

Claremont Colleges

Scholarship @ Claremont

Pitzer Senior Theses

Pitzer Student Scholarship

2018

1.5/2nd Generation Vietnamese-Americans and Their Health Beliefs and Attitudes

Theresa Dang

Follow this and additional works at: https://scholarship.claremont.edu/pitzer_theses



Part of the [Community Health and Preventive Medicine Commons](#), and the [Medicine and Health Commons](#)

Recommended Citation

Dang, Theresa, "1.5/2nd Generation Vietnamese-Americans and Their Health Beliefs and Attitudes" (2018). *Pitzer Senior Theses*. 175.

https://scholarship.claremont.edu/pitzer_theses/175

This Open Access Senior Thesis is brought to you for free and open access by the Pitzer Student Scholarship at Scholarship @ Claremont. It has been accepted for inclusion in Pitzer Senior Theses by an authorized administrator of Scholarship @ Claremont. For more information, please contact scholarship@cuc.claremont.edu.

1.5/2ND GENERATION VIETNAMESE-AMERICANS AND THEIR HEALTH BELIEFS
AND ATTITUDES

A Thesis Presented

By

Theresa Nha Thu Dang

To the Keck Science Department
Of Claremont McKenna, Pitzer, and Scripps Colleges
In partial fulfillment of
The Degree of Bachelor of Arts

Senior Thesis in Human Biology

December 8, 2017

Abstract

Theresa Dang, Claremont, California

Vietnamese immigration is distinct from other Asian/Pacific Islander groups in its context – the bulk of Vietnamese immigration was not of educational, economic, or career opportunity, but a diaspora. After the Fall of Saigon during the Vietnam War, Vietnamese immigrants faced extreme adversities and trauma as they fled to neighboring countries. Understanding the context and history of Vietnamese immigration plays a huge role in the acculturation process, management of health, and ability to navigate institutions among these families. As these immigrant families learn to survive in a new country, they also must face and heal from the emotional, psychological, and physical trauma from their relocation to the United States. This study aims to begin an ongoing dialogue among the children of these Vietnamese immigrants, also referred to as the 1.5 or second generation, about their beliefs and attitudes towards their own health in the context of their family’s immigration story. By using semi-structured qualitative interviews, participating second generation Vietnamese-Americans are given a platform in which they share their childhood experiences of family health and healthcare and how that directly or indirectly impacts their current health and the resulting health-protecting behaviors.

to the wellbeing and happiness of the collective bodies whose stories were shared

Acknowledgments

Thank you, Dr. Alicia Bonaparte and Dr. Rory Spence, for your unending patience and guidance throughout the writing process. Thank you, Dr. Kathy Yep and Dr. Barbara Kim, for your encouragement and positive feedback. I would also like to thank Pitzer College and the Keck Science Department for providing me the means to conduct this research. Lastly, thank you to all my participants for sharing your stories.

Table of Contents

Chapter One: Introduction	1
➤ <i>Contextual History</i>	1
➤ <i>Personal Involvement and Interest</i>	2
Chapter Two: Literature Review.....	5
➤ <i>Current Health Trends of Vietnamese Americans</i>	5
➤ <i>Mortality of Asian American Children and Adolescents</i>	5
➤ <i>Health Insurance Status Within the Asian American Community</i>	5
➤ <i>Government-Assisted Health Insurance</i>	6
➤ <i>Use of Complementary and Alternative Medicine</i>	7
➤ <i>Logistical Barriers to Healthcare</i>	8
➤ <i>The Role of the 1.5 and Second Generation</i>	8
➤ <i>Acculturation and Intergenerational Conflict</i>	9
➤ <i>Mental Health</i>	11
Chapter Three: Methodology.....	13
➤ <i>Participants</i>	13
○ <i>Table 1. Patient Demographics</i>	14
➤ <i>Interviews</i>	15
Chapter Four: Health Portraits of the 1.5/2 nd Generation Vietnamese American.....	18
Chapter Five: Concluding Statements.....	33
References.....	36
Appendix A: Interview Questions.....	39
Appendix B: Description of Codes for Analysis.....	41

Introduction

Contextual History

Immigration has been an integral part of U.S. history and continues to play a role in our current history. Cultural diversity has grown at such a rate in the U.S. that our society has become “a multicultural and pluralistic society” (Nguyen, 2015). This means that American children are being raised in different environments and cultures despite being born and raised in the same country. Second-generation youth, or children of immigrant parents, are among the fastest growing group of American children (Databank, 2014). It is also important to note that Asian and Pacific Islander Americans are one of the fastest growing populations in the US as well (Nguyen, 2015); in fact, “between 1980 and 1990 their numbers grew by 108 percent, more than 10 times the rate for the total U.S. population and between 1990 and 1999 their population grew [by] 43 percent to 10.8 million” (Dhooper, 2003). If that data is further disaggregated, the Vietnamese population represents a rapidly expanding API group at approximately 1.3 million U.S. residents, with nearly half of Vietnamese Americans relocating in California alone (Nguyen 2015). In 2014, the Vietnamese American population alone was the sixth largest immigrant group in the country (Zong & Batalova, 2016).

What differentiates the Vietnamese American population from other API groups is the context of their migration. Unlike many other ethnic groups, the bulk of Vietnamese immigration was not of educational, economic, or career opportunity, but a diaspora. The initial wave of Vietnamese migration was prior to the Fall of Saigon and consisted of well-educated and highly social-ranked individuals who had direct connection to US military servicemen; on the other hand, the second wave, often referred to as “boat people,” were majority Southern Vietnamese individuals and families who fled Vietnam to escape the

conquering community party, or the Viet Cong, during and after the Fall of Saigon (Nguyen, 2015). As these second-wave immigrants fled to neighboring countries, they were faced with extreme adversities and trauma as they were “victims of torture, starvation, malnutrition, assault, rape, and/or robbery” (Nguyen, 2015). The third wave brought Amerasians, defined as “persons of mixed American and Asian descent; especially one fathered by an American and especially an American serviceman in Asia,” to the United States (Mirriam-Webster, 2017). This group was also part of a refugee group that was granted U.S. citizenship by the Amerasians Homecoming Act (Nguyen, 2015).

Understanding the context and history of Vietnamese immigration plays a huge role in their acculturation process, management of their health, and ability to navigate institutions. As these immigrant families learn to survive in a new country, they also have to face and heal from the emotional, psychological, and physical trauma from their relocation to the United States. As a result, it is often the reality of immigrant children to act as intercessors on behalf of their parents in the English-speaking world, including medical institutions (Kim & Yoo, 2014). However, what is unknown is how these lived experiences impact how 1.5/2nd second generation Vietnamese Americans view their own health and the resulting health practicing behaviors that result from it. These unknowns in the health journeys of immigrant children point to the larger question: If second-generation Vietnamese-American act as informal health care support for their immigrant parents, how do these lived experiences impact their beliefs and attitudes towards their own health?

