U.S. is composed of refugees who migrated due to the Vietnam War and their descendants, some of whom call themselves the 1.5 generation (Chan, 2006). According to the 2000 U.S. Census, SEAAs account for 15.2% of those described as Asian and/or Pacific Islanders, totaling more than 3.1 million people (Ngo & Lee, 2007, December. However, according to an earlier report from the U.S. Census Bureau, this estimate is likely unrepresented by approximately 28% (Rynearson & Gosebrink, 1989, June). The authors of the report pointed to "language, cultural differences and the particular circumstances of resettlement" as contributors to this underestimation (1989, p. 1).

As of 2000, Vietnamese make up the largest number of SEAAs with a population of approximately 1.2 million. The Vietnamese reside mostly in California, followed by Texas, Washington, Virginia, Massachusetts, Pennsylvania, and then Florida (Ngo & Lee, 2007). Likewise, the majority of the 206,000 Cambodian Americans live in California, followed by Massachusetts, and Washington (2007). Hmong Americans principally from Laos numbered 186,000 in 2000, with most currently living in large urban areas in California, Minnesota, and Wisconsin (2007). Appendix A provides SEAA national demographics across a U.S. map as of 2010.

Understanding Migrant Status in Relation to Potential Mental Health Outcomes

Overview. Foreign-born Asians living in the U.S. are often differentiated both by their country of origin and by the conditions under which they left their countries. These conditions are reflected in their refugee or immigrant status (Hsu et al., 2004). As noted earlier, SEAAs are unique to many other AAs in that most came to the U.S. as refugees under duress, escaping the Vietnam War (Portes & Rumbaut, 1996). That exodus included those who had opposed the communist regime as well as those who had worked with the U.S. military or various SEA governments. Others included researchers, teachers, healthcare professionals, and lawyers who were part of the educated elite, often also targeted by incoming communist regimes (Davis, 2000).

Refugee Status. If SEAs stayed in their native countries, many would have likely been immediately executed, tortured, or imprisoned. This would have been true for the specific targeted individuals as well as their entire families (Davis, 2000). Their urgent flight allowed these populations to take refuge in the U.S. as enumerated under U.S. Law. This law defines a refugee as "a person who is unable or unwilling to return to his or her home country because of 'a well-founded fear of persecution' due to race, membership in a particular social group, political opinion, religion, or national origin" (American Immigration Council, 2019, June, p. 2).

This definition is founded upon the United Nations High Commission for Refugees (UNHCR, 2010, December) Convention and Protocol Relating to the Status of Refugees 1951 and 1967. The U.S. is a signatory of the Convention and Protocol as of 1968. Furthermore, due to the influx of SEA refugees following the Vietnam War, the U.S. Congress passed the Refugee Act of 1980 which formally incorporated the UNHCR convention's definition into U.S. Law. This law provides the legal framework for the current U.S. Refugee Admissions Program (June

2019) that is under current political assault, yet another source of ongoing distress for SEAA refugees (SEARAC, 2019, May 31).

According to the U.S. government's current standards, registered refugee status accords individuals the right to work upon entry. However, refugees must have a Form 1-94 (Arrival/ Departure Record) on file that is stamped with employment authorization (CitizenPath, 2013-2019). Refugees must likewise apply for a green card one year after entry or risk being deported. This is recommended, should conditions in their countries of origin change such that they would no longer be eligible for refugee status. Likewise, traveling back to their countries of origin while still retaining American refugee status might put these travelers at risk of not being able to re-enter the U.S. (2013-2019).

Immigrant Status. Contrast this migrant status to the U.S. government's definition of an immigrant. According to the U.S. Department of Homeland Security (2018, March 16), an immigrant is an alien (e.g., not a U.S. citizen or national) who is granted the right by the U.S. Citizenship and Immigration Services to live permanently in the U.S. This includes the ability to work without restrictions. These individuals are also called Lawful Permanent Residents who eventually receive a green card as evidence of their immigrant status (2018, March 16).

Contribution to Different Mental Health Outcomes. In terms of mental health implications, it is important to understand the markedly different conditions SEAA refugees and immigrants face during pre- and post-migration. In his kinetic model, Kunz (1973) best explained these distinctions in terms of different flight motivations and patterns.

In terms of motivational factors, Kunz (1973) described refugees as pushed out of their country of origin, fleeing to seek asylum from traumatic events in their native lands. On the other hand, immigrants were pulled toward a new country for resettlement, drawn by perceived

opportunities for a better quality of life, better jobs, and education. Therefore, immigrants made a voluntary decision to migrant, whereas refugees were forced to involuntarily flee. The resulting perceived option to return to their countries of origin is yet another basis of comparison (1973). Typically, immigrants have the ability to return to their native countries, but refugees likely cannot return without risk of physical harm as well as a revoking of refugee status (CitizenPath, 2013-2019; Westermeyer, 1990).

The crux of this comparison is that refugees were often unprepared for the journey ahead when relocating (Pernice & Brook, 1994). Therefore, typically they felt that they had little or no control of their future. This feeling of uncertainty continues through resettlement. On the other hand, immigrants had the advantage of being able to plan for their departure, providing a sense of control of their future (1994). Furthermore, once resettling in the U.S., immigrants are given more legal protection than refugees (Westermeyer, 1990). Lastly, refugees faced far more dire circumstances not only within their country of origin but also during their migration experience (Hsu et al., 2004). While within refugee camps, these dire circumstances included violence, poor living conditions with insufficient access to clean water, sanitation, and inadequate personal hygiene facilities. Furthermore, once arriving in the U.S., they face situations that range from discrimination, unemployment, racism, and at times separation from family members (2004).

Because of these added risk exposures to violence, persecution, and uncertainty, refugees often experience mental health challenges disproportionate to others (Porter & Haslam, 2001). In fact, exposure to conflict in their countries of origin alone is associated with increased development of psychiatric disorders than in those who did not flee (2001). However, forced migration is said to not lead to mental illness in and of itself (Kirmayer et al., 2011, September 6). Instead, Porter and Haslam (2001) suggested that conditions post-exodus often supersede conflict-related

exposures as the primary determinants of mental health. For example, Silove and colleagues (2000) stated that individuals are at higher risk for psychiatric disorders when faced with continuous uncertainties about legal status in resettlement. It is therefore important that clinicians and public health officials better understand how conditions within resettlement placements can increase refugees' risk for psychopathology. Instead, clinicians and public health officials tend to focus solely on pre-migration conditions as the source of psychiatric disorder development (Porter, 2007). In order to help overcome this gap in understanding, this thesis presents findings on SEAA refugees' overall experiencing with mental illness from pre-migration to resettlement.

Theoretical Framework: Social Identity Theory in Relation to SEAA Refugee Mental Healthcare Underutilization

Humans are socially oriented. Besides being a part of our external relationships, social groups shape our internal, mental representations. We internalize group behavior which, in turn, provides us with a sense of social identity (Haslam et al., 2009). To better understand this process, Tajfel and Turner (1979) developed Social Identity Theory (SIT) more than 30 years ago. This theory describes how individuals define their sense of self-worth by their membership in certain social groups. Across the past 30 years, SIT has been sidelined in mainstream, American social psychology. However, this theory's ability to describe behavior, including health seeking behaviors, is increasingly acknowledged as American society becomes more ethnically diversified.

Tajfel (1972) described social identity as the "knowledge that [we] belong to certain social groups together with some emotional and value significance to [us] of [our] group membership" (p. 31). Olmedo (1979) clarified that individuals vary widely in terms of how much they internalize stereotypic group norms and values. However, like Asians overall, SEAs are

collectivist in nature which places greater emphasis upon the group's needs over the individuals' needs (Xiong et al., 2018). Therefore, Xiong and colleagues (2018) asserted a SEA refugee is likely to perceive that his or her very survival is dependent upon his social/cultural group's continued acceptance, particularly when faced with acclimating to a different host country. With continued cultural group acceptance, an individual is likely to experience "stability, meaning, purpose, and direction" which tends to provide a positive foundation for that individual's mental health (Haslam et al., 2009, p. 5). On the other hand, rejection from an individual's social group would likely take a negative toll on that individual's mental health (2009).

Through the lens of SIT, SEAA refugee underutilization of U.S. mental healthcare services can be understood differently. In Southeast Asia, the American concept of mental health is nonexistent. Instead, SEAs use indigenous healers and shaman (Ying, 2001). Once resettled in the U.S., SEAs seek out medical professionals secondarily, somatizing any of their possible mental health issues (Hsu et al., 2004). Somatization is a culturally acceptable way to express mental health conditions to avoid the stigmatization that surrounds mental illness (Lin et al., 1985; see Chapter Two for a more detailed description).

Stigma can also be viewed according to SIT. Tajfel and Turner (1979) described how people tend to parse the world into "them" versus "us" based upon a process of social categorization. SIT calls the "us" group the in-group, typically the dominant group in a society, whereas "them" is the out-group or "the other." In-group members bolster their self-esteem by being in a more powerful group which typically debases the out-group. For SEAA refugees, not only the individual but also his family members carry the stigma of mental illness by being subsequently relegated to the out-group (Lauber & Rossler, 2007).

It follows that SEAA refugees are hesitant to initiate American mental health services which are counter to their cultural group behavioral norms and which could therefore invite additional shame or stigma (both in-group and out-group stigma). For those who do initiate these services, a study by Sue and McKinney (1975, January) found that approximately 52% of Asian clients overall did not return to American mental health clinics following their first visit. Chapter Two expounds on these themes when discussing specific barriers to SEAA usage of U.S. mental healthcare.

Significance Statement

This thesis addresses concerns for the increasing number of SEAA refugees in the U.S. who suffer psychological distress (PD) in significantly larger numbers than the general population, while also experiencing social and resource inequities. These inequities exist due to this population's disproportionate exposure to war-related trauma and ongoing daily stressors in resettlement. Typically, these daily stressors include discrimination as SEAA attempt to assimilate into American culture. While the most recent generation of SEAA refugees did not experience the Vietnam War directly, the intergenerational effects of war exposure are apparent, appearing as scares of cultural historical trauma in their refugee communities.

Despite these challenges, previous research stated that SEAA refugees are less likely to engage in formal, ongoing American mental healthcare services. This thesis explores this disproportionate mental healthcare usage by examining proposed contextual/structural, cultural, and demographic barriers to initiating these services for SEAA refugees in general and SEAA women refugees in particular. Specifically, there is a dearth of research that addresses SEAA refugee gender-based differences in the prevalence and trajectory of mental illness as well as their American mental healthcare seeking behavior. In addition to exploring these gender-based

differences, this thesis recommends steps to help bridge perceptional and structural barriers to SEAA refugee mental healthcare access and utilization.

Chapter Two: Review of the Literature

Definitions of Select Terms and Constructs

Access to Mental Healthcare. According to the National Institute for Health and Care Excellence (2011, May), access to mental healthcare is a complex topic that involves at not only what makes up the ability to physically initiate mental healthcare but also the ability to have effective healthcare treatment, including the engagement of culturally competent mental healthcare providers.

Acculturation. According to Redfield and colleagues (1936), "acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact [with each other] with subsequent changes in the original culture patterns of either or both groups" (p. 149). This definition describes acculturation as a dynamic process between the host country and the individuals coming in contact with it.

Attachment Bond. This is the connection between an infant and his or her primary caregiver, decisively impacting the subsequent psychological, physical, social, and emotional health of the infant. While forming this bond is the easier at birth, it is still possible to create a healthy bond with older children (Benoit, 2004, October).

Bad Wind. Bad wind is a culture-bound syndrome which Cambodians use to describe an illness experience that includes muscle tension or dizziness. Wind is considered a source of energy that runs through the body, a blockage of which is described as tension in joints or the numbing of a bodily limb. The latter is attributed to a blockage of blood flow. When a Cambodian patient has these bodily experiences, he or she then fears that he will have a heart attack, be unable to breath, and/or will have blood vessels bursting in his neck or head. Cambodians believe that these symptoms can lead to blindness or death (Du & Lim, 2015).

Cultural Competency in Healthcare. According to the Centers for Disease Control and Prevention (CDC, 2008), there is no universally accepted definition of cultural competency in healthcare. However, at its core, this generally includes attitudes, skills, behaviors, and polices that give organizations and their staff the ability to work effectively in cross-cultural healthcare contexts. Furthermore, it assumes the ability of organizations and their staffs to continually update their skills and knowledge base about health-related beliefs, attitudes, practices, and community styles with exposure to diverse patients and their family members. This dynamic knowledge base and skill set is needed to improve services, grow effective programs, empower communities by increasing their participation in the healthcare system, and close the gaps in health disparities that minority groups face today in the U.S. (2008).

Cultural, Collective, or Historical Trauma (psychological). This term reflects how emotionally and/or physically distressing events can leave an indelible imprint on an entire cultural group's memories and identities (Alexander et al., 2004).

Culture-Bound Syndromes. This construct refers to a repeated cluster of symptoms and behaviors that are endorsed in a specific geographic area. These symptoms and behaviors may be the result of both physical and PD in an individual. However, these endorsed symptoms and behaviors may not overlap with a specific psychiatric disorder classification in the *Diagnostic and Statistical Manual* (*DSM-5*; American Psychiatric Association [APA], 2013).

Explanatory Models of Illness. Kleinman and colleagues (1978) first introduced this term to describe the culturally influenced process of understanding illness in terms of symptoms and causation of those symptoms leading to expectations of treatment and treatment source. This illness comprehension process can also be described as culturally influenced beliefs that individuals have about "misfortune, suffering, illness, and health" (Dinos et al., 2017, p. 106).

Idioms of Distress. Idioms of distress pose a challenge to Western mental healthcare. This construct was coined by Nichter in 1981 to distinguish between psychosocial distress and colloquial reference to symptomatic presentations that are socially and culturally constructed. However, idioms of distress have not been endorsed as culture-bound syndromes, since they may be specific to an individual but not necessarily by his or her larger cultural group. Idioms of distress are best understood within the context of an individual's illness narrative (Du & Lim, 2015).

Immigrant. An individual who has legally immigrated to the U.S. with lawful, permanent status which is documented with a green card (Hilado & Lundy, 2018).

Intergenerational or Historical Trauma (psychological). This type of psychological trauma occurs when the trauma faced by previous generations has not been addressed. As a result, these unaddressed, adverse mental health consequences are passed down through the generations both within families and entire communities (Duran, 2006). Previous research suggested lasting effects from unresolved trauma tend to worsen with each generation, adversely impacting individuals and whole communities alike (2006).

Mental Health. The World Health Organization (WHO, 2018, March 30) defined mental health as "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 contribute to her or his community" (para. one). According to the WHO (2018, March 30), mental health is just one aspect of being a healthy person whereby "physical, mental, and social well-being" are not simply reflective of an absence of disease. Simply put, "there is no health without mental health" (2018, March 30, para. one).

Psychological Distress (PD). "…all forms of [psychological] distress are locally shaped, including the *DSM-5* disorders" (APA, 2013, p. 758). From this perspective, many *DSM-5* diagnoses can be understood as operationalized proto-types that started out as cultural syndromes and have become widely accepted because of their clinical and research utility. Across groups, there remain culturally patterned differences in symptoms, ways of talking about distress, and locally perceived causes, which, in turn, are associated with coping strategies and patterns of help-seeking" (2013, p. 758). PD level is typically used in research as a measure of unmet mental healthcare need and/or underutilization of these services (Marshall et al., 2006, October).

Refugee. According to the United Nations 1951 Convention relating to the Status of Refugees and as adopted by the U.S. government in 1968, a refugee is a person who "owing to well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country" (UNHCR, 2010, December, p. 3). A person receives the refugee legal status once registering for entry in the U.S. through the U.S. Citizenship and Immigration Services is a branch of the U.S. Department of Homeland Security (Hilado & Lundy, 2018).

Somatization. Somatization is a culturally sanctioned, bodily expression of personal and social distress for which no underlying, organic pathology can be found (Lin et al., 1985). SEAAs tend to somatize their mental health complaints when presenting for treatment as a way of minimizing public stigma that could result from their communities (Ali, 2014).

Stigma. This is a label of shame or disgrace borne by individuals or groups (e.g., the out-group according to SIT in Chapter One) which other groups, usually the dominant group in

society (e.g., the in-group according to SIT), place upon them. This label often leads to expectations of rejection and discrimination (Parekh, 2014).

Therapeutic Alliance. Also known as the therapeutic relationship, this represents the connection between a mental healthcare professional and his or her client. Through this alliance, therapist and client engage in therapy in the hopes of creating beneficial client change (Gelso & Carter, 1994).

Trauma (psychological). Trauma is typically defined as emotionally and/or physically distressing events that overwhelm an individual's perceived ability to cope. The result of that exposure may or may not lead to psychological trauma, based upon the individual's appraisal of that that event or events. The individual's appraisal as to whether the event(s) overwhelm his perceived ability to cope is considered more important for mental health outcome than the exposure itself (Mikulincer & Florian, 1996).

Prevalence and Social Determinants of SEAA Refugee Unaddressed Mental Health Issues

Overview. The U.S. Surgeon General's Report (DHHS, 2001) on minority mental health was among the first to question the low documented prevalence of mental health disorders in AA populations. This report flagged the possibility that the American clinical assessments used to determine prevalence were not culturally sensitive enough to capture actual diagnosable disorders by likely ignoring culturally informed ways of typically somatizing mental health problems (Ali, 2014). Furthermore, this report proposed that prevalence rates were also erroneously understated because they were based upon AAs who did seek American mental health treatment. In contrast, this report pointed out that most AAs did not tend to use these services regardless of what levels of mental illness they could have been experiencing (2014).

Furthermore, Sue and colleagues (2012) stated that the underutilization of mental health services does not accurately portray the true elevated rates of psychiatric disorders that specifically SEAA refugees experienced and continue to experience decades after their initial resettlement in the U.S. Recent, large-scale research studies have revealed a better picture of those rates, especially for SEAA. Seminal studies by Mollica and colleagues (1998) showed for the first time there is a dose-effect relationship between greater exposure to certain types of traumatic experiences such as armed conflict to the development of subsequent, more severe psychiatric symptomology among Vietnamese and Cambodian refugees. A subsequent meta-analysis by Steel and colleagues (2009) found also that specific traumatic events in pre-migration increased the likelihood of the subsequent prevalence of PTSD and depression in populations exposed by mass conflict and displacement. Specifically, their study found that the most robust factor associated with the development of PTSD is torture, while serial exposure to potentially traumatic events overall is the strongest factor associated with the development of depression (2009).

Likewise, Marshall and colleagues (2005; n=490) found that 62% of their Cambodian study participants were still experiencing chronic PTSD as their primary diagnosis with 71% also experiencing co-occurring major depression in the past 12 months. On the other hand, of those with major depression as their primary diagnosis, 86% had secondary, chronic PTSD. Further-more, 51% reported experiencing depression alone (2005). According to the International Society for Traumatic Stress Studies (ISTSS, 2017, November 9), co-occurring PTSD and depression is often prevalent across refugee populations, reflecting greater functional impairment than if one disorder were present alone. In Marshall and colleagues' study (2005), these rates remained elevated in their study sample despite having had Western mental healthcare treatment

across one to five years. Study participants reported severe pre-migration exposure to trauma with 99% almost dying from starvation, 90% had a murdered friend or family member, and 54% reported being tortured (2005).

In the same study, Cambodian participates reported that trauma experiencing continued during post-migration with 70% reporting having violence directed toward them or family members since relocating to the U.S. (Marshall et al., 2005). Findings from Miller and colleagues' study (2002) suggested that, because post-migration stressors are consistent predictors, trauma experienced in post-migration is as powerful in advancing the development of mental illness as are prior war experiences. They were therefore positively associated with the development of PTSD (Steel et al., 1999). Steel and colleagues (1999) reasons that this post-migration stressors continue to deplete refugees' coping resources, making them more vulnerable for more psychological distress (PD). Types of post-migration stressors in the U.S. tend to be increased poverty, unemployment, and unsafe and inadequate housing (Nicholson, 1997; Steel et al., 1999).

Gender Differences. Nicholson (1997) added that low-income SEAA women refugees experienced more PD than their male counterparts. Furthermore, unmarried SEAA women refugees experienced even greater prevalence of depression than their male counterparts. Findings suggested further that being isolated from their social networks and/or their families of origin is more predictive of the development of anxiety disorders other PTSD in SEAA women refugees (1997).

Likewise, SEAA women refugees experienced increased domestic violence (DV) within their families of origin (Min, 2001; Thao et al., 2010, June). Mounting pressure on traditional marriage roles, especially during the initial years of U.S. resettlement, are often

due to high unemployment rates among SEAA male refugees. At the same time, SEAA women are often increasingly able to find better employment options due to the greater increased demand for unskilled labor in the U.S. than in their countries of origin. This reverse in once traditional gender roles often leaves the males in their families feeling alienated in the process, potentially leading to greater risk for DV (2001; 2010, June).

Du and Lim (2015) explained that DV is, in fact, tolerated in several Asian cultures whereby the women and children become scapegoats of their husbands'/fathers' impatience. Tolerance of DV in their countries of origin lays the foundation for SEAA women becoming their families' DV targets in the U.S. due to post-migration stressors. DV includes holding women and children hostage in their houses and taking their passports to keep them from leaving. Physical and mental abuse can likewise escalate against SEAA women and children, perpetuated by the husbands' entire families (2015).

Despite being culturally sanctioned, DV is typically kept a family secret to save face within their AA communities as well as evade criminal prosecution (Masaki and Wong, 1997). Nonetheless, several pilot studies, using multilingual collection protocols, supported initial evidence of an increased risk for DV, especially in SEAA refugee groups. For example, Tran (1997) found that, of the Vietnamese refugee women in New England she interviewed, 53.3% disclosed they were experiencing IPV. In another survey, 44% of Cambodian refugees interviewed said they knew a SEAA woman refugee being abused by her partner (Yoshioka & Dang, 2000). In addition, some previous studies found a link between a SEAA woman refugee's tactic acceptance of DV and having been abused as a child (Ho, Dinh, & Smith, 2017).

Nonetheless, Ho, Dinh, and Smith (2017) stated that these numbers are "consistent with the overall prevalence of IPV [Intimate Partner Violence] in the United States" (p. 515). The

difference is SEAA women refugees were reticence to come forward to report the abuse, seek mental health help, or file for divorce, for fear of breaking up their family units. To do so would amount to facing ostracization from their communities (2017). In fact, in a study by Yoshioka and colleagues (2001), 57% of Vietnamese Americans and 25% of Cambodians agreed with the statement "some wives seem to ask for beatings from their husbands," while 30% of Vietnamese and 44% of Cambodians agreed that violence is permitted when the wife "refused to cook and keep the house clean" (p. 10). Particularly in Cambodian culture, participants stated that martial violence is thought to be "…a normal issue for everyone. It is not important," is attributed to the wife's fault and needs to be kept private among family members (Bhuyan et al., 2005, August, p. 909).

Other contextual reasons that SEAA women refugees did not report and/or present for help in terms of stopping DV included the fact that many SEAA women lived in poor households without the financial resources needed to support themselves outside of their current marriages (Bhuyan et al., 2005, August). For instance, most SEAAs were among the most impoverished minorities in America with 27% of Hmong, 18% of Cambodians, and 3% of Vietnamese families living below the poverty line (SEARAC, 2018, April 11).

Given their pre-migration traumatic stress, Ho and colleagues (2017) found that battered SEAA women were at greater risk for mental health problems such as PTSD, panic disorder, depression, and substance abuse when further compounded by DV. When SEAA women refugees who have experienced DV did present for American mental healthcare, Norton and Manson (1992) suggested that they presented with culturally approved, somatic complaints such as fatigue, chest pain, sleep issues, and headaches when the underlying mental health illness may have been depression according to *DSM-5* (APA, 2013). Therefore, study

investigators recommended that American clinicians need to be aware of the possibility of DV, asking their SEAA women refugee clients about the circumstances surrounding their distress in as culturally sensitive a manner as possible (1992).

Intergenerational Transmission of Unresolved Trauma. The effects of unresolved, intergenerational trauma are insidious. Trauma symptomology becomes compounded and more severe when passed to each subsequent generation with lasting, adverse effects felt within the SEAA community at large (Bith-Melander et al., 2017). While the mechanism underlying the intergenerational transmission process is still being investigated, some studies suggested one of the links is children learning maladaptive coping strategies from their traumatized parents (Devakumar et al., 2014). In these situations, parents cannot establish a healthy connection with their children, called the attachment bond*,* which results in poor parenting skills (see the definition for attachment bond in the definition section above). In turn, their children develop a poor sense of self and inadequate social skills (2014). Since SEAAs have very tightly-knit family units, their children shape their sense of self from both their families and their communities at large (Kinzie, Boehnlein, & Sack, 1998). Field and colleagues (2013) suggested a further link of intergenerational trauma to an increased likelihood that SEAA women would endure IPV without trying to break the chain of continued abuse.

Others suggested that the intergenerational transmission of trauma has a biological basis whereby parents' DNA is modified by epigenetics. This modified DNA is then passed onto their children within the encoding of their genes (Devakumar et al., 2014). Furthermore, there is a culture of silence within SEAA families who have experienced extreme trauma which helps incubate the adverse effects of trauma experiencing across generations. The children internalize this silence, helping lead to complex PTSD (serial exposure to traumatic events), depression, and

anxiety. This translates into SEAA adolescents turning increasingly to substance use, aggressive behaviors, and delinquency (Ngo et al., 2007, December).

