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Asian Americans and cultural values : encountering and overcoming sociocultural barriers to community mental health services : a project based upon an independent investigation

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Asian Americans and Cultural Values:
Encountering and Overcoming Socio-cultural
Barriers to Community Mental Health Services

ABSTRACT

This qualitative study explored the narrative experience of Asian

American/Pacific Islanders (AA/PIs), who have received or are currently receiving

community mental health services. This study was an attempt to illuminate their

experience of *encountering* and *overcoming* socio-cultural barriers to these services.

Historic underutilization of mental health services among AA/PI communities motivated

the need to explore what cultural and/or institutional factors reduce barriers to services.

Four AA/PIs, with an average length of 7.25 years in treatment, were recruited

from a community mental health agency in San Francisco, CA. They participated in 45-

minute to one hour semi-structured interviews discussing their experience in seeking and

accessing mental health services. Thematic analysis was used to identify prominent

themes in the narrative data.

The study identified that individuals encountered specific socio-cultural barriers

to services and utilized both personal and institutional factors in order to manage these

barriers. Participants managed *stigma* with positive emotional and resource support that

came mainly from their parents. Participants overcame *lack of mental health services*

knowledge by complying with referrals, and trusting in clinician and agency outreach to

manage personal and family issues. Findings also underscore the significant collective

role of institutional factors of language services, cultural competency, location and Medi-

Cal (California Medicaid) payment acceptance in outreaching and engaging AA/PIs.

Support from immediate family members (with the exception of extended families) and

friends was crucial in retaining participants in treatment.

ASIAN AMERICANS AND CULTURAL VALUES: ENCOUNTERING AND

OVERCOMING SOCIO-CULTURAL BARRIERS TO COMMUNITY MENTAL

HEALTH SERVICES

A project based upon an independent investigation,
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TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

INTRODUCTION

This qualitative study explored the narrative experience of Asian

American/Pacific Islanders (AA/PIs), who have received or are currently receiving

community mental health services, and to illuminate their experience of

encountering and *overcoming* socio-cultural barriers to these services. The study

focused on exploring the narrative descriptions of socio-cultural barriers on cultural

and institutional levels with an emphasis on the influence of cultural values in

defining how barriers were encountered. Additionally, stigma and community

involvement were highlighted in the context of overcoming these barriers. Other

issues include exploring initial feelings about mental health services, referral sources,

alternative treatment options and service retention.

AA/PIs are currently one of the fastest growing minority groups in the United

States, comprising 5% of the total U.S. population (13.5 million), and projected to

increase up to 10% by 2050 (Reeves & Bennett, 2004). For the past thirty years,

AA/PIs, particularly from those who identify as first and second generation, were

found to underutilize mental health services (Abe-Kim et al., 2007; Kung, 2003;

Matsuoka, Breaux & Ryujin, 1997; Sue & McKinney, 1975; Uba, 1994).

Recent empirical studies found socio-cultural barriers on both cultural and

institutional levels affect utilization rates among AA/PIs (Atkinson & Gim, 1989;

Chang, Tracey & Moore, 2005; Kung, 2003; Shea & Yeh, 2008). Identified

socio-cultural barriers include culturally-influenced stigma (Mallinckrodt, Shigeoka

& Suzuki, 2005), conflict between Asian and Western values (Kim & Omizo, 2003;

Miville & Constantine, 2007), a lack of language accommodations (Uba, 1994) and

a dearth of culturally sensitive mental health providers (Sue & Sue, 2003).

If the AA/PI population doubles in 40 years, underutilization rates may

continue to rise without attention to addressing the issue. Although there is a

growing body of research on AA/PIs and mental health services, the majority of

studies are quantitative in nature which does not capture the rich narrative of the

AA/PI individual experience. Research in this area mainly focuses on help-seeking

attitudes of AA/PIs who have not yet sought mental health services. Many of these

studies focus only on college-level students as their sample population, which limits

the generalizability of AA/PIs who are not college educated. Due to the lack of

qualitative research on AA/PIs who have received community mental health services,

this study serves as an exploratory attempt to elucidate the role cultural values play

in the experience of AA/PIs who seek mental health treatment.

This study may be beneficial to the social work field by offering AA/PIs'

narrative perspective of the socio-cultural barriers they face as well as an

understanding of whether and how they overcome these barriers to successfully

access mental health services. The knowledge gained from the clients' perspective

can lead to developing tools for AA/PIs who face these barriers but are unable to

overcome them. The study may also be a resource for AA/PI communities, clinicians,

and community mental health providers to further develop outreach and gain a better

understanding of how to approach AA/PI individuals in need.

This study was motivated by my own personal experience in witnessing friends

and family members suffer through long-term mental health issues without proper

support. I have seen families deny the existence of psychological issues altogether. I

have observed families crumble when they burden themselves to solely care for

individuals. I have witnessed relatives feel unworthy of having children to prevent

passing on their "illness." And I have seen the lack of community attention to

address the fact that my female counterparts (AA/PI women) are more likely to

contemplate and attempt suicide than compared to all other ethnic groups in the U.S.

(University of Washington, 2009). Thus, this study is an attempt toward this inquiry:

what is the tipping point for AA/PI individuals to elect becoming consumers of

mental health treatment? Can the same methods of overcoming barriers be applied to

other AA/PIs who face them?

This study was conducted by interviewing four English-speaking AA/PI adult individuals who received or who are currently receiving mental health services. The interviews, which lasted between 45 to 60 minutes, were conducted in-person and over the phone. The interviews discussed initial and current feelings about mental health services, referral sources, encountering and overcoming barriers, and service retention.

This study will be presented in further detail in the following four chapters. Chapter II, the literature review section, outlines multiple facets of the AA/PI experience including AA/PI immigration history, acculturation, cultural values and socio-cultural barriers to services for this population. Chapter III, the methodology section, describes the recruitment process and interview procedures, as well as present the overall research process. In Chapter IV, the major findings are presented from selected interviews. The final chapter, Chapter V, discussion, explores the relationship between the major findings from this study and recommendations for further research in the field of clinical social work practice.

CHAPTER II

LITERATURE REVIEW

The purpose of this qualitative study is to explore the narrative experience

of Asian American/Pacific Islanders (AA/PIs) who have received or who are

currently receiving community mental health services. The study will explore

possible socio-cultural barriers they may have encountered and possibly overcame in

accessing community mental health services. This chapter will begin with an

overview of the identity and history of AA/PIs in the United States. I will then

examine the AA/PI identity through the lens of acculturation and cultural values.

The last section will be a discussion of the possible socio-cultural barriers that

AA/PIs face in accessing mental health services, supported by empirical studies of

how acculturation and cultural values affect these barriers.

Asian American/Pacific Islander

In this section, I will explore the experience of AA/PIs in the United States

by highlighting current demographic information and a brief history of this

population's immigration experience. I will also focus on the specific experience of

the Chinese American community in San Francisco, where recruitment for this study

takes place. In this geographic region, AA/PIs represent over 31% of the total

population, with Chinese Americans representing approximately 65% of the AA/PI

community (U.S. Census Bureau, 2007).

The U.S. Census (2000) defines Asian Americans/Pacific Islanders (AA/PIs)

as "…people having origins in any of the original peoples of the Far East, Southeast

Asia, or the Indian subcontinent." (p. 2). AA/PIs are currently among the fastest

growing minority groups in the United States, comprising 5% of the U.S. population

(15.2 million) and is projected to increase to 10% by 2050. The percentage growth

of AA/PIs between 2006 and 2007 was 2.9% (434,000), which represents the highest

increase of all ethnic groups (U.S. Census Bureau, 2009). AA/PIs are also one of the

most diverse groups in the United States—comprised of over 25 different ethnic

groups including East Asians (which include Japanese, Korean, Chinese peoples),

Southeast Asians (which include Filipino, Vietnamese, Cambodian peoples), South

Asians (which include Indian, Pakistani, Sri Lankan peoples), Pacific Islanders

(which include Polynesians, Samoan, Tongan peoples), and general mixed-race

Asians (Miville & Constantine, 2007; Uba, 1994).

It is important to note, however, that AA/PIs are *not* a homogenous group

as a whole, as differences among sub-groups are often overlooked (Lee, 1997). Each

ethnic group has its own unique languages, traditions and customs (Miville &

Constantine, 2007). Uba (1994) asserts in the following:

6

"Similarly, to speak of "Asian American culture" as a singular entity is misleading. Insofar as different Asian Americans reconcile Asian cultural traditions and American culture in different ways, there is no single Asian American culture. Different Asian American groups are not even reconciling the same Asian cultural traditions (because they have come from different countries and at different times in history) to the same experiences in America. (p.12)

There are several factors that differentiate AA/PIs within sub-ethnic groups: age, generation, family income, education attainment, immigration status, immigration experience, exposure to war trauma, levels of acculturation and adherence to Asian cultural values (Kim, Atkinson & Yang, 1999; Lee, 1997; Uba, 1994). For example, a fifth-generation Chinese American may not stringently adhere to traditional cultural values and beliefs compared with a first-generation Cambodian American. AA/PI identities can be understood as dynamically evolving among the complex diversity of their experiences in the United States.

Immigration History

For over 150 years, AA/PIs have migrated and lived in the United States. Beginning in the mid-1800's, Chinese immigrants from southern China, were the first Asian group to immigrate to the United States in order to work in the gold mines of California. Japanese immigrants followed in 1868, primarily settling in Hawaii and California to work on sugarcane and fruit plantations. Korean immigrants arrived in 1903, followed by Filipinos in 1906, and Asian Indians in

1900; these groups replaced the decreasing number of Chinese and Japanese laborers due to the 1882 Chinese Exclusion Act (Kim, Atkinson & Yang, 1999; Uba, 1994). Anti-Asian sentiments, discrimination, special taxes, and anti-miscegenation laws eventually led to the 1882 Chinese Exclusion Act and Immigration Act of 1924 that ended *all* Asian immigration until the late 1940s (Kim, Atkinson & Yang, 1999). The majority of these immigrants were single male laborers and many laws prevented sponsorship of spouses and women to also move to the United States, in order to prevent the establishment of families. Thus there are few descendents of the first immigration wave in the U.S. (Lee, 1997). Between 1848 and 1924, approximately one million Asians immigrated to the United States.

The second wave of Asian immigration occurred in the mid-1960s after the passage of the Immigration Act of 1965 which lifted race-based quotas on immigration (Uba, 1994). Immigrants in this wave included Chinese, Filipino, Japanese, and Koreans who were motivated by higher standards of living and educational opportunities. At the end of the Vietnam War and other U.S. involvements in Southeast Asia, approximately 130,000 Vietnamese refugees arrived in 1975. They were followed by Vietnamese-born Chinese, Cambodians, Laotians, Hmong and Miens to escape persecution in their countries (Uba, 1994). In the third wave beginning in the 1980s, new generations of Chinese, Filipino, Japanese, Thai,

Korean, Samoan, and Indian groups immigrated to the United States. In the last

thirty years, Asian immigrants continue to migrate and settle in the United

States—approximately 33% of foreign-born AA/PIs immigrated in the 1990s, and

17% of AA/PIs immigrated between 2000 and 2004 (U.S. Census Bureau, 2007).

Although AA/PIs reside in all fifty states, the majority reside in Hawaii, as

well as the East and West coast of the United States. As of 2007, over 75% of

AA/PIs live in three major metropolitan areas: the Greater Los Angeles Area (1.87

million), New York-Northern New Jersey-Long Island Area (1.78 million), and the

San Francisco Bay Area (0.98 million) (U.S. Census Bureau, 2007). Over time,

anti-sentiments, discriminatory housing laws, and employment limitations motivated

the development of ethnic enclaves in these metropolitan areas—for example,

"Japantowns", "Koreatowns", "Little Saigons", and "Cambodia Towns." (Lee, 1997).