Personal Involvement and Interest

The goal of this research project is to gain a deeper understanding of the impacts of trauma, immigration, and acculturation (or lack thereof) on the health and wellbeing

Vietnamese immigrant families, especially the children of these families. As the first-born child of Southern Vietnamese refugee parents, my narrative matched all too well with the academic texts that surrounded the conversations of the roles that immigrant children played in the immigrant acculturation process: cultural brokers, informal health care support, translator, institutional representative and liaison, etc.; and these roles have seriously impacted the relationships I have with my parents, with my parents' health, and with my own body and health. As a student seeking to pursue a health professions career, I cannot help but realize that my many encounters and interactions with U.S. healthcare was, more often than not, draining to my overall health and further damaging to my parents' overall wellbeing. Moving away to college has allowed me to take greater autonomy of my own body, which means I am faced with the responsibilities of caring for all aspects of my health and wellbeing, however I may define it. What does that look like when I had dedicated much of my life caring for the health and wellbeing of my parents? Does the advocacy I had pushed for on behalf of my parents' health reflect in my own adult life? What happens to the health trajectory of a whole community of Vietnamese American children if their childhood closely mirrored mine?

There is currently little to no research available that considers how Vietnamese American immigrant children evaluate their physical, emotional, and mental health and whether their past childhood experiences impact how they take care of their own health. Despite the critical roles that these immigrant children may play in the wellbeing of their families' lives, their labor often goes unrecognized and uncompensated. As their time and energy is continuously dedicated to the survival and wellness of their family in addition to their own personal and educational goals, we do not know how they care for themselves, or if

they care for themselves at all. By interviewing second generation Vietnamese American college students, this research project intends to start an internal dialogue within the Vietnamese Americans who participate in my study with the hope that they will actively and consciously analyze the significance of immigration on their health and wellbeing. This research project can also start an external dialogue with the general public in hopes of a greater recognition of the lifelong and intergenerational impacts of diaspora, war, and trauma on health and wellbeing. This research project can also be used as a basis for a possible longitudinal study that extends beyond these students' college years and can also provide a method of quantifying health trajectory and health outcomes.

Literature Review

Current Health Trends of Vietnamese Americans

Major health concerns within the Vietnamese American community are diabetes, cardiovascular disease, obesity, tuberculosis, hepatitis B and cancer; in fact, Vietnamese Americans have the “highest incidence and mortality rates from liver, lung, and cervical cancer (Nguyen, 2015). In particular, the Asian American community carries disproportionate rates of incidence and prevalence of Hepatitis B, making it a major health disparity in the Asian American community (Yu & Vyas, 2009). Despite this alarming information, a large portion of the Vietnamese American community does not seek medical attention or preventative care due to a variety of reasons, including healthcare barriers.

Mortality of Asian American Children and Adolescents

The leading causes of death in Asian American children ages one to four in 2004 were injuries, homicide, influenza, and pneumonia; Asian American children ages five to nine, leukemia and brain cancer; Asian American children ages ten to fourteen, injuries, suicide, and brain cancer; Asian American children ages fifteen to seventeen, injuries, homicide, and suicide (Bloom, Dey, & Freeman, 2006). Suicide among Asian American adolescents have been particularly alarming (Yu & Vyas, 2009), and may suggest lack of awareness of or care for mental health issues.

Health Insurance Status Within the Asian American Community

Like many other racial and ethnic minority groups, Asian American families face discrimination in as well as barriers to the U.S. healthcare system, resulting in higher rates of morbidity and mortality (Nguyen 2015). Being labeled as the “model minority,” a myth that

states Asian Americans as primary examples of upwards assimilation and educational and economic success, gravely overlooks the healthcare disparities and the socioeconomic needs of Vietnamese Americans within the Asian American community. Asian Americans are more likely to be uninsured than the white population, with 21% of Vietnamese Americans leading that percentage among other large Asian communities (Lee et al, 2010). Lack of health insurance can often be a result of low income and educational levels, explaining why a significant portion of Vietnamese Americans are uninsured since their income and education levels are one of the lowest among Asian American groups (Nguyen, 2015). If Vietnamese American families can secure a steady incomes and jobs, it is still more than likely that their employment does not offer health insurance benefits. Vietnamese immigrants, due to the nature of their migration, are often unable to apply for high salary, white-collar jobs and are more likely to be employed in service occupations and production, transportation, and material moving occupations (Zong & Batalova, 2016). These occupations usually do not offer employer-sponsored health insurance.

Government-Assisted Health Insurance

While public health services and benefits exist for low-income and uninsured families, children of immigrant parents are less likely to utilize them because their immigrant parents a) do not know that their child qualifies for public assistance services, b) do not know how to access these services, or c) are afraid that applying will reveal any undocumented status (BeLue et al, 2014). According to a survey study conducted by Dr. Rhonda Blue and her associates, she also found that first-generation families were more likely than other parents to not consider health insurance when prioritizing financial needs (2014). This may

mean that immigrant families may receive the majority of their care through safety-net hospitals and free clinics.

Use of Complementary Alternative Medicine

Additionally, both insured and uninsured Asian American families are likely to use complementary and alternative medicine (also referred to as CAM), treatments that are used either alongside or instead of standard Western medical treatments (Complementary and ..., 2015). In fact, over 75% of Asian American participants in a study conducted by Sunmin Lee and her colleagues had responded saying that they had used CAM in lieu of Western care due to lack of insurance or even delays in the Western healthcare system (2010). It is also noteworthy to consider that negative perceptions of Western medicine as a more potent form of care with greater adverse side effects have also pushed Asian American families to use CAM as well (Lee et al, 2010). Use of complementary alternative medicine can suggest an inaccessibility within the Western healthcare system or lack of medical literacy, especially in terms of preventative care. According to the 2005 National Health Interview Survey, “nearly one-third of Asian American children did not have contact with a doctor or health professional in the past six months, a rate higher than all other racial/ethnic groups,” which can suggest either good health or lack of access (Yu & Vyas, 2009, pg. 112). If these practices are carried beyond childhood without gaining better access of Western healthcare or Western medical literacy, these families may live their adulthood lives never interfacing with health insurance companies and Western medical institution. Lack of utilization of Western healthcare resources may be a contributing factor to high rates of chronic diseases and illnesses in the Vietnamese American community as listed in the “Current Health Trends in Vietnamese Americans” section.

Logistical Barriers to Healthcare

Even if Vietnamese individuals did have some access to healthcare, many logistical barriers exist as well. These include time constraints from their working schedule, lack of translation services, culturally competent health services, and childcare. Studies have also shown that Vietnamese Americans would seek more routine care if a Vietnamese physician was available, and more Vietnamese females would prefer to see a female physician for gynecological exams (Lee et al, 2010).

The Role of the 1.5 and Second-Generation

It more often than not that the children of immigrants play major supportive roles in their parents' and caretakers' lives from childhood to adulthood. The 1.5 generation is a term used to describe individuals who immigrated to the U.S. as children or adolescents, with the cut off age for 1.5 definition at 12 years old (Rojas, 2012); and the second generation refers to individuals who were born in the U.S. to immigrant parents. While their parents and caretakers are learning to (or not learning to) acculturate and adapt to American culture, lifestyle, and language, there is an extreme role reversal in which second generation children eventually are the most equipped to navigate the American world and act as cultural brokers, mediators, translators, and more. They bridge the communication gaps and negotiate structural and institutional disparities that immigrants may and usually encounter (Yoo & Kim, 2014). This means that these immigrant children are asked to translate for their parents in their doctors' offices, contact medical offices regarding health reports, negotiate medical bills with health insurance companies, and help physicians monitor their parents' medical compliance, etc.