Understandably, there are few research studies examining the prevalence of intergenerational trauma in refugees overall. In their systematic review of intergenerational trauma across refugee populations, Sangalang and Vang (2017, June) stated that psychiatric outcomes in refugees' offspring include developing complex PTSD, other anxiety disorders, mood disorders, and increased PD associated with believing they need to bear the burden for their parents' trauma. Collectively, this leads to higher risk for abuse and neglect within their families. However, not all studies found adverse mental health outcomes in refugee offspring, suggesting there are some protective measures that refugee families can mobilize to buffer their children from developing psychiatric disorders (2017, June).

Specific to the intergenerational transmission of mental health problems in SEAA refugees, Vaage and colleagues (2011) conducted a longitudinal study of Vietnamese fathers. In their study, the investigators looked at the fathers' PTSD symptomology when first arriving in Norway as a baseline (1982; T1). This baseline was then compared to their children's mental health status 23 years later (T3 in 2005/2006; T2 was conducted three years after birth; n=145 fathers; n=127 children, ages four to 23, all born in Norway). Investigators factored in both pre-migration and post-migration conditions. Findings suggested that the fathers' PTSD experiencing at arrival was the most important predictor of their children's subsequent mental health. The Vaage and colleagues (2011) concluded that having a traumatized parent threatens a child's need for feeling secure and protected (e.g., secure base) for healthy psychological development (2011). Other studies concluded that maternal psychopathology was more associated with the later development of mental health problems in their children (Rousseau et al., 1998). However,

Rousseau and colleagues (1998) stated that cultural differences may play a role with SEAA refugees such that the stronger father-child bond is more essential to a child's healthy psychological development than the mother-child bond.

Conclusion. There remains a need for more systematic, rigorous, and culturally informed research studies that include larger samples of SEAA refugees, particularly women, to better determine the prevalence and the course of their often-chronic psychiatric conditions. Previous research provided a profile of refugee communities that are still suffering from psychiatric disorders long after their resettlement in the U.S. These disorders likely stem not just from their experiencing of pre-migration traumatic events but are often further exacerbated by violence and other inadequate socioeconomic conditions in post-migration. The risk of not adequately addressing these chronic psychiatric conditions is the continued mantel of cultural or historical trauma, leaving indelible marks on individuals, families, and communities alike. The next section discusses the concept of minimally adequate care, broadening the definition of access to mental healthcare, meant to better address these chronic psychiatric conditions.

Current SEAA Refugee U.S. Mental Healthcare Usage Patterns

Overview. The previous section presents statistics from epidemiological and community-based studies that, while limited, shed some light on the prevalence of specific psychiatric disorders within the SEAA refugee community. Despite this documented need, the U.S. Surgeon General's Report (DHHS, 2001) stated that only 17% of AAs experiencing psychiatric disorders sought any form of assistance with 6% or less utilizing American mental healthcare services. These rates contrasted markedly with an estimated 54% of the general American population who sought out professional mental healthcare during the same time period (Meyer et al., 2009).

Eisenberg and colleagues (2007) estimated further that overall AAs are two to five times less likely to use mental healthcare services than their Caucasian counterparts. Instead, AAs' more likely choice is seeking treatment in a primary care facility only after exhausting their more typical means of help-seeking. These typical means of help-seeking are consulting first with family members and secondarily with traditional healers. However, once deciding to consult an American mental healthcare professional, AA present more in terms of culturally sanctioned somatic symptoms instead of mental health issues (Young et al., 2001, January).

This pattern of mental healthcare seeking behavior is also true of SEAAs. Their somatic symptoms are based in SEAA refugee beliefs that psychological distress is organic, reflecting an imbalance in mind and body. Culturally approved symptoms range from headaches, stomach pains, seizures, and paralysis (Nishio & Bilmes, 1987). Some suggested these somatic idioms of distress are a culturally acceptable way for SEAAs to display their suppressed negative emotions (Gold, 1992a). For example, SEAAs experience PTSD with co-occurring, cultural idioms of distress that include khyâl panic attacks. These attacks accompany a fear of death from bodily dysfunction and/or other somatic symptoms such as tinnitus (e.g., ringing in their ears), dizziness, headaches, to sleepiness. These symptoms are manifested according to the perceived level of attack severity (Hinton et al., 2010).

Other SEAA beliefs surrounding the causation of mental illness include metaphysical, supernatural forces such as bad wind which impacts both the mind and body (Indochinese Cultural & Services Center, 1982; see a definition of this culture-bound syndrome above). Therefore, any imbalance in the mind is treated by attending to the body (Moon et al., 1982).

In terms of mental healthcare, talk therapy is not only confusing to SEAA refugees but also stigmatizing and therefore largely avoided (Chin et al., 1993). Consequently, American

mental healthcare is seen as a last resort. Only after typically seeking help from family members or using traditional healer will SEAA refugees seek American professional mental healthcare. The consequences are their symptomology has likely become more severe and unmanageable with the delay in seeking professional care (Thao et al., 2010, June).

SEAA Mental Healthcare Utilization. While there is a body of research on overall AA mental healthcare utilization, little previous research focused expressly on the mental healthcare utilization of SEAAs. However, one study by Akutsu and Chu (2006) was an exception. This study was conducted within a culturally competent, community mental health clinic. In that setting, Akutsu and Chu (2006) found that SEAAs did seek professional mental healthcare help, specifically for depression and somatic problems. Chen and colleagues (2003) agreed with the study done by Thao and colleagues (2010, June) that once SEAAs presented for mental healthcare treatment in the U.S., they tended to have more severe symptomology. Chen and colleagues (2003) added that this especially concerns PTSD. Similar to AAs, SEAAs presented with depression as their number one complaint and anxiety disorders as their second (2006).

However, unlike most AAs who are reticent to disclose suicide ideation, in Akutsu and Chu's (2006) sample, almost all Cambodian and Iu Mien American patients (the latter are from Laos) expressed a need to address suicide ideation and somatic complaints when also endorsing depression as their primary concern. Furthermore, one-quarter of Cambodians patients also expressed experiencing co-occurring anxiety disorders with their depressive symptoms. Likewise, Vietnamese Americans presented with primary complaints of depression, suicidality, and somatic problems in lesser numbers than Cambodians and Iu Mein but endorsed psychotic disorders in greater numbers. The study authors (2006) concluded that, once given access to

culturally competent mental healthcare, SEAAs had an increased willingness to disclose what are typically hidden mental health issues, particularly suicide ideation and psychotic disorders.

Furthermore, Akutsu and Chu (2006) found that Cambodians were the most likely of the three SEAA refugee ethnic groups to seek out American mental healthcare. The Hmong were the least likely. More typically, SEAAs went indigenous healers and shaman instead of traditional mental healthcare providers, partly because of the perceived inadequacies of mainstream American mental health services (Lin et al., 1985). In fact, Gong-Guy and colleagues (1991) stated that SEAA refugee participants in their study continued to practice traditional healing while also receiving professional mental healthcare treatment.

Gender Differences. Worldwide, refugee women face unique acculturation stress during resettlement. This acculturation stress includes changes in family and social networks, increased social isolation, morphing gender roles, racism, language barriers, intergenerational conflict, and changes in status both within their family units and communities (Lazarus, 1997; Scheffler & Miller, 1991). This unique acculturation stress stems from the typical female caregiver role whereby females carry the extra responsibility of helping their families acclimate to their adapted country (Lovell et al., 1987). Typically, they often neglect focusing on their own mental health-care needs in favor of being their families' gatekeepers into the American mental healthcare system (National Asian Women's Health Organization, 1995).

As a consequence, Chung and Kagawa-Singer (1993) found that SEAA women refugees experienced higher PD than did SEAA male refugees. The California SEA Mental Health Needs Assessment 1986 study findings concurred (n=959 women, n=1221 men), attributing the cause of this distress to likewise significantly greater pre-migration stressors for the women study participants. These pre-migration stressors included greater numbers of women subjects losing

their spouses and close family members than male study participants and having less education with poorer literacy rates in both their native languages and in English (Chung et al, 1998, February). Likewise, previous studies found that SEAA women refugees were more likely to seek out American professional mental healthcare than their male counterparts. Increased distress was considered the likely motivator (Leong & Zachar, 1999; Thikeo et al., 2015). This latter finding is discussed more fully in the "Barriers" section that follows.

Minimally Adequate Care. The previous discussion within this section described how Cambodian refugees were more likely to seek out American mental healthcare than the Hmong and Vietnamese (Akutsu & Chu, 2006). In their study with Cambodian refugees, Marshall and colleagues (2005) found a similar utilization pattern specifically with those experiencing major depression, PTSD, or their co-occurrence. These study participants received American mental healthcare in rates on a par with the American public with similar diagnosable disorders (2005). Therefore, the question remains: why do Cambodian refugees who received culturally competent American mental healthcare services still have high levels of chronic PTSD and depression decades beyond initiation resettlement? The answer lies in addressing the nature of adequacy of care.

Wong and colleagues (2015, September 9) sought to answer this question by doing an ecologically valid, naturalistic study of existing services in Western mental health centers and clinics. This study design contrasted with prior studies which focused on investigating standard of care interventions tested only through controlled clinical trials. For their study, Wong and colleagues (2015, September 9) used a randomized sampling design of Cambodian refugees (n=490) in specialized mental health centers and clinic settings. Study participants met criteria for diagnosable PTSD or major depression using the Composite International Diagnostic

Interview (CIDI). The CIDI was administered face-to-face with supervised, trained interviewers using a version translated into the Khmer language with back translation methods. Participants were asked from what kind of mental health professional they sought care over the past five years, the nature of that care, and the quality of communication during treatment (2015, September 9).

Results were then compared to evidence-based guidelines and criteria abstracted from previous studies as to what constitutes minimally adequate care (MAC; Wang et al., 2002). MAC is defined as follows:

- Pharmacology for two or more months of an antidepressant or anxiolytic medication along with four or more visits to the prescribing psychiatrist or medical doctor, OR
- Psychotherapy consisting of eight or more visits with the psychiatric or specialized mental health provider with average sessions of 30 minutes or more for the past 12 months (Wang et al., 2002)

Study results showed that, while Cambodian refugees were receiving MAC consistent with the general public with the same diagnosable conditions, the nature of their care was significantly different. For example, Cambodian refugee study participants saw primarily psychiatrists at over double the rate of the U.S. public (Wang et al., 2005) and more than five times the rate of foreign-born AAs also experiencing depression and anxiety disorders (Sribney et al., 2010). Furthermore, Cambodian refugees in the study saw medical doctors at about 10 times the rate for foreign-born AAs with criteria-level mental health disorders. In addition, Cambodian refugees used pharmacotherapy at almost double that of Caucasians and six times that of AAs, all of whom were experiencing depression and anxiety disorders (Wong et al., 2015, September 9). Furthermore, Cambodian refugees received mental healthcare from

non-physician, mental healthcare professionals at the rate of 4% (n=11) compared to Caucasian Americans' rate of 19% and foreign-born AAs at 14% with the same disorders (Sribney et al., 2010).

Wong and colleagues (2015, September 9) concluded that Cambodian refugee study participants' mental healthcare was composed of primarily of pharmacotherapy (their preference according to the discussion above) and limited, low intensity, trauma-focused psychotherapy. Their 29-minute sessions, typically with psychiatrists facilitated by interpreters, would likely not provide adequate treatment time. Instead, evidence-based guidelines stipulate trauma-focused psychotherapy should be eight to 12 sessions of 60 to 90 minutes each when provided in the patient's native language (Foa et al., 2009). These guidelines state further that pharmacology is the second line treatment in tangent with the primary use of trauma-focused psychotherapy. It is important to note that these guidelines are increasingly seen as the treatment of choice for refugee populations (Hinton et al., 2005).

In fact, the underuse of evidence-based psychotherapy to address PTSD is a wide spread issue in the U.S. today across all populations (Foa et al., 2013). Therefore, the lack of provision of evidence-based, trauma-focused therapy remains a barrier to access of effective mental healthcare for all Americans. Providing such effective care is in line with the National Institute for Health and Care Excellence's (2011, May) expanded definition of access to mental healthcare. This expanded definition describes access to mental healthcare as a complex topic that encompasses both what makes up the ability to physically initiate mental healthcare and the ability to have effective healthcare treatment. Effective treatment includes the engagement of culturally competent mental healthcare providers. This thesis focuses on the contextual, cultural,

and demographic barriers to access and engagement with mental healthcare. Treatment content is not covered as this is beyond the scope of this work.

Conclusion. From their study of seven different AA ethnic groups, Akutsu and Chu (2006) concluded that no two groups presented with the same clinical profiles. Similarly, Chung and Lin (1994, April) found intragroup differences in mental health seeking behavior within SEAAs. For example, Cambodian refugees in the U.S. were more likely to seek mainstream professional mental healthcare services, while the Hmong were the least likely. Fung and Wong (2007) suggested that the basis for these intergroup and intragroup differences was each group's unique pre-migration experiences as well as differing experiences once relocating to the U.S. These differences included length of stay in resettlement, language, acculturation, perceived accessibility to mental healthcare, as well as each subpopulation's explanatory model of illness (1994, April).

In summary, these and other studies emphasized that referring to SEAAs as a singular clinical population would be an invalid mental healthcare approach. Instead, the specific needs of each of the three SEAA refugee populations, including those specific to women, should be fully assessed before being able to provide more effective mental healthcare access to and delivery of culturally competent interventions. Furthermore, the importance of providing culturally competent care cannot be overstated as witnessed by the willingness of SEAA patients to divulge suicidal ideation when in recent years there has been a heightened concern for suicide among AAs in general (Chu et al., 2011). As a nation, we must stop paying lip service to what appears to be culturally competent care because minimally adequate care is not enough. Instead, we need

to invest in training our mental healthcare professionals in evidence-based, culturally competent care that fully meets the needs, not just the preferences, of our refugee clients.

Current Research on Overall Barriers to SEAA Mental Healthcare Seeking Behaviors

Overview. As previously discussed, there is consensus that refugees experiencing mental health problems are disadvantaged in myriad ways that hamper their ability to access adequate mental healthcare. According to Dixon-Woods and colleagues (2005, August), most research in this area has been confined to the following: 1) issues surrounding clinicians' frequently lacking cultural competency in assessment and diagnosis across patient populations, and 2) concerns on how to increase their cultural competency. However, Uwakwe, Jidda, and Bahrer-Kohler (2017) contended that this perspective is too narrowly defined for what is a much more complex experience for all refugees negotiating access to American mental healthcare services.

For example, the National Institute for Health & Care Excellence (2011, May) in the United Kingdom developed clinical guidelines with a classification of factors that influence access to mental healthcare across all population. These guidelines are grouped according to specific themes as follows:

- *Individual factors* that may reduce access to mental healthcare, including gender, attributes, beliefs, cultural differences, and behaviors
- *Practitioner-level factors* that may influence inequity in access to mental healthcare for the individual
- *System and process-level factors* such as policy, agency/organizational structure, organizational norms which may contribute to reducing access to healthcare for certain vulnerable groups

- *Resource-oriented or practical factors,* including transportation infrastructure, program scheduling, childcare issues, and health insurance coverage (2011, May)

Barriers for AAs. Specific to AA underutilization of mental healthcare services, the U.S. Surgeon General's Report (DHHS, 2001) described the following types of barriers. While more than a decade old, these findings still hold true:

- Cultural differences as to how the patient experiences and then describes his or her symptoms
- Cultural differences include idioms of distress which are typically somatic symptoms
- Cultural bias in how the clinician or researcher assesses those symptoms
- Individual's decreased perception for a need for mental health treatment
- Stigma in the usage of such services and/or around mental health diagnoses in general
- Wishing to save face and therefore avert shame arising from stigma for both the individual and his family when using those services and/or receiving treatment
- Preference for using family support and traditional healing methods instead of professional mental health services
- Foreign-born status
- Acculturation or length of time in the U.S.
- Lack of culturally appropriate services in terms of clinician cultural competency as well as match of client to clinician in ethnicity, gender, and/or language abilities
- Lack of health insurance

This thesis adds to this discussion by parsing out these and other potential barriers as well as contributory factors that likely block access to mental healthcare access for SEAA refugees. These barriers and factors are grouped according to contextual, cultural, and demographic

characteristics. When possible, factors particular to SEAA women refugees are emphasized. Recommendations for change are detailed in Chapter Five.

2.1 Contextual Barriers

Overview. To better understand SEAA refugees' underutilization of professional American mental health services, most researchers have focused on the influence of cultural differences (Fung & Wong, 2007). Therefore, there are few studies about service utilization in terms of how physical and structural/contextual barriers impact the initiation and engagement of these services. Leong and Kalibatseva (2011, March) contended that contextual barriers to seeking mental healthcare are likely more associated with social class than to culture.

Difficulty Navigating the American Healthcare System, including Mental Healthcare. In Um's (2014) study, SEAA refugees described the overall American healthcare system as confusing and complicated. Leong and Kalibatseva (2011, March) concluded from their study findings that there is a perceived opportunity cost involved, given the amount of time that is needed to initially go and then return for follow-up. SEAA study subjects described working multiple jobs to take care of their families with limited time to avail themselves of these services (2011, March). Nguyen and colleagues (2008) commented that some local assistance programs provide community health navigators to help refugees steer through the overall healthcare system in a more timely and effective manner. Unfortunately, the number of programs providing such assistance have drastically decreased through the decades due to limited resources (2008).

Geographic Inaccessibility of Healthcare Services/Lack of Transportation. In Thao and colleagues' (2010, June) interviews within the Hmong community in Washington state, key informants flagged lack of transportation as one of the most insurmountable barriers in accessing

any healthcare service. Because many Hmong families do not own a car nor know how to drive, the key informants suggested that mental healthcare professionals need to provide reliable transportation options to make their services more accessible. Otherwise, often without much English language capabilities, SEAAs cannot successfully navigate alternative public transportation (2010, June).

Limited Healthcare Insurance Coverage. Results from the 2010 U.S. Census (2011-2013) showed that approximately 21% of Cambodians, 19% of Laotians, and 16% of Hmong Americans had no health insurance. The lack of health insurance and the cost of mental health services create common barriers for SEAAs' accessibility to mental healthcare services. Co-pays for those who do have insurance create another barrier. Due to limited employment benefits or no employment, SEAAs refugees often lack adequate insurance coverage for primary care visits (their preference for addressing mental health disorders), let alone coverage for professional mental health services (Um, 2014). Reeves and Bennett (2004) concluded that being underinsured or uninsured as well as higher rates of poverty as system-level and care process factors constitute considerable barriers for SEAA refugees to access for American mental healthcare.

Therapist-Client Congruence. There is an acknowledged dearth of language and culturally appropriate mental healthcare services for SEAA refugees (Tran, 2018). Nation-wide, there is a need to increase the numbers of ethnic AA clinicians who can speak the various languages of their AA clients. For example, the National Alliance for Mental Illness Multicultural and International Outreach Center (NAMI, 2003) estimated that there are only 70 AA clinicians per 100,000 Asian American-Pacific Islanders in the U.S.

Besides providing language-appropriate services, culturally competent mental health professionals provide treatments underpinned by similar worldviews and cognitive styles that match their SEAA clients (Aggarwal et al., 2016; Zane et al., 2005). Research showed that SEAAs are more likely to both initiate American mental healthcare as well as stay in treatment if provided culturally congruent care (2016; Sue & Sue, 1999).

2.2 Cultural Barriers

Overview. Cross-cultural psychiatry emphasizes that a culture's explanatory model of illness is the deciding factor as to what treatment path members of that culture will expect (see the definition section below for explanatory model of illness). Consequently, a culture's explanatory model of illness influences the conceptualization, expression, choice of preferred medical/mental health treatment pathways, and the preferred choice of treatment provider (ISTSS, 2017, November 9).

Acculturation. In their study, investigators Kim and Omizo (2003) found a significant positive association between greater acculturation and positive attitudes toward seeking professional, American mental healthcare. Chung and Lin (1994, April) described that greater acculturation among specific SEAA refugees stems from previous high levels of contact with Western practices and culture in pre-migration, more proficient English language ability, and more formal education. Chung and Lin (1994, April) suggested that of the three SEAA ethnic groups, Vietnamese American refugees had the highest exposure to Western culture through French colonization (1875-1954) and the American occupation during the Vietnam War. Therefore, findings from these studies implied that Vietnamese American refugees have the greatest likelihood of utilizing American mental healthcare.

Similarly, Ownbey and Horridge (1998) found a positive association between length of residency in the U.S. and acculturation levels. On the other hand, in an ethnographic study, the CDC's (2008) in-depth interviews more specifically stated that, rather than length of U.S. residency, living in a rural area prior to migrating to the U.S. is associated with the continued use of traditional healthcare methods. This study finding implies that acculturation is not necessarily tied to length of residency.

Explanatory Model of Illness. Many SEAA do not initiate using American mental healthcare services, because they perceive a mismatch in American views of mental illness and its treatment compared to their beliefs about the source of illness, the illness trajectory, and treatment (Ng, 1997, June 1). For example, Vietnamese refugees believe that mental illness is untreatable, a belief that leads to not seeking and benefiting from mental healthcare. Furthermore, if a Vietnamese refugee seeks such care, he or she would be regarded by their refugee community as lacking personality and dignity (1997, June 1). Similarly, Laotian refugees view mental illness as a form of punishment that the sufferer is enduring because of supporting a cultural taboo or having bad blood (1997, June 1). In addition, the Hmong people (from Laos) believe that mental illness is indicative of spiritual sickness which represents an imbalance of spirit and body within their culture cosmology (Carteret, 2012, January 9). Some American mental health professionals are bridging this gap by working in tangent with traditional healers which builds greater trust, helps forge better therapeutic alliances, and ultimately leads to better care (Gong-Guy et al., 1991).

Family Structure and Support. Recently, a few studies reported family and marital discord among the SEAA refugee communities. These issues are traditionally kept private and not disclosed to those outside of their families, let alone to mental health professionals (Akutsu

& Chu, 2006). However, for some SEAA refugees, increased family discord is the reason they turn to American professional mental healthcare when they are unable to confide in their family members. Family is their traditional source of solving mental health-related or any other problem (2006). In their ecological model of refugee stress, Miller and Rasmussen (2017, April) reminded us that increases in family conflict, escalating often to violence, is one of many typical outcomes for refugees who have faced pre-migration armed conflict, followed by a spectrum of post-migration or displacement-related stressors. American professional mental healthcare therapists are advised to explore the possibility of family and marital discord especially with SEAA women, no matter what complaint brought them into treatment, because silence remains the typical SEAA refugee response to family and marital discord (see domestic violence below in the "Demographic Barriers" section for more information).

Gender Role Changes.

Hmong Families. Interviews with key informants can provide important insight into issues that would otherwise be private in SEAA refugee families, particularly those pertaining to women. For example, interviews for a recent needs assessment of Hmong refugees in Washington provided the following insight (Thao et al., 2010, June):

> … several key informants felt divorce, infidelity, and polygamy were major issues that impacted the mental well-being of Hmong families, especially Hmong women. Polygamy is a culturally and socially accepted practice within the Hmong community; however, it may not be as highly accepted as it once was due to the influence of mainstream U.S. social norms and values that disapprove of polygamy. Several key informants reported that Hmong wives/mothers and children become depressed and hopeless from experiences of divorce, marital problems, and polygamous marriages or

> relationships. They also felt Hmong women are often unable to financially support themselves and have lower income levels than their ex-husbands. Furthermore, they mentioned that divorced women are also commonly ostracized in the community and may lack the support of their family and/or clan. Anecdotal accounts of suicide and homicide incidents within the community are believed to have resulted from family instability and mental health issues. (2010, June, p. 20)

Not having the support of their family and/or clan for Hmong refugee women is significant. Despite increased acculturation, Hmong families remain highly collectivist and clan oriented (e.g., extended family members). However, without their clans or clan leaders' guidance and protective source for coping, Hmong women are more likely to turn to American mental health services (Thao et al., 2010, June).

Cambodian Families. Cambodian families' stories of resettlement in the U.S. are similar to Hmong families with notable differences. Family therapist McKenzie-Pollack (2005) described how Cambodian family structure has changed:

> One of the most devastating aspects of the Pol Pot Regime was that, in an attempt to impose a new social order, a systematic effort was made to destroy the family. Children were separated from, and encouraged to spy on, their parents. Women were tortured to make them report on their husbands. Large numbers of men were led off and executed because of alleged involvement with the old regime. A major consequence of the genocide is that many Cambodian families are now headed by women, many of them illiterate and without job skills transferable to an industrialized society. (2005, p. 291)

McKenzie-Pollack (2005) emphasized that the intake process, required to receive mental health treatment, is confusing, frustrating, and can also be terrifying for Cambodians (see the next

discussion on "Mistrust of the American Healthcare System" for more information). Case in point, McKenzie-Pollack (2005) recounted how a Cambodian widow came to see her, describing an experience with a psychiatrist two years earlier in which the Cambodian widow felt like she was being interrogated during a torture session in Cambodia. Yet, what she was experiencing the standard mental status exam, the first step needed to receive U.S. mental healthcare services (2005).