These enclaves act as beacons to attract new immigrants as it offers a familiar and

virtually seamless transition to the United States with jobs, community support and

ethnic cohesion built-in. Indeed, the history of AA/PIs in the United States is a

testimony to the variability and identity of AA/PIs as a whole.

Chinese Americans in San Francisco

This research study focuses on the San Francisco Bay Area where the

Chinese American community represents the majority of AA/PIs (65%) in this area.

The 2005-2007 American Community Survey (2007) by the U.S. Census reported

that Chinese Americans comprise approximately 20% of all San Francisco residents,

compared with 45% non-Hispanic White, 17% Hispanic, 7.3% African Americans

and 13.1% other AA/PIs. Chinese Americans are also the largest ethnic group,

representing 22.4%, of the total AA/PI population in the United States. Further, this

group represents 1.2% of the total U.S. population with the majority residing in

metropolitan areas on the East and West coasts. (U.S. Census ACS, 2007).

The Chinese American community in San Francisco speaks Cantonese

dialect and retains slightly different cultural values compared to mainland Chinese.

The majority of the Chinese American community in San Francisco traces their

heritage back to Hong Kong and southern China. Hong Kong had significant British

influences as a previous Britain colony while southern China had a long history of

international exposure compared to the majority of China (So, Lin & Poston, 2001).

Both Hong Kong and southern Chinese individuals speak Cantonese dialect, which

is derived from Mandarin. Mandarin is the official spoken language of China. There

is a significant disparity between Mandarin and Cantonese dialect as the majority of

people who speak Cantonese cannot speak Mandarin, and vice versa (So, Lin &

Poston, 2001). Although Hong Kong and southern Chinese are two separate regions,

individuals from both groups share the same dialect which accelerated the cohesion

in creating the Chinese American community in San Francisco.

So, Lin, and Poston (2001) assert Hong Kong and southern China's interrelated history greatly contributed to the present Chinese American community. Hong Kong began as a fishing village located on the edge of southern China. It eventually became a military port with high exposure to the Pacific Ocean. However, Hong Kong became a British colony in 1842, and endured until 1997 as the result of the Treaty of Nanking, after the First Opium War between China and Britain (So, Lin & Poston, 2001). As Hong Kong became more westernized, China's political reach strengthened in southern China. During the Cultural Revolution of China in 1966, Hong Kong served as an asylum for many Chinese escaping political persecutions as it offered an alternative political system to communism. Although China regained sovereignty of Hong Kong in 1997, the city continues to hold many British economic and political systems under the principle of "one country, two systems" (So, Lin & Poston, 2001). Hong Kong and southern China's history of Western influence may have reduced the overall anxiety to immigrate to the United States because of the Western similarities.

In the 1850s, the first wave of Chinese immigrants arrived in the United States from the southern Chinese port city of Guangzhou, also known as Canton, The location of Guangzhou made it a significant trading port with numerous ties to

the world outside of China. News of the California Gold Rush attracted many

Chinese peasant farmers to California, which became known as the "Gold

Mountain" that offered dreams of financial success (So, Lin & Poston, 2001).

Eventually most of the Chinese immigrants became laborers until immigration was

halted with the Chinese Exclusion Act of 1882. (Lee, 1997).

Hong Kong Chinese began to immigrate to the United States in the second

wave and comprised the majority of Chinese immigrants in the third wave of

immigration from 1965 to present. Despite the enormous economic growth in Hong

Kong, the majority of Hong Kong Chinese immigrants were working-class with

limited socioeconomic mobility. Many were attracted by employment and

educational opportunities that were unattainable for them in Hong Kong (i.e.

tuition-free public schools) (Lee, 1997). Immigrant families often relied on their

children's education to provide upward mobility. However, those with established

trade skills (home construction, culinary) or experience with small businesses were

able to achieve some financial success. Immigration also increased due to family

sponsorships, word-of-mouth success, and the establishment of Chinatowns in the

United States (So, Lin & Poston, 2001).

The location of both Hong Kong and southern China were pivotal to U.S.

immigration. Both Hong Kong and southern Chinese were motivated to emigrate in

order to obtain "the American Dream" of opportunities which were unavailable and

unattainable for them at home. The Chinese American community in San Francisco

reflects the unique complexity of AA/PI identity in the United States influenced by

acculturation and the negotiation of cultural values and norms.

Acculturation

This section will discuss the role of acculturation in the AA/PI community.

I will then discuss three models of acculturation to the AA/PI experience and their

strengths and limitations in applicability.

The degree of acculturation is an important construct in understanding the

AA/PI community as it highlights the heterogeneity of intra-ethnic group differences

(Chang, Tracey & Moore, 2005; Kim et al., 1999; Kim & Omizo, 2006; Sue & Sue,

2003). One of the earliest definitions of acculturation was offered by Redfield,

Linton and Herskovits (1936) as "those phenomena which result when groups of

individuals sharing different cultures come into continuous first-hand contact, with

subsequent changes in the original culture patterns of either or both groups" (p. 149).

Recently, Kim et al. (1999) defined acculturation as "the differences and changes in

values and behaviors that individuals make as they gradually adopt the cultural

values of the dominant society…" (p. 342). Since AA/PIs represent a minority in the

United States, they are likely to experience acculturation to the dominant Western

culture. However, varying degrees of acculturation may be determined by length of

generation (Kim, et al., 1999). For example, a fourth generation Filipino American

may have adopted more values and behaviors of the dominant culture compared to a

recently immigrated Vietnamese-American. Berry, Kim, Power, Young and Bujaki

(1989) further proposed that acculturation manifests in behavior, identity, values and

attitudes.

Previous empirical studies assert acculturation is related to several social

adjustment variables which affect the AA/PI community (Atkinson & Gim, 1989;

Gim, Atkinson & Kim; 1991; Kim & Omizo, 2006; Kung, 2003; Le & Stockdale,

2008). One of these assertions is that acculturation is related to how AA/PIs perceive

mental health services. For example, in a study of 1,735 Chinese Americans, Kung

(2003) found higher rates of acculturation were correlated to a higher tendency to

seek help for emotional distress from informal sources, like friends and family, than

from professional sources. However, those with diagnosable Diagnostic and

Statistical Manual, Fourth Edition, Text Revision, (DSM-IV-TR) mental disorders

were more willing to seek help from professional sources than informal sources. In

another study, Gim, Atkinson and Kim (1991) suggest cultural sensitivity and ethnic

similarity of clinicians to clients are important in serving less acculturated AA/PIs.

Another belief is that acculturation is related to familial conflicts. For example, Le

and Stockdale (2008) found in a sample of Cambodian, Chinese, Laotian/Mien, and

Vietnamese individuals, acculturative dissonance—the difference in acculturation

degree between a parent and child—was a significant predictor of peer delinquency

and severe violent behaviors. Acculturation is also related to overall psychological

well-being. For example, Kim and Omizo (2006) found that higher rates of

acculturation were related to higher cognitive flexibility (willingness to adapt to

situations), general self-efficacy (willingness to initiate behaviors for specific goals)

and collective self-esteem (self-worth based on a role in a social group). Thus,

acculturation is an important construct to understand intra-group differences within

the AA/PI community (Chang, Tracey & Moore, 2005).

Acculturation models

There are currently three models that assess acculturation for the AA/PI

community. The models include the following: the Suinn-Lew Self Identified

Acculturation Scale (SL-ASIA) created by Suinn, Rickard-Figueroa, Lew, and Vigil

(1987); Berry's (1989) model of acculturation; and the Racial/Cultural Identity

Development model (R/CID) created by Sue and Sue (2003). The SL-ASIA (1987)

is a one-dimensional acculturation model while Berry's (1989) model and R/CID

(2003) are two-dimension in design. All three models are designed for individuals

who identify with Asian culture, identify with American culture or those who

identify with both cultures.

Suinn-Lew Self Identified Acculturation Scale

The SL-ASIA (1987) has been used frequently in the past two decades in research on counseling AA/PIs in over 16 empirical studies (Ponterotto, Baluch & Carielli, 1998). The model views acculturation on a single dimension, with a range of Asian-identified as a category on one spectrum, bicultural in the middle, and Western-identified on the other end of the spectrum. The one-dimension assumes that if an individual identifies more closely with one culture, then the individual identifies less with the other culture; thus the degree of acculturation is defined by two dependent culture variables (Chang, Tracey & Moore, 2005).

The 26-item SL-ASIA (1987) measures acculturation by assessing identity, language, attitude, friendship choice, and generation level. Although the SL-ASIA (1987) has been deemed reliable for various AA/PI ethnic groups in the United States, with coefficient alphas ranging from .83 to .91, it has been shown to be limiting since it was primarily developed with college-level students as the sample (Ponterotto, Baluch, & Carielli, 1998). Ponterotto, Baluch, and Carielli (1998) found a decrease in reliability on non-college level AA/PI groups as the coefficient alpha decreased to .79 for English-speaking Asians in Singapore, to .72 for Japanese international students and to .68 for Cambodian/Vietnamese refugees. Another

limitation to the SL-ASIA is the one-dimensional model. The one-dimensional

model suggests an individual can only identify with a culture dependent on

identification with the other culture. For example, if an individual identifies 35%

with Asian culture, the remaining 65% is identified with American culture.

Two-dimension models on the other hand, places Asian and American culture on

two separate dimensions. The models are able to measure identification to either

culture independent of each other. For example, an individual can identify 80% with

Asian culture and 75% with American culture. Thus, the one-dimension model

offers less insight on the process of AA/PI acculturation compared with the

two-dimension models of Berry (1989) and the R/CID (2003) (Chang, Tracey &

Moore, 2005).

Berry's model of acculturation

Berry's (1989) model of acculturation suggests acculturation is comprised

of two independent dimensions of ethnic group identification and dominant group

identification. These two dimensions define the following four distinct acculturation

modes: a) integration; b) assimilation; c) separation; and d) marginalization. In

integration, the individual values both ethnic and dominant group cultures. In

assimilation, the individual only values the dominant group culture. In *separation*,

the individual only values the ethnic group culture; and in *marginalization*, the

individual values neither culture. In the integration mode, the model accounts for the

individual to value both ethnic and dominant culture at varying levels independent

of each other. For example, an individual can highly value both ethnic and dominant

cultures, rather than be forced to negotiate between the two, as the SL-ASIA (1987)

model requires (Ponterotto, Baluch, & Carielli, 1998).

Racial/Cultural Identity Development model

Sue and Sue (2003) developed the (R/CID) by integrating past ethnic

identity models including Cross's (1971) model of Black racial identity development

model and Kim's (1981) Asian American identity developmental model. The R/CID

consists of five linear stages: 1) conformity; 2) dissonance; 3) resistance and

immersion; 4) introspection; and 5) integrative awareness. Within each stage, there

are four separate beliefs on how the individual evaluates the self, others of the same

ethnic group, others in a different ethnic group, and others in the dominant group.

The *conformity stage* is when the individual holds positive attitudes

toward the dominant group and negative attitudes towards one's own and other

ethnic groups. The *dissonance stage* is when the individual is conflicted with

vacillating attitudes of one's own ethnic group, other ethnic groups, and the

dominant group. The *resistance and immersion stage* is when the individual holds

positive attitude to one's own ethnic group, empathy for other ethnic groups and

negative attitudes toward the dominant group. The *introspection stage* is when the

individual reassesses one's own attitude towards their own ethnic group and the

dominant group to less rigid perceptions. The *integrative awareness stage* is when

the individual appreciates both positive and negative aspects toward all groups and

feels secure, with minimal psychological costs to one's own identity. The dissonance

and introspection are transitional stages while the other three stages are more

grounded in identifying with ethnic and dominant cultures similar to the SL-ASIA

(1987) and Berry's (1989) model. The distinction of the R/CID (2003) is that stages

are linear and sequential over time versus the static stages of the other two models.