Acculturation and Intergenerational Conflict

Differences in cultural norms and values also create rifts between immigrant parents and their children when seeking and navigating healthcare services. Many Asian American immigrants do not receive routine checkups and regular preventive care because it is not norm in their country or origin; in fact, those who express this sentiment usually reserve trips to hospitals or doctors only for immediate and curative treatment (Lee et al, 2010). This indicates a lack of awareness of preventative care in these communities despite mass preventative care education programs in the United States. Because these Asian American immigrants do not practice and enforce preventative care, children of these immigrants are likely to pick up these health-practicing behaviors as well, resulting in a decreased utilization of healthcare services (Lee et al, 2010).

For second generation Vietnamese Americans who are able to adjust and quickly adapt to the host culture and environment, generational gaps between the younger Vietnamese American and the older Vietnamese Americans become starkly contrasted as traditional roles become reversed as the elderly Southeast Asians must learn to cope with “their rapidly acculturating younger family members, while taking on different roles and expectations in a confusing and often frightening culture that’s divergent from and foreign to Southeast Asian cultures” (Lee et al, 2010, pg. 4). For example, both parents and children alike may switch between languages they are more comfortable with and proficient in when speaking on topics that are more difficult or controversial (Trinh, 2009). Conversing in a common language can promote feelings of cohesion between parent and child (Tseng & Fuligni, 2000), whereas conversing in different language can lead to misunderstanding and frustration, particularly if phrases or words are interpreted differently in other languages

(Trinh, 2009). Additionally, Asian adolescents have reported greater difficulty in communicating with their parents, their fathers in particular, due to an emphasis on unquestioned authority of fathers in Asian cultures (Rhee et. al, 2003). In areas that involve individual health and wellbeing, loss of individual autonomy of own bodies can be experienced due to strained parent-child dynamics, especially if the child is better versed in Western medicine practices and knowledge than the parent.

Furthermore, the older generations may expect a collective and family-based approach to healthcare and health-making decisions, the younger generations may be more internally biased towards an individualistic approach to healthcare based by their socialization of mainstream American culture. These cultural differences in making healthcare decisions may mean that while the older generations want to look towards their family and children to make informed decisions about their health, the younger generation may not understand these actions and view these interactions as burdensome dependency rather than cultural practice and may advocate or ask of the older generations to make more decisions on their own. Moreover, children may feel inadequate about their ability to accurately translate or interpret concepts and meanings, especially if they are not fluent in their parents' primary language. Alternatively, contributing to their families' wellbeing and survival can build self-confidence, interpersonal skills, and language abilities (Yoo & Kim, 2014). While losing touch with traditional family values does not leave the second generation at fault, it can leave the older generation feeling isolated and lost when making health and healthcare based decisions. (Lee et al, 2010). As a result, the collectivist mentality can be attributed to the low insurance rates of foreign-born and unacculturated immigrants in the States. (Lee et al, 2010).

Mental Health

Due to the nature of the childhoods that many Asian Americans face as 1.5 and second-generation children as mentioned in the prior two sections, these individuals can be susceptible to serious mental health challenges, emotional, or behavioral issues as they acculturate and grow up with immigrant parents. Depression and depressive symptoms have been found to be commonalities among many Asian American youth, especially young girls (Yu & Vyas, 2009). In a national survey, 30 percent of Asian American girls in grades 5 through 12 reported suffering from depressive symptoms (Yu & Vyas, 2009). Increased length of stay in the United States, along with increased acculturation, seem to exacerbate negative problems in adolescent health. This can be attributed to feelings on conflict within these 1.5 and second generation children due to existence in dual cultures – those of their ethnic heritage and mainstream American culture. A study conducted by Williams and colleagues note that Japanese American youth who seemed to have stronger cultural ties to Japanese culture were less likely to report depressive symptoms (2005). Another study noted that longer residencies in the United States had a tendency to increase depressive symptoms among urban Korean American adolescence (Cho & Bae, 2005). If particular attention was directed towards the Southeast Asian American community, a strong longitudinal relationship was found in perceived intergenerational gap in acculturation, intergenerational conflict, and depressive symptomology (Ying & Han, 2007).

Even though mental health interventions and services are available and effective, surveys conducted in 2011 have found that only 59.6 percent of individuals with mental illness reported receiving treatment for their conditions. Lack of treatment can be attributed to stereotypes depicting people with mental illness as being “dangerous, unpredictable,

responsible for their illness, or generally incompetent can lead to active discrimination, such as excluding people with these conditions from employment and social or educational opportunities” (Corrigan et al., 2014). Stigma and displays of discrimination can become internalized, leading to the development of self-stigma. People with mental illness who internalize this stigma may begin to think of themselves as unable to recover, undeserving of care, dangerous, or responsible for their illnesses, leading to feelings of shame, low self-esteem, and inability to accomplish their goals (Corrigan et al., 2014). Additionally, to avoid being discriminated against, people may also try to avoid being labeled as ‘mentally ill’ by hiding or denying their mental health issues and refusing to seek care (Corrigan et al., 2014). As a result, people who start mental health treatment may drop out. One out of five patients quit treatment prematurely, with 70 percent of all dropouts occurring after the first or second visit (SAMHSA, 2012). Low-income and uninsured patients are especially at high risk for dropping out of care (Olfson et al., 2009). Patterns of care seeking and dropout differ across age and demographic groups. Although symptoms of disorders and mental illness usually begin during adolescence and young adulthood, young adults are less likely than older adults to use mental health services; additionally, in 2011, the Asian community was least likely to receive any treatment for mental health among any other racial group, with White adults seeking services at 16.6 percent, Blacks, 7.6 percent, Hispanics 7.3 percent, and Asians at 6.5 percent (SAMHSA, 2012). These studies and findings can conclude a relationship between race and use of mental health services partially mediated by socioeconomic status, with poor ethnic-minority groups at greatest risk for not seeking mental health treatment.

Methodology

One-point-five and second-generation Vietnamese Americans college students in Southern California were asked to participate in a half-hour to an hour interview. I chose to interview current 1.5 and second-generation college students because college or university can mark a significant transition from adolescence to adulthood and independency. Especially if these immigrant children move away to college, there is a large possibility of a much more active and ongoing reflection about their identity, childhood, and health. Additionally, educational institutions that offer a private liberal arts education can be more hyper-aware of mental health issues and often promote a lot of mental health resources specific to their attending students, especially since the institution can be a lot smaller as opposed to public institutions. 1.5 generation Vietnamese Americans were included in this study in addition to the second generation because their immigration to the States at such a young age can result in a faster acculturation process in comparison to their parents and older family members, therefore leading to an active participation in mediating American institutions non behalf of their parents or other family members.