Vietnamese Families. In all AA families, including the Vietnamese, the husband has the traditional role of chief provider and decision maker (Fox, 1991). The wife is the caregiver, providing comfort and protection for the children. She is not expected to interact with the outside world. However, when resettling in the U.S., these gender roles have slowly reversed. Fox (1991) described how the availability of a large number of low paying jobs for women in the U.S. give Vietnamese women a chance to work outside the home, gaining economic independence. At the same time, their husbands often face unemployment without the ability to easily transfer their job skills to an industrialized society (CDC, 2008).

Furthermore, their children who have grown up in the U.S. become often more proficient in English than their parents, becoming a bridge to the outside world. Their children's greater English proficiency contributes also to role confusion for many Vietnamese families (Fox, 1991). Nowak (2005) pointed out that Vietnamese women and children become more quickly acculturated to American society than Vietnamese men. Often, Vietnamese wives rise to increased position of authority within their families, given their increased financial status due to greater employment opportunities than their husbands (Gold, 1992b).

Mistrust of American Healthcare System. The U.S. Surgeon General (DHHS, 1999) identified mistrust of the American healthcare system as a major deterrence to racial and ethnic

minorities availing themselves of these services. As concerns SEAA refugees, Ellis and colleagues (2011) added that mistrust of American healthcare professionals stems from a general mistrust of authority from having experienced persecution, victimization, and trauma experiencing, including torture, in their home countries. Furthermore, SEAAs fear a lack of confidentiality with concerns that information about having mental health problems might somehow get back to their communities, stigmatizing and shaming themselves as well as their families (Ortiz, 2008). This is especially true of SEAA women refugee who have experienced gender-based violence in their home countries and/or in post-migration. SEAA refugees' fear of lack of confidentiality is especially true when mental health services include interpreters who are likewise community members (2008). Therefore, mental healthcare providers are advised to only hire professional interpreters instead of using community members or even children of the families they serve (2008).

Religion.

Overview. Many values and beliefs SEAAs have a religious basis, shaping their views of a mind-body integration and how they orient internally to themselves (Du & Lim, 2015). In addition, these religious-based values and beliefs help SEAA refugees navigate their external world. An understanding of SEAA refugees' religious values and beliefs in relation to their culture is therefore essential in understanding their mental health seeking behaviors (2015).

Vietnamese. Most Vietnamese practice Confucianism with some having converted to Roman Catholicism following French colonialism (Gerber et al., 1999). Confucianism espouses "filial piety, respect for authority, self-development, and scholarship," with adherence to a hierarchical order whereby community and family needs are above the needs of the individual (Du & Lim, 2015, p. 141). This orientation translates into Vietnamese American refugees

typically considering the therapist as an authority figure and teacher, providing counsel to help them address their suffering. Those who are Roman Catholics tend to be more acculturated and are therefore often amenable to seeking American mental healthcare (Hsu et al., 2004).

Cambodians. The majority of Cambodians are Theravadin Buddhists. The basic tenet Buddhism espouses is karma whereby Buddhists accept that they are not able to control their own "destiny" (Gerber et al., 1999). Suffering is considered an integral part of life. Therefore, Cambodian American refugees consider outside help from American mental healthcare providers superfluous (1999). Du and Lim (2015) suggested that this belief system translates into one of the three following types of help-seeking behavior:

1) an individual experiencing mental illness and his or her family collectively feel shame and guilt, resulting in hiding or denying illness which is viewed as an admission of wrong behavior in the past;

2) the individual with mental illness views this illness as a punishment which he or she seeks to address through Buddhist teachers to ameliorate past wrongdoings; or, alternatively,

3) an individual accepts mental illness in resignation, passively doing nothing (2015).

Laotians. Ninety percent of Laotians are Theravadin Buddhists. Because of their religion, like Cambodians American refugees they tend to not seek outside help for mental health issues (Gerber et al., 1999). Additionally, for many Laotians, their form of Buddhism incorporates animistic beliefs (Outsama, 1992). Animists ascribe souls and spirits to all human beings, animals, and inanimate objects. Illness is viewed as a punishment by "gods, ancestor spirits, evil spirits or the loss of one's soul" (Du & Lim, 2015, p. 146). With this understanding, Mercy Medical Center in Merced, CA, has integrated shamanism into their model of traditional

American healthcare, incorporating specific ceremonies that can address illness in a more culturally appropriate manner (Puno, 2017 February 10).

Stigma. Like other Asian cultures, SEAA refugees hold strong beliefs about stigma surrounding mental health issues and treatment. Some of these beliefs are, however, specific to their SEA cultures, based upon their explanatory models of illness (see the “Cultural Barriers” section above). The U.S. Surgeon General (DHHS, 1999) described stigma as "the most formidable obstacle to future progress in the arena of mental illness and health" (p. 3). Uwakwe and colleagues (2017) stated further that the repercussions of stigma are profound, creating “a vicious cycle of rejection and disadvantage that surrounds all those who live with a mental disorder” (p. 25). This includes repercussions not only in the families whose members are experiencing mental illness but also within the health and social systems ideally meant to support individuals (2017). In fact, Tran (2018) stated that on the macrosocial level, institutional policies, intentional or not, continue to support stigma surrounding mental illness by not providing equal access to culturally competent mental healthcare. Therefore, it stands to reason that Hernandez and colleagues (2014) as well as others called stigma the most significant barrier to mental healthcare access.

2.3 Demographic Barriers

Overview. Investigators Thikeo and colleagues (2015) found acculturation to be the most robust demographic variable leading to increased positive attitude and behaviors toward American mental healthcare for both male and female SEAA refugees. This finding resulted from a hierarchical multiple regression analysis of all demographic variables identified in their study. Acculturation contributed the most significant and unique variance over and above the other demographic variables. The other demographic variables examined in this study included

the following: 1) continuous variables age, education level, family income, and number of years living in the U.S., and 2) categorical variables gender, ethnicity, health insurance, employment status, religious belief, and languages spoken at home (2015).

Age. Nguyen and Lee (2012) found that age is inversely related to seeking American mental healthcare. Study findings suggested that with older age, Vietnamese Americans refugees stigmatized going for professional mental healthcare services more than their younger counter-parts (2012). Ruzek and colleagues (2011) commented that finding may be partly due to older Vietnamese Americans being less acculturated than younger Vietnamese Americans. However, the kinship structure within SEAA families dictates that the elder males remain the decision-makers. Given this kinship structure, the stigma against mental health professional services may likely be the predominant viewpoint even if the younger household members are inclined otherwise (Lin & Lu, 2013). Furthermore, in their study Ruzek and colleagues (2011) found that younger Vietnamese college students mitigated any family or societal stigma by using more indirect methods of obtaining information about mental health, including searching the Internet or taking a college class as opposed to going to the university counseling center.

Domestic Violence (DV). While women experience DV across all ethnic and cultural groups, there is increasing awareness among American mental healthcare and public health professionals alike that women respond to DV in accordance to their social and cultural values (Yoshioka et al., 2001). Previous studies on SEAA women refugees documented how sociocultural factors such as language, gender roles, migration status, religious values, acculturation, and their orientation toward how they seek help (whether professional and/or traditional healers) tempered how they responded to DV (2001). Likewise, structural factors influenced how SEAA refugee women responded. These structural factors included limited

financial resources often impoverished SEAAs face, traditional networks of social support from their refugee communities and other family members, and whether culturally competent care was in proximity of their homes (Bhattacharjee, 1997).

Gender. In a pilot study of 108 Cambodian and Laotian refugees, Thikeo and colleagues (2015) found that SEAA women refugee study participants were significantly more likely to recognize the need for mental healthcare, seek professional psychological services, be more open to discussing their problems, and have more confidence in the American, professional mental healthcare system than their male counterparts. Additionally, Fung and Wong's (2007) study results concluded that the main factors influencing SEAA women refugees study participants' positive attitudes toward seeking professional mental healthcare were "perceived access to culturally, linguistically and gender appropriate healthcare" (p. 228; see "Gender Role Changes" in the "Cultural Barriers" section above).

Legal Migration Status. For SEAA refugees, the looming current threat of deportation back to their country of origin is also an increasing source of stress and therefore another potential determinant for increased mental distress (Steel et al., 2004). However, a refugee's legal status may also impede him or her from seeking relief through American mental healthcare services for fear of coming under increased scrutiny for deportation reasons (SEARAC, 2019, May 31).

Limited English Proficiency (LEP). In California where most SEAAs reside, the majority of first-generation Cambodian and highland Laotian refugees had little to no education before coming to the U.S. This means they tend to have LEP proficiency as well (Grant et al., 2011, November). In a 2007 California survey, 92% of those refugees with LEP reported that they had unmet needs for mental health services with an estimated 70% receiving no treatment

(2011, November). These findings held true across all racial and ethnic groups who had LEP, demonstrating that the language barrier is a considerable barrier that serves to deter SEAAs and all other racial/ethnic groups from initiating professional mental healthcare (Tran & Ponce, 2017). According to the 2010 U.S. Census, in California 41.2% of Cambodians, 39.7% of Hmong, 38% of Laotians, and 50.1% of Vietnamese Americans had LEP (U.S. Census Bureau, 2011-2013).

Summary Remarks on Barriers to Mental Healthcare Access for SEAA Refugees

According to the reviewed studies, stigma was endorsed as the most pervasive and formidable barrier to accessing mental healthcare across all races and ethnicities in the U.S. (DHHS, 1999; Hernandez et al., 2018; Tran, 2018). However, several studies suggested that having access to culturally competent mental healthcare may overcome barriers such as stigma. For example, Fung and Wong's (2007) study results submitted that having access to a culturally congruent healthcare provider was a robust predictor of increased help-seeking behavior even when controlling for insurance coverage.

Fung and Wong (2007) added that SEAA refugees are a diversified group with differences in attitudes toward seeking American mental healthcare services. Hence, in those groups where perceived access was not an issue, then study findings suggested that explanatory models of illness were the next most prominent predictor of professional mental healthcare service seeking attitudes (2007). On the other hand, investigators Thikeo and colleagues (2015) found acculturation to be the most important demographic variable for both male and female SEAA refugees. Their study findings suggested that increased acculturation led to increased positive attitudes and behavior seeking toward American mental healthcare (2015).

In summary, while SEAAs are the fastest growing segment of the AA population, we still know little about their U.S. mental healthcare seeking behavior (Vong & Choi, 2014). This is partly due to our continuing perception that AAs are monolithic in their make-up and needs despite each AA ethnic subpopulation having its own history, culture, and traditions. In turn, these differences between each AA subgroup influence their explanatory models of illness and therefore their mental healthcare seeking behavior (2014).

Furthermore, we have little disaggregated data due to a limited number of SEAA specific studies, identifying their barriers to access for these services (2014). For example, we assume that there is a unidirectional relationship between increased acculturation to U.S. society to increased U.S. mental healthcare seeking behavior as discussed in the reviewed studies. Yet more research need to be conducted to determine if this association holds consistently true for SEAA refugees. Additionally, more research is needed to better describe the synergy between how SEAA refugees' ethnicity, culture, and gender interact to influence their U.S. mental healthcare seeking behavior (2014).

To address these and other current gaps in research, the systematic review described in Chapter Four delves further into identifying contextual, cultural, and demographic barriers to U.S. mental healthcare seeking for SEAA refugees, particularly for women, that contribute to their underutilization of these services. This thesis concludes with discussions in Chapter Five on how these barriers to access for SEAA refugees impact the fields of U.S. public health, providing recommendations on interventions to decrease these identified obstacles to receiving adequate American mental healthcare services.

Chapter Three: Methodology—Data Collection and Analysis

Overview

Despite the increasing awareness of gender-based differences in the prevalence and trajectory of mental illness across all races and ethnicities, research in this area has not been fully addressed (Bolea-Alamanac, 2017). Because of this general lack of research, this thesis seeks to bridge the gap in our knowledge base about SEAA gender-based differences in the experience of psychological distress (PD) and the perceptional and structural barriers which block/prevent SEAA refugee utilization of American mental healthcare. These barriers are classified into contextual/structural, cultural, and demographic categories. Specifically, this chapter focuses on the methodology used to provide a systematic review of the literature.

Literature Search Methodology

The search strategy for appropriate literature sources for this systematic review was based upon two sets of guidelines: 1) Emory University's Woodruff Health Sciences Center Library online guidelines (WHSCL; Emory Libraries & Information Technology, 2019) and 2) *the Cochrane Handbook for Systematic Reviews of Interventions* (CHSRI; Lefebvre et al., 2008). Both suggested starting with the two standard health sciences databases *PubMed* (n=9) and *EMBASE* (n=25). *PubMed* provides access to over 30 million citations from primarily the *MEDLINE* database with references and abstracts on biomedical and life science literature dating back to 1966. *EMBASE* contains over 12 million records from 1974. These database publication start dates were essential to include literature from 1975 to the present to encompass the earliest time period SEA refugees came to the U.S. (see Table 3.2 for literature inclusion/ exclusion criteria). Use of the *Web of Science* database (n=7) expanded the search to include literature in multi-disciplinary areas within the social sciences and humanities. Thereafter, both the WHSCL

online guidelines (2019) and the *CHSRI* (2008) recommended using subject-specific databases. *PsychInfo* (n=23) and *Anthropology Plus* (n=106) were chosen as the most appropriate for this systematic review. Search terms per database as well as the filters used are listed in Table 3.1.

However, this index search using these specific databases did not provide the depth of coverage in examining gender-specific, sensitive issues such as DV. Consequently, the search strategy was expanded to include handsearching and snowballing techniques. The *CHSRI* (2008) described handsearching as a “manual page-by-page examination of the entire contents of an entire issue or conference proceedings to identify all eligible reports of trials” (p. 107). In their study of the effectiveness and efficiency of search methods in systematic reviews, Greenhalgh and Peacock (2005, November 5) recommended enhancing handsearching strategies with snowballing. Snowballing was described as “reference tracking,” whereby the reference lists of full text papers are scanned for relevant journal articles and gray literature (2005, November 5, p. 1064). Both strategies can help overcome the limitations of databases which may be “poorly or inaccurately indexed or underindexed,” while also identifying hard-to-locate gray literature, including dissertations, association publications, and web sites (Rutgers University Libraries, 2019, September 20, para. five). Gray literature makes “important contributions to any systematic review” by providing data not covered in commercial publications (Paez, 2017, p. 234). Consequently, publication bias may be reduced by adding data from non-commercial sources, allowing for a more comprehensive presentation of the evidence base (2017).

Following these recommendations, snowballing was used first to scan the reference sections of pertinent, full-text journal articles identified during the database index search. Journal articles that focus specifically on SEAA women refugees and any sensitive issues such as DV were chosen for further consideration. Four pertinent journals were identified through snow-

balling which were the *Hmong Studies Journal*, the *Asian American Journal of Psychology*, the *Journal of Immigrant and Minority Health*, and *Violence against Women Journal*. Extensive handsearching was conducted in each of these four journals. Handsearching of the *Hmong Studies Journal* was the most productive, leading to a web site with links to SEAA ethnic-specific bibliographies. These bibliographies were divided into subheadings that included mental healthcare. Their listings included gray literature such as dissertations and association publications. Together, snowballing and handsearching efforts yielded 35 relevant publications for an overall search total of 205 journal article and gray literature sources.

Duplicate journal articles found through the index search were eliminated through an electronic sorting process, using EndNote x9 citation management software. A manual sorting process was necessary to eliminate publication duplicates identified through snowballing and handsearching techniques. All articles were then compared to whether they were cited previously in this thesis literature review. If so, they were eliminated to avoid duplicate information. Two exceptions were qualitative studies that contributed additional information to the systematic review knowledge base. Overall, 31 publications were discarded through these steps.

Thereafter, the remaining 174 publications' titles and abstracts (when available) were scrutinized for relevancy according to Table 3.2 *System Review Eligibility Inclusion/Exclusion Criteria*. EndNote x9 was used to view the titles and abstracts of those publications retrieved during the database index search. Those publications located through manual snowballing and handsearching techniques required further manual scanning of their titles and abstracts. This process eliminated 111 publications.

The full-text of the remaining 63 publications went through an additional eligibility inclusion/exclusion criteria screening, also using the criteria detailed in Table 3.2. This eligibility

process was paired with quality assurance screeners for either qualitative or quantitative and mixed-methods study studies. Quantitative and mixed-methods study quality assurance was evaluated using Pettigrew and Roberts' (2006) recommendations as follows: 1) adequate description of methods in sample selection, 2) adequate sample size, 3) description of participant inclusion/exclusion criteria, 4) participant characteristics, 5) representativeness/ generalizability, 6) reliable and valid measures used, and 7) evidence of appropriate analytic methods. However, several quantitative and mixed-methods studies that use convenience or snowballing sampling methods were retained despite potential data quality issues, because they added important descriptive information to the knowledge base needed for this inquiry.

Quality screening for qualitative studies included the following: 1) worthy topic, 2) rich rigor, using sufficient, appropriate, and complex theoretical constructs, 3) sincerity such that study investigators used self-reflexivity during the study investigation, 4) transparency in describing methods used, 5) research provides significant contribution, 6) researchers considered ethnical issues and addressed their process in resolving these issues, and 7) the study has meaningful coherence (Tracy, 2010). During this qualitative study screening process, three studies were excluded because of their lack of transparency in the reporting of their research methods.

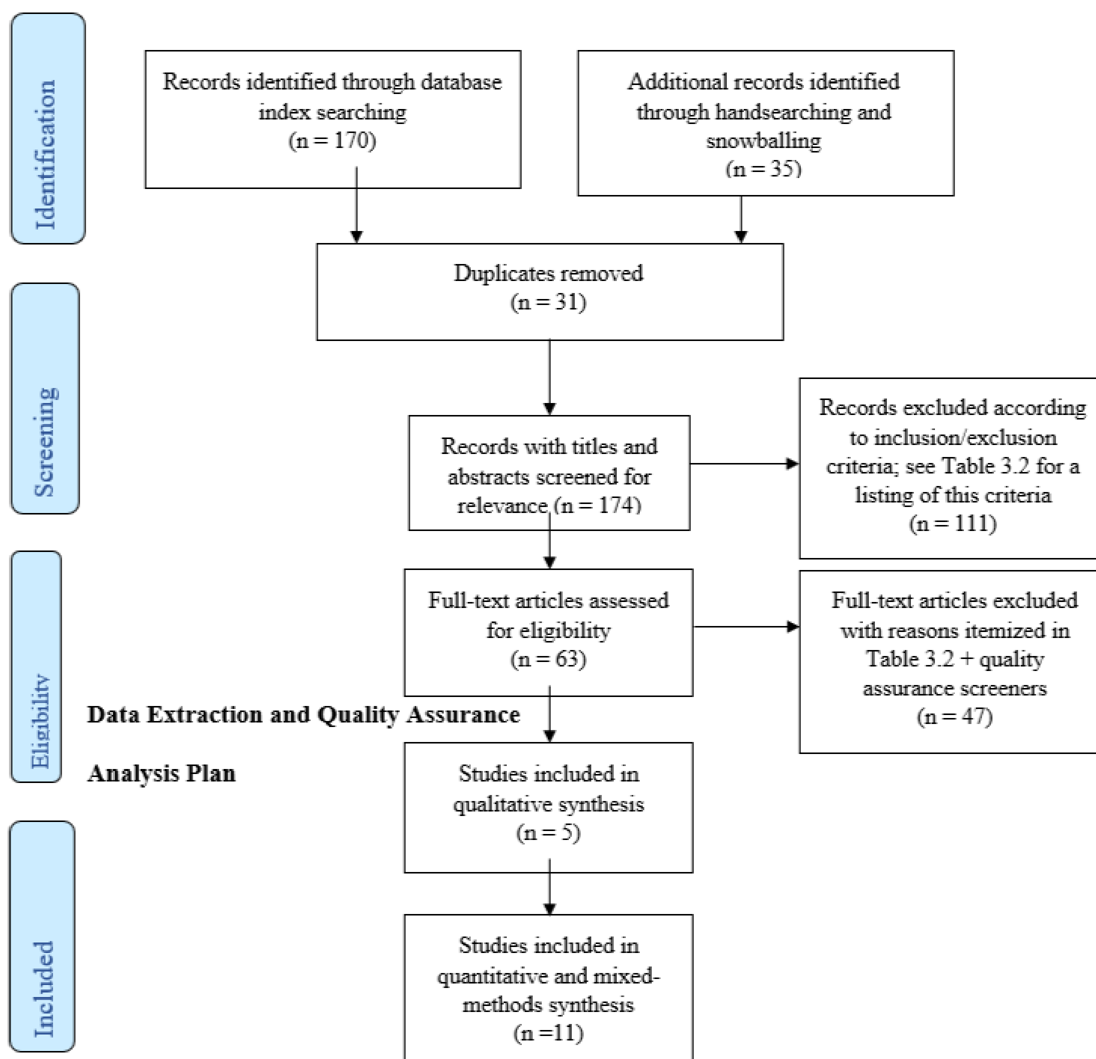
This multi-step eligibility process excluded 47 publications, leaving five qualitative and 11 quantitative and mixed-methods studies. See Figure 3.1 for the *PRISMA Flow Diagram* for an overview of the systematic review search process.

Table 3.1 ***Systematic Review Search Term Criteria, Listing of Databases, and Other Resources***

Database and Other Sources with Filters Used	**Search Terms**
PubMed Filter: None; search was not limited by whether article had full text access through *PubMed*	(“Southeast Asian" or Cambodia or Cambodian or Laos or Laotian or Vietnam or Vietnamese or Khmer or Hmong or Iu-Mien or Iu Mie) AND (refugee or refugees or migrant or migrants) AND (women or woman or female or females) AND (“mental health” or “psychiatric” or “mental health care” or “mental healthcare”) AND (United States[tw] or US[tw] or USA[tw] or American[tw]) AND (barrier or barriers or underutilization or access)
PsychInfo Filters: 1) Publications from Jan. 1975 to Sept. 2019, 2) Age 18 years or older, 3) General public intended audience, 4) Classification code 3370 Health and Mental Health Services, 5) English language, 6) Female population group, 7) All document types, 8) All methodologies, and 9) No restriction on whether limited by full text access ***Anthropology Plus*** Filters: 1) English language, 2) Publications from 1975 to 2019, and 3) No restriction on whether limited by full text access ***EMBASE*** ***Web of Science*** Filters for both: 1) Publications from 1975 to 2019, and 2) No restriction on whether limited by full text access	(“Southeast Asian" or Cambodia or Cambodian or Laos or Laotian or Vietnam or Vietnamese or Khmer or Hmong or Iu-Mien or Iu Mie) AND (refugee or refugees or migrant or migrants) AND (women or woman or female or females) AND (“mental health” or “psychiatric” or “mental health care” or “mental healthcare”) AND (United States or USA or US or American) AND (barrier or barriers or underutilization or access)
Handsearching and Snowballing	Linking from relevant journal articles to specific publications on sensitive and under-reported topics for SEAA women refugees such as DV and the topic of gender itself. A subject-specific web site yielded ethnic-oriented bibliographies on mental health topics for all three refugee groups (Greenhalgh & Peacock, 2005; Lefebvre et al., 2008; Rutgers University Libraries, 2019, September 20).

Table 3.2 ***Systematic Review Publication Eligibility Inclusion/Exclusion Criteria***

Category	Inclusion Criteria	Exclusion Criteria
Age	18 years or older	Children, adolescents, youth
Countries of Origin	Southeast Asian countries directly involved in the Vietnam War: Cambodia, Laos, and Vietnam; this area was formerly called Indochina	All other Southeast Asian countries as shown in map, Figure 1.1
Country of Residence	United States	All other developing and developed countries
Ethnic groups	Cambodian Americans, including the Khmer; Laotian Americans including the Hmong and Iu Mien; Vietnamese	Studies that address the needs of Asian Americans refugees without parsing out these ethnic subgroups
Migrant Status	Refugee: denotes displacement trajectory instead of length of time in resettlement, regardless if they later transitioned to immigrant status; migrant	Immigrant: note that the label “immigrant” was sometimes incorrectly used; each article using the word “immigrant” to describe subjects was scanned to doublecheck usage
Publication Dates	1975 to present (1975 marks the first date when SEA refugees came to the U.S. following the Vietnam War)	Pre-1975
Publication Language	English	All others
Research Publication Methods	Qualitative, quantitative, and mixed-methods studies; one study is a secondary data analysis of a quantitative probability study	Each study’s methodology was evaluated in terms of the context and purpose to determine usability. In some instances, nonprobability sampling methods were appropriate when recruiting hard-to-research, ethnic minority groups
Research Publication Type	Peer-reviewed journals and gray literature (governmental, nonprofit, associations, unpublished theses and dissertations, nonfiction book chapters)	Commentary and op-eds
Study Subject Gender/Population	Women singularly; women when pooled with men when women were represented in approximately 50% or more of each sample; women when represented in a large enough sample size that bias was minimized even if they did not represent 50% of the overall sample size (based upon National Institute of Health’s [NIH] mandate that any funded research must capture information on women and ethnic groups in a proportionate manner to ensure studies are valid and generalizable NIH, 2001, October).	Men singularly or when pooled with women where men comprised greater than 50% of the overall sample size; a small body of literature on SEAA college students was excluded as they were not representative of the general SEAA refugee population; studies that had mental health professionals as subjects, interviewed about SEAA clients
Study Topic	Help-seeking behavior in general with American mental healthcare seeking behavior in particular; mental healthcare is the focus	Medical healthcare seeking behavior, except when that included mental health issues; this required some additional reading scrutiny



Data Extraction

This researcher developed a paper-based data log template to facilitate data extraction. Data was extracted for analysis purposes according to two categories: 1) those variables identified as most relevant in previous study findings, and 2) those variables that potentially described new associations that were underexplored in the current research literature. Variables

that were relevant in previous studies included age, gender, ethnicity, and length of residency in the U.S. (a proxy for acculturation; Selkirk, Quayle, & Rothwell, 2014, February). Those variables that were not highlighted in previous studies included employment status, country of origin as some SEA ethnic groups lived across multiple countries, participant generation, and if they had identified multiple trauma experiencing across pre-migration, migration, and resettlement. The latter variable was pertinent since most studies focused on a singular trauma exposure, ignoring the potential importance of distress being compounded through multiple trauma exposures.