The R/CID offers a comprehensive understanding of acculturation of ethnic groups

but it does not account for intra-group differences among the AA/PI community

(Chang, Tracey, & Moore, 2005).

These three models offer a conceptual framework to AA/PI acculturation

in terms of understanding the relationship between identification with one's own

ethnic culture and the dominant culture. However, the SL-ASIA (1987) is restricted

to a one-dimensional spectrum which does not fully allow for an integrated view of

biculturalism in individuals. On the other hand, Berry's (1989) model and the R/CID

(2003) are structurally restricted in terms of their rigid domains: individuals may not

exhibit the behaviors or attitudes to fit into just one domain; instead, individuals may

fit in between two or several domains at once. The two models do not offer how

individuals can be assessed fluidly and do not account for adherence to cultural

values, an essential component to acculturation (Kim, et al, 1999).

Cultural values in acculturation

The three acculturation models highlight the components of identity and

attitudes in the process of acculturation but are not explicit about assessing cultural

values. Kim et al. (1999) assert cultural values should not be neglected in

acculturation as "the essential core of culture consists of traditional ideas and

especially their attached values" (Kroeber & Kluckhohn, 1952, p. 181). Kim et al.

(1999) suggest the current models of acculturation for AA/PIs are limited due to

their lack of assessing adherence to dominant (Western) and Asian cultural values.

Therefore, assessing adherence to cultural values is a vital aspect to AA/PI identity.

Sodowsky, Kwan and Pannu (1995) suggest first-generation AA/PIs may adopt

behaviors of the dominant culture (e.g. English language preference) at a faster rate

than the cultural values of the dominant culture (e.g. individualism). The authors

found behaviors are adopted first because they are needed to survive economically.

However, there are fewer reasons to adopt values at the same rate. For example,

changes in diet may emerge first with an increased intake of American food

depending on costs and availability of ethnic food ingredients. Thus, a distinction

between behaviors and cultural values may change as they occur in the acculturation process (Sodowsky, Kwan and Pannu, 1995).

The different rates in acculturation of behaviors and cultural values can be understood as *enculturation*. Kim and Hong (2004) defined enculturation as "the process of retaining one's indigenous cultural values, behaviors, knowledge and identity" (p. 15). Researchers argue enculturation is an additional dimension in understanding intra-group difference among AA/PI acculturation (Kim & Hong, 2004; Kim & Omizo, 2006; Shea & Yeh, 2008). In addition to adopting the behaviors and values of the dominant culture, enculturation is related to psychological concepts of help-seeking attitudes (Shea & Yeh, 2008) and perceived stigma in seeking or to seek counseling (Kim & Omizo, 2003; Miville & Constantine, 2007). Kim et al. (1999) believe assessing enculturation of one's own ethnic cultural values is a better predictor to psychological concepts than assessing behaviors because the conflict of Asian values to Western values affects individual well-being greater than conflict of behaviors.

Asian Values Scale

Kim et al. (1999) developed the Asian Value Scale (AVS) as a psychometric tool to assess enculturation. The AVS was developed to explore relationships of adherence to Asian cultural values and counseling concept; for example, the AVS

can illuminate the relationship of Asian cultural values to attitudes of seeking mental health services (Kim et al., 1999). In the development of the AVS, Kim et al. (1999) reviewed literature on Asian cultural values and distributed a nationwide survey to 103 Asian American psychologists. They then conducted three focus groups comprised of 765 AA/PI professionals and college-level students and conducted three separate studies for confirmation of internal consistency, validation, and test-retest reliability. This resulted in a 36-item Asian cultural values instrument on a 7-point Likert scale. The resulting AVS had a coefficient alpha of .81 and .82 in internal consistency from two separate studies and a coefficient of stability of .83 for the sample who completed the AVS twice over two weeks (Kim et al., 1999). The AVS demonstrated reliability in assessing Asian cultural values among AA/PI professionals and college-level students. The researchers also found AVS scores changed slower than SL-ASIA (1987) scores over a two-week period which supports Sodowsky, Kwan and Pannu (1995) suggestion that Western values are adopted slower than Western behaviors.

One of the limitations in using the AVS is its limited applicability to the AA/PI community. Although the sample was diverse in terms of age, generation and residence, the education criteria were limited to college-level or higher. The recruitment method only involved AA/PI professionals and college-level students

from Hawaii and California universities which excluded AA/PIs who were not in college and who do not have a college-level education. The Current Population Survey (CPS) administrated by the U.S. Census in 2004 found 27.05% of AA/PIs 25 years or older hold a Bachelor's degree or higher (U.S. Census Bureau, 2007). Thus, the AVS, in terms of demonstrability, may be limited to AA/PIs with a college-level education and not for the majority of AA/PIs who are less educated and/or from a lower socioeconomic background (Kim et al., 1999).

The AVS is also limited in terms of language availability. The AVS was developed in English for an English-speaking sample. The U.S. Census (2000) found more than a third of AA/PIs are non-English speakers or speak very limited English at home. Thirty-seven percent (3,962,270) of AA/PIs surveyed stated their language abilities to be "Non-English at home, English spoken less than very well." (Reeves & Bennett, 2004) Thus, the AVS did not account for the Asian cultural values of non-English speakers who are a significant portion of AA/PIs in the United States. Another limitation of the AVS is the disproportion of certain AA/PI ethnic groups in the sample. The 36 Asian cultural values may be more salient for the overrepresented groups and less salient for the underrepresented (Kim & Hong, 2004). For example, Filipino, Chinese and Korean ethnic groups represented over 50% of the sample, while Laotian and Asian Indian together represented less than

5%. Overall, these three limitations create a significant disadvantage in utilizing the

AVS for research for marginalized AA/PI groups who are not college-educated,

non-English speakers and/or who represent a minority AA/PI ethnic group in the

United States.

Asian Values Scale-Revised

After several uses of the AVS in counseling outcome studies, Kim and

Hong (2004) revised the AVS with the Rasch model, which resulted in the Asian

Value Scale-Revised (AVS-R) assessment tool. Kim and Hong (2004) assert that the

AVS required revisions to address the limitations identified by previous studies that

employed the instrument. The limitations include questionable independent strength

of the 36 Asian cultural value statements and ambiguity between categories of

agreement in the 7-point Likert scale. The Rasch's model is used to analyze the

relationship outcome between a trait level and the item's difficulty level (i.e., in

determining the appropriate order of questions in a survey). The Rasch model was

chosen because of its history of rigorous analysis in psychometric assessment tools

to increase validity (Kim & Hong, 2004). Kim and Hong (2004) evaluated the AVS

with the Rasch model on the components of test of category use, dimensionality, and

appropriateness of difficulty level. The sample data of 618 AA/PI college students

from California, Hawaii and Maryland. were obtained from past studies that used the

AVS as a measurement. The revision resulted in a 25-item questionnaire of Asian

cultural values from the original 36 items and a 4-point Likert-type scale (1 =

strongly disagree; 4 = strongly agree) from the original 7-point scale. The AVS-R

had a person separation reliability of .80, compared to internal consistency

coefficients of .81 and .82 of the original AVS. There is also significant validity

between the original AVS and the AVS-R with a Pearson correlation coefficient

of .93 (p = .000) (Kim & Hong, 2004). The Rasch model improved the AVS-R by

strengthening the Asian cultural value statements and reducing the category of

agreement to 4-point Likert because the 7-point Likert was redundant.

However, the limitations of the AVS discussed previously were not

addressed by the modified AVS-R. The AVS-R was revised with similar sample

traits from the original AVS, with college-level students from Hawaii and California

universities with the addition of students from Maryland.. The AVS-R was revised

only in English, and again, did not take any other languages into consideration.

Additionally, the top three ethnic groups in the sample, Chinese (24.6%), Korean

(22%) and Filipino (13.9%), are identical to the sample in the original AVS. Thus,

Filipino, Chinese and Korean cultural values may be overrepresented in the AVS-R

versus other groups (Kim & Hong, 2004). Like the AVS, the AVS-R may only be

applicable to college-level university students, thereby limiting the overall

applicability of utilizing this scale for research.

Themes in Asian cultural values

Despite the limitations of the AVS-R, the instrument does provide a comprehensive and rigorous review of Asian cultural values shared among many AA/PI ethnic groups (Asian Indian, Thai, Cambodian, Chinese, Filipinos, Hmong, Japanese, Koreans, Laotians, Taiwanese, Vietnamese and multi-ethnic Asian Americans) in the United States (Kim & Hong, 2004). Although not all AA/PI ethnic groups share similar cultural values, Uba (1994) cites many ethnic groups collectively share cultural values grounded in the belief systems of Confucianism, Taoism and Buddhism. In the development of the AVS and revision of the AVS-R, Kim, et al. (1999; Kim & Hong, 2004) identified six themes related to the three influencing belief systems in Asian cultural values. The six themes are the following: collectivism, conformity to norms, filial piety, family recognition through achievement, emotional self-control, and humility.

Collectivism is the core theme that underscores the other five categories. Collectivism in Asian culture is defined as prioritizing the needs and values of extended families with obedience, duty, and interpersonal harmony from the individual (Kim et al., 1999; Kim & Hong, 2004; Shea & Yeh, 2008; Uba, 1994). In short, the family and group needs precede the individual's desires. Reciprocation to

and from others is expected to create interdependence of the family (Uba, 1994).

Additionally, the self is defined by one's relationships with others (Kung, 2003).

Putting one's own needs ahead of others is often frowned upon and discouraged as it

is perceived to be self-serving and disruptive to group harmony (Uba, 1994).

 Conformity to norms is an emphasis to conform to the norms of the group,

whether it is the dominant group or one's own ethnic group. Conformity to norms

stem from collectivism to ensure survivability and to avoid ostracism by the group

(Kim et al., 1999; Uba, 1994). For example, immigrant parents often avoid teaching

their native language to their children and encouraging them to only speak English

at home to ensure English proficiency.

 Filial piety is the expectation of respect toward parents, adults and

ancestors. Filial piety is the emphasis to take care of and support elders with

unquestioned obedience (Uba, 1994). Rebellion, confrontation, and bringing shame

to the family is highly discouraged (Kung, 2003). An example of filial piety is when

an individual majors in marine sciences and minors in art in order to fulfill the needs

of the parents and self, with a greater emphasis placed on satisfying the parents'

needs before the individual's needs.

 Family recognition through achievement is the emphasis of elevating the

status of the family through achievements (Uba, 1994). Achievement is gained by

self-discipline, hard work, education attainment, and career attainment (Kung, 2003).

For example, the social status of parents with children in prestigious careers will rise

in the community as they are perceived as successful parents. Community members

may turn to these parents for parenting advice and referrals. At the same time,

personal failure can bring shame to the entire family (Uba, 1994). For example, a

family member diagnosed with a mental health disorder may indicate the family

failed to properly raise their child effectively. Different AA/PI ethnic groups

associate mental health issues with negative connotations of hereditary weaknesses,

supernatural punishment or curse, poor diet, organic factors, and poor emotional

self-control (Uba, 1994).

Emotional self-control represents the esteemed trait to contain, regulate,

and restrict the emotional needs and wants of the self. Emotional self-control is

required to ensure collectivism and that filial piety is attained (Kim & Omizo, 2006;

Uba, 1994). An example of emotional self-control is when an individual withholds

expressing feelings of frustration to relatives who decide to treat a mentally ill

family member at home, rather than seek professional services. The goal of

emotional self-control is to limit self-awareness on some level, which may lead to

independence or self-will. Thus it could lead to straining filial piety and eventually

lead to bringing shame onto the family.