Participants

I recruited six participants were recruited through convenience sampling, “a specific type of non-probability sampling method that relies on data collection from population members who are conveniently available to participate in study” (Saunders, et al. 2012). I reached out to student organizations and affiliated groups I had personal connections at my college with and directly contacted additional 1.5 and 2nd generation students I knew. Of the six individuals who agreed to participate in my study, one self-identified as 1.5 generation Vietnamese American woman and the remaining five self-identified as second generation

Vietnamese American, 3 women and 2 men (Table 1). All participants, ranging from 19 to 21 years old, stated they came from low-income families (Table 1). Aside from one participant who did not know her health insurance status, all other respondents were recipients of MediCal, California's public health insurance program which provides needed health services for low-income individuals and families (Table 1).. Five of the six participants are state natives, and the remaining interviewee is an out-of-state college student. Five of the students currently attend four-year colleges/institutions in the Southern Western US region, while the remaining participant had just completed their licensed vocational nursing program at their local community college (Table 1). Five of the participants identify as heterosexual and one identifies as bisexual.

Table 1. Participant Demographics

	Age	Sex	Gender	Generational Status	Year in College	Health Insurance
Subject 1	21	Woman	Female	2	4	MediCaid
Subject 2	19	Woman	Female	1.5	3	MediCaid
Subject 3	21	Woman	Female	2	4	Unknown
Subject 4	21	Man	Male	2	4	MediCaid
Subject 5	21	Man	Male	2	Currently Unenrolled	Medicaid
Subject 6	19	Woman	Female	2	1	Medicaid

Participants were told with full disclosure that the participation in my research study consisted of a single half hour to an hour-long conversation that would be centered around their childhood and their current physical, mental, and emotional health. Participants I had interviewed were comfortable to answer all questions and disclose personal information due to the pre-existing relationships I had with them.

Interviews

To answer the given research question, qualitative research methods were the most fitting route to obtain answers. Qualitative research strives to understand experiences and attitudes – data that cannot be necessarily measured through quantitative means. Qualitative methods aim to “answer questions about the ‘what’, ‘how’ or ‘why’ or a phenomenon rather than ‘how many’ or ‘how much’, which are answered by quantitative methods” (Bricki and Green, 2009). To obtain the data, I engaged in semi-structured interviews that allowed for not only in-depth answers and data, but also a more open and intimate relationship with the interviewees in loosely structured way. Qualitative research methods aimed to provide me greater freedom in understanding participants’ current perspectives on their health by providing flexibility in the interviews. No single immigration story is the same, so it was expected that participants could have varying perspectives on their health and wellbeing.

I fully disclosed with the participants before the interviews that I was interested in the relationship between their family’s immigration and survival in relation to their current relationship with their own health. Once they agreed, I gave them a consent form that detailed the purpose of the research as well as informed them that interviews would be audio-recorded and transcribed. They were then given three days to opt out of the research project before scheduling them for an interview. Interviews were held in the interviewee’s place of

choice and comfort. For interviewees that lived in further range, skype interviews were conducted in private rooms. The interviews focused on their past and current health experiences with their families both in their home lives and within Western medical institutions as detailed in the interview questionnaire included in Appendix A of this report. Audio recordings were taken by digital recording and fully transcribed by myself. To ensure the safety and confidentiality of the participants, audio recordings and the transcribed interviews were kept on a secure flash drive and folders that only I had access to.

I used grounded theory analysis to analyze the data. Grounded theory, which is a qualitative research approach, attempts to develop theory about a particular phenomena of interest by identifying core theoretical concepts in the gathered data (Trochim, 2006). The interviews, once transcribed, were thoroughly read and then its contents were organized by identifying common themes, identified by the description of preliminary codes for analysis included in Appendix B. In coding all interviews, eight common themes were found throughout the data, some of the eight more prominent than others.

Health Portraits of the 1.5/2nd Generation Vietnamese-Americans

While there were points of similarity across the interviews, each interview was unique in the ways each participant's family life and experiences affected their current perspective on health. The following individual portraits of each interview subjects allow for the preservation of their voices and the integrity of their stories as we follow their health journeys and see how and why they have changed. When viewed collectively, the portraits allow for a more holistic understanding of the relationships of Vietnamese immigration, family culture, and health and healthcare. It is a reminder of how Vietnamese diaspora has impacted each family differently, and in turn, is coped with individually.

Ivy

As a second-generation, Chinese-Vietnamese college student, her health journey has been an ongoing, yet transformative experience. Because Ivy is the only child of her family and one of the eldest of her generation, her life experiences as one of the first native Asian American left her performing multiple health duties in the family:

I remember it being like middle school earliest where I accompany my aunts and uncles to their doctor appointments or I would go with them to get checkups. And more importantly, when they had their own children, I was always there for their appointments too, whenever they were sick... Like a translator. And same...with my grandparents... I think translating at the appointments, booking appointments, kind of things that a lot of people who speak English very well take for granted... Like looking up symptoms online, things like that...

However, these translating and booking responsibilities did not extend to all members of the family. She spoke on her family dynamic, heavily based on Vietnamese culture, which was determined by age and gender status, and how this dynamic purposefully excluded Ivy and

her generation from more ‘adult conversations’ about health such as insurance policies or collective healthcare making decisions, conversations. This lack of conversation left her with a singular definition of health based on her observations and everyday interactions with her family:

A lot of discussion around health in my family was surrounding towards my grandparents or the women in my family who had actual complications like physical complication that you can see; and so I think going into college and, like, being apart from my family for the first time, I came into college with the understanding that health was only physical, and that you have to see illnesses in order to know that they’re there.

Her singular definition of health as physical health would soon prove detrimental to her as she entered her first year at college. She noticed that she could not keep up with the academic curriculum, and she noticed that she always took longer than her classmates to complete assignments or exams. Not knowing she had attention deficit disorder and anxiety disorder, her frustration only grew and left her feeling isolated and struggling academically during her first year at college. Despite the amount of free academic and mental health resources available to her at her college, she did not take any actions toward her mental health until her later years in college after explicit intervention by a staff member.

... even though I felt the need for help, I couldn’t bring myself to ask for help so a lot of the biggest reasons... the reason why I got the help... is people telling me that I need help and like the kind of moments were I’m like, ‘Oh my god. This isn’t normal.’

With her MediCal insurance and busy family life at home, she is unsure how often she will be able to regularly access mental health services. It is also important to note that her parents are currently unaware of her mental health diagnoses and that she currently seeks treatment and care. She hopes to withhold that information from them, which impact how often she seeks services at home. Even though Ivy has regular access to Vietnamese doctor at Vietnamese clinic in her hometown, she laments lack of professionalism and open-mindedness. She had found out that the clinic had released her medical information, including the prescriptions she's taking, to her mother without Ivy's consent; and while she has not been extremely bothered that her mother obtained this information, she felt let down by her clinic.

You can't have, or at least to my knowledge, from what I've accessed in the past, you can't have a space where the [physician's] progressive, culturally competent, from the same background, and professional.