Data was extracted in waves. In the initial wave, data was used to provide information for Tables B.1 and B.2 that document *General Characteristics of Systematic Review Selected Studies* (Appendix B) and Tables C.1 and C.2 *Methodological Characteristics of Systematic Review Selected Studies* (Appendix C). In turn, this data was used to calculate frequencies and percentages provided in the section entitled "Systematic Review Study Characteristics" in Chapter Four. Thereafter, data was extracted to provide analysis of key findings which is also reported in Chapter Four.

Analysis Plan

Quantitative and Mixed-Methods Study Analysis. Comparing content across a diverse set of variables was inherently difficult when including both quantitative and mixed-methods studies. These studies differed in study design, participant characteristics, methodology, and measures used (Centre for Reviews and Dissemination, 2008). To identify key topical themes across these studies, this researcher did a qualitative analysis. Through this analysis, a key list of variables was developed. These variables were associated either directly or indirectly with U.S. mental healthcare help-seeking behavior in previous studies, becoming the basis of the data log

described above. This key list was supplemented with other variables of interest in this systematic review that were not previously highlighted in previous studies such as SEAA women refugee employment status. Thereafter, each study's findings were then compared to this overall key variable list to determine consistencies, inconsistencies, and the possible reasons (if documented) leading to any differences in findings.

Key variable groupings that emerged from the qualitative analysis were overarching themes of ethnicity, PD, coping styles, patterns of American mental healthcare seeking behavior, and barriers to that behavior. These barriers were contextual/structural, cultural, demographic, and other factors. Variable values were then recorded into a data log for each publication. The addressing of overall article quality issues is discussed above in "Literature Search Methodology," since this step was incorporated into the initial article selection process.

Qualitative Study Analysis. Similar to the synthesis method for quantitative and mixed-methods studies described above, Glaser and Strauss (1967) recommended the constant comparative method as an effective means of synthesizing qualitative research. This method was originally developed by Glaser and Strauss (1967) to analyze data within primary research when developing a grounded or emergent theory. However, Glaser and Strauss (1967) acknowledged that this method can also be used effectively with existing secondary data (pp. 61-62, 111-112). O'Connor and colleagues (2008) described the importance of this method as assurance "that all data are systematically compared to all other data in the data set. This assures that all data produced will be analyzed rather than potentially disregarded on thematic grounds" (p. 41).

This systematic review of five qualitative studies followed the constant comparison method described by Corbin and Strauss (2015). As an initial means of breaking data into manageable pieces, Corbin and Strauss recommended grouping similar data in each study

together and then labeling each data set with a conceptual heading. Each study's identified concepts were then grouped into categories (2015). Each category was subsequently "developed in terms of properties and dimensions" (2015, pp. 7-8). Corbin and Strauss (2015) defined properties as "characteristics that define and describe concepts. For example, flight has the property of duration" (p. 220). In turn, dimensions are differences within properties, providing specificity and range to the overall concepts (2015, p. 220). Resulting categories across all five studies were organized into emergent, overarching themes that parallel those used in the quantitative and mixed-methods studies analysis. These categories included ethnicity, PD, and coping styles, American mental healthcare seeking behaviors, and barriers to these behaviors. Barriers were parsed into contextual/structural, cultural, and demographic factors. Qualitative article quality assurance is discussed above in "Literature Search Methodology" as an incorporated step within the initial article selection process.

Chapter Four: Results

Overview: Study Selection

Using index database searches as well as snowballing and handsearching methods, a total of 205 publications were initially identified to adequately address this thesis' research objectives. Thirty-one of these publications were eliminated through the duplication screening process. The titles and abstracts (when available) of the remaining 174 publications were evaluated for relevancy according to Table 3.2 *Systematic Review Eligibility Inclusion/ Exclusion Criteria*. This latter process eliminated 111 publications. An additional eligibility inclusion/exclusion criteria screening was conducted on the full-text of the remaining 63 publications, also using Table 3.2. This eligibility review was paired with quality assurance screeners for either qualitative or quantitative/mixed methods study designs. This multi-step eligibility process excluded an additional 47 publications, leaving five qualitative and 11 quantitative/mixed-method studies for the final analysis.

Systematic Review Study Characteristics

The search for appropriate research studies considered both peer-reviewed and gray literature, published from 1975 to 2019. The former year was the first year SEA refugees migrated to the U.S. This search yielded 13 articles from peer-reviewed journals (81.3%, 13/16) and three gray literature publications (18.7%, 3/16), one of which was a dissertation and two theses. The peer-reviewed journals were interdisciplinary in nature, spanning applied psychology, social work, nursing, ethnic studies, and public/environmental/occupational health. The dissertation and theses sourced from graduate studies in clinical psychology, sociology, and public health. See Appendix B, Tables B.1 and B.2, for other general study characteristics and Appendix C, Tables C.1. and C.2, for methodological study details.

This search yielded 10 quantitative (62.5%, 10/16), one mixed-methods (6.3%, 1/16), and five qualitative publications (31.2%, 5/16). Selected studies were published according to the following: 1) one published from 1994 to 2000 (6.3%, 1/16), 2) 10 between 2001 and 2010 (62.5%, 10/16), and 3) five from 2011 and 2019 (31.2%, 5/16). Data collection for the oldest publication began as early as 1985.

All studies were conducted in the U.S. to facilitate access to resettled SEA refugees. The majority of the studies were administered in the largest SEA ethnic communities on the east and west coasts (56.3%, 9/16), contributing to their generalizability. Study subjects were predominantly Cambodian refugee adults (37.5%, 6/16), followed by Vietnamese (31.2%, 5/16), Hmong (12.5%, 2/16), and SEA refugee adults in general (18.8%, 3/16). Given that the emphasis of this systematic review is on gender differences, more than half of the chosen studies have an exclusive female sample population (56.3%, 9/16), including all five of the qualitative studies. The other studies contributed to the knowledge base by providing sample comparison data on males and females within each profiled ethnic group. One publication compared males and females across all three ethnic groups (6.3%, 1/16). See Appendix B, Tables B.1 and B.2 for further details on study data collection sites, ethnic make-up, and gender composition across all selected studies.

Concerning methodology, the range in study designs among the quantitative research studies was as follows:

1) six were descriptive, cross-sectional study designs with a single sample group (37.5%, 6/16), 2) one provided a comparison group within a descriptive, cross-sectional study design (6.25%, 1/16), 3) two used a cross-sectional, random sampling design (12.5%, 2/16), 4) one was a mixed-methods, descriptive, cross-sectional study with a qualitative component (6.25%, 1/16), and

5) one is a secondary data analysis of a previous needs assessment (6.25%, 1/16). The latter was included in this systematic review because of its significant contribution to this knowledge base.

The qualitative publications were also diverse in study design: 1) two used participatory action research (12.5/%, 2/16), 2) one was a qualitative cross-sectional design (6.25%, 1/16), 3) another used qualitative grounded theory design (6.25%, 1/16), and 4) one used a phenomenological approach (6.25%, 1/16). No quantitative, mixed-methods, or qualitative study provided follow-up data collection.

Convenience sampling was the preferred sampling method across all quantitative, mixed-methods, and qualitative studies (50.0%, 8/16), followed by a combination of snowballing and convenience sampling (18.75%, 3/16), snowball sampling (12.5%, 2/16), probability sampling using clustering of households in census tracks (12.5%, 2/16), and finally one study was a secondary analysis of an existing data set from a needs assessment (6.25%, 1/16). As a novel approach, two studies used convenience samples recruited via the Internet. One of these two studies used Amazon Mechanical Turk, an Internet crowdsourcing web site, for both participant recruitment and the platform onto which the study survey was uploaded for self-administration.

In terms of critiquing selected study sample size, the definition of what constitutes a small sample size depends upon the study objective (see Appendix B, Tables B.1 and B.2, for specific study research objectives and sample sizes). Smaller sample sizes are likely sufficient when describing the characteristics of a single ethnic group or enclave of refugees, such as the prevalence and nature of domestic violence amongst a specific SEAA community. However, with larger sample sizes, study findings are more reliable.

In this review, the majority of quantitative/mixed-methods studies were descriptive in nature. This made the usage of smaller sample sizes more understandable within the context of recruiting hard-to-reach populations required to examine sensitive issues. Two of the quantitative studies that were probability, cross-sectional in design used cluster sampling for which sample sizes were calculated, whereas the other studies did not describe how they ascertained their sample sizes.

The qualitative studies in this review had sample sizes that are consistently smaller than those used by the selected quantitative/mixed-methods studies as shown in Appendix C, Tables C.1 and C.2. Patton (2015) stated that "there are no rules for sample size in qualitative studies. Sample size depends on what you want to know, the purpose of the inquiry, what's at stake, what will be useful, what will have credibility, and what can be done with the available time and resources" (p. 311). Morse (2000) qualified further that within qualitative studies "there is an inverse relationship between the amount of useable data obtained from each participant and the number of participants," making this a dynamic tradeoff between sample size and quality of data (pp. 4-5).

Analysis of Major Themes and Findings

Overview. Key findings from selected studies for this systematic review focus on how SEAA refugees, particularly women, experienced PD with their subsequent help-seeking choices. Barriers to accessing American mental healthcare services are also highlighted when SEAA women refugees indicated a preference for seeking these services beyond their traditional resources. The following analysis is broken down into the following key themes: 1) levels of PD, 2) gender-based violence—domestic violence, 3) American mental healthcare seeking behavior, and 4) barriers to American mental healthcare seeking behavior.

4.1 Levels of Psychological Distress (PD)

Overview. Four studies in this review examined continued levels of PD among all three SEAA ethnic groups and how this PD impinges on their current functioning across other domains, including physical health. Marshall and colleagues (2006, October) indicated in their study that research in this topic area typically used levels of current psychological distress as proxy variables for unmet need for mental healthcare. In turn, unmet need assumed current barriers to access to American mental healthcare services, leading to no initiation or underutilization of these services (2006, October).

Cambodian Refugees. Two studies in this review confirmed previous research stating that Cambodian refugees had the highest levels of PD among all SEAA refugees despite resettling in the U.S. over two decades ago (Chung & Bemak, 2002, Winter; Marshall et al., 2006, October). Using a large, representative sample of Cambodian refugee adults (females n=61%), one of these two studies found that all 339 participants met criteria for a least one psychiatric disorder as follows: PTSD 88%, 76% major depression, and 5% alcohol use disorder (2006, October). In addition, this study indicated that these psychiatric disorder rates significantly exceeded rates found in national representative samples of individuals with documented mental health need: PTSD 3.5% and major depression=6.7% (National Comorbidity Survey, 1994-1995; 2006, October).

Furthermore, in a secondary analysis of data from the California SEA Mental Health Needs Assessment, the second study findings suggested that Cambodian refugee women experience greater PD levels than Cambodian men ($t=2.10$, $p<.04$; women $M=35.29$, $SD=2.69$; men $M=31.33$, $SD=23.04$; Chung & Bemak, 2002, Winter). Premigration exposure to genocide during the Pol Pot Regime followed by their flight to refugee camps in Thailand combined to

create a significant distress predictor for both genders. Specific to Cambodian men, a greater number of years spent in refugee camps was a primary predictor for current PD, whereas fewer years in U.S. resettlement was a significant predictor for Cambodian women (2002, Winter). Other significant predictors for PD for both Cambodian men and women included limited English proficiency (LEP). LEP was positively associated with the inability to secure and maintain employment, leading to lower income. Low or no formal education in premigration was also an impediment to gainful employ (2002, Winter).

In a third review article, Berthold and colleagues (2014) found that higher levels of current PD in Cambodian refugees were also associated with greater numbers of physical health conditions. Sixty-one percent of participants in this study reported being diagnosed with three or more physical conditions co-occurring with depression, PTSD, or both (N=136). Specifically, Cambodian refugee study subjects experiencing co-occurring PTSD and depression had 1.85 times more physical health conditions than those Cambodian refugees without PTSD or depression ($p>.001$; CI 1.334-2.566). Age was the moderating variable such that Cambodian refugee adults with no or one mental health disorder reported fewer health conditions when they were young but more as they aged. In contrast, Cambodian refugees with both depression and PTSD had a consistent number of medical health conditions across their life spans (2014). Study findings suggested that it is essential for both medical and mental health providers to recognize and treat co-occurring health conditions. Furthermore, this study cautioned that Cambodian refugees might develop co-occurring disorders at a younger age than the general American public (2014).

Hmong/Laotians Refugees. Likewise, results from the California SEA Mental Health Needs Assessment supported that women Laotians reported significantly higher levels of PD

than their male counterparts (women n=300, M=36.33, SD=23.30; men n=423, M=26.65, SD=17.36; Chung & Bemak, 2002, Winter). According to a multiple variable regression analysis, significant predictors of psychological distress in Laotian women were multiple traumatic events. For Laotian men, significant predictors included multiple traumatic events, being responsible for making the decision to leave Laos (76.6%), and LEP (75.0%). This study found that LEP created a disadvantage for securing and maintaining employment as well as understanding and accessing community mental health resources. Because Laotians faced many adjustment challenges in U.S. resettlement, study findings suggested that Laotian men may feel guilty for making the decision to leave Laos, thereby exposing their families to yet more unexpected difficulties, especially as concerns financial autonomy (2002, Winter).

Vietnamese Refugees. Findings from a secondary data analysis of the California SEA Mental Health Needs Assessment supported that Vietnamese women refugees also experienced higher PD than Vietnamese male refugees (women n=359, M=27.01, SD=18.13; men n=508, M=23.73, SD=18.56; Chung & Bemak, 2002, Winter). Variables that contributed significantly to Vietnamese women refugee high PD included someone else in their family being responsible for deciding to leave Vietnam following the Vietnam War, fewer years in a refugee camp, fewer years in resettlement in the U.S., low income, and older age. For Vietnamese men, significant psychological stressors included exposure to multiple traumatic events, low income, large family size while in resettlement in U.S., and older age (2002, Winter).

In the same secondary analysis, Vietnamese women refugee study subjects reported an average of six years of resettlement time in the U.S. yet still were experiencing elevated PD (Chung & Bemak, 2002, Winter). Therefore, study findings suggested that U.S. refugee policies may be underestimating how long it takes for some ethnic groups such as the Vietnamese to

reach resettlement stabilization in re-establishing jobs, financial sustainability, and attaining adequate language skills (2002, Winter).

SEAA Refugees. Conducting in-depth interviews with SEAA refugees from all three ethnic groups, one qualitative study findings suggested shifting the conversation from labeling SEAA refugees as suffering from mental illness to experiencing cultural bereavement (Davis, 2000). This term was thought to be more appropriate for those with high ethnic identity (Eisenbruch, 1991). Davis (2000) suggested the following:

> …mental health diagnoses obliterate the human and complex portrait of the meaning of experiences when individuals with strong ethnic identity are involved. In changing the paradigm from one of mental illness to that of human loss, the meaning of the individual becomes paramount. In other words, when cultural bereavement is acknowledged as an acceptable way of being in the world for refugees, they can be assisted toward further adaptation because their experiences can then be acknowledged, justified, and validated. (Davis, 2000, p. 158)

Davis (2000) stressed further that this approach champions the resiliency of the human spirit, "fortified through strong family and community affiliation" (p. 159).

4.2 Gender-Based Violence: Domestic Violence.

Overview. Four studies in this review examined sociocultural factors such as language, gender roles, and beliefs. Study findings suggested how these factors shaped SEAA women refugees' interpretations and response to DV, including what help they sought.

Cambodian Refugees. A single study in this review examined the sensitive issue of gender-based, domestic violence among Cambodian refugees resettled in the U.S. This study used community-based participatory action research to facilitate study participants' discussions

of this sensitive issue (Bhuyan et al., 2005, August). When asked about their Cambodian community awareness and perceptions toward domestic violence (DV), participants stated that DV is acknowledged as common, is not considered okay, but is condoned nonetheless. Study findings suggested that major constraint was Khmer cultural norms which pressured families to keep discussions about DV between the husbands and wives concerned. With the overarching value of keeping families intact, divorce was not considered an option. However, it was culturally acceptable for Khmer women to confide in close friends for support (2005, August).

Furthermore, Khmer women in this study were told that they "must endure according to their karma [e.g., fate in Buddhism]" with wives often blamed for the violence (Bhuyan et al., 2005, August, p. 910). The study subjects described being blamed because it was considered their responsibility to maintain family harmony. The Khmer women subjects described Cambodian society as patriarchal with the male as "head of household and women are 'below them' " (2005, August, p. 910). Given these cultural norms, study participants suggested creating opportunities in their U.S. resettlement communities for Khmer women to form groups in which to learn, support, and help each other solve problems rather than seeking outside mental health or community-based, victim social services (2005, August; see section on "Barriers to Accessing American Mental Healthcare: Gender-based violence—DV, Cambodian refugees" for a more detailed discussion on their help-seeking preferences).

Hmong Refugees. No study in this review profiled Hmong refugee women's experiences with gender-based violence.

Vietnamese Refugees. Two studies in this review examined Vietnamese women refugees' experiences with DV and their help-seeking behaviors. With increased acculturation, one study stressed that adherence was lessening to the Vietnamese traditional culture with its

Confucian norm of women's subordination to men. Specifically, increased acculturation included increased awareness of the American ideal of gender equality (Bui, 2003, February). A Vietnamese refugee in the second study commented on adaptive changes she has been undergoing since resettling in the U.S.:

> [I]n Vietnam… I also was beat by my husband several times but endured. Like, I think to have a husband I must follow him. If he kills me, it's OK. But when I come here, I have a different way of thinking, difference from Vietnam. A man is also a human being. A woman is a human being. I think equal. (Shiu-Thornton, 2005, August, p. 966)

Studying findings suggested that many Vietnamese women faced similar concerns as Cambodian women refugees which tended to keep both Vietnamese and Cambodian women in their abusive relationships. But study subjects described that those Vietnamese refugee women who could work, had attained greater levels of American education, and had contacts with mainstream American society were more likely to use emotional support resources outside of their person networks. Those resources included the use of victim social services (Bui, 2003, February).

4.3 American Mental Healthcare Seeking Behavior.

Overview. A total of nine studies discussed SEA refugee norms about mental healthcare seeking as well as their utilization of a spectrum of mental health support. This support ranged from consulting with family members to using professional mental healthcare services as an alternative or complementary treatment option.

***Cambodian Refugees*.** Contrary to other research, including other studies in this review, findings for two review publications suggested that Cambodians refugees did utilize both American medical and mental healthcare (Berthold et al., 2014; Marshall et al., 2006, October).

In the first household survey of a randomized sample of Cambodian adult refugees in the U.S., 70% of participants endorsed having had contact with a Western medical provider to address their mental health problems within the past 12 months (N=339; 2006, October; sample is described in Table B.1). Study findings suggested that seeking professional mental healthcare services was more likely among study participants who were older, female, married or widowed, and were on government assistance. After adjusting statistically for variables that would most likely influence service seeking such as psychiatric symptoms and trauma severity, study findings demonstrated that the following variables were positively associated with seeking American mental healthcare: age (older), gender (female), LEP, premigration education level of three or less years, unemployed, retired or disabled, on government assistance (e.g., living in poverty) and having had health insurance (2006, October).

From the basis of these study findings, Marshall and colleagues (2006, October) disagreed with previous research that Cambodian adult refugees underutilized American mental healthcare. They concluded instead that "the lack of seeking service in itself may not be a sufficient or accurate explanation for the mental health problems that characterize the Cambodian refugee community" (2006, October, p. 1833). Due to the high levels of PD Cambodian refugees continued to experience, particularly women, the study authors recommended that there is a need for further research on lack of culturally appropriate treatment effectiveness instead of assuming mental healthcare underutilization (2006, October).

Findings from these two review studies (Berthold et al., 2014; Marshall et al., 2006, October) were in contrast to another study in this review (Sok, 2004, May). In this third study, participants endorsed utilizing mental health services only as a last resort (50%). Instead, Cambodian study subjects described talking initially with family members (40%). Of that 40%,

66.7% of study subjects said they preferred going to siblings for emotional support. Outside of seeking help from family members, a majority of respondents indicated that they went to friends for support (94.3%). When deciding to seek professional mental healthcare services, this third study added that subjects with increased acculturation were more likely to go to psychiatrists or psychologists instead of seeking care from their physicians which was their typical first healthcare contact (2004, May).

Using data from qualitative interviews, a fourth review article provided a more nuanced view of Cambodian refugee women's perceptions of health and their help-seeking behavior (Catolico, 2013). The core theme arising from these interviews was a need for "seeking life balance" from amidst the "chaos" of escaping Cambodia, the camps, and resettling in the U.S. Study participants expressed that one of the principle ways of maintaining life balance was "sustaining the centeredness of family kinship and unity" (2013, p. 239). They described how mothers and elders passed down indigenous ways of knowing how to care for family members. Using indigenous practices and healers meshed with these indigenous ways of knowing and the participants' need to create/maintain "family kinship and unity." Indigenous practices included Buddhist prayers and blessings. On the other hand, the study subjects described how adherence to Western treatment conformed with their spiritual notions of "doing good" for themselves (2013, p. 240).

Cambodian study subjects did not express a preference for indigenous or American healthcare. Instead, both were "used in a manner that was useful and meaningful" with respect to each individual participant's sense of knowing for her family and herself (Catolico, 2013, p. 241). Study subjects stated that often translated into the following help-seeking behavior, presented in order of preference: 1) using traditional healing practices, 2) integrating traditional

practices with American medicine (self-medication), and 3) self-reliance. If those strategies didn't work to eliminate or minimize illness, then study subjects described that secondarily they would ask advice of others, specifically "family members, trusted others in the community, and close friends" (2013, p. 242). Lastly, if this step didn't adequately address illness for themselves or their family members, only then would they "resort" to American healthcare, including mental healthcare (2013, p. 241). Study findings indicated that these themes arose out of grounded theory predicated upon the social, historical, cultural, and political influences as these shaped participants' perceptions of health and their subsequent help-seeking behavior (2013).

Hmong Refugees. One article in this review addressed the important of understanding generational differences in utilizing American healthcare, including mental healthcare (Lee, 2002, December). According to Lee (2002, December), the first generation of any refugee group, including the Hmong, had a "strong attachment to traditional culture and customs. The second generation (American born) generally abandons its culture and customs and becomes totally absorbed into American society." Lee (2002, December) suggested this means that second-generation Hmong refugees would be more open to solely utilizing American mental healthcare. On the other hand, Lee (2002, December) comments "the third generation will try to retrieve its culture and customs" (p. 76). Therefore, the third generation would more likely access American mental healthcare in conjunction with indigenous care instead of exclusively using one or the other. However, this study findings suggested that, while the Hmong would be increasingly open to accessing American mental healthcare, they still lacked the means with which to do so, including income and the convenience of proximal, culturally competence providers (2002, December).

Vietnamese Refugees. Like the other SEAA ethnic groups, a study by Luc (2018, August) found that Vietnamese American refugees considered professional mental healthcare services a last resort treatment option. Nonetheless, surprising findings in a second study showed that, when the study's first-generation Vietnamese American refugee subjects did seek professional mental healthcare, they were not deterred by high structural/contextual barriers, specifically client-provider incongruence (Luu et al., 2009).

In other words, study subjects stated they had more positive attitudes about seeking professional mental healthcare when the provider did not have the same cultural background, including not being a native speaker (e.g., client-provider incongruence; Luu et al., 2009). Study results suggested that this preference stemmed from Vietnamese trust issues associated with strong public stigma surrounding mental illness within Vietnamese communities. Study findings suggested that the Vietnamese study subjects could have been highly fearful of confidentiality breaches which overrode their general preference for providers with the same cultural background as indicated in previous research (2009).

A single study examined Postpartum Depression (PPD) in Vietnamese women refugees who had given birth within the last 12 months (N=15; Park et al., 2015). In order to capture individual and social determinants influencing healthcare utilization, this mixed-methods study used the Andersen and Aday Behavioral Model and Access to Medical Care (Aday & Andersen, 1974) as a conceptual model to shape the study interview guide. Interviews revealed how PPD traditions were maintained as an important part of the participants' cultural heritage. Study subjects described the objective of PPD traditions is to allow mothers time to heal bodily "while preventing the aging process and future health problems" (2015, p. 435). However, mothers reported feeling "isolated" during the rigorous 30-day traditional rules that concern dietary and

activity restrictions following giving birth (n=10). They described that their conventional roles as women in Vietnamese society contributed to a feeling of sadness/depression beyond what they typically experienced following giving birth. Study subjects indicated reasons for this ongoing sadness/depression principally involved the lack of support from their husbands in doing housework besides working outside the home while also taking care of the children (2015).