Humility is the emphasis to be humble and modest about one's own

achievements. Humility is encouraged for group harmony to reduce tension and

envy (Lee, 1997; Uba, 1994;). For example, an individual chooses to state, "Oh I'm

still in school" rather than assert "I'm a pre-doctorate graduate student studying

biochemical engineering at Harvard." AA/PI adherence to the six Asian cultural

themes identified in the AVS-R plays a significant role in perceptions of mental

health services. Empirical studies which used the AVS and AVS-R found AA/PI

college-level students with strong adherence to Asian cultural values held lower

levels of willingness to seek psychological help, attach perceived stigma (Kim &

Omizo, 2003; Miville & Constantine, 2007) and held less positive attitudes to

mental health services (Miville & Constantine, 2007; Shea & Yeh, 2008). Kim and

Omizo (2003) found, when controlling for generation status, gender and previous

counseling experience, emotional self-control and conformity to norms were most

related to negative perceptions of mental health services.

Underutilization of mental health services

This section will discuss the underutilization of mental health services

among the AA/PI community. I will explore the barriers to services on both cultural

and institutional levels that contribute to underutilization.

Researchers have found AA/PIs have historically underutilized mental

health services in the United States (Abe-Kim et al., 2007; Kung, 2003; Matsuoka,

Breaux & Ryujin, 1997; Sue & McKinney, 1975; Uba, 1994). Underutilization is

defined as the under use of mental health services based on the AA/PI population

compared to the general population and/or other ethnicities, particularly European

Americans (Uba, 1994). Underutilization of mental health services has been

documented for over thirty years. In their study over a three-year period, Sue and

McKinney (1975) found AA/PIs accounted for 0.7% of clients in 17 community

mental health clinics in Seattle, while making up 2.4% of the city's overall

population. In another study, Sue and Sue (1974) found Chinese and Japanese

American college students accounted for 4% of clients at a university mental health

clinic while making up 8% of the student population. Both studies found AA/PI

clients exhibit more psychotic features than the control groups. The researchers

suggested the higher rate of psychotic features is influenced by cultural factors that

inhibit self-referrals to professional help early in the development of mental health

issues. Thus, AA/PIs may not have lower rates of mental health issues, but rather,

that there are barriers for AA/PIs to seek professional help. However, the study was

limited due to not taking utilization rates of other non-Asian ethnic groups into

consideration.

　　　　More recently, studies with a larger sample size have shown similar

underutilization patterns (Abe-Kim et al., 2007; Matsuoka, Breaux & Ryujin, 1997).

Matsuoka, Breaux & Ryujin (1997) analyzed AA/PI utilization rates of all types of

mental health services (state and county mental hospitals, residential treatment

centers, multi-service mental health organizations, etc.) with data from the National

Institute of Mental Health (NIMH) conducted in 1986. The study found AA/PIs were

three times less likely to utilize mental health services compared to European

Americans. In a state-wide comparison with large and moderate size AA/PI

populations, Colorado was the only state that had no significant utilization rates

between AA/PIs and European Americans (Matsuoka, Breaux & Ryujin, 1997).

Although this study highlights the overall utilization rates of AA/PIs, it does not

account for within-group differences (e.g., immigrant status).

In another national study, Abe-Kim et al. (2007) examined the utilization

rate of mental health services among immigrant and U.S.-born AA/PIs. The

researchers found 8.6% of AA/PIs utilized multiple services (primary medical care,

mental health care, human service providers, alternative services) for mental health

issues compared to 17.9% of the general population. The study also found that first

and second generation AA/PIs utilized services at 7.4% and 8.1% respectively

compared to 19.3% of third generation AA/PIs. However, they did not find any

associations with utilization rates to language and years in the United States for

31

non-U.S. born AA/PIs (Abe-Kim et al., 2007). This study continues to echo the

underuse of mental health services among AA/PIs but most importantly, it found the

underuse is more prevalent among first and second generation AA/PIs. Although the

study did not determine any barriers to professional service to mental health issues

for 1st and 2nd generation AA/PIs, a number of studies suggest underutilization of

services is associated with socio-cultural barriers.

Barriers to treatment

Previous studies have found underutilization of mental health services for

AA/PIs related to socio-cultural barriers on both cultural and institutional levels

(Atkinson & Gim, 1989; Chang, Tracey & Moore, 2005;Gim, Atkinson & Kim,

1991; Kung, 2003; Shea & Yeh, 2008). The cultural level consists of the degree of

acculturation and adherence to cultural values. The institutional level consists of the

model minority myth and the lack of culturally sensitive mental health providers.

Acculturation

On the cultural level, underutilization of mental health services is

understood by the conflict between Western psychotherapy and AA/PI beliefs,

attitudes, and values (Atkinson & Gim, 1989). Conflict arises from value differences

between the two. The basis of Western psychotherapy is solving issues in an

interpersonal relationship between a therapist and client. However, Asian cultures

generally value keeping and resolving interpersonal issues within the family (Uba, 1994). The degree of acculturation affects the intensity of these conflicts depending on the individual's adherence to Asian cultural values. For example, Atkinson and Gim (1989) found college-level students, who scored high on the SL-ASIA (which demonstrated being more acculturated), were more open to seeking Western psychotherapy and were more open to discuss personal issues with a therapist compared to those who were less acculturated. In the development of the SL-ASIA, Suinn, Rickard-Figueroa, Lew, and Vigil (1987) hypothesized that higher acculturated AA/PIs shared more similar behaviors and values to European Americans. Thus, those who were more acculturated may encounter fewer conflicts to Western psychotherapy.

In another study, Mallinckrodt, Shigeoka & Suzuki (2005) found acculturation affects how AA/PIs perceive mental health issues. The researchers compared the results of an etiology beliefs survey filled out by both AA/PI college students and mental health professionals. They found that those who scored higher on the SL-ASIA (which demonstrates being more acculturated) had more similar scores to the professionals than to those who were less acculturated. The study suggests the similar scores of more acculturated AA/PIs and professionals may hold fewer conflicting mental health etiology beliefs, thus, indicating that more

acculturated AA/PIs may be more open to Western psychotherapy (Mallinckrodt,

Shigeoka & Suzuki, 2005). However, because this study is based on a sample

population of primarily college-level students, it is limited in applicability since it

cannot be generalized to other AA/PIs in the community who may not have a

college-level education.

Furthermore, few studies of acculturation and mental health services exist

that recruit non-college-level students outside of university campuses. Kung (2003),

however, analyzed secondary data from the Chinese-American Psychiatric

Epidemiological Study with 1,735 participants in a large metropolitan area (Los

Angeles County). Kung (2003) found that highly acculturated Chinese Americans

were more likely to seek help for emotional distress from informal and professional

sources than less acculturated Chinese Americans. This finding aligns with studies

of samples of college-level students that demonstrate acculturation affects the

willingness of AA/PI individuals to seek mental health services. In addition, Kung

(2003) also found 19% those who had a DSM-IV-TR diagnosable disorder utilized

medical or mental health services compared to 40% of the general population. This

finding suggests Chinese Americans, despite having a diagnosable disorder,

underutilize services for psychological issues. Although acculturation affects how

mental health services are perceived, is it especially important to examine the

specific cultural values that may conflict with Western psychotherapy.

Cultural Values

In addition to the degree of acculturation, adherence to Asian cultural

values is related to underutilization of mental health services. Studies have found

AA/PIs with higher adherence to cultural values held less positive attitudes to

seeking Western psychotherapy and attached more stigma to these services (Kim &

Omizo, 2003; Miville & Constantine, 2007; Shea & Yeh, 2008). The Asian cultural

values of *emotional self-control* and *filial piety* may greatly influence the

underutilization of services (Miville & Constantine, 2007; Shea & Yeh, 2008; Uba,

1994). Both cultural values contribute to the stigma of seeking help for mental

health issues.

As previously discussed, emotional self-control to regulate and control

emotional needs and wants from the self is valued in the AA/PI community (Kim &

Omizo, 2006). The strength of emotional self-control is perceived by how well one

regulates one's own emotions. Further, psychological issues and disorders that

manifest in emotional distress suggest the individual has poor emotional self-control.

Further pressure is placed on the family to contain and resolve individual difficulties.

Therefore, when there is a social expectation for the individual and family to

manage the internal self, it may be difficult to seek community or professional help

because it can shame the family (Uba, 1994). According to Atkinson and Gim (1989) "…Asian Americans may try to resolve their problems on their own, believing that mental health can be maintained by avoiding bad thoughts and exercising willpower" (p. 209). Expressing feelings to a professional in a therapeutic context may be unnatural and embarrassing. The stigma attached to services is supported by studies that found AA/PIs tend to only seek help once symptoms are most severe (Kung, 2003; Matsuoka, Breaux & Ryujin, 1997).

Filial piety is another cultural value that amplifies the stigma attached to mental health services. Filial piety is the expectation to respect parents and adults through conformity to social norms and achievement (Uba, 1994). Admittance to mental health issues is especially shameful to a family. It suggests the family has poor child-rearing skills which contributes to poor emotional self-control of the individual (Miville & Constantine, 2007). Although mental health issues can be attributed to heredity, it is especially shameful to suggest the family has hereditary flaws (Uba, 1994). Often times, families are reluctant to openly discuss mental health issues as they are often regarded as "family secrets" (Kim & Omizo, 2003). This was supported by Kung's (2003) study that found Chinese Americans with immigrant parents were less willing to seek help from friends and families to avoid bringing shame onto the family. Both cultural values of emotional self-control and

filial piety contribute greatly to the stigma attached to mental health services which

therefore lead to the underutilization of such services. However, barriers to services

also exist on the institutional level.

Model minority myth

Socio-cultural barriers to mental health services on the institutional level

include the model minority myth and lack of cultural sensitive mental health

providers. The model minority myth is the core foundation to institutional barriers as

institutions continue to adhere to the myth by underestimating the need of AA/PIs

(Uba, 1994). The term "model minority" was first described in the mid-1960s by

William Peterson for minority groups that have idealistically adapted and achieved

success in the United States (Sue & Sue, 2003). The model minority is often

associated with AA/PIs due to equal or higher levels of socioeconomic status,

education attainment and occupational prestige compared to the other ethnic

minority groups (Reeves & Bennett, 2004). This has been perpetuated frequently in

the media, most notably in popular media such as *Newsweek* and *Time* and *60*

Minutes (Le, 2010). However, many have argued that the model minority is a myth

and a volatile stereotype, since the stereotype over-emphasizes AA/PI success and

de-emphasizes the problems and psychological costs AA/PI continue to face (Miller

& Garran, 2008; Sue & Sue, 2003). The assertion that the model minority is a myth

has been supported when looking at within-group differences among the AA/PI

community as some group needs may be overlooked (Le, 2010; Sue & Sue, 2003).

As stated earlier, AA/PIs are not a homogenous group, but when perceived as one, it

is often misleading. While it is true some AA/PIs have achieved success, not all

groups have attained this, particularly immigrants, refugees, Southeast Asians and

Pacific Islanders (Le & Stockdale, 2008; Sue & Sue, 2003; Uba, 1994). Catering to

the model minority myth may leave out crucial services that these specific groups

may need due to their immigration or refugee status or trauma from their

immigration experience.