Despite ready access to a Vietnamese physician and clinic, Ivy has been hesitant to talk about more 'progressive issues' such as reproductive, sexual, and mental health. When she opened up to her physician about these types of health, she recalled her physician's disdain and refusal to address her mental and learning disorders, leaving her to seek mental health services on her own.

As a whole, her discovery of expansion of mental health as well as her personal experiences at Vietnamese clinics has been extremely eye-opening to her. Even though her childhood was structured in a way that also pushed her to take care of others, with higher education and push from others, she has been inspired as an aspiring physician to incorporate a practice that is culturally competent and generationally understanding, because as Ivy

concludes, ‘What’s the point of healthcare accessibility if you’re only making it accessible to only one population?’

Tam

Rose, who had immigrated to the United States at a young age, has noticed a stark contrast between the definitions of health at her home life and her college life. Aside from the lack of availability at her local Vietnamese clinics due to overcrowding, Rose noted that her family often did not seek out Western medical services due to the Vietnamese culture surrounding health and healthcare:

...growing up in Vietnam, you know... like... Access to a doctor is not as convenient nor is it as medical and not as advanced as it is here [in the United States]. So when it comes to any medical problems, they’ll try to remediate it, or, like, fix it with like, um, Eastern medicine...rather than actually going to the doctor so they can diagnose you.

This Vietnamese perspective view of medical care as a purely curative and immediate form of care continued to push Rose and her family to prolong the process of seeking medical attention, hoping that ‘waiting it out’ or resorting to traditional Eastern medicine would address the medical issues instead. This behavior was also reinforced by her surrounding ethnic community, which shared similar sentiments about health and seeking healthcare services. These health proscriptive behaviors, or behaviors that do not promote health, began to reflect in Rose’s actions as she transitioned into a liberal arts college:

I don’t think my parents and I were that much different because I also find myself procrastinating and trying to prolong having to go to the doctor as much as possible...

and try to avoid having to drink medicine and stuff like that. That's just like something that just kind of stuck with me.

Additionally, her understanding of health also proved to be a singular version of health as she noticed the difference in conversations about health among her college peers. Rose had only viewed health as a purely physical form. So when mental health was introduced to her a form of health, it was a completely foreign concept that was hard for her to conceptualize.

I didn't realize mental health was a thing until college, and that's when I start having conversation about it. And honestly, as I am in college more, and I am privileged to have a community that cares about mental health... that's when I start, like, taking acknowledge of it. But even then, it is still hard for me to grasp and get my head around, um, even though I know it's real and I truly it's real. But because how I was raised and, um, and how my thinking process is molded...

Ideas of health and wellbeing also continued to expand as her peers and college friends started to talk about diet and exercise, conversations that were lacking in her family life and hometown:

I eat healthier than I've ever eaten, and I've eaten more frequently and taking care of myself when it comes to the food aspect of my health... the nutrition aspect of my health because I go to [named attending college] and I'm surrounded with people who are very affluent from high social class and they're very conscious about they put in their body... and that has influenced me a lot.

Rose lamented the lack of conversations about healthy eating and overall health amongst her family members. She mentioned that despite her mother's push for a thinner, more elegant

body figure, Rose's mother never provided any guidance or advice on how that to achieve those specific body standards.

Towards the conclusion of the interview, Rose defined health and wellbeing as a Westernized idea, explaining that good health and wellbeing is only obtainable by following Western cultural values and having a higher socioeconomic status. If it had not been for her attendance at a majority higher class and white liberal arts institutions, she does not believe that she would have been able to truly learn how to take care of her physical and mental health, a concern she has for the remainder of her 1.5 and second generation community still living in ethnic communities.

Thalia

Thalia's earliest exposure to healthcare was unique to those of the other interviewees. Thalia, an out-of-state college student currently attending a private liberal arts college in California, grew up with her mom's constant care and watch. Because her mother and grandparents owned a Chinese medicine store, her family rarely interfaced with any Western medical institution, relying on only the medicines available in her grandparent's business for her health needs. Whenever Thalia and her family did decide to visit a Western physician, they would visit a family friend who was not only well versed with Eastern medicinal practices, but also fluent in both English and Cantonese. As a result, whenever Thalia and her siblings would visit that physician, her parents or grandparents would be the ones conversing with the physician, leaving Thalia out of the conversation. This only exposure left Thalia feeling uncomfortable when she started visiting other Western physicians as she got older and began making her own appointments. As the majority of the medications she was taking

were Chinese medicine, she never really knew how to inform physicians unfamiliar with the practice of her complementary and alternative medicinal practices:

I've always kind of felt uncomfortable at doctor's appointments... because you know how'd you make an appointment, they're like, 'Are you taking any medication?' I always felt really awkward about that question because I don't know if that meant you're taking any medication like Tylenol?... I never really understood that distinction... I also didn't understand where Chinese medication came into play in that question, either. Do I mention that I'm taking herbs on the side?

Lack of conversation lead to poor doctor-patient relationships, with Thalia carrying a kind of wariness towards Western medicine, an attitude inherited from her mother, who feared the potency, adverse effects, or possible addictive properties of Western drugs and medication. Her transition to a college located thousands of miles away from home, proved to be an even more difficult health challenge for her. Normally reliant on her mother to attend to her medical concerns and inquiries, the sudden and complete isolation from her main source of healthcare left her feeling clueless and worried, leaving her to rely on the most available and accessible type of health information, Western or allopathic medicine.

When I was younger, I always trusted what my mom had to say about health... I always take what my mom would prescribe to me. Since I've moved away... I've used way more Western medication in the last three years [at college] than I've ever had growing up... I was looking up these things on the Internet and doing a lot of searching up on my own, but if you're using the Internet, that's going to be very Western, you know? And I've also noticed that, like, my paranoia around my sickness has definitely heightened now that I've away from home.

Her transition into college also exposed her to a different aspects of health: mental and sexual health. While she was used to ingesting or receiving some sort of medication for her health, taking care of her emotional and mental health proved more complex. She had to find different strategies that allow her to figure out which best benefitted her mental health, which for her meant adjusting her lifestyle.

In the past two years, I've been much more conscious about how I take care of myself, my emotions, my well-being, my physical well-being, Um... and again, that isn't necessarily taking medication, per say, but it's like doing more, like, lifestyle things...that maybe improve long-term health instead of short term.

Her lifestyle changes included exercise, reflective writing, community health, eating healthy, etc. While she is glad that her understanding and advocacy of her own health and wellbeing is in her hands, she laments the direction in which she takes care of her health. Since her time at college and her physical separation at home, she has felt like she has lost a part of herself and her sense of home because of her dependence on Western medication and Western diagnoses and medical information, equating these forms of health seeking services as form Western assimilation:

I think that there is a kind of...separation between the two, because...the health I did learn from home was so informal and so culturally based...the health I talk about these days...reminds me of so much whiteness and Westernization and stuff. So there is a big disconnect... It's kind of depressing.

Still, Thalia's journey with her health and wellbeing is an ever-changing one, and she hopes she can find a balance in merging her Eastern-based health roots and current Western health.