Interviews from this study revealed that only one of the 15 participants has ever used an American mental healthcare provider (e.g., a psychologist; Park et al., 2015). Almost all mothers said they would be willing to seek professional mental healthcare (n=14) but would need to consult their families first being doing so. Likewise, most emphasized that they would consider doing so if their "sadness/depression was extremely severe and/or professional help was their last resort" (2015, p. 437). Instead, they preferred getting social support from family, friends, and the church (n=13). The majority stated that they would rather distract themselves from their sad feelings with other activities as exercising and/or shopping (n=11). Study findings suggested that participants preferred to call their experiencing "sadness" instead of depression, the latter term being more stigmatizing. But the authors conceded that likewise the participants might not have understood the terms "depression" and "PPD" (2015, p. 438).

4.4 Barriers to Accessing American Mental Healthcare Utilization.

Cambodian Refugees.

Contextual/Structural Barriers versus Cultural Barriers. Other research primarily endorsed cultural barriers, including stigma, as the most formidable barriers to accessing American mental healthcare. In contrast, three studies in this review stressed that contextual/structural barriers were the most consequential for Cambodian refugees when attempting to access professional mental healthcare services (Berthold et al., 2014; Marshall et

al., 2006, October; Wong et al., 2006). Two studies endorsed lack of transportation to and from appointments as well as language incompatibility with mental health providers as the main contextual/structural barriers (2014; 2006, October). Language incompatibility was considered a structural barrier as the unavailability of a provider who didn't speak the same language necessitated the need for an interpreter or agency training of Khmer-speaking providers (2006).

The third study stressed high cost (80%) and language-incompatibility (66%) as the primary contextual/structural barriers for Cambodian refugee study subjects for both those without need for mental health services and those with self-reported need (N=490; Wong et al., 2006). Cultural barriers were ranked the least important (7% of respondent endorsement), including anticipated racial/ethnic discrimination (15%), shame (5%), preference for indigenous treatment (5%), and discouragement from family members (<1%). Using chi-square tests, study data showed that only the endorsement of cost as a barrier varied by gender with men more likely than women to endorse this barrier. Language-related barriers were endorsed more often by those with LEP, lived in poverty, had no high school education, and had no health insurance. Those with no high school education were also more likely to report not knowing about services and not having transportation. Endorsement of discrimination as a barrier was not associated with any significant demographic factor (2006).

Wong and colleagues (2006) concluded that accessing healthcare was cost-prohibitive for most Cambodians (most study subjects' yearly income was less than $25,000). Therefore, providing or reimbursing for transportation would be one step toward making mental healthcare services more affordable. Otherwise, healthcare reform is needed to help Cambodian and other refugees gain greater access to services. Berthold and colleagues (2014) suggested that community nonprofits providing Cambodian community health workers could help with

navigating the healthcare system, easing contextual/structural barriers by providing language translation services and transportation.

Cultural Barrier: Gender-based Violence—DV. As discussed above, Cambodian cultural norms dissuaded Khmer families from discussing DV with outsiders. DV could take the form of husbands controlling their wives, keeping them "from working, going to school, learning English, and developing skills for independence" (Bhuyan et al., 2005, August, p. 911). Focus groups conducted in the single study in this review revealed that the Cambodian women refugee victims often had limited awareness of available DV victim community services. Furthermore, the study participants feared their husbands would hurt or kill them, their family members, and their helpers, including mental health providers, if they had told outsiders about the abuse (2005, August). Another study with SEAA women participants experiencing DV agreed with these findings, stating that respondents ranked the following reasons for not seeking professional mental healthcare: 1) "feeling shameful" (41.9%), 2) "feeling scared" (41.9%), 3) "negative reactions from others" (14.5%), and 4) "lacking information" (1.5%; Lee & Law, 2001, p. 18).

In addition, participants from the first study expressed how the goal of mainstream American mental healthcare of getting survivors safely away from their abusers is counter to the Khmer cultural goal of keeping families together (Bhuyan et al., 2005, August). Study subjects stressed how they would prefer support groups that could train them in, for instance, in daily living tasks and language acquisition besides educating their husbands about U.S. laws against abuse (2005, August).

Cultural Barrier: Acculturation. A single study in this review examined the association between the level of acculturation among Cambodian adult refugees and their attitudes toward seeking American mental health services (Sok, 2004, May; see Table B.1 for sample make-up).

Findings supported previous research that as subjects' acculturation levels increased, their likelihood to utilize the services of psychiatrists or psychologists also increased (55%). Likewise, 42.5% of respondents did not think traditional healers or herbal remedies are more effective than modern medicine (2004, May).

On the other hand, less than half of study subjects reported that they first consulted with family members about emotional issues (40%; Sok, 2004, May). Thereafter, they typically discussed their emotional issues with friends rather than seeking outside healthcare providers (94.3%). Fifty percent strongly agreed or agreed that mental health services would be their last resort, if they needed help with emotional problems. Study independent T-tests determined that there were no significant differences in acculturation according to gender nor age after U.S. resettlement (2004, May).

Findings from another study that examined Cambodian women refugee experiences with DV commented on how acculturation impacted different members of Cambodia families in both positive and negative ways (Bhuyan et al., 2005, August). Several study participants experiencing DV stated that they "often feel at a disadvantage because their abusers [e.g., their husbands] tend to speak more English and are more knowledgeable about how things work in this country" (2005, August, p. 914). Therefore, these Cambodian women refugees often felt isolated. This resulted in their feeling incapable of both leaving their abusive relationship and reaching out beyond their personal networks to seek professional services for help with their emotional and safety issues (2005, August).

Hmong/Laotians Refugees.

Physical/Perceived Barriers. Using Andersen's Behavioral Model (Andersen, 1968), one study examined physical and perceived barriers preventing the Hmong of Fresno County, CA,

from accessing American healthcare services, including mental health (Lee, 2002, December). The Andersen Behavioral Model (1968) was developed to explain people's healthcare utilization patterns, using environmental and population factors as the overall frame. Environmental factors include physical, political, economic, and external factors. External factors are outside of an individual's control as cultural competency of the providers as well as a population's past experience with the healthcare facilities and their providers. Population factors are classified as predisposing, enabling, and need variables. Predisposing variables are sociodemographic factors as gender, age, ethnicity, marital status, religion, explanatory models of health/illness, and group norms for help-seeking behavior (1968). Enabling variables include financial resources as family income and health insurance coverage, cognitive resources as awareness of healthcare services, and community resources (1968). Need variables are an individual's health status prior to utilization, including health status diagnosed by a healthcare provider and an individual's perceived need shaped by cultural explanatory models of illness (1968). Study findings suggested the following:

1) Cultural Barrier: Acculturation. Across the research literature, acculturation was measured either by a specific instrument designed for that purpose or the length of residency in the U.S. In regard to this study, acculturation was measured by early and recently resettled Hmong. Findings suggested that "there is no significant difference between early and recently arrived Hmong adults with respect to identified predisposing variables, enabling variables, need variables, and external variables relating to access to healthcare services in Fresno County, CA" (Lee, 2002, December, p. 70). However, certain sub-variables showed significance: employment (p=.01), annual gross income (p=.04), use of Hmong indigenous medicine (also used to address mental health issues; p=.05), and belief in the quality of care from American providers (p=.05). Lee

(2002, December) concluded that these sub-variable differences were understandable based upon earlier arriving Hmong having more time to find and retain employment, providing higher gross annual income than their more recently arriving counterparts.

2) Demographic Barrier: Age. Study findings suggested “there is no significant difference between young and old Hmong adults according to the identified predisposing, enabling, need variables, and external factors relating to access to healthcare services in Fresno County, CA” (Lee, 2002, December, p. 69). Specific sub-variables, however, showed significance, including number of members of household (p=.002), marital status (p=.00), education level (p=.00), requiring an interpreter at treatment site (p=.00), compatibility with providers’ cultural back-ground (p=.003), past experience with provider on-site wait times (p=.04), ability to have healthcare procedures explained (p=.000), belief in healthcare providers’ competency (p=.000), and satisfaction with past healthcare provided (p=.001). Lee (2002, December) concluded that the significance of these sub-variables is not surprising, because early Hmong had a greater knowledge of the American healthcare system, more time to adjust to U.S. society, and more employment opportunities. This study’s findings also suggested that the use of indigenous Hmong medicine is not significantly associated with neither age nor gender but is associated with acculturation as mentioned above (2002, December).

3) Demographic Barrier: Gender. Study findings suggested “there is no significant difference between male and female Hmong adults with respect to the identified predisposing variables, enabling variables, need variables, and external variables related to access to healthcare” (Lee, 2002, December, pp. 70-71). However, significant sub-variables showed differences between genders in relation to accessing healthcare on the basis of marital status (p=.0001), employment (p=.000), gross income (p=.004), health insurance (p=.025), experiences of waiting (p=.03), and

thorough treatment of illness (p=.05). Lee (2002, December) concluded that these differences are commensurate with the patriarchal family structure maintained in most Hmong refugee families such that male head-of-households become decision makers, including making decisions about accessing American healthcare (2002, December).

Cultural Barrier: Acculturation. Another review study analysis found that there was a weak but statistically significant positive correlation between Hmong refugee gender and level of acculturation. Study results find that Hmong refugee women (N=222) tend to be willing to seek professional counseling services (p<.05; Lor et al., 2017]. Furthermore, when controlling for variations in acculturation levels, this study finds that Hmong refugee women who had less stigma (cultural barrier) toward professional counseling services tended to also have more positive attitudes toward and a greater willingness to use counseling services (2017).

Vietnamese Refugees.

Cultural Barrier: Gender-based Violence—DV. In a qualitative study by Shiu-Thornton and colleagues (2005, August), Vietnamese refugee women already experiencing DV expressed a need for mental health services. Study findings suggested that this recognition of a need for professional mental healthcare was likely associated with increased acculturation and therefore likely increased exposure to the American ideal of gender equality. In particular, study subjects expressed a need for support groups and interpreters. Interpreters were described as extremely important to facilitate learning “what assistance and range of services are available, how to access them, and how to utilize them” (2005, August, p. 971).

Study subjects stated further that the main reason they did not tend to seek professional mental healthcare services was their overall lack of knowledge about available resources and their options or choices among those resources (Shiu-Thornton et al., 2005, August). Other

barriers to access and utilization centered on getting a provider with whom they already have a relationship, who has a shared cultural and language background, and who can understand "the meaning of women's experiences" (2005, August, p. 972). Participants stressed that they felt they would be better understood, could trust, and would have greater confidentiality with providers who can speak their language and understand their culture. Also, the participants expressed a preference for female providers who likewise would understand the complex emotional issues Vietnamese women refugees face when experiencing DV. These emotional issues include "fear of the perceived consequences for speaking out about abuse [and the] fear that the abusive situation could worsen if abuse were reported" (2005, August, p. 972).

Cultural Barrier: Stigma. One review study contributed to the knowledge-base by distinguishing between stigma and self-stigma as they impacted Vietnamese refugee subject (called immigrants in this study) attitudes toward professional mental healthcare seeking (Luc, 2018, August). This study used Vogel and colleagues' (2006) definitions of stigma which are divided into public stigma and self-stigma. Public stigma is the group or societal perception that an individual is socially unacceptable. This is comparable to Social Identity Theory (SIT, Chapter One, pp. 20-23) in which societal norms upheld by the in-group pressure individuals to conform or risk ostracization. Self-stigma is an individual's internalization of that in-group stigmatization which likely leads to lower self-esteem.

Using a correlation analysis, this study found a moderate negative association between self-stigma and Vietnamese refugee attitudes toward seeking professional mental healthcare services ($p<.001$; Luc, 2018, August). Furthermore, this finding was upheld when using a single regression analysis that controlled for acculturation level. Luc (2018, August) cited Vogel and colleagues' suggestion that interventions addressing reducing self-stigma could encourage

positive attitudes toward seeking professional mental healthcare despite any public stigma to the contrary (Vogel et al., 2006, as cited in Luc, 2018, August).

In the single review study that examined PPD among Vietnamese refugee mothers, a majority of participants (n=14) reported that stigma is the main reason they didn't utilize professional mental healthcare. The participants report further that they would only seek these services if their sadness/depression "was extremely severe and/or professional help was their last resort" (Park et al., 2017, July, p. 437). One participant described the Vietnamese cultural norm of "not seeking care" as follows:

> I think our Vietnamese never come to those services. Our Vietnamese are very strong. American always comes to see counselors. Majority of our Vietnamese don't come to see these professions. I have a strong mind. I am sad, but I don't need to see them.
> (Park et al., 2017, July, p. 437).

Cultural Barrier: Acculturation. Research in this area of study tended to equate length of residency in the U.S. to acculturation, making this a demographic variable in this review. One of the two studies in this review examining the experience of DV among Vietnamese women refugees (called immigrants in this study) suggested that the willingness for these women to reach out for services outside of their personal networks was not a function of a "normal" progression through time which the acculturation construct assumes (Bui, 2003, February). Instead, this willingness to reach out to victim social services, for instance, was more a function of gaining greater financial independence through employment and the structuring of more division of labor in their households. The latter allowed Vietnamese women refugees more freedom to attain an education. Vietnamese women refugees then had the scaffolding they

needed to encourage them to reach outside of their traditional social and personal networks to seek safety from abusive marital relationships (2003, February).

Participants in the second study stated that “awareness of marital conflict among Vietnamese, the concept of DV, is a result of migration to the United States and the acculturation process” (Shiu-Thornton et al., 2005, p. 966). Otherwise, participants stated that “martial conflict was perceived as ‘ordinary’ and, when it occurred, was considered a personal, private family matter” (2005, August, p. 966). Furthermore, study participants attributed their increasing acculturation to also increasing their awareness there is a difference between marital conflict and DV as well as an increased “awareness of the psychological and emotional dimensions of abuse” (2005, August, p. 966). Study participants pointed out their need for support groups, especially for husbands through which they could understand the full implications of DV, including U.S. legal repercussions (2005, August, p. 966).

A third study challenges previous research findings that increased acculturation in Vietnamese refugees led to more positive attitudes toward seeking professional mental healthcare services (subjects are called immigrants in this study; Luc, 2018, August). Using correlation analysis, this study found that the association between acculturation and attitudes toward professional mental healthcare services in Vietnamese refugee subjects is not significant ($p=.78$). Luc (2018, August) suggested that Vietnamese refugees tended to hold onto their traditional cultural view that mental health services are negative and used only as a “last resort” (p. 50). Furthermore, Luc (2018, August) rejected that longer residency in the U.S. led to increased acculturation, since residency in and of itself gave “more opportunities to adjust to American culture if they choose to” make those changes (2018, August, p. 50).

Unlike most of the studies in this review which used proprietary instruments rather than standardized measures, one review study examined Vietnamese American refugee subjects' attitudes toward American mental healthcare services by using a Vietnamese version of the Attitudes toward Seeing Professional Psychological Help Scale-SF (Cronbach's alpha of 0.66 for acceptable internal consistency; Luu et al., 2009). Findings were contrary to those found by Luc (2018, August) whereby acculturation was significantly associated with positive attitudes toward seeking psychological help ($p<.01$). The majority of study participants were first generation Vietnamese refugees, 23% of whom graduated from college and had lived in the U.S. on average 17.28 years (2009).

Demographic Barrier: Gender. In contrast to mixed results in other research, results from one review study showed that gender is significantly associated with attitudes toward seeking professional mental healthcare (Luc, 2018, August). Using an independent sample T-test, this study found that Vietnamese women refugees had significantly more positive attitudes toward American mental help-seeking than did their male counterparts (women $M=27.01$, $SD=4.98$; men $M=24.68$, $SD=4.75$; $p=.004$; 2018, August).

Summary Comments

As suggested by review study findings, SEAAs faced barriers to American mental healthcare seeking to varying degrees according to a host of factors. These factors included age, ethnicity, gender, acculturation, social and economic status, education, LEP, therapist-client congruence, and the proximity of culturally appropriate care. Chapter Five provides a review of select study key findings in comparison with previous research with the objective of addressing research objectives. Discussions on "Implications to U.S. Public Health" are also presented along with an overview of current and suggested interventions meant to decrease barriers to access.

Chapter Five: Discussion

Overview

This chapter explores the following research objectives in the "Discussion of Review Studies' Key Findings" in the next section:

5.1) Identify how SEAA refugee characteristics as gender, ethnicity, and culture influence help-seeking behaviors for American mental healthcare services,

5.2) Identify the contextual/structural, cultural, and demographic variables that impede SEAA women refugees from accessing American mental healthcare,

5.3) Identify the most robust predictor barrier variable for each of the three SEAA ethnic groups, blocking their engagement in and underutilization of American mental healthcare services, and

5.4) Examine the research assumption that increased acculturation leads to increased U.S. mental healthcare seeking behavior hold true for SEAA refugees.

A discussion of the strengths and limitations of this review follows that discussion. Thereafter, descriptions of current (5.5) and recommended approaches (5.6) are provided to address the remaining research objectives on how to effectively decrease barriers to accessing American mental healthcare services.

Discussions of Review Studies' Key Findings

5.1 Objective One: Gender, Ethnicity, and Cultural Influences on Help-Seeking Behaviors.

Overview. Many SEAA refugee characteristics influence their attitudes toward seeking professional mental healthcare in the U.S. Gender, ethnicity, and culture are thought to be among the most influential characteristics leading to the formation of attitudes toward seeking this level of care. In turn, SEAA refugee attitudes toward engaging in professional mental healthcare

services are likewise thought to impact their actual behavior toward physically seeking these services. Therefore, a better understanding of how gender, ethnicity and culture combine to ultimately influence mental healthcare seeking behavior is one pathway to better understanding typical SEAA refugee underutilization of these services.

Gender. Research found consistently that SEAA women refugees experienced more PD than their countrymen (Chung & Bemak, 2002; Chung et al., 1998). Study findings suggested that more elevated PD was the likely reason why SEAA women refugees utilized American professional mental healthcare more than their male counterparts (Leong & Zachar, 1999; Thikeo et al., 2015). Specifically, in a pilot study of 108 Cambodian and Laotian refugees, Thikeo and colleagues (2015) found that SEAA women refugee study participants were significantly more likely to recognize the need for mental healthcare, seek professional psychological services, be more open to discussing their problems, and had more confidence in the American professional mental healthcare system than their countrymen.

Furthermore, in the first household survey of a randomized sample of Cambodian adult refugees in the U.S., Marshall and colleagues (2006, October) suggested that seeking professional mental healthcare services was more likely among study participants who were female, older, LEP, pre-migration educational levels of three or less years, unemployed, retired or disabled, on government assistance (living in poverty), and had health insurance. These review study results were upheld after adjusting statistically for variables that would most likely influence service seeking such as levels of psychiatric symptoms and trauma severity. Likewise, using an independent sample T-test, results from another review study by Luc (2018, August) showed that Vietnamese women refugee study subjects had significantly more positive attitudes toward American mental healthcare seeking than males.

On the other hand, five review studies stated that SEAA refugees of both genders saw American mental healthcare as the treatment of "last resort." The consequences were their symptomology had likely become more severe and unmanageable with the delay in seeking professional care (Catolico, 2013; Luc, 2018, August; Park et al., 2015; Shiu-Thornton et al., 2005, August; Sok, 2004, May).

***Ethnic Factors*.** Research findings were mixed as to which ethnic group of the three was more inclined to use American mental healthcare services. Using data from community mental health clinics, one other research study found that Cambodians were the most likely of the three SEAA refugee groups to seek out American mental healthcare. Hmong were the least likely (Akutsu & Chu, 2006). Fung and Wong (2007) suggested the basis for different professional mental healthcare help-seeking intergroup and intragroup utilization rates was each group's unique pre-migration experiences followed by differences in experiences from U.S. resettlement. Resettlement differences included length of stay in resettlement, language acquisition abilities, acculturation rates, and perceived accessibility to mental health services (2007).

On the other hand, research by Chung and Lin (1994, April) equated the greatest likelihood of utilizing American mental healthcare with higher pre-migration levels of contact with Western practices and culture, more proficient English level ability, and more formal education. Therefore, findings from this study suggested that Vietnamese American refugees would be the most likely to seek professional mental healthcare due to having more familiarity with Western culture through previous French colonization and the Vietnam War (1994, April).

Two review studies challenged other research that suggested Cambodian refugees underutilize American mental healthcare. According to the first household survey of the largest

Cambodian refugee community in the U.S., Cambodians utilized American mental healthcare in rates that exceeded those of a national sample of Americans in the National Comorbidity Survey (Marshall et al., 2006, October). Furthermore, study findings indicated that factors traditionally linked to unmet needs for mental healthcare treatment were instead positively correlated with seeking mental healthcare in the Cambodian refugee study sample. These factors were LEP, little premigration education, and being retired or disabled (2006, October).

Marshall and colleagues (2006, October) suggested that there were several possible reasons why these factors were not barriers to access for their Cambodian refugee subjects unlike the other two SEAA refugee ethnic groups. These reasons included Cambodia refugees had a significantly greater mental health burden than other SEAA ethnic groups. Therefore, Cambodian refugees were typically immediately provided social services when arriving in the U.S., increasing their initial familiarity with health service providers. Furthermore, Cambodians survived genocidal atrocities beyond their control, potentially shifting their perception of self-responsibility in developing mental illness. Study findings suggested that this potential shift in locus of control may have lessened the perception of stigma within the Cambodian refugee communities surrounding mental healthcare services. Finally, their continued extreme poverty and disability levels gave them access to federally funded health insurance, the lack of which became a barrier to access for many SEAA refugees (2006, October).

Cultural Factors. Medical anthropologists and other researchers have focused the most on cultural factors to better understand SEAA refugee mental healthcare utilization (Leong, 1994). Specifically, cultural explanatory models of illness, beliefs surrounding stigma of mental health issues, and acculturation were the most cited cultural barriers to mental healthcare service utilization. This objective discussion focuses on the impact of explanatory models of illness as a

cultural barrier. Acculturation as a cultural barrier as it impacts utilization is discussed under research objective four below.

According to the International Society for Traumatic Stress Studies (ISTSS, 2017, November 9), cross-cultural psychiatry emphasizes that a culture's explanatory model of illness is the deciding factor as to what treatment path members of that culture will prefer. Consequently, a culture's explanatory model of illness influences the conceptualization, expression, choice of preferred medical/mental health treatment pathways, and the preferred choice of treatment provider (2017, November 9).

However, other research presented in this thesis suggested otherwise. Fung and Wong (2007) concluded from their research that in Asian refugee and immigrant communities explanatory models of illness have little meaning when there was a lack of professional mental health-care services as well as the perception that there was a lack of access. In other words, only when study subjects perceived that access to this level of adequate care was available did any potential differences in explanatory model of illness between themselves and mental health providers became relevant. From these results, researchers Fung and Wong (2007) concluded that study subject help-seeking behaviors were affected by many other "systemic sociopolitical factors" that take precedence over any explanatory models of illness (p. 227).

Two other research studies viewed SEAA refugee help-seeking utilization from a different perspective. From their research findings (1991), Gong-Guy and colleagues (1991) suggested that SEAA refugees tended to utilize traditional healers and American mental healthcare providers in tangent. Researchers Gong-Guy and colleagues (1991) stated that having this kind of collaborative care built greater trust, helped forge better therapeutic

alliances, and ultimately led to better care. In a review study, Catolico's (2013) study results supported these findings using in-depth qualitative interviews with Cambodian refugee women. Study subjects stated that going to indigenous healers meshed with their desire to honor their traditions but likewise going to American mental healthcare providers conformed with their spiritual notions of "doing good" for themselves (2013, p. 240). Study subjects expressed not having a preference for indigenous or American healthcare but instead both are "used in a manner that was useful and meaningful" according to an individual participant's sense of knowing for her family and herself (2013, p. 241).

Four other selected review studies agreed with the declining relevance of cultural factors in determining professional American mental healthcare seeking behavior in SEAA refugees. In his thesis, Lee (2002, December) concurred that third generation Hmong in resettlement tended to blend American mental healthcare providers with indigenous care. However, Lee (2002, December) concluded that, while the Hmong were increasingly open to accessing American mental healthcare, they still lacked the means with which to do so, including income and the convenience of proximal, culturally competent providers.

Moreover, three other review studies stressed that contextual/structural barriers were the most consequential for Cambodian refugees when deciding whether they would seek American mental healthcare (Berthold et al., 2014; Marshall et al., 2006, October; Wong et al., 2006). Two of these studies endorsed lack of transportation to and from appointments as well as language incompatibility with American mental health providers as the greater determinants (2014; 2006, October). Language incompatibility was considered a structural barrier as the unavailability of a provider who didn't speak the same language necessitated the need for an interpreter or agency training of Khmer-speaking providers (also called "client-provider

incongruence”). The third review study stressed high cost (endorsed by 80% of study subjects) and language incompatibility (66% endorsement) as the primary contextual/structural barriers for their Cambodian refugee study subjects for both those without mental health needs and those with self-reported needs (Wong et al., 2006). Cultural barriers were ranked the least important (7% endorsement; 2006).

Summary Comments on Research Objective One. In terms of gender, research agreed that SEAA women refugees are more likely than their male counterparts to initiate professional mental health treatment. The influence of ethnicity on mental health utilization patterns was less clear. Research was mixed as to the influence of ethnicity on American mental health seeking behavior. Using clinical records from multiple culturally competent community mental health centers, one other research study found that Cambodians were the most likely and Hmong the least likely to utilize American mental healthcare (Akutsu & Chu, 2006). Overall, research stated that SEAA refugees tended to underutilize these services.