In short, institutions that adhere to the model minority myth may perceive

that AA/PIs face fewer issues (Sue & Sue, 2003). The lower utilization rates of

mental health services for AA/PIs contribute to the myth as it suggests AA/PIs

encounter less psychological issues since they don't seek services (Uba, 1994). Thus,

institutions may de-emphasize the need for services in AA/PI communities by

providing less outreach, language services and cultural competency. The myth also

suggests if AA/PI can adapt successfully in the United States, then they, too, can

resolve issues at a faster rate (Le, 2010). The myth is reinforced by AA/PIs who

value the trait of emotional self-control. AA/PIs who adhere more to this value may

be more reluctant to discuss psychological issues outside of informal sources (e.g.,

friends and family). This creates fewer demands for institutions to direct resources to

reach out and provide AA/PIs specific services (Kung, 2003; Sue & Sue, 2003).

Conclusion

This literature review explored AA/PI culturally-specific barriers to mental

health services by examining Asian cultural values and AA/PI acculturation. These

barriers were discussed in relation to AA/PI underutilization of mental health

services. As illustrated, the majority of previous research findings on AA/PIs and

mental health services were derived from quantitative data with college-educated

AA/PIs. Although previous research laid the groundwork of mental health service

needs for AA/PIs empirically, a lack of qualitative data may suggest more can be

explored in the AA/PI community. By capturing qualitative data, this qualitative

study strives to demonstrate the value of AA/PI narratives in illuminating how

individuals manage and possibly overcome socio-cultural barriers. The following

chapter discusses the methodology of data collection for this study.

CHAPTER III

METHODOLOGY

Research Design

The purpose of this qualitative exploratory study is to illuminate the

narrative experience of AA/PI individuals and explore the possible socio-cultural

barriers they may have *encountered* and possibly *overcame* in accessing community

mental health services. My research questions are the following: what influences

AA/PIs' decision to seek or receive treatment? What role do cultural factors have on

AA/PIs when encountering and/or overcoming barriers to community mental health

services? The study has two goals: 1) to explore the possible AA/PI specific

socio-cultural barriers to services and 2) to discover the factors and techniques

AA/PI individuals utilized to overcome these barriers.

Unlike previous studies that primarily collected quantitative data with

surveys and instrument tools, this study interviewed participants to address the lack

of qualitative data on AA/PIs and mental health in the social work field. Gathering

qualitative data was purposely selected in order to delve deeper into the subjective

experience of mental health treatment, a sensitive and stigmatized option for health

care in the AA/PI community (Rubin & Babbie, 2007). This study explored AA/PI narrative experiences in accessing community mental health services, which previous empirical studies have not addressed. This study is exploratory in design in order to amplify qualitative data in hopes of exploring experiences beyond researcher-devised surveys and instruments.

Criteria for Sample Selection

A total of four individuals participated in the study. I recruited my participants based on four specific inclusive criteria: a) participants must identify as Asian American/Pacific Islander, b) participants must be receiving or have received mental health services; c) participants must be able to read, speak, and understand conversational English; and d) individuals must be 18 years of age or older. Exclusion criteria included not having minors participate, since services are not often voluntary and to exclude non-English speakers due to lack of funding to hire interpreters.

The overall method of my sample selection is *non-probability*, with a theoretical sample focus. My sample choice is influenced by research suggesting AA/PIs underutilize mental health services due to cultural and institutional barriers. Therefore, *purposive sampling* is used to recruit atypical cases of AA/PIs who have received or are currently receiving services. An extensive process was required to

recruit participants who fulfilled the four specific inclusion criteria.

Recruitment Process

To find my sample population, I approached four separate community mental

health agencies under the City and County of San Francisco Community Behavioral

Health Services (CBHS) in San Francisco, CA. The agencies include the following:

Southeast Child Family Therapy Center, Sunset Mental Health clinic, Richmond

Area Multi-Services, Incorporated (RAMS) Adult Outpatient, and Personal Assisted

Employment Services Counseling and Pre-Vocational Services (PCS). The agencies

were selected because they serve four different districts with significant AA/PI

population and provide subsidized services for low-income individuals and families.

Recruiting at agencies also ensures participants are receiving or have received

mental health services. After receiving initial support from these agencies, the

agencies directed me to the research, evaluation, and quality management

department of CBHS for review. CBHS agreed to review and approve the study

within a week after my submission of the letter of approval (Appendix A)from the

Smith College Human Subject Committee. After I submitted the letter of approval,

CBHS took four weeks to grant me the final approval to recruit despite my weekly

check-in.

After receiving CBHS approval, I gave a presentation at the four community

mental health agency staff meetings that entailed the following: I requested 15

minutes for my presentations with the average time ranging between 8 and 15

minutes in length. I provided all the recruitment materials for each individual agency.

The recruitment materials included 30 copies of the *description of the study* form

(Appendix D) and 30 copies of the *informed consent packets* (Appendix C)—this

packet included an informed consent form, a contact information sheet, and a

self-addressed stamped envelope. The description of the study form provided

instructions for clinicians to identify and recruit participants.

I followed a structured format for all presentations. The format included the

following outline: self-introduction, study objectives and research questions,

examples of socio-cultural barriers to mental health services, the nature of

participation, clinicians' recruitment role and questions and answers. I handed out

the description of the study forms after my self-introduction and passed out

informed consent packets before the questions and answers. Range of questions

raised by clinicians included clarification of clinicians' recruitment role, clarification

of additional participant criteria (e.g. psychotic clients), recruitment window time,

and number of participants needed for the study. I concluded the presentation by

reviewing my contact information, listed in the description of the study form for

additional questions.

After the first presentation, a clinician suggested providing flyers to aid in recruitment. I then provided 30 flyers for each of the next three agencies. The flyers were used by clinicians as visual aid to recruit potential participants. The flyers were not posted in public.

It was imperative for me to be clear about the clinicians' recruitment role since the study participation was largely dependent on clinicians' outreach. I instructed clinicians to briefly introduce the study by uniformly asking identified clients if they wanted to voluntarily participate in a research study about their experience of access to mental health services, involving a 45-60 minute in-person or phone interview. Clinicians also informed clients that they would be given $25 in cash for their participation. Clinicians then gave individuals the informed consent packet if they expressed interest.

Clinicians instructed clients to keep the informed consent packet themselves and that they were not obligated to disclose their participation status. If clients refused to participate in the study, they had to discard the packet on their own. Clinicians were informed to tell participants to direct all questions regarding the study back to me. I chose this method to prevent coercion and minimize any influence on the relationship between clinician/agency and client. If clients decided to participate, they read and signed the consent form, filled out the contact

information and mailed both forms in the pre-paid self-addressed envelope within 30 days.

Within seven days of receiving signed informed consent and contact information forms, I contacted and scheduled participants for a 45-60 minute interview. Of the 120 informed consent packets I provided for the agencies, I received four confirmations from participants via mail. The four participants for my study were recruited from my field placement agency, Southeast Child Family Therapy Center.

Data Collection

The data for the study was collected through individual phone and in-person interviews between March and April of 2010. One interview was conducted in-person at an agency and three interviews were conducted over the phone. Data was collected through *semi-structured open-ended* questions. The questions format allowed for flexibility of themes and experiences which was core to the exploratory research purpose. Due to the flexibility of the semi-structured format, the interviews lasted approximately 29 to 51 minutes. The shortest interview was 29 minutes and the longest interview was 51 minutes. The mean interview length was 41 minutes. The length was dependent on the participants' willingness to elaborate on his/her narratives. The questions followed an interview guide which allowed discussion

between the participants and myself (Please see the comprehensive Interview Guide

in Appendix E).

I. DEMOGRAPHIC
- Race/ethnicity
- Age
- Place of birth and generation
- Residency
- Length in treatment
- Marital status

II. REFERRAL
- Initial feelings and reaction
- Referral

III. CULTURAL BARRIERS TO SERVICES
- Encountering barriers
- Overcoming barriers

IV. INSTITUTIONAL BARRIERS TO SERVICES
- Encountering barriers
- Overcoming barriers

V. COMMUNITY
- Disclosure to friends or family
- Alternative treatment

VI. CONCLUDING QUESTIONS
- Reasons to stay in treatment
- Agency services for you as an AA/PI

Before the interviews began, I reviewed the informed consent and answered

any questions regarding the interview process, confidentiality and how the data

would be used. I explained that the interview questions would be separated into two

categories, demographic and personal experience. I began the interviews with

demographic questions, continued with initial feelings about mental health services,

etc. as laid out in the Interview Guide (Appendix E). I generally followed the order

of questions in the Interview Guide. At times, I omitted questions that were

addressed earlier. At other times, I changed the order of questions to ensure narrative

content continuity.

The semi-structured question format allowed for additional questions to

clarify and expand on the narrative content. Because of the open-ended nature of the

questions on socio-cultural barriers, I followed-up with questions to rule-out barriers

not brought up; e.g. how important is location of the agency for you? How far would

the agency have to be for you not to go? I concluded the interviews by clarifying and

summarizing the narrative content. After the interview, I answered questions and

compensated participants $25 for their time. I gave $25 in cash for the in-person

interview and mailed $25 in check form for the phone interviews. Three interviews

were conducted entirely in English, and one interview was conducted with a mix of

English and Cantonese. I translated the Cantonese to English during transcription.

Both phone and in-person interviews were recorded with a digital audio

recorder. The phone interviews were recorded with an additional accessory of a

telephone recording device. The interviews were uploaded onto a flash drive to

ensure no data was saved on a personal computer. Once uploaded, the audio files

were appropriately renamed with a code consisting of four alphabets and numerical

value, e.g. EL55. Each alphabet and number was generated by a random drawing

process without correspondence to identifying information. Data backups were made

weekly and saved on an external hard drive. The flash drive and external hard drive

were placed in a locked cabinet when not in use.

Data Analysis

The interviews were transcribed with the assistance of software. that allowed

me to replay and adjust the speed of audio playback. I used *grounded theory*

thematic analysis to analyze the data with a combination of *open coding* and

selective coding techniques. The open coding allowed me to discover emerging

themes and units with minimized bias. The selective coding allowed me to discover

theoretical-identified themes, e.g. influence of cultural values to perceptions of

mental health services.

CHAPTER IV

FINDINGS

The purpose of this study was to illuminate the narrative experience of AA/PI

individuals who have received or currently receiving community mental health

services. This study explored the experience of *encountering* socio-cultural barriers

to accessing mental health services. But beyond examining these barriers, this study

explored how individuals *overcame* or *managed* these barriers to receive services.

The interview guide, organized in six sections, was used to capture narrative data,

divided into the following sections: 1) Demographics, 2) Initial thoughts and referral,

3) Cultural barriers to services, 4) Institutional barriers to services, 5) Staying in

treatment and 6) Community.

Key findings from this exploratory study suggest that stigma and lack of mental

health services knowledge represent major socio-cultural barriers to mental health

services for Chinese Americans. Overall, individuals overcame or managed stigma

with positive emotional and resource support from parents. In the end, participants

spoke on the lack of mental health services knowledge with referrals, clinician's

outreach in Cantonese, and unmanageable personal and family issues. This study

also found highlighted institutional factors of language services, cultural competency,

location and Medi-Cal (California Medicaid) payment acceptance collectively

played a significant role toward outreach and engagement with Chinese American

clients. Participants stayed in long-term treatment because of noticeable progress

and reduction in presenting symptoms. The majority of participants received social

support after disclosing to friends about their treatment. However, participants were

not willing to disclose their mental health treatment to extended family members to

prevent rumors and criticisms. All participants asserted they will recommend mental

health services to their community.

In the *demographic* section, participants were asked about their ethnicity, age,

generation, place of birth and length in mental health treatment.

The *initial thoughts and referral* section explored participants' initial thoughts

and feelings of mental health services and how they were referred.