Khoa

For Khoa, a second generation college student, his parents' immigration seemed to have directly affected his family dynamic and relationship with his parents. Most of his exposure to health prescriptive behaviors, or behaviors that promote health came from his mother, while his father, with whom Khoa was not as emotionally connected to, took more of the legal side of healthcare. However, both parents encouraged Khoa to turn towards home remedies or Eastern medicine, fearing the perceived high cost of utilizing Western healthcare services such as emergency rooms:

I feel like in terms of like documents and legality was my dad just given that he was the head of the household. Where as my mom... I guess it comes from her experience... living in poverty back in Vietnam after the Fall of Saigon... she just emphasized... how no amount of money is worth your health, essentially. So then that's why, I mean for the most part, for taking care of health, she was doing preventative measures like trying to get us to eat well and be careful of certain things.

It was through Khoa's mom that he learned how to take care of his body through diet, Eastern medicinal practices, and good preventative health habits such as consuming appropriate amounts of water and getting enough sleep. When he moved to college, only a few hours away from his hometown, he continued to practice the health prescriptive behaviors his mother had instilled in him to the best of his ability; he was not prepared to learn about or take care of mental health, which he was educated of when he entered into college. While his parents had encouraged him to 'be strong' and "have a strong mind" growing up, Khoa speculated that their encouragement was to reinforce gender stereotypes which often depict men as emotionally unavailable individuals. As a result, lack of

acknowledgment and conversation at home meant that he knew little about taking care of his mental health when he started his college career.

Coming to college...I try to do what my mom has told me... but I still feel like not being home gives me less access to physical health because I don't have someone to perform [certain Eastern medicinal practices such as coining] on me. Honestly, I'm still trying to figure out how exactly what works in terms of, like, taking care of myself mentally.

So far, Khoa's found that it is easiest to take care of his mental and emotional health when he focuses his energy and community building and community health. For him community, whether it is an ethnic student organization or a dance group, provides a support system in which he is able to express himself in ways that promote good community health and unity. He is also comforted by the fact that other members who share similar ethnic and socioeconomic backgrounds tend to feel like their mental health is in better conditions when they collectively work on community health despite available mental health services at the college he attends.

My mental health is interestingly tied into the community, so I think that might play a reason as to why I work towards building a community; and I feel like that could be a way of myself trying to, like practice being healthier mentally, you know? Just seeing communities happen makes me feel better...

While he still hesitates to actively engage with Western institutions, due to a perceived fear of cost that has been carried on since childhood, his ability to carry on health practices and prescriptive behaviors at home always a connection with his mother and provides him a

foundation in which to connect with other Vietnamese students as he strives to build a supportive community at his college.

Jason

Jason, a recently licensed vocational nurse, has lived at home with his parents and older siblings. As the youngest child in his family, he never recalled having any specific responsibilities for his family's wellbeing and healthcare making decisions during his adolescent years. Those duties were usually reserved for his older cousins and siblings, 6 and 9 years his senior. It was his older brother who navigated cultural and linguistic differences for his parents and monitored their health and health protecting behaviors. It was also his older brother who pushed his parents to move towards Western medicine, convincing them that polypharmacy and Eastern medicine itself were both outdated, inferior, and ineffective in treating medical issues:

We used to go to, uh, more Vietnamese doctors, but we kind of grown out of it. It's mainly because my brother kind of talked to my parents, like, 'Oh, you shouldn't be doing this for, uh... broken leg. You shouldn't be doing that. You shouldn't be putting feces on whatever and rubbing on it.. It won't make you better.' So then we just kind of grew out of it.

As his siblings grew older and became more independent, every member of his family was left to handle their own personal insurance on their own. For Jason, this part of independency has pushed him to mold his own health and wellbeing to incorporate different parts of his life, allowing him greater body autonomy and more health making decisions for his body.

I think, um, being healthy is holistic. You have to feel good spiritually and, um, physically, emotionally, and it just all have to come together and be balanced.

For Jason, this new outlook on health and wellbeing has meant eating and drinking appropriately, adjusting his exercise routine, attending religious services, and balancing a healthy and positive social life. While it was at first difficult implementing these new routines in life, he has found that he cannot live without these adjustments because they allow him to feel confident about his body and overall health. His mother's recent lung cancer diagnosis has also pushed his parents and himself to incorporate healthier foods into their diet as preventative measures for his father and him. However, Jason's health protective behaviors, or actions used to prevent health problems, does not necessarily apply to his engagement with Western medical institutions.

I don't visit the doctor every six months or every year or have my annual checkups... Sometimes I just forget and, um, it's a really bad habit of mine. I really should do my early checkups, but I just keep forgetting.

Still, Jason feels blessed to have relatively good health and has taken his mother's stage 4 cancer diagnosis as a reminder to not take his health and life for granted.

Lucy

Lucy, a second generation first year at university, has always remembered her father going in and out of emergency rooms and hospitals amidst her fond memories of her childhood. Despite her parents' constant interactions with Western medical institutions, she never really recalled any other exposure to healthcare-centered conversations, attributing this lack of conversations to her parents' desire to shield more difficult and somber topics from

her and her siblings. Other than that, the only conversations she had about health and healthcare were about appointments with her family care physician.

For me, I didn't really talk about healthcare. I think Mom and Dad did an exceptionally good job shielding us from topics that were a little difficult so healthcare bills, mortgage, all of those things... physical healthcare like seeing our primary physician things like that we do talk about because that's not stigmatized...

Even then, Lucy is not able to freely talk about her overall physical health with her parents. Because her parents hold very traditional, conservative, and Christian values, certain aspects of health such as sexual and reproductive health have been deemed taboo; and while Lucy is technically a legal adult, her attempts to seek specific services for her sexual and reproductive health has constantly been barred by her parents' lack of privacy and insistence on their physical presence:

We come from a very conservative Catholic traditionalist family, so things like birth control or abortion are just no-gos... Stigmatized...we're not even allowed to have discussions about it. It's just... 'If you do it, you're a bad person.' ... I recently wanted to talk about birth control with my primary physician and I wanted to go in for a second shot for HPV... but my primary reason was that I had discoloration on my chest...when [my mom] found out, she insisted on going, um... would not leave until I gave her consent to leave, which was a forced consent, and so I wasn't able to discuss those things with my physician because she was there the whole time.

Lucy has also found that some of her physical conditions have also been worsened by her poor mental and emotional health. While she is aware of mental health services available that

are covered by her health insurance, she has been unable to properly start and maintain treatment due to the extremely negative connotation that mental health has for her parents, particularly her mother. Time and time again, her parents have discouraged her and her siblings from seeking mental health services, believing that these services do not work and are only reserved for 'crazy' individuals:

So no matter how many times I go to see my primary care physician for my physical problems, I will never get the results unless I address... my mental health first, which is something I can't easily do. It's something I can do. It's not something very easy for me to do. So even if I say I'm taking care... I'm taking care of my physical health to the best of my abilities. I can't really say that unless I've sought out help for mental and emotional health, too.