On the other hand, in a review study, Marshall and colleagues (2006, October) made a strong argument contesting previous research conclusions that Cambodians underutilized American mental healthcare. Instead, Marshall and colleagues (2006, October) challenged the traditional research assumption that continued elevated PD levels equated with unmet need for mental health services. Instead, their study findings show that Cambodian study subjects had utilization levels exceeding those of a nationally representative American sample. Study findings suggested that instead of underutilization of mental health services, Cambodians experienced care that did not meet minimally adequate care levels.

Based upon Marshall and colleagues (2006, October) study findings, this researcher suggests that more robust research is needed to determine if research is validly attributing

SEAA continued elevated levels of PD to underutilization of mental healthcare services. This is, in fact, one of the traditional research markers for unmet psychological need. Instead, SEAA refugees may have received ineffective minimally adequate mental healthcare that did not appropriately address their PD. In turn, when perceiving that this care was ineffective, SEAA refugees may have decided to terminate care.

This researcher points out that studies in this review were predominantly descriptive, using convenience and/or snowball sampling methods across community samples. Community samples of SEAA refugees that did not also include clinical samples were likely more homogenous in make-up and therefore not representative of the entire SEAA refugee population. In fact, the two research studies cited in this thesis that did include clinical samples found that there is not underutilization of care (Akutsu & Chu, 2006; Marshall et al., 2006 October). In other words, the research standard of equating continued elevated PD with underutilizing mental healthcare may not be valid for the SEAA refugee populations in general as well as other highly traumatized populations. (See the section "Suggested Future Research" in this chapter for a more detailed discussion).

Lastly, research was divided between endorsing cultural factors or structural/contextual factors as predominantly influencing SEAA refugees' attitudes toward mental healthcare seeking behavior. Review research stressed that structural/contextual factors were perceived as increasingly more influential than cultural factors. This researcher suggests that cultural factors such as explanatory models of illness are continually evolving, including following contact with American mental healthcare services, whereas contextual/structural factors are more stable environmental or infrastructural features. This could explain review research findings that suggested the declining influence of cultural factors. In response to objective one, this

researcher recommends doing future multivariate empirical research to determine how the factors of gender, ethnicity, and culture interact to influence American mental healthcare seeking behavior and how this interaction may change through, for instance, the process of acculturation.

5.2 Objective Two: Barriers to SEAA Refugee Women Mental Health Help-Seeking

Consistently, research indicated that SEAA women reported bearing the responsibility of maintaining cultural values and beliefs within their families and communities. In a previous study by Lovell and colleagues (1987), SEAA women refugees described often being their families' caregivers**,** including helping family members adjustment to U.S. resettlement. Moreover, other research findings described the unique stress SEAA refugees faced including acculturation stress from the erosion of family/social networks, social isolation, changing gender roles, language barriers, low socioeconomic status, and intergeneration conflict (Lazarus, 1997; Scheffler & Miller, 1991).

Additionally, as discussed in objective 5.1 above, research indicated elevated PD levels in SEAA women refugees above that of males (Akutsu & Chu, 2006; Chung & Bemak, 2002, Winter; Chung et al., 1993). Likewise, this elevated PD was suggested to be the main reason SEAA refugee women utilized American mental healthcare services at greater rates than SEAA refugee men (Leong & Zachar, 1999; Thikeo et al., 2015). In a pilot study of 108 Cambodian and Laotian refugees, Thikeo and colleagues (2015) found that SEAA women refugee study participants were significantly more likely to recognize the need for mental healthcare, seek professional psychological services, be more open to discussing their problems, and had more confidence in the American professional mental healthcare system than their countrymen.

Despite having higher mental healthcare service utilization rates than SEAA refugee males, barriers remain that block SEAA refugee women from equitably accessing these services.

The majority of research has stressed that SEAA refugee women tended to conform to more traditional resources to address mental healthcare needs, turning to professional mental healthcare only as a last resort (Catolico, 2013; Luc, 2018, August; Park et al., 2015; Shiu-Thornton et al., 2005, August; Sok, 2004, May; Thao et al., 2010, June). For example, traditionally family and marital discord is kept private and not disclosed to those outside of their families (Akutsu & Chu, 2006). Yet, in a qualitative review study by Shiu-Thornton and colleagues (2005, August), Cambodian women refugee study participants stated that increased family discord was the reason they turned to American professional mental healthcare when they were uncomfortable confiding in their family members (2006). Study subjects expressed a preference for community peer-based support groups and interpreters. Interpreters were described as extremely important to facilitate learning "what assistance and range of services are available, how to access them, and how to utilize them" (2005, August, p. 971). In fact, participants expressed that they still hesitated to seek outside mental health services despite family discord due to their overall lack of knowledge about available outside mental health resources and their options or choices among those resources (2005, August).

Furthermore, participants in this review study stated that other barriers to access and utilization centered on getting a provider with whom they already have a prior relationship, who has a shared cultural and language background, and who understands "the meaning of women's experiences" (Shiu-Thornton et al., 2005, August, p. 972). Participants stressed that they felt they would be better understood, could trust, and would have greater confidentiality with providers with the same cultural background. Also, the participants expressed a preference for female providers who likewise understand the complex emotional issues Vietnamese women refugees face when experiencing DV. These emotional issues include "fear of the perceived consequences

for speaking out about abuse [and the] fear that the abusive situation could worsen if abuse were reported" (2005, August, p. 972).

In a previous research study, Thao and colleagues (2010, June) found a similar perspective among their Hmong refugee women study subjects. They remained highly collectivist and clan oriented despite increased acculturation. However, when the Hmong refugee women subjects stated they couldn't turn to their clan and clan leaders for guidance and a protective source for coping, they turned instead to American mental health services. Likewise, findings in another previous study suggested that one of the main factors influencing attitudes toward seeking professional help in SEAA refugee women is the systematic issue of "perceived access to culturally, linguistically and gender appropriate health," the limited availability of which likely explained their low utilization of these services (Fung & Wong, 2007p. 227).

Summary Comments for Research Objective Two. This researcher cautions that much of the research on SEAA refugee mental healthcare utilization measured study subject self-reported attitudes and willingness to utilize these services as the basis for their discussions on underutilization patterns. It is an age-old research question in the field of psychology whether attitudes and the willing to do something like utilizing mental healthcare services equate to the actual behavior of utilizing these services. According to Wicker (1971), most people assumed that changing someone's attitudes could then lead to changing behavior.

Dozens of social psychology studies beginning in the 1960's challenged that idea (Myers, 2004). Myers (2004) pointed out that the relationship between attitudes and behaviors is influenced by both internal thoughts and external influences. In the case of SEAA women refugees, external influences extend from family to societal cultural norms as well as

environmental factors such as transportation infrastructure. The SIT described in Chapter One notes that cultural and societal norms as external factors are more important in SEA collectivist cultures than in American individualist culture.

Shiu-Thornton and colleagues review study (2005, August) findings supported the influence of external factors. Cambodian women refugee study subjects indicated that their motivation for seeking professional mental healthcare came from a disruption in their typical cultural norm for help-seeking with emotional problems. Study subjects stated that help-seeking begins traditionally with consulting family members. However, when experiencing familial or marital conflict, they emphasized that they would be more likely turn to outside mental health sources (2005, August). Their hesitation to then actually seek these outside mental health sources was due to their overall lack of knowledge about available outside mental health resources and their options or choices among those resources (2005, August).

Based upon this latter comment, this researcher suggests that ease of access may be the key in translating positive attitudes toward actual mental healthcare seeking behavior. The community peer-based, support groups subjects suggested in the Shiu-Thornton review study (2005, August) could overcome barriers like transportation, cost, time spent in travel, language and culture incompatibility, and potentially cultural and society norms against seeking outside emotional help. More research is needed on actual determinants to behavior resulting in mental healthcare utilization. Research presented in the "Recommended Intervention Approaches" section in this chapter continues this discussion on how these community-based psycho-educational groups can likewise potentially provide psychological benefits while also providing instrumental learning opportunities (see "Recommended Intervention Approaches" in this chapter to continue this discussion).

5.3 Objective Three: Barrier Predictor Variables across SEAA Ethnic Groups.

Cambodian Refugees. Previous studies endorsed cultural barriers, including stigma, as the most formidable barriers to SEAAs accessing American mental healthcare. In contrast, three studies in this review stressed that contextual/structural barriers were the most consequential for Cambodian refugees (Berthold et al., 2014; Marshall et al., 2006, October; Wong et al., 2006). Two review studies endorsed lack of transportation to and from appointments as well as language incompatibility with mental health providers as the main contextual/structural barriers (2014; 2006, October). Language incompatibility was considered a structural barrier as the unavailability of a provider who didn't speak the same language necessitated the need for an interpreter or agency training of Khmer-speaking providers (2006).

The third review study stressed high cost (80%) and language-incompatibility (66%) as the primary contextual/structural barriers for Cambodian refugee study subjects for both those without need for mental health services and those with self-reported need (N=490; Wong et al., 2006). Cultural barriers were ranked the least important (7% of respondent endorsement), including anticipated racial/ethnic discrimination (15%), shame (5%), preference for indigenous treatment (5%), and discouragement from family members (<1%). Using chi-square tests, study data showed that only the endorsement of cost as a barrier varied by gender with Cambodian study subject men more likely than women to endorse this barrier. Language-related barriers were endorsed more often by those with LEP, lived in poverty, had no high school education, and had no health insurance. Those with no high school education were also more likely to report not knowing about services and having transportation barriers. Endorsement of discrimination as a barrier was not associated with any significant demographic factor (2006).

Wong and colleagues (2006) concluded that accessing healthcare was cost-prohibitive for most Cambodians (most study subjects' yearly income was less than $25,000). Therefore, this study concluded that providing or reimbursing for transportation would be one step toward making mental healthcare services more affordable. Otherwise, healthcare reform would be needed to help Cambodian and other refugees gain greater access to services (2006).

Hmong Refugees. There was limited research overall on Hmong mental health seeking behavior. However, research supported the same findings for Hmong refugees as mentioned above for Cambodian refugees. Those findings emphasized that contextual/structural barriers were the most formidable obstacles for mental healthcare service utilization. In previous research by Thao and colleagues' (2010, June), Hmong key informant interviews in Washington state flagged lack of transportation as one of the most insurmountable barriers to access. Because many Hmong families did not own a car nor knew how to drive, the key informants suggested that mental healthcare professionals needed to likewise provide reliable transportation options to make their services more accessible. Otherwise due to LEP, Hmong refugees could not successfully navigate public transportation (2010, June).

Likewise, one review study pointed out that across the generations Hmong refugees were increasingly open to accessing American mental healthcare (Lee, 2002, December). However, despite these increasingly positive attitudes, this study indicated that Hmong still lacked the means with which to access mental healthcare, including income and the convenience of proximal, culturally competent providers (2002, December).

Vietnamese Refugees. Unlike other SEAA ethnic groups, surprising findings in a review study suggested that first-generation Vietnamese study subjects were not deterred from using American mental healthcare services due to high contextual/structural barriers (Luu et al., 2009).

Specifically, in this review study, study subjects had more positive attitudes about seeking professional mental healthcare when the provider did not have the same Vietnamese cultural background, including not being a native speaker. Study findings suggested that Vietnamese American refugee subjects may have had trust issues with mental health providers who were Vietnamese, because of the strong public stigma associated with mental illness in Vietnamese communities. Moreover, study subjects may have been highly fearful of confidentiality breaches potentially sourcing from Vietnamese mental health providers which overrode their general preference for providers with the same cultural background (2009).

Summary Comments for Research Objective Three. This section's discussion of the role structural/contextual barriers across SEAA refugees illustrates Morris and colleagues' (2009) point that many of these barriers were inter-related, jointly contributing to a larger access to care problem. However, in the instance of Luu's (2009) study results for first-generation Vietnamese refugees, structural/contextual factors were instrumental in overcoming what would otherwise be construed as a typical access problem, e.g., culturally incongruent American mental healthcare providers. In objective 5.1, research findings suggested that the influence of cultural factors shifted such that structural/contextual factors became increasingly more influential in shaping attitudes toward American mental healthcare than cultural factors. More research is needed to understand if study subject age or generation is a moderating variable in determining which barrier may be the most influential in shaping SEAA refugee attitudes toward utilizing American mental healthcare services. The predominant usage of cross-sectional instead of longitudinal studies in this research area is hampering the understanding of how specific factors may shift from being barriers to becoming instrumental and vice versa in terms

of American mental healthcare utilization. Using stratified samples that represent multiple generations would also be beneficial.

5.4 Objective Four: Rethinking Acculturation as a Cultural Barrier.

Vong and Choi (2014) stated that research has traditionally assumed that there is a unidirectional, positive association between refugee increased acculturation to U.S. society and increased U.S. mental healthcare seeking behavior. However, research findings on SEAA refugees have been mixed.

A study conducted by Thikeo and colleagues (2015) provided the most detailed empirical support for this assumption. Study findings suggested that acculturation was the most robust demographic variable leading to increased positive attitude and behaviors toward American mental healthcare for both male and female SEAA refugees. This finding resulted from a hierarchical multiple regression analysis of all demographic variables identified in their study. Acculturation contributed the most significant and unique variance over and above the other demographic variables as follows: 1) continuous variables age, education level, family income, and number of years living in the U.S., and 2) categorical variables gender, ethnicity, health insurance, employment status, religious beliefs, and languages spoken at home (2015).

As shown in Thikeo and colleagues' (2015) study findings, three review study findings also supported a positive association between increased SEAA refugee acculturation and U.S. mental healthcare seeking behavior (Luu et al., 2009; Shiu-Thornton et al., 2005; Sok, 2004, May). A single study in this review examined the association between acculturation among Cambodian adult refugees and their attitudes toward American Healthcare seeking (Sok, 2004, May). Study results showed that as subjects' acculturation levels increased, Cambodian adult refugee subjects' likelihood to utilize the services of American psychiatrists or psychologists

also increased (55%; 2004, May). Similarly, a second review study by Luu and colleagues (2009) found that acculturation experienced by their Vietnamese refugee subjects was significantly associated with positive attitudes toward seeking psychological help ($p < .01$). The majority of the study participants were first-generation Vietnamese refugees, 23% of whom graduated from college and had lived in the U.S. on average 17.28 years (2009).

A third review study of Vietnamese refugee women who had experienced DV revealed yet other effects of acculturation (Shiu-Thornton et al., 2005). Study subjects stated that their understanding that DV is not normal martial conflict was itself shaped by the acculturation process. Study subjects described marital conflict in Vietnamese traditional culture as "ordinary" and when it occurred was "considered a personal, private family matter" (2005, August, p. 966). Furthermore, once increasing their awareness of the American ideal of gender equality through acculturation, study participants described a parallel increase in awareness "of the psychological and emotional dimensions of abuse" (2005, p. 966). Thereafter, they recognized a need for mental healthcare services which they preferred as community-based support groups (2005).

On the other hand, three additional review studies found no significant association between SEAA refugee acculturation and U.S. mental healthcare seeking (Bhuyan et al., 2005, August; Bui, 2003, February; Luc, 2018, August). Using a correlation analysis, Luc (2018, August) found that the association between acculturation and attitudes toward professional mental healthcare in their Vietnamese refugee subjects was not significant ($p = .78$). Cambodian women refugee participants in Bhuyan and colleagues' (2005, August) qualitative study commented further that acculturation impacts different members of Cambodian families in both positive and negative ways. Several study subjects had experienced DV during which they said they felt increasingly "at a disadvantage because their abusers [e.g., their husbands] tend to speak

more English and are more knowledgeable about how things work in this country" through acculturation (2005, August, p. 914). At the same time, study subjects said they felt increasingly isolated and incapable of leaving their abusive relationship by reaching out beyond their personal network to seek professional services (2005, August).

In yet another review qualitative study with Vietnamese women refugees who had experienced DV, Bui (2003, February) concluded that the willingness for them to reach out to professional mental healthcare services outside of their personal networks was not a function of a "normal" progression through time which the acculturation construct assumes. Instead, this willingness to reach out to victims' social services was more a function of gaining greater financial independence and the structuring of more division of labor in their households. The latter allowed study subjects more freedom to attain an education, giving them the scaffolding they needed to reach outside of their traditional social and personal networks in seeking safety through professional victim social services (2003, February).

Summary Comments for Research Objective Four. This researcher challenges the limited scope of this review's studies and other research in terms of their conceptualization of acculturation as a construct. The first issue is the limited nature of the definition of acculturation most research has used. Redfield and colleagues (1936) provided this benchmark definition: "Acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact [with each other] with subsequent changes in the original culture patterns of either or both groups" (p. 149). This definition describes acculturation as a dynamic process between the host culture and those coming in contact with it.

However, most research examining SEAA refugee acculturation presented that process as linear and unidirectional whereby the SEAAs are expected to change in adapting to mainstream American society without commensurate changes in American society (Vong & Choi, 2014). According to most research studies, the consequences of SEAA "not" acculturating was limited success and ability to survive as well as the limited ability to effectively access American mental healthcare (2014). This researcher submits that the American mental healthcare system is not effectively supporting acculturation as part of the dynamic, bidirectional acculturation process as described in Redfield and colleagues' (1936) definition. Some researchers on SEAA mental healthcare needs called this continued evidence of American mental healthcare system institutional racism (Alvarez & Shin, 2014).

In line with the faulty assumption of acculturation as a unidirectional, linear process, most research on SEAA refugee acculturation levels used single proxy measures of acculturation. These proxy measures included variables such as generational status, length of time in the U.S., and English language proficiency levels (Wang & Kim, 2014). From a linear conceptualization of acculturation, sociological theories hypothesized that longer contact with mainstream culture, including successive generations in resettlement, resulted in higher levels of acculturation (Gordon, 1964). However, instead of using proxy measures to determine acculturation levels, more recent psychological theories emphasized shifts in behavioral and psychological dimensions as more appropriate determinants. Furthermore, these researchers suggested that behavioral acculturation may take place faster than a change in more entrenched cultural values in order to address more pressing survival issues within mainstream culture (Szapocznik & Kurtines, 1980).

This researcher concludes that measuring acculturation levels must be viewed from several angles to have a better assessment of its impact on individuals. Assessing this impact includes factoring in differing acculturation rates for different members of the same family. There are, in fact, several standardized measures for Asian acculturation levels, including the Suinn-Lew Asian Self-Identity Acculturation Scale. Instrument developers Suinn, Ahuna, and Khoo (1992) commented that they added up to 26 new items to this scale to incorporate current theories that endorsed acculturation as not linear and unidimensional but multi-dimensional and orthogonal. Only three of the 16 studies in this review used this standardized instrument (Lor et al., 2017; Luc, 2018, August; Luu at al., 2009).

Strengths and Limitations of Review Studies

Strengths. The main strength of this review is its inclusion of qualitative, mixed-methods, and quantitative studies from both peer-reviewed journals and gray literature. Findings from each of these research methodologies blended to create a more comprehensive picture of SEAA refugees' explanatory models of mental health and their preferred methods of help-seeking as influenced by historical, contextual, cultural, and sociodemographic factors. Data collection differences between the various research methodologies allowed for a nuancing of human experience that helped shape a subtler understanding of the distinctions between and within each of the three SEAA ethnic groups. Furthermore, to encourage readers to better understand SEAA ethnic group's similarities and differences, this thesis emphasizes these across all its chapters.

Limitations. The main limitation of this review is the small number of studies that were selected. Through time, research on the needs of SEAA has declined as the years lapsed since the end of the Vietnam War. As mentioned in the "Systematic Review Study Characteristics" section

in this chapter, 62.5% of the selected studies were published from 2001 and 2010 with 31.2% published between 2011 and 2019. Additionally, publications were not selected for this systematic review if they were included in the review of the literature to avoid duplication of information. Therefore, the small number of review studies does not reflect the overall pool of available literature in this research topic.

Less rigorous methodology is another major limiting factor. A majority of the studies were descriptive in nature, using a single sample population without a comparison or control group. Furthermore, most studies were cross-sectional in design with no study providing follow up data collection. Small sample sizes were typically used which was likely sufficient when doing descriptive studies of a single ethnic group, but which also limited the generalizability of study findings.

In addition, samples were primarily recruited through convenience or snowballing sampling methods, resulting in SEAA subjects who were likely more homogenous in nature. These sampling methods were often needed when recruiting hard-to-reach populations, especially when investigating sensitive topics such as mental health issues, including DV. However, subjects recruited in the community at large through nonprobability sampling methods would tend to be significantly different in demographic traits, cultural identity and adaptability as well as mental health status than SEAA samples the included those already utilizing community mental health clinics. Therefore, study findings must be considered in light of the less rigorous methodology used to determine their findings.

Equally important, the quality of study instruments used to collect data were questionable. Many measures were often proprietary and/or not standardized on the study subject population. For example, only two studies described using behavioral models that addressed

healthcare utilization for proprietary questionnaire development (e.g., Andersen Behavior Model, 1968; Andersen and Aday Behavioral Model and Access to Medical Care Model, 1974). Another study stipulated that the authors used cross-cultural research in determining that their interview questions should be structured with an open-ended response format (Eyton & Neuwith, 1984). Furthermore, the remaining studies did not provide detailed information about their proprietary instrument development process.

Likewise, if provided in another language, few studies detailed how their measures were translated, including whether a back-translation process was used which increases the content validity and reliability. Furthermore, the interviewers' gender and language compatibility may have also biased results. Several study investigators stressed that they provided interviewers who were from the same communities as the study subjects. Using interviewers from the same community was often cited as a means of creating a safe environment because of greater prior familiarity with the subjects and their culture. However, many SEAA subjects pointed out that they worried confiding to fellow community members may lead to breaches of confidentiality, risking potential public stigmatization. This fear may have therefore led to response bias.

These study characteristics among others call into question the overall validity of the study data provided. Therefore, this researcher submits that findings from these studies and therefore this review are preliminary in nature. These findings can provide a basis for future research that is a more thorough and rigorously examination of the nature of SEAA refugee access to and utilization of American mental healthcare services.

5.5 Objective Five: Current Interventions Intended to Increase Engagement in Mental Healthcare Services

Based upon the previous discussion on barriers, interventions focused on decreasing *stigma* and increasing *mental health literacy* seem particularly relevant in potentially improving mental health treatment seeking behaviors. General strategies targeting the American public include training interventions and educational programs as well as using mass media campaigns (Corrigan, 2011). The down-side is most of these efforts are short-term (Corrigan & Gelb, 2006).

However, Davidson and colleagues (2018) pointed out that digital storytelling is now being used to address mental health *stigma*. This type of application is also driving an increased interest in other web- or smartphone-based interventions. Davidson and colleagues (2018) stated that previous studies showed that these electronic applications did tend to improve awareness and interest which, in turn, were associated with a reduction in stigma surrounding mental illness. Furthermore, these methods of delivery overcame barriers to access, including limited transportation, time constraints, scheduling problems, and concerns about confidentiality. All of these have been identified as obstacles to initiating access to mental healthcare for SEAA refugees (2018).

The lower cost of delivery for electronic interventions instead of in-person methods would tend to also make them more attractive to SEAA refugees who face high rates of poverty and unemployment (Davidson et al., 2018; Reeves & Bennett, 2004). The down-side of these approaches is their likely greater appeal to younger generations as described in Ruzek and colleagues' (2011) study findings. This study showed how younger Vietnamese college students mitigated any family, community, and/or public stigma by using the Internet, for example, as an indirect means of obtaining information on mental health (2018). This is another example of how

SEAAs tried to mitigate possible in- and out-group stigmatization from exploring mental health topics as described within the SIT (see Chapter One for a discussion on the SIT).

In California, the SEARAC (2019, July 3) is taking the lead in this area by initiating its digital Mental Health Collection. The Mental Health Collection is an effort to learn more about ways SEAAs have or have not accessed American mental healthcare. This campaign's objectives include identifying gaps in mental healthcare services to inform policy recommendations for community-based services. Likewise, this effort is also providing a forum for SEAAs to share their personal stories, including successful use of Western mental healthcare (2019, July 3). Davidson and colleagues (2018) discussed how several studies showed evidence that using peer narratives does help reduce stigma which, in turn, has been associated with improved mental health treatment seeking behavior. Stories like the following have come out of the SEARAC's (2019, July 3) story collection:

> It has been over a year since I developed my mental health team of a psychologist, psychiatrist, primary care physician and therapist, who have helped me to be a little stable, realize the impact my behaviors have on others, develop healthy coping mechanisms and allow myself to be happy. I believe if I did not have my mental health care team my relationships will continue to be unstable. I would still act hasty without considering the consequences at times and feel a sense of worthlessness and hopelessness. ~Cambodian/Khmer, 18-24 year old female
>
> (2019, July 3, para. five)

5.6 Objective Six: Recommendations for Intervention Approaches

Davis (2000) is the only review study researcher who found that we often take a lopsided view of SEA refugees as they author their own identities in U.S. resettlement. Instead, Davis (2000) considered the meaning of suffering in the context of "the resiliency of the human spirit, fortified through strong family and community affiliation" (p. 159). Kulfried and Camino (1994) pointed out social and humanitarian organizations often are at fault in stereotyping the refugee experience at large as common experiences of "victimization and abuse, atrocities, violations of human rights, traumas, flight, and barriers to adjustment" (p. xiii). These authors added that this is understandable when providing services to large numbers of people with limited organizational assistance funding (1994).