The *cultural barriers to services* section explored the experience of

encountering culturally influenced barriers and what was done to overcome or

manage them. The purpose of this section was to identify factors that assisted

participants to seek services.

The *institutional barriers to services* section explored the experience of

encountering institutional barriers and how it affected participants to seek services.

The *staying in treatment* section explored what factors contributed to long-term therapy.

The *community* section explored personal disclosure to friends and family, seeking alternative treatment and whether participants would recommend services to the community.

Demographics

A total of four (n = 4) individuals participated in this study. All participants are Chinese-American. One female and three males participated in the study with three individuals identifying as 1st generation and one as 2nd generation. The youngest person was 18 and the oldest was 47 years old. The three 1st generation Chinese-Americans emigrated from the cities Guangzhong and Macau of China. The youngest age of immigration was 4 and the oldest was 33 years of age. In terms of the total number of years participants have been receiving mental health treatment, it ranged from five years to twelve years; the average was 7.25 years. All participants are still currently receiving services. Demographic details for each participant are illustrated in table 1.

TABLE 1. Demographics

	P1	**P2**	**P3**	**P4**
Ethnicity	Chinese	Chinese	Chinese	Chinese
Gender	Female	Male	Male	Male
Age	47	18	18	19
Place of birth	Guangzhong, China	San Francisco	Macau, China	Guangzhong, China
Generation	1st	2nd	1st	1st
Age of immigration	33	n/a	8	4
Residency	San Francisco	San Francisco	San Francisco	San Francisco
Years in treatment	6	6	5	12
Years in current agency	4	6	5	1
Marital status	Married	Not married	Not married	Not married

Below are brief sketches of the four participants. Some identifying details were changed to protect the confidentiality of participants.

Participant 1:

P1 is a 47 year-old 1st generation Chinese American married mother with a teenage daughter. P1 immigrated to the United States from Guangzhong, China in 1996 and has lived in San Francisco ever since. For the past five years, her daughter received individual therapy at an outpatient clinic while P1 attends family and collateral therapy sessions.

Participant 2:

P2 is an 18 year-old 2nd generation Chinese American male. He was born and raised by his single father in San Francisco and currently lives with his father and grandparents. He began receiving individual therapy at an outpatient clinic at age 12 and continues to attend sessions.

Participant 3:

P3 is an 18 year-old 1st generation Chinese American male. He was born in Macau, China and immigrated to the United States at age eight. He was raised by a single mother. He began receiving individual therapy at an outpatient clinic at age 13 and continues to attend sessions.

Participant 4:

P3 is a 19 year-old 1st generation Chinese American male. He was born in Guangzhong, China and immigrated to the United States at age the age of four. He was raised by a single mother with three other siblings. He began receiving mental health services at a group home when he was six years old. He continues to attend individual sessions.

Initial thoughts and referral

This section explores initial thoughts about mental health services, referral source and reactions to referral. This was important to explore as it is a precursor to encountering socio-cultural barriers.

Initial thoughts about mental health services

In discussing initial thoughts of mental health services, two themes emerged: *stigma* and *lack of knowledge.* Two participants, P2 and P3, described their stigma towards therapy. Both participants recalled their thoughts during adolescence right before they were referred to services.

P2: I thought it was for people with mental issues and I'm not that person.

P3: I thought it was for mentally retarded people. Like slow people. Like for people who got problems. I thought it was like, not for me. That's about it. I didn't think I needed it. I didn't think I was that kind of person.

Both participants stated "mental" and "people" as stigma to therapy. And both asserted they didn't belong in the same category. When asked what influenced their

initial thoughts about therapy, both participants referenced due to media and friends.

Both denied being influenced from their families.

The other two participants described lacking any knowledge of mental health

services before they were referred.

> P1: I don't have any knowledge for mental health services even though I was a
> nurse in China. I didn't think I needed help for mental health for my daughter.

P4 was unable to recall his thoughts before he was referred at age six, but shared his

mother's perspective.

> P4: It was new to her. She didn't know what it was. [The school counselor]
> wanted me to be placed out of home. You see, my parents were separated and
> they had four kids. My sister and brother lived with my aunt because of abuse.
> And she didn't want anymore of her kids away from home [sic].

Referral source

All four participants referenced "school" as the primary referral source to

mental health services. Two participants reported "teachers" and "counselors"

initiated referrals after observing behavioral and academic changes.

> P1: So the teacher talk to me, she said [my daughter] cannot focus on learning
> in the class. And so sometimes she cries in school and the counselor tell me I
> can get some help from somewhere. So that is why they tell me about mental
> health. …And then they chose an office close to my house.

> P2: I think counselors put me in special education classes. And they told my
> dad I should see a therapist.

P3 described his mother's concerns over his academic challenges that lead to an

on-site therapist referral.

P3: …I was getting bad grades and then like my mom went to the school and the therapist worked there I think. And they did some tests about me having ADD or some shit like that. The therapist was working there at the school. I saw her there first and then at the office (outpatient).

P4 described being diagnosed by his primary care doctor who suggested his school monitor him. His school eventually referred him to live at a group home.

P4: I think my doctor diagnosed me at a very young age, I think 5 or 6 and told my school about it. And during my school's IEP (Individualized Education Program), they decided for me to live out of home.

Although school was the primary referral source to mental health services for all participants, personal and professional sources initiated preceding concerns.

Reactions

In addition to referral information, participants were asked about their reactions. Major reactions include *parental relief* and participants' *anxiety*. Two participants described their own and their parents reactions. A total of three parents (including P1) expressed positive or mixed relief about the referrals.

P1: I was very confused about how to help [my daughter] manage her feelings. …So when the counselor tell me [sic] I can get mental health service, I really want to try it.

P3: My mom was okay with me seeing the therapist. She just wanted me to do better in school.

P4: My mom was not really okay with me living in a group home in the beginning. But after a while I think she needed some rest. She had a lot of trouble handling 4 kids. …She was overwhelmed so in the end she just went along with it.

Two participants experienced fear and anxiety about the referrals but P4, who was

referred to a group home expressed a stronger reaction.

> P4: I just remember being very scared. It was like they just took me away from my family. What could I do right? I was 6. I barely knew what was going on. I didn't understand why I couldn't live with my aunt and my brother and sister.

> P2: I didn't want to go. I was afraid of people. Like different people at the agency. …like all kinds of people that I've never seen before. …like strangers.

The parents experienced some relief after the referral although they were not fully informed about mental health services. However, the participants receiving services did not have the most positive reactions with anxiety towards meeting new people or environmental change..

Cultural barriers to services

Due to the premise of the study, the majority of the interviews focused on exploring socio-cultural barriers to mental health services. Socio-cultural barriers were divided into cultural/social obstacles and institutional obstacles to treatment. In terms of cultural and social barriers, participants were asked to recall what factors from the self, family and social environment may have held them back to seek mental health services. The most salient cultural and social barriers participants cited were a sense of *stigma* and a *lack of knowledge about mental health services*. The following section will discuss these individual barriers.

Encountering stigma

Three participants described stigma to mental health services by attaching

feelings of shame to it. Shame seemed to manifest in how participants disassociated themselves from "those people" who receive therapy.

> P2: …I'm not that person. I'm not one of those people. Like I don't have any mental issues.

> P3: Yeah I felt ashamed in the beginning. I guess there is no one else like me I guess. I didn't know anyone who needed to see a therapist.

> P4: I just knew this wasn't normal. There were many kids [at the group home] worse than me. I know I am not one of them. So like, why am I here?

Although stigma is not a direct barrier to receiving services for minors, it does affect their level of engagement in therapy. For example, P3 stated, "I would have found some way to stop therapy if my friends knew about it." When asked how he would stop therapy, he replied, "I don't know. Like not go or tell my mom it is making me worse." Despite these feelings of shame, he has been able to manage the stigma of seeking treatment and has remained in therapy for over five years.

Overcoming or managing stigma

The three participants overcame or managed stigma in different ways but share a common factor: all three received *adequate support from at least one parent* to initiate and remain in therapy. This is a key revelation as parents encouraged participants to attend by providing emotional and resource support (for example, bus passes and transportation). Parents also engaged with therapists by attending collateral and family sessions. P2's father disclosed personal information to

convince P2 to attend the first session.

> P2: My dad told me he had the same mental health problem. That's what he's been through before but he didn't see a therapist. He knows that therapy can help me out.

In addition, his father drove him to the agency for the first two months until he felt

comfortable taking the bus there. P3's mother supported him by agreeing to attend

family sessions.

> P3: My mom supported me by telling me to go. She wanted me to do better or something like that. She wanted a Chinese therapist so she can understand too. She said she will see [the therapist] too. And I'm like I guess I'll go.

P4's mother told him the group home will be a temporary stay until things got better.

She promised him he would return home and vowed she will not have three children

taken away from her. All three participants named their parents as their primary

support to receive mental health services, which was the first step to overcoming

stigma.

In addition to parental support, each participant had different ways to address

the stigma. P2 engaged in therapy to "get better" and not be perceived as someone

with mental health issues.

> P2: It's like, I'm not that person. So how can I change myself from being that person. Maybe if I got better, I won't need [therapy] anymore.

P3 took a different approach. His mother's support was enough for him to see the

on-site therapist. However, he managed the stigma by making sure his friends didn't

find out. He stressed the importance of confidentiality between him and his therapist

at school.

> P3: I would like avoid or not say hi to my therapist when she was walking around school. I think especially when my friends were around.

When asked what he thought about how his friends may perceive him, he described:

> P3: I guess I didn't want them to know. Like the first thing people think about a therapist is like "there is something wrong with you" so I guess I didn't want to tell them. So don't want them to think badly of me. I don't want them to look at me different.

He has not told any of his friends or extended family during the past five years and does not plan to in the future. P2 and P3 still identify with the stigma of mental health services but state they no longer feel ashamed of receiving it. They managed the stigma by consciously addressing the shame, either throug*h engaging in therapy or not disclosing it.* P4 on the other hand, stated he still sees the stigma, especially in the Chinese American community but he no longer internalizes it.

> P4: I've had [services] for so long. I just learned to accept it because it was what I needed. It became normal to me and I don't see any shame in it.

Lack of knowledge

The second barrier for participants, primarily the parents, is lack of mental health services knowledge. P1 and P4's mother did not have any knowledge about mental health services and struggled for a period of time until they were referred. P1 tried to help her daughter for two years before she learned about professional mental health services.

> P1: I didn't know how to help her feel more happy and handle her angry or

help her get better at math. So I spend many time [sic] with her. She had

problems for two years before the counselor told me about mental health.

P4 believes his mother knew about mental health services after his primary care

doctor suggested seeking services.

P4: I don't know if my mom knew about mental health services until after the
school had me to live at a group home. I know my brother and sister were
taken away to live with my aunt but didn't have therapy before.

Overcoming lack of knowledge

Both mothers' lack of mental health knowledge was addressed by *referrals*,

clinicians' outreach in Cantonese and a *sense of desperation*. The mothers reacted

similarly with relief when referred for services. P1 described receiving quality

service when a social worker travelled with her to a Chinatown agency but referred

her to an outpatient clinic closer to her home. P1 credited the Cantonese-speaking

clinician at the outpatient clinic for explaining therapy thoroughly to her and how it

may benefit her daughter. The clinician's gender also motivated P1 to try therapy.

P1: I think [the therapist] is very professional. [She] can speak Cantonese and
also [she] is a lady and very nice. I think my daughter prefer a lady than a man.
So I think it is good for her. So that is why I come here.

Although it was important having Cantonese-speaking clinicians reach out, both

parents experienced some desperation to help their child. P4's parents divorced after

years of domestic violence before P4 was referred to live at a group home. As a

result, his aunt had legal guardian of his older brother and sister. P4 and his sister

continued to live with the mother but she was "overwhelmed" and had trouble

managing P4.