Even though Lucy believes the prospects of her receiving effective mental care is bleak unless her parents are willing to open-mindedly support and participate, a factor she is doubtful of, she holds a lot of sympathy and empathy for her parents. Lucy's few conversations with her parents about their immigration to the United States has provided insight that has allowed her to get a glimpse of the trauma and dire situations her parents have been put through, events which she believe has contributed to her father's post-traumatic stress disorder and depression. As refugees of the Vietnam War, Lucy believes the cycle of violence her parents experienced has been passed down to her generation through transgenerational trauma, trauma that is transferred from the first generation of trauma survivors to the second and further generations of offspring of the survivors via complex post-traumatic stress disorder mechanisms (Portney, 2003). However, she does not know how this transgenerational trauma will play into her adulthood as she transitions into college

as it continues to give her anxiety about her future career goals, which currently are undecided.

Concluding Statements

Across these interviews, the participants had overlapping themes despite the uniqueness of each story. For most of the interviews, mental health seemed to be a relatively new and ongoing discovery. Especially for Lucy and Ivy, their newfound understanding of mental health became crucial to their overall health and wellbeing as their physical and mental health appeared to be intertwined. For others, mental health was navigated through other means whether it meant actively taking better care of their physical body or promoting community building and care, like Thalia and Khoa. Regardless, it seemed like the most heightened awareness of understanding of and action on mental health occurred in the participants who were attending private liberal arts institutions. Participants also seemed to associate mental health and more ‘progressive forms’ of health like sexual and reproductive health as a ‘Westernized’ and individualistic form of care, while the versions of health they were exposed to at home were associated more with community or ‘Vietnamese’ health.

Alternatively, most participants seemed to carry certain health proscription behaviors from their youth and childhood, the most common being the lack of interfacing with Western medical institutions such as utilizing emergency services and scheduling doctor appointments. The reasoning factors, however, differ among individuals. Ivy, Rose, and Khoa had pre-conceived notions about high cost and lack of insurance coverage, which mentally prevented them from actively utilizing Western healthcare services. Thalia, whose primary source of health and healthcare came from Chinese influences, left her with little experience and knowledge of navigating Western services. Jason simply forgot to schedule appointments as maintaining those checkups were not his priority. Lucy, on the other hand, believed taking action towards her physical health were pointless unless she was able to

address her mental and emotional health needs concurrently, a difficult task as her parents are the main barriers to her access of those services.

While college did mark a pivotal transition to adulthood, it seemed like participants who had a physical separation from their parents seemed to take more action towards taking care of all aspects of their health, specifically mental and sexual/reproductive health, than individuals who still lived in their hometown and with their parents. With exposure to different people from differing backgrounds and direct access to services provided by the school, these 1.5 and second-generation individuals seemed to have a stronger belief of autonomy of their own health and body.

These findings are important to understanding the lives of immigrant children because it allows us to know what aspects and what moments in their lives were crucial to their development and understanding of their own health. It is clear that mental health is still heavily stigmatized among Vietnamese-American communities, unless exposed to institutions or environments that actively destigmatize and provide resources catered to specific demographics (in this case, mental health resources specific to college students). Other barriers to healthcare persists within the 1.5 and second-generation community due to the lack knowledge about health insurance plans and coverage as we saw in Khoa and Rose's interview who believed that certain Western healthcare services were unaffordable. Those who attended a private liberal arts and progressive institutions, it was exposure to more affluent communities that allowed them to gain better understanding of the means and ways to take active care of their health. This is important to note because all my participants came from low-income families. We can infer from the participants' stories that there is a relationship between race, socioeconomic class, immigration status culture and health

outcomes. Race and culture seem to further impact attitudes towards certain aspects of health such as mental and sexual and reproductive care. Class and immigration status seems to not only affect access to Western health services but also affect the access of knowledge surrounding health and wellbeing.

What does the mean for our healthcare system? If the aim of our healthcare is to close health disparities and healthcare barriers, this means that our healthcare system needs to achieve several goals. It needs better widespread outreach and culturally-sensitive education programs on the *multiple aspects of health*, especially towards immigrant communities where cultural and traditional values do not necessarily align with ‘Western health’ and healthcare. There needs to be more mental healthcare services available to ethnic communities, especially immigrant communities that have come from extreme trauma and conditions. Last, but not least, our healthcare systems and governments, both state and federal, need to ask why these low-income immigrant communities do not seem to have as much access to both the knowledge and physical means to take better care of their health.

In retrospect, I would have liked to have expanded this study into a longitudinal study. Surveys before the interview, sometime after the interview, and post-graduation could have been conducted to monitor health outcomes of the participants. The surveys could have served several purposes: a) monitor health conditions of the participants over a specific period of time, b) detect if the interview indirectly served as a form of health intervention and if health behaviors changed post interview, and c) observe if certain health practices were maintained post-graduation and into later adulthood.

References

- "Amerasian." *Merriam-Webster.com*. Merriam-Webster, n.d. Web. 2 Dec. 2017.
- BeLue, R., Miranda, P.Y., Elewonibi, B.R., Hillemeier, M.M., (2014). The Association of Generation Status and Health Insurance Among US Children. *PEDIATRICS*, 134(2), 307-314. Doi: 10.1542/peds.2013-3337
- Bloom, B., Dey, A.N., & freeman, G. (2006). *Summary health statistics for U.S. children: National Health Interview Survey, National Center for Health Statistics*. Washington, DC: National Center for Health Statistics.
- Bricki, N., Green, J. (2009). A Guide to Using Qualitative Research Methodology. *Research Tools*. 1-28.
- Cho, S., Bae, S.W. (2005). Demography, psychosocial factors, and emotional problems of Korean American adolescents. *Adolescence*, 40, 533-550.
- Complementary and Alternative Medicine. (2015, April 10). Retrieved December 02, 2017, from <https://www.cancer.gov/about-cancer/treatment/cam>
- Corrigan, P.W., Druss, B.G., Perlick, D.A. (2014). The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care. *Association for the Psychological Science*, 15(2), 37-70. Doi: 10.1177/1529100614531398
- Databank, (2014). Immigrant Children: Indicators of Child and Youth Well-Being. *Child Trends Datbank*. Retrieved from <https://www.childtrends.org/indicators/immigrant-children/>
- Dhooper, S.S., (2003). Health Care Needs of Foreign-born Asian Americans: An Overview. *Health & Social Work*, 28(1): 63-71.