But if we continue to take a deficit-focused approach to understanding SEAA refugee experiences, particularly women, we are missing the bigger picture of how they have the strength to endure beyond these otherwise traumatizing events from which they also have the ability to thrive and even prosper (Camino, 1992). Davis (2000) stated further that by shifting "the paradigm from one of mental illness to that of human loss," we are refocusing the conversation to one of cultural bereavement instead of PTSD (p. 158). In so doing, Davis suggested (2000) SEAA women refugees can feel "acknowledged, justified, and validated" as they rebuild their lives and their families' lives toward a better future (p. 158).

This researcher submits that we already have the answers on how to create more innovative and approachable interventions to decrease the barriers of access to mental healthcare services for SEAA women refugees. Those answers come from SEAA women refugees themselves. Previous research found consistently that SEAA refugees see using American mental healthcare services as a "last resort." Five of the review studies confirmed this

perspective (Catolico, 2013; Luc, 2018, August; Park et al., 2015; Shiu-Thornton et al., 2005, August; Sok, 2004, May). As an alternative, participants in two review studies emphasized that community-based support groups would create opportunities for refugee community members to learn, support, and help each other to solve problems rather than seeking outside mental healthcare services (Bhuyan et al., 2005, August; Shiu-Thornton et al., 2005, August).

This researcher submits that community-based, support and psychoeducational group work is one solution in which SEAA refugee women of the same ethnic group can come together. These groups invite connection and provide a place in which participants can disclose otherwise sensitive topics in a safe, nonjudgmental setting (Lundy et al., 2018). Creating these gatherings in their own communities overcomes many of the barriers to utilizing professional mental healthcare, including cost, transportation, and client-provider congruence issues like language and an understanding of cultural ramifications. Additionally, support groups provide a cohesive, consistent structure and environment that can help refugee women overcome experiences of feeling isolated and being outsiders (2018).

Moreover, Miller and Rasmussen (2017, April) stated "it should be possible to improve the mental health of refugees through interventions that are not formally conceived of as psychotherapeutic in nature. Projects aimed at fostering livelihoods, changing policies to permit refugee employment, reducing family violence, …. and creating settings where people can find new sources of social support may not be designated to improve mental health yet may do so collaterally" (pp. 132-133). Researchers Miller and Rasmussen (2017, April) added that community interventions developed to provide refugees with social support networks are not novel. Yet, few research studies investigated the psychological benefits that can likewise come from these interventions.

Goodkind's (2006, March) mixed-methods research on the Refugee Well-Being Project (RWBP) was one of the few exceptions. RWBP was developed using an ecological and empowerment perspective. To ensure ecological validity, stakeholders, including the Hmong refugee participants, were invited to help develop this intervention. There were two components to this project: 1) Learning Circles, and 2) Advocacy. The Learning Circles are based upon mutual learning whereby undergraduates learned about Hmong culture, while the Hmong experienced one-on-one tutoring such as preparing for the citizenship exam. Advocacy involves the pairing of an undergraduate with one to three refugee partners. The students worked four to six hours weekly to mobilize community resources, fulfilling the unmet needs identified by the refugee partners. In turn, the students empowered the refugees to be their own advocates concerning job seeking, language acquisition, and access to public transportation, among others (2006, March).

Quantitative research findings from this study (Goodkind, 2006, March) showed that Hmong participants improved in quality of life, experiencing decreased PD, increased English proficiency, and increased in awareness of community resources. Qualitative, in-depth interviews focused on participant experiences through which the following themes emerged: 1) "valuing Hmong women's knowledge and experience," 2) "validation of Hmong women's identify," 3) "appreciation of the strength and resiliency of Hmong women," 4) "recognition of society's responsibility in the process of refugee resettlement and the need for system-level change," and 5) "increases in participants' environmental mastery and self-confidence" (2006, March, p. 84).

Goodkind (2006, March) summarized findings as Hmong participants benefited from engaging in more instrumental learning of concrete skills while the undergraduates described

experiencing more transformative, conscious-raising. Goodkind (2006, March) stressed how paying attention to the psychological needs of refugees is inadequate if other material, social, educational needs, and resettlement adjustment challenges are not also addressed. This requires the creation of alternative, hybrid intervention approaches with broader definitions of the helper as collaborator, not the expert (2006, March). Furthermore, a collaborative group format is important to allow the Hmong to foster self-efficacy after having felt powerless when forced from their home lands into subsequent U.S. resettlement (Ager, 1999).

Implications for U.S. Public Health

The composition of American society is shifting dramatically. According to the 2000 Census (U.S. Census Bureau, 2000), Hispanics and Asian Americans are the two fastest growing racial and/or ethnic groups in the U.S. population. Updated population statistics from the Pew Research Center show that overall the U.S. Asian population grew 72% from 2000 to 2015, the fastest growth rate across all major racial and/or ethnic groups (Lopez et al., 2017, September 8). In fact, the recent waves of Asian refugees and immigrants comprise one-quarter of all individuals settling in the U.S. since 1965. Currently, 73% of all Asians in the U.S. are foreign born (2017, September 8). Furthermore, census population projections suggest that minority groups will combine to be the new majority in the U.S. as of 2050 (Xu et al., 2001, December). Some call this momentum "the emerging majority" (2001, December, p. 30).

With this dramatic shift in the American population, it is a moral imperative now more than ever to eliminate racial and ethnic disparities in access to healthcare, including mental healthcare. Beyond improving access, eliminating racial and ethnic disparities includes bolstering healthcare treatment to levels that are more responsive to the cultural needs of America's ever-changing population make-up.

Accordingly, *Healthy People 2020*'s overarching goals include the following: 1) "achieve health equity, eliminate disparities, and improve the health of all groups, and 2) create social and physical environments that promote good health for all" (DHHS, 2001, November, p. 2). One of the targets for achieving health equity and eliminating disparities is to assess those conditions according to "race/ethnicity, gender, socioeconomic status, disability status, lesbian, gay, bisexual, and transgender status, and geography" (2001, November, p. 2). In turn, one of the 26 leading health indicators is "access to health services" (2001, November, p. 2). *Healthy People 2030* is projected to extend these stipulations (DHHS, n.d.).

When compared to general healthcare access, Wells and colleagues (1987) stated that disparities in access to mental healthcare for all Americans seemed more formidable. In fact, Morris and colleagues (2009) commented that barriers to accessing mental healthcare are inter-related, combining to create an even larger access to care problem. In its recently released *American's Mental Health 2018*, the National Council for Behavioral Health (2019) agreed that "American mental health services are insufficient, and despite high demand, the root of the problem is lack of access…"

When left untreated, mental illness is often debilitating with cumulative effects not only on the individual but also on his or her community at large. For example, the consequences of untreated intergenerational trauma are compounded across SEAA offspring. Simply put, the public health system of the U.S. as a whole is taxed when racial/ethnic minorities such as refugees and new immigrants as well as all Americans are unable to adequately access basic healthcare, including mental healthcare. An economically productive and vibrant nation needs all of its citizenry to fully contribute for a better collective future.

Suggested Future Research

We still know little about SEAA refugee mental health needs, specifically women, and how to adequately provide access to mental health services to address these needs. This dearth of knowledge is despite SEAAs being in the fastest growing minority group in the U.S., four decades or more in U.S resettlement, their increased vulnerability to mental health issues from extreme trauma exposure starting in their countries of origin, and their continued economic deprivation in U.S. resettlement.

In particular, more rigorous empirical studies are needed to provide more robust findings beyond those available through the descriptive studies that currently dominate this research area. More rigorous empirical studies include providing probability studies with calculated sample sizes and comparison or control groups. Disaggregation of data should be built into these studies' data collection protocol, providing disaggregation on multiple variables as ethnic group, gender, and U.S. geographical location. Geographical location must be provided as population needs vary according to region with different levels of quality of mental healthcare services as well as infrastructure and other deficits that constitute barriers to access to mental healthcare.

Additionally, more study designs are needed that are longitudinal with follow up data collection instead of the current predominate use of cross-sectional studies. Longitudinal studies would provide the much-needed insight into the impact of intergenerational trauma on the SEAA refugee community. Furthermore, samples could be stratified to include different generations within studies to address the remaining research questions as to potential changing mental health needs, changing understandings of their cultural explanatory models of illness, potential intergenerational acculturation stress, and different perceived barriers to access for mental healthcare services.

Likewise, less proprietary and more standardized instruments need to be used in these studies such as the Harvard Trauma Questionnaire (HTQ), the gold standard in evaluating the effects of refugee trauma. Of its six versions, the HTQ has three written expressly for SEAs, including a Vietnamese, Cambodian, and Laotian versions (Harvard Program in Refugee Trauma, n.d.). A further benefit of the HTQ is its ability to capture data on up to 82 traumatic events across a lifespan when there is evidence that Cambodians who lived through the Khmer Rouge genocide experienced 8 or more 16 trauma events during that time period alone (Kinzie et al, 1984). Most research in this field tends to erroneously focus trauma exposure data collection on pre-migration experiencing when researchers Miller and colleagues (2002) stated that post-migration studies have consistently predicted that trauma experienced during this phase are as powerful in advancing the development of mental illness as are prior war experiences. As a trauma psychologist, this researcher submits that trauma has a compounding effect such that any trauma data collection instrument must consider lifetime exposure like the HTQ, not limiting the focus only to specific time periods whether they are pre-migration or time spent in resettlement.

Additionally, future research on SEAA refugee barriers to access for mental healthcare would benefit from embracing a common framework. This researcher recommends the Behavioral Model of Health Services Use (BMHS; Davidson et al., 2004, Spring). This model extends the Andersen Behavioral Model of Health Services Utilization (Andersen, 1968) described in depth as the basis of one review study in Chapter Four (Lee, 2002, December; see Chapter Four, “Barriers to Accessing American Mental Healthcare Utilization: Hmong/Laotian Refugees”). Using for instance the BMHS that addresses healthcare utilization patterns allows for a consistent baseline comparison for findings across studies. This consistent comparison baseline

would then serve to create a knowledge base beyond the descriptive research studies that currently dominate the field.

In fact, the Behavioral Model of Health Services Use provides for a multivariate analysis of factors on the individual, community, and system levels, including social, economic, structural, and the public policy environment, all of which can constitute barriers of access. Davidson and colleagues (Davidson et al., 2004, Spring) emphasized that using a “compre-hensive and systematic approach suggested by [this] framework will enable researchers to strengthen the external validity of results by accounting for the influence of a consistent set of contextual factors across locations and populations” (p. 21). Furthermore, Karikari-Martin (2010) noted that when this model was used in numerous research studies worldwide, beneficial changes to health policy changes resulted.

There remains a need for future empirical studies that examine more about what decision process is involved in SEAA refugees’ consideration of using American mental healthcare services and the barriers to increased utilization. But there is also a need for more phenome-nological studies of both the refugee experience and that of the professional American mental healthcare provider. Acculturation is a bidirectional process. Suggested questions could preface the following:

1) What is it like for the prospective SEAA refugee client or family members to consider using outside services? What differences do men and women SEAA refugee clients experience in making that decision?

2) What is it like to use either a provider who is of the same culture versus one that is not? How important is it to have a provider who is not only of the same culture but also the same gender as the SEAA client?

3) What is the meaning of the experience of each actor in this overall transaction, e.g., the client, community health workers, and the mental health provider? All of these actors are needed to engage in the process, for instance, from assessing mental health needs, initiating community outreach including increasing mental health literacy, and providing greater access to transportation and language options. Successful navigation of all of these steps is essential for SEAA refugees to have equal access to American mental healthcare services.

Qualitative research adds to the knowledge base, then, by allowing for more in-depth insight about SEAA attitudes, feelings, and behaviors which are often not captured as thoroughly in structured empirical instruments. Furthermore, qualitative research allows for the introduction of topics not previously anticipated which can help facilitate future research hypothesis development.

Conclusions

This year marks the 45th anniversary of the first wave of SEAAs arriving in the U.S. after the end of the Vietnam War and the Fall of Saigon (SEARAC, 2020, May 5). At that time, three million SEAs escaped from Vietnam, Cambodia, and Laos, settling across the U.S., the UK, France and Australia. Today more than three million SEAs live in the U.S. alone. While these ethnic communities have made significant advances in the last four decades, including contributing across all facets of American society, a large number of SEAAs still lack adequate access to professional mental healthcare (2020, May 5).

Several review studies challenged the notion that the most significant barriers facing SEAAs' access to American mental healthcare are culturally oriented. Overall, research findings were inconsistent concerning the association between SEAA cultural values and mental healthcare help-seeking behavior. Instead, a number of review study findings indicated contextual/

structural barriers as the main obstacles to accessing these services. These contextual/structural barriers included object poverty, lower educational attainment, lack of access to viable transportation options, and lack of health insurance.

Changes to contextual and structural barriers require changes to overall American infrastructure policies surrounding, for instance, the availability and coverage of health insurance, the provision of adequate and affordable transportation, affordable educational opportunities, and equal access to culturally appropriate mental healthcare for all Americans, not just SEAAs. Recent changes to federal deportation rules have also become an increasingly pressing concern for SEAAs whereby over 15,000 SEAAs continue to face final orders of removal (SEARC, 2020, May 5). This added pressing concern contributes to SEAA refugees' already general, elevated levels of PD.

Several review studies pointed out that our American conception of what it takes to be resettled falls short with how long it takes SEAAs to attain sustainable housing, employment, and adequate language skills. Instead, all of these factors continue to contribute to SEAA barriers to accessing adequate mental healthcare services. Our national refugee policy allows for support for eight months after initial arrival under the Office of Refugee Resettlement (2012) when several studies showed that six years or more after resettlement, SEAA refugees were still struggling to adapt (Chung & Bemak, 2002, Winter).

Furthermore, the underuse of evidence-based psychotherapy to address PTSD is a wide spread issue in the U.S. today across all populations (Foa et al., 2013). Therefore, the lack of provision of evidence-based, trauma-focused therapy remains a barrier to access of effective mental healthcare for all Americans. Providing such effective care is in line with the National Institute for Health and Care Excellence's (2011, May) expanded definition of access to mental

healthcare. This expanded definition describes access to mental healthcare as a complex topic that encompasses both what makes up the ability to initiate mental healthcare and the ability to receive effective healthcare treatment. Effective treatment includes the engagement of culturally competent mental healthcare providers. However, it matters not how effective evidence-based and culturally sensitive American mental healthcare services become, if barriers that limit access to those services remain for SEAAs and the general American public alike.

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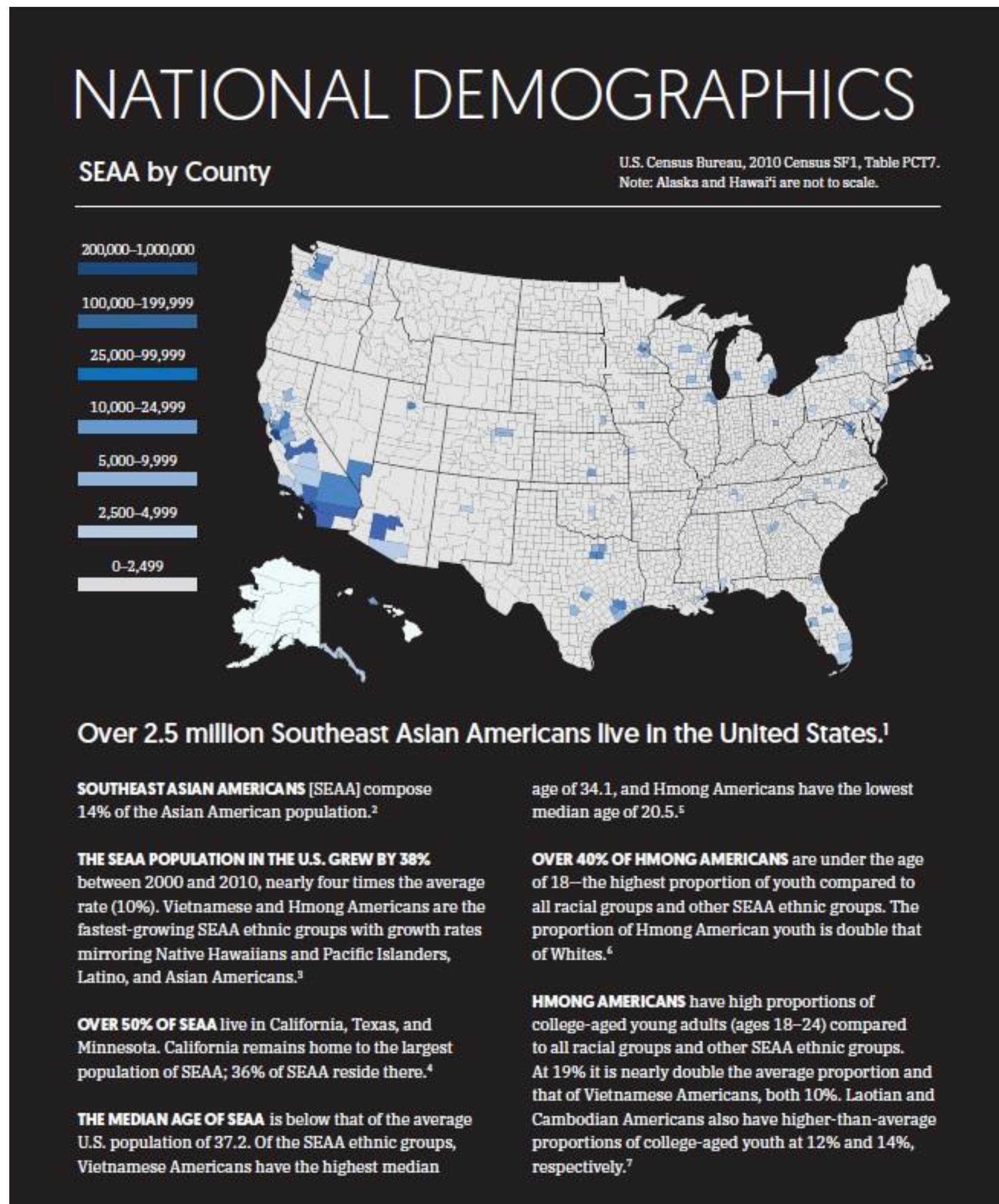
Appendices

Appendix A: National Demographics: SEAA by County (2010)



NATIONAL DEMOGRAPHICS

SEAA by County

U.S. Census Bureau, 2010 Census SF1, Table PCT7.
Note: Alaska and Hawai'i are not to scale.

Over 2.5 million Southeast Asian Americans live in the United States.[1]

SOUTHEAST ASIAN AMERICANS [SEAA] compose 14% of the Asian American population.[2]

THE SEAA POPULATION IN THE U.S. GREW BY 38% between 2000 and 2010, nearly four times the average rate (10%). Vietnamese and Hmong Americans are the fastest-growing SEAA ethnic groups with growth rates mirroring Native Hawaiians and Pacific Islanders, Latino, and Asian Americans.[3]

OVER 50% OF SEAA live in California, Texas, and Minnesota. California remains home to the largest population of SEAA; 36% of SEAA reside there.[4]

THE MEDIAN AGE OF SEAA is below that of the average U.S. population of 37.2. Of the SEAA ethnic groups, Vietnamese Americans have the highest median age of 34.1, and Hmong Americans have the lowest median age of 20.5.[5]

OVER 40% OF HMONG AMERICANS are under the age of 18—the highest proportion of youth compared to all racial groups and other SEAA ethnic groups. The proportion of Hmong American youth is double that of Whites.[6]

HMONG AMERICANS have high proportions of college-aged young adults (ages 18–24) compared to all racial groups and other SEAA ethnic groups. At 19% it is nearly double the average proportion and that of Vietnamese Americans, both 10%. Laotian and Cambodian Americans also have higher-than-average proportions of college-aged youth at 12% and 14%, respectively.[7]

Source: U.S. Census Bureau, 2010, SF1, Table PCT7

Appendix B: *General Characteristics of Systematic Review Selected Studies*

Table B.1 ***General Characteristics of Included Quantitative and Mixed-Methods Studies*** **(n=11)**

Legend: AA = Asian American, C = Cambodian, L = Laotian, NR= Not Reported, SEA = Southeast Asian, V = Vietnamese, VA = Vietnamese American

Authors	Relevant Research Objectives	Participant Ethnicity, Sample Size	Gender	Age: Mean/median in yrs. (SD)	Sample Location(s)	Length of Residence in U.S.: Mean/ Median in yrs. (SD)
Berthold *et al.*, 2014	Identify the extent of possible co-morbid physical and mental health problems in C adults living in Connecticut and W. Massachusetts; explore their interrelationship, and how they may be related to access to mental and physical healthcare	C refugees: N=136	Females: 61% (n=83) Males: 29% (n=53)	Mean: Males/females combined: 56.5 yrs. (11.83)	Connecticut and Western Massachusetts	NR
Chung & Bemak, 2002, Winter	Investigate predictors of psychological distress within a SEA refugee nonclinical community sample; explore intergroup and gender differences as well as the intersection of gender and ethnicity as predictors of distress within V, C, and L refugee adults	V refugees: N=867 C refugees: N=590 L refugees: N=723	V Females: 41.4% (n=359) V Males: 58.6% (n=508) C Female: 50.8% (n=300) C Male: 49.2% (n=290) L Female: 41.5% (n=300) L Male: 58.5% (n=423)	Median (NR): V Females: 33 yrs. V Males: 35 yrs. C Females 38 yrs. C Males 38 yrs. L Females 38 yrs. L Males 38 yrs.	NR	Mean (NR): V Females: 5.5 yrs. V Males: 5.9 yrs. C Females: 3.7 yrs. C Males: 3.8 yrs. L Females: 5.4 yrs. L Males: 5.3 yrs.