> P4: My mom was feeling overwhelmed. I was out of control and hard to handle and [the school] wanted me to live out of home because of my behaviors. I don't think she could have handled it.

The combination of referrals, clinician's outreach and exhausting personal resources may have motivated the parents to learn about mental health services.

In addition to this combination, P1 described other factors that motivated her to learn about professional services. A couple years before her daughter was referred, her 17-year-old nephew on her husband's side committed suicide. She believes he may have been depressed but no one in the family realized or reached out. This led her to be extra cautious over her daughter.

P1 also discussed feelings of *isolation* as her only family in the United States includes her husband and two children. Although her husband's family is in the United States, she doesn't have a positive relationship with them. The isolation encouraged her to seek out other means of support.

> P1: In America, nobody help, I don't have family in America, only my husband. Since my family is in China, I can't get any help from them. So I want to get help from other people. So I come [to this agency].

Institutional barriers

The second category of socio-cultural barriers that emerged was the experience of institutional barriers. Participants did not discuss barriers on the institutional end. Therefore in the interview, I ruled out individual barriers, e.g. how important is

having a Chinese therapist? Will you see a non-Chinese therapist? Through this

process, participants revealed what barriers didn't exist. In fact, agencies played a

significant role in reducing these barriers to enable better outreach and service to the

Chinese community. These salient non-barriers are *language*, *cultural competency*,

location and *Medi-Cal payment acceptance*. These four factors encouraged rather

than impede participants to receive mental health services. All participants reported

these factors hastened and facilitated treatment after referral and the initial intake.

Language needs

All four participants discussed the importance of having Cantonese-speaking

clinicians. Cantonese-speaking clinicians allowed parents to understand mental

health services and engage in therapy. Participants who received services as minors

stressed the importance of having Cantonese-speaking clinician to communicate

with their parents; otherwise parents would not have consented to treatment. Each

participant's perspective is illustrated below:

> P1: If I don't know the meaning, then I don't get what they say. Meaning is so
> important for me to know. I also need to know the knowledge. If I don't know
> the meaning, I have to change [the therapist/agency].

> P2: Yes it was important [to have a Chinese-speaking therapist in 6th grade]. I
> can tell them my feelings. So sometimes when I don't know how to say it in
> English, I can use Chinese. …They meet with my dad once every month. He
> speaks Chinese and not very good at English. He understands but doesn't
> know how to say it.

P3: Yeah the therapist was able to speak English and Chinese. It was important because my mom would sometimes go too. So the therapist was able to talk to my mom in Chinese which was helpful. …Yeah my mom would change to a Chinese therapist if non-Chinese so she can understand too.

P4: It was very important for my mom to understand where I was going and what therapy was about. I don't think she would have let me go if she didn't understand. I think she really liked [the therapist] because she explained it very well to her.

The agencies also provided language services to accommodate non-English

speaking clients and families. Therefore language was no longer a barrier for these

participants to access services.

Cultural competency

Three participants stated the importance of cultural competency in seeing their

therapists. They believe clinicians who understand Chinese culture were better

equipped at helping them. They define cultural competency as understanding the

difference between Chinese and American cultural values and applying it in therapy.

P1: [My therapist] is Chinese. She know Chinese culture and it is very good. She can really understand my family.

P2: Yeah it was important for the therapist to understand Chinese values and culture. They need to understand how Chinese families are. …Cuz Chinese families do different things than like American families. Like we get more pressure and I think they understand that.

P4: I think Chinese therapist have a different mindset. People who are not Chinese don't understand what we went through or how things came about. Chinese therapists know the culture. …It is very important to have a therapist

who understand my culture. Very important to have a therapist who understand

me as a person.

Thus, three out of the four participants cited their clinicians were able to provide

cultural competency and was not a barrier to access services.

Geographic proximity

All four participants spoke of the convenience of location. Participants valued

that clinics were in the neighborhood, close to home and were within easy access by

public transportation. P1's first agency was a five minute drive from home. Her

current agency is within walking distance away. P3 described being motivated to see

the on-site therapist because his appointments were during class time.

P3: I guess I went to [therapy] cuz she took me out of class. So yeah I didn't
have to go to class. So it motivated me to see her.

P2, P3 and P4 currently take public transportation to their agencies which they find

convenient. Although P4 initially lived in a group home, his outpatient sites

afterwards were close to home and easy to access.

P2: It was easy for me. I would take the bus to go to therapy. When school was
over, I go there, and then talk for an hour and then take the bus home. …The
bus will take 5-10 minutes to arrive there and 5-10 minutes to go home.

P3: I took the bus to go to the office. It was an okay distance from my school
and house. The distance was not an inconvenience.

P4: Location didn't really matter. Transportation was very convenient. I think
the closer the better but it is easy to navigate the city.

The agencies located in or near at-risk communities were not a barrier to access

services; in fact, closer distance may have motivated participants to attend.

Medi-Cal coverage

All four participants had Medi-Cal to cover all mental health service expenses.

Since the agencies accepted Medi-Cal, participants did not encounter financial

barriers to services. In fact, having expenses covered made it easier to access

services. P1 reported, "everything is covered by Medi-Cal, so I don't need to worry

about my insurance or anything." When I asked what they would do if the services

were not covered, she replied, "it really depends on how much. I may not afford it. If

it is not helpful I will not pay for it." Other participants expressed the benefits of full

coverage.

> P3: I think [Medi-Cal] covered it. I don't think my mom could pay for it if we
> didn't have insurance.

> P4: I think everything was covered by Medi-Cal. …My mom wouldn't have
> enough money to pay for all those years.

Therefore, there were no issues in paying for services.

Staying in treatment

The average length of treatment for the four participants is 7.25 years. This is a

significant length of time as AA/PIs are known to underutilize mental health services.

When asked what kept them in treatment, "progress" was mentioned by three

participants, "learned a lot" was mentioned by two participants, and "for my mom"

was mentioned by one participant.

> P1: I think [my daughter] get a lot of progress. Since she get a lot of mental services. Even though sometimes she said "I don't like here I don't like come here [sic]." But she get a lot of progress. Including myself and my husband. And I learned a lot of knowledge. So I feel like I would keep coming here.

> P2: I like to learn from what [the therapist] say and what I have to do to be better. I was able to learn a lot. I think I made good progress. …That is what kept me to continue to see them. Nothing else motivated me to stay [in treatment].

> P4: I think I made a lot of progress over all these years. I don't think I would be here talking to you if I didn't get any better. I was very challenging when I was young.

> P3: Cuz… I don't know. I guess my mom still encourage me to go.

When asked if there were any other reasons to continue therapy, P3 replied:

> P3: No I guess not. Nothing. Mainly for my mom. I don't know why she wants me to continue seeing a therapist. She never told me.

In addition to these factors, P1 described the flexibility of her clinician to include

her husband in family therapy; he was initially skeptical of therapy.

> P1: Before, he did not know how necessary, how useful for [my daughter] to get mental service. I think he said, "can have services or not have services." Meaning as long as mom is home, it is okay. …So he was not committed to come here. …So after [my daughter] come here, they want him to do family therapy. They would wait for him after work to join family therapy. And then, I think he learned a little bit and little bit. …I think he learned a lot but he needs to keep learning.

However, she also described a cost to Western therapy. P1 described making

compromises between Chinese and American cultural values and parenting

techniques.

P1: You know some Chinese culture is very good. I learn from my parents, they have a lot of good cultural values, like respecting elders, share with your friends and your relationship but I cannot find that the same in America. …Actually I changed a lot [since therapy]. So that is why I cannot use the old way. I can't use the same methods from my parents to apply to [my daughter]. Only American ways to help [my daughter].

When asked how she felt about it, she replied:

P1: It is tragic. America has some good methods and China used to have some great methods. I would want to use a mix of Chinese and American ways. I think that would be best.

Community

The interviews concluded with questions regarding the role of community for participants. The following issues related to community were discussed: 1) disclosure to friends or family; 2) alternative treatment; and 3) recommendations.

Disclosure to friends and family

Three participants reported they disclosed receiving mental health services to their friends and discussed the benefits of disclosure. They found friends to be a *strong support* to continue therapy. However, three participants were cautious to *not disclose to extended family* members. Only one participant shared information to one extended family member.

P1 described her close friendship with her boss and how she supported P1's family in therapy.

P1: I just told one friend, my boss. She is very nice. She give me a lot of support. ...I told her because [my family] spend a lot of time with my boss and

co-worker. And so they know about my daughter, like this and like that. So when I have to not work, like go to appointments, I tell her.

And her boss reacted with support:

P1: And then she said "its okay I can help you, you can [continue therapy appointments]." So she just give me flexible schedule as long as I finish the job it is okay. I think I can never get such help from anyone before.

Her boss revealed her son received mental health services in the past:

P1: She also share her feelings with me. She is a single mom and has a kid. A little bit older than [my daughter]. Her kid is little bit like [my daughter]. Mental problem I think. ….And she also talk about her son, how she handle her son. By now her son is very good, she got a result I think [laughter.]

P1 stressed the importance of this relationship as it supports her in therapy and

allows her to be employed. P2 disclosed to his close friends in 9th grade, a year after

he began therapy. Although none of his friends receive services, they are very

supportive of him.

P2: I told my close friends. They know I go to a therapist and they help me feel a little better. Sharing with them makes me feel better and they are helpful to me. They support me and I support them.

When asked how he expected them to react, he stated:

P2: To like keep it as a promise and don't tell other people. …They actually did keep it as a promise. I trust them. …I don't know other friends who see a therapist.

P4 shared similar thoughts about disclosing to friends.

P4: A couple of my best friends know. I mean I don't talk about it a lot but they have always been supportive.

Although three participants were willing to disclose to their friends, they were more

cautious about disclosing to extended family members. P4 is the only participant

who has an extended family member who knows about his treatment because of her

involvement with the family.

> P4: My mom only told her sister because she raised my brother and sister. She doesn't know too much detail but she knows what is going on.

All four participants revealed they want to *prevent rumors and criticism* from

spreading through extended family members.

> P1: I don't have a good relationship with my husband's family. …I don't want them to know much detail. I will keep some secrets. I don't want them to talk bad stuff about my family.

> P2: I don't want [extended family] to know that I have this kind of mental issue. Maybe they might criticize me.

> P3: My [extended family] doesn't know. No one else knows. Not even my friends knows. …My reason? I guess I didn't want them to know. Like don't want them to think badly of me. I don't want them to look at me different. …I don't have plans to tell my friends or family later on.

> P4: It is like family business, don't want to share too much outside. There is a Chinese saying, "don't spread bad things about the family." Like don't want rumors to start. So only my aunt's family knows but other family members don't know about the services.

Alternative treatment

None of the participants sought direct alternative treatment (e.g. other forms of

therapy, non-Western medicine, religion) for mental health symptoms. However, two

participants did use Chinese Buddhism to supplement therapy. For example, they

would pray to deities to get better but did not pray consistently.

> P1: [My daughter] did not refuse "*bai san*" (Chinese Buddhism prayers) but

she cannot keep the routine. But it's okay. I will keep the routine to pray. …I hope I can get some help.

P2: Well I did seek religion, like [Chinese Buddhism]. Some days I do feel like I want to pray but I don't always do it.

Recommendations

Participants were asked whether they would recommend mental health treatment to friends or family. All participants replied they would refer friends or family if they need it. P1 stated she would be careful about giving too many details.

P1: If somebody need help I will tell the people. But I would not tell about [my daughter] things. I want to keep some secret from people. But I will share the information if they need it. I will tell if they need the help.