- Do, M.P., Hutchinson, P.L., Mai, K.V., VanLandingham, M.J., (2009). Disparities in health care among Vietnamese New Orleanians and the impacts of Hurricane Katrina. *Res Social Health Care*, 27, 301-319, doi: 10.1108/S0275-4959(2009)0000027016
- Lee, S., Martinez, G., Ma, G.X., Hsu, C.,E., Robinson, E.S., Bawa, J., Juon, H., (2010). Barriers to Health Care Access in 13 Asian American Communities. *Am J Health Behav*, 34(1): 21-30.
- Nguyen, G.D., (2015). Generational Conflicts among Vietnamese Americans in the Helath Care Decision Making Process. *Online Journal of Health Ethics*, 11(2).
<http://dx.doi.org/10.18785/ojhe.1102.03>
- Olfson, M., Mojtabai, R., Sampson, N.A., Hwang, I., Druss, B., Wang, P.S., ... Kessler, R.C. (2009). Dropout from outpatient mental health care in the United States. *Psychiatric Services*, 60, 898-907. Doi:10.1176/appi.ps.60.7.898
- Portney, C. MD. (2003). Intergenerational Transmission of Trauma: An Introduction for the Clinician. *Psychiatric Times*, 20(4).
- Rhee, S., Chang, J., & Rhee, J. (2003). Acculturation, communication patterns, and self esteem among Asian and Caucasian American adolescents. *Adolescence*, 38(152), 749-768.
- Rojas, L. B. (2012). Gen 1.5: Where an immigrant generation fits in. Retrieved December 02, 2017, from <http://www.scpr.org/blogs/multiamerican/2012/03/21/7963/what-is-a-1-5-where-an-immigrant-generation-fits-i/>
- Substance Abuse and Mental Health Services Administration. (2012). Results from the 2011 National Survey on Drug Use and Health: Mental health findings (NSDUH Series, H-45, HHS Publication No. [SMA] 12-24725). Rockville, MD: Author.

- Tseng, V., & Fuligni, A.J. (2000). Parent-adolescent language use and relationships among immigrant families with East Asian, Filipino, and Latin American backgrounds. *Journal of Marriage and the Family*, 62, 465-476.
- Trinh, N. (2009). *Can we talk? Language patterns and intergenerational conflict in Vietnamese-American families*. University of California, Santa Cruz.
- Williams, J.K.Y., Else, I.R.N., Hishinuma, E.S., Goebert, D.A., Chang, J.Y., Andrade, N.N., et al. (2005). A confirmatory model for depression among Japanese American and part-Japanese American adolescents. *Cultural Diversity and Ethnic Minority Psychology*, 11(1), 41-56.
- Ying, Y.W., Han, M. (2007). The longitudinal effect of intergenerational gap in acculturation on conflict and mental health in Southeast Asian American adolescents. *American Journal of Orthopsychiatry*, 77(1), 61-66.
- Yoo, F.J., Kim, B.W., (2014). *Caring Across Generations: The Linked Lives of Korean American Families*. NY & London: New York University Press.
- Yu, S.M., Vyas, A.N. (2009). "The Health of Children and Adolescents." *Asian American Communities and Health*. San Francisco: Jossey-Bass. Pg. 107-131
- Zong, J., Batalova, J. (2016). Vietnamese Immigrants in the United States. *Migration Information Source*. Retrieved from <https://www.migrationpolicy.org/article/vietnamese-immigrants-united-states>

Interview Questions

Childhood/Lived Experiences:

- Who did you grow up with? Who were your primary caretakers?
- Where did you grow up? What was your childhood environment like?

Healthcare Experience and Decision Making

- During your childhood and adolescence, who was involved in healthcare-making decision?
 - How were they made?
 - Did you have a role in the healthcare making process?
 - (If answered yes) What role did you play and what duties did they entail?
 - (If answered no) Who was involved in those decisions and what roles did they play?
- How was the healthcare system and medical institutions navigated in your family household?
 - Were there any difficulties or obstacles faced? If so, please describe them.

Current Perspective on Own Health

- What is your definition of health and wellbeing?
 - Does this include different aspects of health (mental, physical, emotional)?
- Do you currently make active decisions about your own health? Why or why not?
 - How do you take care of your mental health?
 - How do you take care of your physical health?
 - How do you take care of your emotional health?
 - Do you take your family history into account?
- What is your current relationship with the American healthcare system?
- Do you have any current health conditions (if comfortable disclosing) that you are currently seeking care for?

- Do prior experiences with healthcare and medical institutions impact the way you approach your health and interact with medical institutions?
- What external factors impact your health-making decisions? (environment, health insurance status, access to grocery stores, etc.)

Description of Codes for Analysis

I created the following preliminary codes for analysis of the interviews conducted with each participant. These codes were created to mark points of similarity from one another when coding the interviews.

Preliminary Codes for Analysis of Subject Interviews:

Theme: Health

- a) Definition: overall definition of and attitude towards health
- b) Aspect1: comments made about health as a physical/physiological form
- c) Aspect2: comments made about health as a mental/emotional form
- d) Aspect 3: comments made about health as a spiritual form

Theme: Perception of Health

- a) Perception1: comments made about health as individualistic
- b) Perception2: comments made about health as community health
- c) Perception3: comments made about health as “Vietnamese health”
- d) Perception4: comments made about health as “Western health”
- e) Perception5: comments made about religious influences on health

Theme: Responsibility

- a) Responsibility1: acknowledgment of personal active role in family’s healthcare and healthcare making decisions
- b) Responsibility2: acknowledgment of active role of other family member in family’s healthcare and healthcare making decisions

- c) Duty1: comments made about roles taken on at a young age
- d) Duty2: comments made about roles of siblings/relatives

Theme: Health Practicing Behaviors

- a) Practice1: comments made about health practicing behaviors kept from home
- b) Practice2: comments made about health practicing behavior from college transition
- c) Practice 3: comments made about seeking/using personal insurance
- d) Medicine1: comments made about using complementary alternative medicine
- e) Medicine2: comments made about using Western healthcare services
- f) Medicine3: comments made about indirect health practicing behaviors

Theme: Access to Healthcare Support

- a) Attitude1: positive comments about access to healthcare services
- b) Attitude2: negative comments about access to healthcare services
- c) Barrier1: comments made about health insurance status and coverage
- d) Barrier2: comments made about culturally competent services
- e) Barrier3: comments made about cultural views that impact access
- f) Barrier4: comments made about cost in accessing healthcare services
- g) Barrier5: comments made about intergenerational conflict
- h) Barrier6: comments made about logistical barriers to healthcare services
- i) Barrier7: comments made about accessing mental health services
- j) Benefit1: comments made about location of healthcare services

Theme: Parent-Child Conflict

- a) Conflict: mention of explicit difference in health and healthcare seeking behaviors

- b) Example1: fear of Western medicine due to lack of education
- c) Example2: fear of Western medicine due to prescription drugs
- d) Example3: lack of privacy between parent and child
- e) Example4: parents' lack of acknowledgment of mental health as a medical issue
- f) Example5: lack of communication in regards of health between parent and child
- g) Example6: conflict due to manifestations of intergenerational trauma
- h) Example7: conflict due to Vietnamese culture where power is stratified by age

Theme: Mental Health

- a) Perspective1: lack of awareness
- b) Perspective2: refusal of acknowledgement as a type of health
- c) Perspective3: stigmatized
- d) Perspective4: mental health as a "white man's disease"
- e) Perspective5: acknowledgment of mental health/illness
- f) Signs1: suspicion of mental illness present

Theme: Pivotal Moment

- a) Definition: moment(s) where view of healthcare/health has been altered, changed, eye-opening, or refined
- b) Moment1: change in family member's physical health as a pivotal moment
- c) Moment2: family member's mental health as a pivotal moment
- d) Moment3: change in personal physical health as a pivotal moment
- e) Moment4: change in personal mental health as a pivotal moment
- f) Moment5: change in personal life as a pivotal moment