Table B.1 ***General Characteristics of Included Quantitative and Mixed-Methods Studies (n=11):*** **continued**

Legend: AA = Asian American, C = Cambodian, L = Laotian, Not Reported=NR, SEA = Southeast Asian, V = Vietnamese, VA = Vietnamese American

Authors	**Relevant Research Objectives**	**Participant Ethnicity, Sample Size**	**Gender**	**Age: Mean/Median in yrs. (SD)**	**Sample Location(s)**	**Length of Residence in U.S.: Mean/ Median in yrs. (SD)**
Lee, 2002	Examine barriers or perceived barriers that prevent the Hmong of Fresno, CA, from accessing American (e.g., Western) healthcare, including mental healthcare	Hmong Americans: N=163	Females: 48.5% (n=79)	Mean: 30-39 yrs. 30.9% (NR)	Fresno, California	Mean: 16 yrs. or more 53.4% (n=87) (NR)
Lee & Law, 2001	Examine the perception of sexual violence against women and help-seeking responses to sexual victimization among 4 Asian groups; SEAAs was 1 of the surveyed groups; examine respondents' perceived severity of the problem, relationships between perpetrators and victims, preferred preventive measures, and help-seeking methods	SEAA: 34.9% of overall sample N=186 (n=65, V: 34, C: 5, L: 26)	Females: 69% of SEAA sample (n=45)	Median: Female SEAAs 21 to 30 yrs. 36.2% (n=16) (NR)	NR	Median: 6 to 10 yrs. 44.6% 11 to 20 yrs. 41.1% (NR)
Lor, Rodofa, & Limberg, 2017	Investigate the relationship between Hmong women's level of acculturation, perception of stigma, and the expression of attitudes toward professional psychological help and willingness to see a counselor	Hmong American women: N=222	Females: 100%	Mean: 18 to 25 yrs. 46.0% 26 to 35 yrs. 41% (NR)	NR	Median: 20 or more yrs. 96.4% (NR)

Table B.1 ***General Characteristics of Included Quantitative and Mixed-Methods Studies (n=11)*****: continued**

Legend: AA = Asian American, C = Cambodian, L = Laotian, Not Reported=NR, SEA = Southeast Asian, V = Vietnamese, VA = Vietnamese American

Authors	Relevant Research Objectives	Participants' Ethnicity, Sample Size	Gender	Age: Mean/median in yrs. (SD)	Sample Location(s)	Length of Residence in U.S.: Mean/ Median in yrs. (SD)
Luc, 2018, August	Examine the relationship between acculturation level, self-stigma, and attitudes toward seeking professional psychological help among VA; understand how VA's attitudes toward mental health services and the effects of acculturation and self-stigma influence their perceptions of these services and the likelihood of using srvs. when needed	VA adults* N=161 *migrant status NR but only 0.29% were born in U.S.	Females: 52.2% (n=84) Males: 47.8% (n=77)	Mean: Males/females combined 35.78 yrs. (12.15)	NR	NR
Luu, Leung, & Nash, 2009	Examine 3 variables that may have an impact on attitudes of VA toward seeking professional psychological help: 1) acculturation, 2) cultural barriers, and 3) spiritual beliefs to be used in the development of more culturally competent mental health outreach to VAs	VA adults* N=210 *migrant status not reported by 89% were born outside of the U.S.	Females 50% (n=105) Males 50% (n=105)	Mean: Females: 40.94 yrs. (NR) Males: 45.59 yrs. (NR)	Houston, Texas	Mean: Males/females combined: 17.28 yrs. (NR)
Marshall *et al.*, 2006, October	Investigate the rates and correlates of mental health service seeking among a representative sample of C refugees, drawn from their largest U.S. community, for which there is a lack of empirical data on their mental health service seeking behavior despite their high levels of distress	C refugee adults: N=339	Females: 57.2% (n=194) Males: 42.8% (n=145)	Mean: Males/females combined: 53.7 yrs. (10.9)	Long Beach, California	Mean: Males/females combined: approximately 20 yrs. (NR)

Table B.1 ***General Characteristics of Included Quantitative and Mixed-Methods Studies (n=11):*** **continued**

Legend: AA = Asian American, C = Cambodian, L = Laotian, Not Reported=NR, SEA = Southeast Asian, V = Vietnamese, VA = Vietnamese American

Authors	**Relevant Research Objectives**	**Participants' Ethnicity, Sample Size**	**Gender**	**Age: Mean/median in yrs. (SD)**	**Sample Location(s)**	**Length of Residence in U.S.: Mean/ Median in yrs. (SD)**
Park *et al*., 2015	Explore VA mothers' perceptions and experiences with postpartum traditions, postpartum depression (PPD), and their mental health help-seeking behavior to understand the underlying reasons for their underutilization of mental health services despite severity of untreated PPD and its effects on their entire families	VA mothers: N=15	Females: 100%	Mean: 32.3 yrs. (4.3)	Northern California	Mean: 18 yrs. (8.6)
Sok, 2004, May	Investigate the relationship between the degree of acculturation among C adult refugees and their attitudes toward seeking mental health services to increase social worker understanding of C refugee needs	C adults: N=40	Females: 65% (n=26) Males: 35% (n=14)	Mean: Males/females combined: 21-25 yrs. (n=21) (NR) 31-35 yrs. (n=23) (NR)	Long Beach, California	NR; age when arrived in U.S. males/females combined: 1-8 yrs. old 66.7% (n=26) (NR) 9-17 yrs. old 28.2% (n=11) (NR)
Wong *et al*., 2006	Examine the relative importance of structural versus cultural barriers to mental health care among a representative sample of C refugees with a probable need for mental health care	C adult refugees: N=490	Females: 61% (n=299) Males: 31% (n=191)	Mean: Males/females combined: 52 yrs. (13.4)	Majority in Long Beach, California	Mean: Males/females combined: 23 yrs. (NR)

Table B.2 ***General Characteristics of Included Qualitative Studies (n=5)***

Legend: AA = Asian American, C = Cambodian, L = Laotian, Not Reported=NR, SEA = Southeast Asian, V = Vietnamese, VA = Vietnamese American

Authors	**Relevant Research Objectives**	**Participants' Ethnicity, Sample Size**	**Gender**	**Age: Mean/median in yrs. (SD)**	**Sample Location(s)**	**Length of Residence in U.S.: Mean/ Median in yrs. (SD)**
Bhuyan *et al.*, 2005, August	Explore how once resettling in the U.S. the differential cultural beliefs of C women influence attitudes, interpretations, and responses to domestic violence, including mental health help-seeking behavior	C adult females: N=39	Females: 100%	Mean: 44 yrs. (NR)	Seattle, Washington	NR
Bui, 2003, February	Examines help-seeking behavior among abused VA women to understand factors associated with their decisions to seek help from diverse sources, including personal networks, the criminal justice system, and victim service agencies	VA women: n=39 Community key informants: n=11	Females: 100%	Median: 40 yrs. (NR)	Orange Cty., CA Boston, MA Houston, TX Lansing, MI	Median: 8 yrs. (NR)
Catolico, 2013	Define C women's perspectives on health from the time of initial resettlement to changes that happened following resettlement	C adult females: N=39	Females: 100%	Median: 29-43 yrs. 31% (n=12) (NR) 64+ yrs. 28% (n=11) (NR)	California	Median: 16-20 yrs. 59% (n=23) (NR) <1-5 yrs. 25% (n=10) (NR)

Table B.2 ***General Characteristics of Included Qualitative Studies (n=5):*** **continued**

Legend: AA = Asian American, C = Cambodian, L = Laotian, Not Reported=NR, SEA = Southeast Asian, V = Vietnamese, VA = Vietnamese American

Authors	Relevant Research Objectives	Participants' Ethnicity, Sample Size	Gender	Age: Mean/median in yrs. (SD)	Sample Location(s)	Length of Residence in U.S.: Mean/ Median in yrs. (SD)
Davis, 2000	Examine the meaning of SEA women's experiences through which significant ethnic factors and psychological resilience are identified when not explored in previous research	SEA women adults: N=19 (V: n=15, C: n=3, L: n=1)	Females: 100%	Mean: 38.7 years (NR)	Central Pennsylvania	Mean: 22 yrs. (n=14) (NR)
Shiu-Thornton, 2005, August	Examine VA survivors of domestic violence (DV) about community perceptions of DV, awareness of services, cultural factors that affect service utilization, acculturation and changing gender roles to improve DV services in the Seattle and King County, WA	VA females: N=43	Females: 100%	Mean: 44 yrs. (NR)	Seattle and King County, Washington	NR

Appendix C: Methodological Characteristics of Systematic Review Selected Studies

Table C.1 ***Methodological Characteristics of Included Quantitative and Mixed-Methods Studies (n=11)***

Legend: AA = Asian American, C = Cambodian, L = Laotian, Not reported=NR, SEA = Southeast Asian, V = Vietnamese, VA = Vietnamese American

Authors	Study Design/ Sampling Method/Funding	Participant Selection: Inclusion /Exclusion Criteria	Instrument(s) Used/Construct Being Measured	Data Collection Procedures/ Timeframe	Data Analysis Steps
Berthold *et al.,* 2014	Descriptive, cross-sectional survey design Snowball sampling with initial participants recruited from Buddhist temples CDC funded through community partner	Inclusion: 1. Born in Cambodia before Khmer Rouge regime (KRR) fell on Jan. 7, 1979 2. Lived in Cambodia during KRR 1975-1979 3. Resettled in U.S. as a refugee 4. Resident of Connecticut or W. Massachusetts	62-item survey questionnaire, developed in collaboration with Harvard Program in Refugee Trauma, measuring demographics, perception of own general health status, probable physical health conditions, health access barriers, self-reported markers for possible PTSD and/or depression	Community health workers, who were college educated and bilingual in Khmer/English, conducted the survey in a 90 min. interviews; conducted in participants' homes in Khmer language Timeframe: June 2011	SPSS analysis; basic descriptive statistics used to analyze discrete variables, including demographics; zero-order bivariate correlations and chi-square tests of independence used to examine associations between age, gender, and mental/physical conditions
Chung & Bemak, 2002, Winter	Data analysis of California SEA Mental Health Needs Assessment (SEAMH) study Random generation of phone numbers V sample; multi-cluster sampling C and L Funding Asian Community Mental Health Srvs.	Nonclinical community sample drawn from 9 counties in California where 90% of SEA refugee population in state resided; all participants drawn from three SEA ethnic groups, ages 18 to 68 yrs.	Three measures for depression, anxiety, and psychosocial dysfunction symptoms derived from Health Opinion Survey	SEAMH study: Bilingual interviewers recruited from each targeted community within 9 counties; interviews with V by phone given phone usage prevalence among this population; face-to-face interviews and use of key informants with C and L due to less familiarity with interview process Timeframe: 1986-1987	5 premigration and 6 postmigration variables loaded onto a single distress factor identified as neurasthenia, a culturally sanctioned idiom of distress; 3 of each pre- and post-migration variables chosen to perform a multiple regression analysis, controlling for age, yrs. in U.S., and level of formal education

Table C.1 ***Methodological Characteristics of Included Quantitative and Mixed-Methods Studies (n=11):*** **continued**
Legend: AA = Asian American, C = Cambodian, L = Laotian, Not Reported=NR, SEA = Southeast Asian, V = Vietnamese, VA = Vietnamese American

Authors	Study Design/ Sampling Method/ Funding	Participant Selection: Inclusion/Exclusion Criteria	Instrument(s) Used/Construct Being Measured	Data Collection Procedures/ Timeframe	Data Analysis Steps
Lee, 2002	Descriptive, cross-sectional study design Convenience sampling Funding source not reported	Inclusion: 1) Hmong adults living in Fresno, County, California 2) Subjects were ≥18 yrs. Exclusion: 1) Hmong who lived outside of Fresno allowed to take the survey, but their data was excluded from analysis Subjects were compensated with water bottle	A 29-item survey on demographic and barriers to access w/ 4 components of the Andersen Behavior Model (1968): predisposing factors, enabling, needs, and external factors; survey was available both in English and Hmong language.	Investigator set up a booth within the Hmong New Years, multi-day celebration for the Hmong in Fresno; subjects solicited to participate by investigator; once consenting, subjects given option of self-administering the survey or being interviewed by the investigator or research assistant Timeframe: Dec. 27, 1998-Jan. 3, 1999	Data analyzed using Measures of Central Tendency and Pearson Chi-Square with Yates Correction Factor to determine significance; IVs are gender, age, and length of residency in the U.S.
Lee & Law, 2001	Descriptive, cross-sectional, comparative study Convenience sample Funding from Ohio Dept. of Health, Rape Prevention/Crisis Interv.	Inclusion: 1) AAs who shopped in the catchment area of survey 2) No age, gender limitations	Demographic questionnaire gender, age, education, marital status, occupation, yrs. in residency in U.S., and ethnicity; 11-item questionnaire w/ 7 questions on severity/nature of problem, preferred prevention steps, help-seeking, 4 questions on knowledge of community services	Trained, bilingual interviewers conducted questionnaires at frequented locations as grocery stores, ethnic churches, ESL classes, schools and colleges to solicit potential subjects; questionnaires in English or 1 of 6 foreign languages that included Khmer, Laotian, and Vietnamese. Timeframe: NR	All questions close-ended and therefore didn't require coding. Descriptive statistics were conducted to create a profile of each subject; Chi-Square analyses and analyses of variance used to examine the association between study variables and subject demographics

Table C.1 ***Methodological Characteristics of Included Quantitative and Mixed-Methods Studies (n=11):*** **continued**

Legend: AA = Asian American, C = Cambodian, L = Laotian, Not Reported=NR, SEA = Southeast Asian, V = Vietnamese, VA = Vietnamese American

Authors	Study Design/ Sampling Method/ Funding	Participant Selection: Inclusion/Exclusion Criteria	Instrument(s) Used/Construct Being Measured	Data Collection Procedures/ Timeframe	Data Analysis Steps
Lor, Rodofa, & Limberg, 2017	Descriptive, cross-sectional study design Convenience sampling via an Internet solicitation Funding NR	Inclusion: 1) Hmong women who had access to and willingness to complete online surveys 2) Reading/writing English only as surveys were not translated	Demographic questionnaire form, Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA), Stigma for Receiving Psychological Help, the Attitudes toward Seeking Professional Psychological Help—Short-Form, and the Willingness to See a Counselor Questionnaire	Data Collection occurred through an Internet-based solicitation to participate to which 306 responded; only 222 fully completed the online surveys, data from which was used for the analysis Timeframe: NR	According to responses to the SL-ASIA, participants were categorized into 3 tiers of the independent variable, acculturation: less, bicultural, and more acculturation; hypothesis testing used Pearson correlations with a test of significance, looking at, for instance, acculturation to expression of attitudes toward seeking counseling services
Luc, 2018, August	Descriptive, cross-sectional study design Convenience sample, recruited through Amazon Mechanical Turk, an Internet marketing search engine Funded NR	Inclusion: 1) VAs who are ≥18 yrs. 2) Participants able to read/write English or Vietnamese in order to complete survey 3) Access to Internet Compensation: about 60 cents upon completing the survey	Demographic questionnaire, Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA), a modified version of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH-SF), Self-Stigma of Seeking Help Scale	Survey generated as a composite of all the instruments listed through Qualtrics, an online survey platform that also generates graphics and analytics; survey then uploaded to the Internet Timeframe: NR	Data exported from Qualtrics into SPSS for descriptive statistics for results from SL-ASIA, ATSPPH-SF, demo-graphics; hypotheses testing included conducting bivariate correction (H1), multiple regression analysis (H2), and t-test (H3) for differences between VA genders to attitudes toward help-seeking

Table C.1 ***Methodological Characteristics of Included Quantitative and Mixed-Methods Studies (n=11):*** **continued**
Legend: AA = Asian American, C = Cambodian, L = Laotian, Not Reported=NR, SEA = Southeast Asian, V = Vietnamese, VA = Vietnamese American

Authors	**Study Design/ Sampling Method/ Funding**	**Participant Selection: Inclusion/Exclusion Criteria**	**Instrument(s) Used/Construct Being Measured**	**Data Collection Procedures/ Timeframe**	**Data Analysis Steps**
Luu, Leung, & Nash, 2009	Descriptive, cross-sectional study design Convenience sampling Funding NR	Inclusion: 1) V or Chinese V 2) Ages 18 to 75 yrs. 3) Resident of Houston, TX 4) Consented Compensation: pocket calendar upon completion of survey due to sensitive nature of content	Suinn-Lew Asian Self-Identity Acculturation Scale and Attitudes toward Seeking Professional Psychology Help standard instruments; 2 others developed for this study: Cultural Barriers Scale and Spiritual Beliefs Scale about subjects' beliefs in spiritual causes of mental problems; all instruments in English, translated into Vietnamese and then back translated for validity	Investigator and 6 trained assistants recruited participants at community festivals, a V religious center, and a V business; assistants trained to recruit, administer questionnaires, and translate. All potential participants screened for inclusionary/exclusionary criteria and consented for voluntary participation. . Timeframe: NR; administration time of 3 months, 2 to 8 hours per day	A standard multiple regression analysis, assessing association between the IV's and DV's according to 8 demographic variables of education, occupation, religious affiliation, marriage, birthplace, and gender; 15 records deleted due to missing data
Marshall *et al.*, 2006, October	Cross-sectional probability study design Cluster sampling of households from which interviewee selected Funding NIMH / Nat'l Inst. on Alcohol Abuse and Alcoholism grants	Inclusion: 1) C refugees who met 12-month criteria for PTSD, major depression, or alcohol use disorder 2) Utilization of mental health services within previous 12 mos. 3) Resided in Long Beach, CA 4) Consenting to interview; nominal financial incentive	Screeners: Composite Int'l Diagnostic Interv. (CIDI): assess PTSD Alcohol Use Disorder Identification Test Study Interview: Extensive work went into development of interview with focus groups of community experts and mental health advisors; modified version C Harvard Trauma Questionnaire	Interviews conducted face-to-face interviews within the homes of the selected random sample of C; extensive work went into development of interview with focus groups of community experts and expert mental health advisors Timeframe: 2003-2005	Differences in rates of seeking mental health srvs. determined with bivariate logistic regressions; multivariate logistic regression used to examine rates of seeking srv. across subpopulations

Table C.1 ***Methodological Characteristics of Included Quantitative and Mixed-Methods Studies (n=11):*** **continued**
Legend: AA = Asian American, C = Cambodian, L = Laotian, Not Reported=NR, SEA = Southeast Asian, V = Vietnamese, VA = Vietnamese American

Authors	Study Design/ Sampling Method/ Funding	Participant Selection: Inclusion/Exclusion Criteria	Instrument(s) Used/Construct Being Measured	Data Collection Procedures/ Timeframe	Data Analysis Steps
Park *et al.*, 2015	Mixed-methods, cross-sectional nonprobability study Convenience / snowballing sampling Funding from San Jose State University grant	Inclusion: 1) VA mothers who had given birth to at least 1 live infant in previous yr. 2) Consenting to screeners and qualitative interview 3) Ages ≥18 yrs. 4) Able to read/write/speak English or Vietnamese Compensated with $25 gift card to large retail store, given local mental health resource list	Screeners: Demographic survey, mental health services questionnaire, Edinburgh Postnatal Depression Scale Qualitative interview: Conceptual development guided by Andersen and Aday Behavioral Model and Access to Medical Care Model (1974); asked cultural identity, experience with sadness/ depression, how postpartum depression is viewed in V culture/ traditions, help-seeking attitudes	PI and 2 trained bilingual/bicultural V female interviewers administered informed consent, screeners, and then conducted 1 to 2 hr. interview in private settings; interviews conducted in English and Vietnamese Timeframe: 2012	Interview data was transcribed, uploaded, and analyzed using NVivo v.8 followed by content analysis; PI created coding dictionary for questions a priori to cover a range of potential themes as based upon previous research and conceptual models; 2 raters independently analyzed the qualitative data, using data dictionary with results compared for consensus on observed emergent themes
Sok, 2004, May	Descriptive, cross-sectional study Purposive sampling Funding NR	Inclusion: 1) C adults (age NR); 2) Born in Cambodia, in refugee camp, or born in U.S. 1980-1983, came to U.S. as refugee 1980 to 1990; 3) Studied a minimum of 2 yrs. in an English-only school; 4) Resident of Long Beach	Self-administered questionnaire used to measure attitudes toward seeking mental health srvs., help-seeking behaviors, acculturation, ethnical attitudes / behaviors / practices; section on Multigroup Ethnic Identity	3 community organizations identified potential study participants who were given consent cover letter, questionnaire, community referral list of licensed mental health professionals in event became distressed when responding Timeframe: NR	Percentages/frequencies for demographics and attitudes toward seeking mental health services, Pearson's r correlations for associations between acculturation scores and attitudes toward seeking mental health srvs.

Table C.1 ***General Characteristics of Included Quantitative and Mixed-Methods Studies (n=11):*** **continued**

Legend: AA = Asian American, C = Cambodian, L = Laotian, Not Reported=NR, SEA = Southeast Asian, V = Vietnamese, VA = Vietnamese American

Authors	**Study Design/ Sampling Method/ Funding**	**Participant Selection: Inclusion/Exclusion Criteria**	**Instrument(s) Used/Construct Being Measured**	**Data Collection Procedures/ Timeframe**	**Data Analysis Steps**
Wong *et al.*, 2006	Cross-sectional probability study design Cluster sampling of households from which interviewees were selected Funding not reported	Inclusion: 1) C refugees who migrated to U.S. prior to 1992 cut-off after which U.S. favored repatriating instead 2) Met 12-month criteria for PTSD, major depression, or alcohol use disorder 3) Resided in Long Beach, CA	Screeners: Composite Int'l Diagnostic Interv. (CIDI): assess PTSD Alcohol Use Disorder Identification Test Study; sociodemographic questionnaire; treatment barrier 9-item questionnaire developed for study by reviewing existing literature	Interviewers selected by C refugee community advisor and were C refugees themselves, required to read/write/speak fluent Khmer and English; conducted structured face-to-face household interviews averaging 2 hrs. each Timeframe: NR	Descriptive statistics used to analyze sociodemo-graphic; for subgroup with at least 1 of 3 probably psychiatric diagnoses (n=339) used chi-square tests to examine association between sociodemographics to 5 most commonly endorsed barriers to mental health treatment

Table C.2. ***Methodological Characteristics of Included Qualitative Studies (n=5)***
Legend: AA = Asian American, C = Cambodian, L = Laotian, Not Reported=NR, SEA = Southeast Asian, V = Vietnamese, VA = Vietnamese American

Authors	Study Design/ Sampling Method/ Funding	Participant Selection: Inclusion/Exclusion Criteria	Instrument(s) Used/Construct Being Measured	Data Collection Procedures/ Timeframe	Data Analysis Steps
Bhuyan *et al.*, 2005, August	Qualitative, participatory action research (PAR) design Convenience, purposive sampling Funding from U.S. Dept. of Justice, Office of Justice Program Awards	Inclusion: 1) C women who had previously used victim srvs. (67%, n=26) 2) C women who had not previously used victim srvs. (33%, n=13) 3) Consented to be in a focus group study	Focus group interview guide developed in collaboration with C community partners, translated from English into Khmer	Each participant given option of face-to-face interview for confidentiality reasons vs. focus grp. attendance; all accepted focus grps., 6 total with 6 to 10 participants each with bicultural/bilingual facilitator from Refugee Women's Alliance; groups conducted in Khmer with qualitative interviewing techniques Timeframe: NR	All focus groups recorded with permission, trans-lated into English/ tran-scribed; transcripts were reviewed, entered into NUD*IST software pkg for analyzing text-based data; main themes / concepts organized into codes that gave structure to analyzing / compiling data; research teams made initial write-up, shared with research participants to provide feedback
Bui, 2003, Feb.	Qualitative, cross-sectional study design Snowballing / convenience sampling Funding NR	Inclusion: face-to-face and telephone participants (n=39); 1) V women who had sought and/or received DV help; 2) V women who had not; 3) V refugee previous or current; 4) Residents of 1 of 4 sites Inclusion: Community key informants who work with abused VA women (n=11)	Interview instrument for face-to-face / telephone guided by Connell's (1987) model of gender role structure with 3 intertwining elements: division of labor, power system of state/institutions, and heterosexuality ideology; community sample interview unstructured, focused on criminal justice policies/processes	Data collected in 4 V communities representative of U.S. geographic areas.; core sample in-depth interviews 2-3 hrs. each; semi-structured questionnaire primarily open-ended questions (face-to-face, n=28; phone n=6); interviews with community key informants unstructured, lasted less than 1 hr. each (n=11) Timeframe: not reported	Description of data analysis steps was sparse; all interviews except 1 conducted and recorded in V, 1 mixed English / V; all transcribed into English for data processing but also retained V transcripts for data analysis to avoid losing original meaning of V terms and idioms

Table C.2 ***Methodological Characteristics of Included Qualitative Studies (n=5):*** **continued**

Legend: AA = Asian American, C = Cambodian, L = Laotian, Not Reported=NR, SEA = Southeast Asian, V = Vietnamese, VA = Vietnamese American

Authors	Study Design/ Sampling Method/ Funding	Participant Selection: Inclusion/Exclusion Criteria	Instrument(s) Used/Construct Being Measured	Data Collection Procedures/ Timeframe	Data Analysis Steps
Catolico, 2013	Qualitative, grounded theory study design Convenience / snowballing sampling Funding NR	Inclusion: 1) C women refugees/immigrants across varied ages within a single C community 2) Consented Provided referrals to social srv. agency nearby as well as religion leaders and lay headers if subjects became distressed during interview	Interview questionnaire primary source of data, developed for this study to explore C women's health perceptions in resettlement; questions were open-ended and provided in Khmer	C women refugees / immigrants recruited through a social srv. org. community contacts/other subjects; face-to-face interviews conducted in community Buddhist temple or at subjects' homes; major probing subjects' perceptions of health once resettled/how have changed with sociodemographic and historical data Timeframe: NR	Data analysis began with deciphering interview content in Khmer into English with intent to convey true content, idiomatic expression, and "preservation of in vivo codes" that reflected thoughts, beliefs, and behaviors of subjects; ground theory guided the evolution of conceptual categories from which theory emerged, "essentially grounded in the data" (Catolico, 2013, p. 237)
Davis, 2000	Phenomenological, qualitative study Snowballing or network sampling from first participants' referrals Funding NR	Inclusion: 1) SEA women adults 2) Refugees who are interchangeably called immigrants 3) Lived in central Pennsylvania Did not receive financial compensation but did receive a copy of interview transcript	Open-ended interviews exploring meaning behind subjects' refugee experience guided by Munhall's (1994) description of phenomen-ology as "an understanding of meaning of being human" by understanding "specific experiences" (p. 173); Munhall stresses method should not eclipse the goal	Questions related to health/illness experiences; subjects encouraged to describe life stories, events, memories as came up; interviews for 2 to 3 hrs., conducted at subjects' homes; clarified themes during follow-up Timeframe: NR	Study data was combination of transcribed audiotaped initial and follow-up interviews with field notes; analysis by hand sorting to identify themes as they emerged from what researcher called "exquisite detail" (p. 147). These themes included "the horror of war," "betrayal," "in the camps," and "a new country, a new life"

Table C.2 ***Methodological Characteristics of Included Qualitative Studies (n=5):*** **continued**

Legend: AA = Asian American, C = Cambodian, L = Laotian, Not Reported=NR, SEA = Southeast Asian, V = Vietnamese, VA = Vietnamese American

Authors	Study Design/ Sampling Method/ Funding	Participant Selection: Inclusion/Exclusion Criteria	Instrument(s) Used/Construct Being Measured	Data Collection Procedures/ Timeframe	Data Analysis Steps
Shiu-Thornton, 2005, August	Qualitative, participatory action research (PAR) design Convenience, purposive sampling Funding from U.S. Dept. of Justice, Office of Justice Program Awards	Inclusion: 1) VA women refugees who had used DV srvs. 2) VA women refugees who had not used DV srvs. 3) Screened for ethnic identification, experience with DV and use of srvs. 4) Consented Excluded: Any potential participant at risk of DV due to participation in study given assistance instead	Background demographic, 8-item screener for self-administration; focus group guide developed in collaboration with community partners to prompt answers on cultural context of DV, community perceptions/descriptions of DV, awareness of srvs., cultural factors influencing srv. utilization; translated into V	Screener with background demographics conducted prior to 4 focus grps.; participants given choice of individual interviews or focus grps. with all choosing grps. which facilitated grp. interaction and comparison of experiences; grp. facilitators bicultural / bilingual V, recruited through partner agencies; qualitative data collection ended when data was saturated with no new information emerging; community member interviews also conducted but not described	All focus groups recorded with permission, translated into English and tran-scribed; transcripts were reviewed and entered into NUD*IST, a software package for analyzing text-based data from which main themes / concepts were organized into codes that gave structure to analyzing / compiling data; research teams made initial write-up with research participants providing feedback