P2 believes his community can benefit greatly from mental health services.

P2: If people need [therapy] I could tell my therapist to add them too. …I think [my agency] can help more Asian people. Currently it doesn't help enough people. I would like to see the agency help other people, like different races. They can maybe tell them that they need help with their problems.

Conclusion

This chapter presented the findings of an exploratory qualitative study with four AA/PIs participants currently receiving mental health services. The findings revealed two major socio-cultural barriers to accessing services and identified how participants reacted to the barriers. In short, cultural barriers appeared most salient while institutional factors actually increased access to services. However, the application of the findings from this study may be quite limited due to the small sample size (n=4). Key findings of the study will be further investigated in the next

chapter along with implication of the limitations.

CHAPTER V

DISCUSSION

This qualitative study explored the narrative experience of four AA/PI

individuals who are currently receiving community mental health services. The goal

of this study was two-fold: to explore specific socio-cultural barriers to mental

health services for AA/PIs and to discover the factors and techniques AA/PIs utilized

to overcome these barriers.

Each of the four narrative encounters revealed similarities and differences in

regard to navigating socio-cultural barriers. In this chapter, major findings will be

compared and contrasted with previous research presented in this study. The

following topics will be reviewed: a) characteristics of participants b) reactions c)

encountering and reacting to socio-cultural barriers and d) social support. This

chapter will also explore limitations in this study followed by a discussion of

implications for social work practice and recommendations for future research.

Characteristics of participants

All four participants were recruited from an outpatient agency that serves

children and families in San Francisco, California. Although the sample size was

small, the four participants share a number of similar characteristics. Although

AA/PI represents multiple ethnicities, all of the participants in the study were

Chinese American. This was due to the fact that all participants were recruited from

the same agency—one that primarily supports Chinese and Chinese individuals—as

well as the fact that Chinese Americans make up 65% of AA/PIs in San

Francisco—more than any other AA/PI demographic group. (U.S. Census ACS-Chin,

2007).

Three of the four participants immigrated to the U.S. and are considered 1st

generation Chinese Americans. Of the three, two immigrated during adolescence (<

age eight) and one immigrated during adulthood (age 33). Only one participant is

native-born. Although I did not include an acculturation assessment scale for

participants, findings of a study by Kim and Hong (2004) suggest 1st and 2nd

generation AA/PIs from communities with a significant AA/PI population adhere

more strongly to Asian cultural values than 3rd or higher generation levels of AA/PIs.

It is relevant to suggest that these four participants have a strong adherence to Asian

cultural values as it may increase the validity of the barriers they identified. Previous

research suggests AA/PIs with a strong adherence to Asian cultural values are likely

to encounter more significant barriers in seeking and accessing mental health

services (Kim & Omizo, 2003; Shea & Yeh, 2008).

All four participants chose their preferred interview method, either in-person or over the phone. Three of the four interviews were conducted over the phone and one was conducted in-person. Three participants chose to be interviewed over the phone, and reported this was due to convenience and comfort. One participant chose to be interviewed in-person because she believed her limited English could be best understood in-person rather than over the phone. Having these interview options may be important when collecting AA/PI mental health-related qualitative data. However, there are strengths and weaknesses to both methods. I noticed the in-person interviewee provided lengthy and more detailed narratives than the phone interviewees. Although one in-person interview cannot represent all in-person interviews, I felt a higher level of engagement which may have prompted the participant to reveal more of her experience. The phone interviews felt less personal and participants elaborated less even when prompted. A potential weakness of in-person interviews is AA/PIs may be extra sensitivity in discussing personal experiences as the findings suggest a high correlation of shame and stigma closely attached to mental health related issues for AA/PIs. AA/PIs may be more comfortable with interviews conducted over the phone because of the anonymity-like quality. Therefore, I suggest future qualitative data collection to include both in-person and phone interviews despite the drawbacks.

Referral source

All four participants did not directly seek out mental health services. One participant's mother sought help from a medical doctor for a participant's behavior issues. Another participant's mother sought help from a school counselor for their academic issues. Two other participants did not seek any formal (professional) or informal (community) help. All participants were eventually referred to mental health services by school counselors. Kung's (2003) study also found Chinese Americans with a diagnosable mental disorder are three times more likely to be referred by a professional source to mental health services than self-referral. This finding indicates the importance of formal sources to refer AA/PIs to mental health services.

Reactions

In terms of the issue of referring to mental health services, two primary reactions that emerged for AA/PIs were parental relief and anxiety. The parental relief can be explained by the mental stress and difficulty in managing their children's issues. P1 described her sense of helplessness of managing her daughter's needs for two years on her own before being referred. She shared that if the referral was not made, she intended to continue aiding her daughter without any professional

help. P4 described his single mother as "overwhelmed" when simultaneously dealing with Child Protective Services (CPS) and his behavior issues at home. The parental relief is a reaction to gaining some assistance to issues beyond their control. Previous research supports this as AA/PIs receiving mental health treatment tend to have more severe psychological symptoms compared to the general population (Snowden & Hu, 1997; Sue & Sue, 2003; Uba, 1994). Often times, AA/PIs prioritize self-managing (Loo, Tong & True, 1989) and family managing (Kung, 2004; Loo, Tong & True, 1989) mental health symptoms over seeking professional help.

Although the parents revealed they lacked mental health services knowledge, the parents may have also harbored less-willing attitudes to seek professional help. Multiple studies found AA/PIs who highly adhere to Asian cultural values have reduced tendencies to seek and receive mental health treatment (Kim & Omizo, 2003; Kung, 2003; Miville & Constantine, 2007). The studies suggest these attitudes are rooted in Asian cultural values of filial piety and conformity to norms. AA/PIs who adhere to these values may feel pressured to manage emotional distress within the family to prevent social ostracism (Uba, 1994). They may perceive receiving professional help indicate a lack of family support or hereditary flaws which can bring shame to the family (Shea & Yeh, 2008). These findings, along with the support of previous research, suggest a crucial role for professional sources to

closely detect and refer 1st and 2nd generation AA/PIs to mental health services, as they may be less willing to self-refer.

The second reaction of anxiety can also be understood in regard to filial piety and conformity to norms. Participants recalled past adolescent feelings of anxiety towards professional therapy. If participants were used to keeping interpersonal issues within the family, sharing issues with outside sources may be unfamiliar and contradictory to traditional values (Sue & Sue, 2003). The anxiety may have been amplified as it involved a confidential relationship with someone outside the family. This anxiety, which has the potential to affect the individual's level of engagement in therapy, may be reduced if therapists share the same ethnic background. This will be discussed further in the *institutional factors* section.

<div align="center">*Socio-cultural barriers*</div>

Encountering stigma

One of the key findings from this study is the identification of stigma and lack of mental health knowledge as socio-cultural barriers to mental health services. Although participants were minors when they attached stigma to mental health, it is important to realize adolescents identified with perceived stigma beginning at a young age. In this study, a participant was as young as six years old when he attached stigma to mental health treatment. Although stigma has been widely

discussed in previous literature, Iwasaki's (2005) distinguished between *self-stigma*

and *social stigma* which can be applied to the stigma expressed by participants in

this study. Iwasaki (2005) defines social stigma as stigma towards services and

self-stigma as internalized mental illness stigma which affects self-esteem and

self-efficacy.

The participants experienced stigma differently. P2 and P4 only experienced

social stigma to mental health services. They shared having some initial shame and

reacted by disassociating themselves from the stigma. P3 experienced both social

and self-stigma with stated feelings of long-term shame and secrecy. Participants

encountered stigma differently which may have influenced how they self-managed

the stigma.

Overcoming or managing stigma

Three participants, P2, P3 and P4 experienced social stigma. Only P3

experienced both social and self-stigma. All three participants stated getting used to

therapy helped reduce some stigma.

> P4: I've had [services] for so long. I just learned to accept it because it was
> what I needed. It became normal to me and I don't see any shame in it.

In addition, P2 and P4 referenced disclosing their treatment to friends in order to

overcome social stigma. However, P3 chose not to disclose to friends, possibly as a

way to manage the stigma. It is possible his experience of self-stigma influenced his

decision to not disclose for fear of feeling worse about himself. He stated no future

plans to disclose.

> P3: My [extended family] doesn't know. No one else knows. Not even my
> friends knows. …My reason? I guess I didn't want them to know. Like don't
> want them to think badly of me. I don't want them to look at me different. …I
> don't have plans to tell my friends or family later on.

This demonstrates how stigma is experienced either as social or self or as both. This

finding may contribute to the formulation of AA/PI specific outreach to address both

internalized stigma and stigma towards mental health services. Hence, stigma can be

experienced differently which further complicates the barriers.

Role of parents

In addition to self-managing, participants received significant parental support

that alleviated stigma. Parents provided support through encouragement, resources

and engaged in family and collateral sessions. Participants emphasized the

importance of this support in allowing them to begin and engage in long-term

therapy.

I believe that the Asian cultural value of filial piety may have amplified the

strength of parental support for AA/PI individuals. Filial piety greatly emphasizes

respect and support to parents and ancestors (Uba, 1994). AA/PIs are expected to

listen to parents and may be more willing to try therapy with their support.

Individuals may be less concerned about bringing shame to the family because there

is support to address mental health issues (Abe-Kim, Takeuchi & Hwang, 2002).

Kung (2003) found Chinese Americans sought families as a primary support source

for emotional distress (secondary only to managing distress on their own). This key

finding in parental support suggests the importance of parents in initiating and

supporting AA/PI individuals to seek or receive treatment; thus family support is a

protective factor in order to challenge barriers to mental health services.

Lack of mental health knowledge

The second salient barrier to mental health services, particularly for parents, is

lack of mental health service knowledge. Although there is a lack of recent data on

mental health knowledge among AA/PIs, the Asian American Field Survey found

only 4% of Chinese, Filipino, Japanese, Korean and Samoan Americans in five

low-income urban communities learned about mental health services through

outreach and ethnic media (Office of Special Concerns, 1977). Lack of service

knowledge may be a particular problem for AA/PI immigrants (Uba, 1994). In

another study, Loo, Tong and True (1989) found 74% of 108 Chinese Americans

from San Francisco Chinatown, 81% who are foreign-born, stated they lacked

knowledge about medical and mental health clinic for emotional problems. This is

supported by this study's findings of immigrants who described they lacked

knowledge of services.

P1: I don't have any knowledge for mental health services even though I was a nurse in China. I didn't think I needed help for mental health for my daughter.

The lack of service knowledge can be understood as a lack of culturally appropriate outreach to AA/PI communities, including language and cultural competency barriers (Komiya, Good & Sherrod, 2000). However, it appears institutional factors are significant in educating and outreaching to AA/PIs about services. This is supported by Loo, Tong and True's (1989) suggestion that underutilization of services for AA/PIs in the community, compared to AA/PI college students, is not due to unwillingness to admit to psychological issues; rather, it is due to the lack of resources, knowledge and accessibility to services.

Overcoming lack of mental health knowledge

One of the key findings from this study revealed how participants overcame their lack of service knowledge through numerous institutional factors. Community agencies that were in convenient locations, clinicians that demonstrated cultural competency, availability of language services, and Medi-Cal acceptance all represent institutional factors that enabled participants to access mental health services more quickly and effectively.

All participants referenced these institutional factors as aids in educating them about professional help for behavioral and emotional distress. This is contrary to literature on institutional barriers for AA/PIs to access mental health services, which

includes inaccessible locations (Uba, 1994), lack of insurance, lack of language services, (Snowden, Masland & Ciemens, 2006) and lack of cultural competent clinicians and clinics (Gim, Atkinson & Kim, 1991).

This conflict can be explained by the geographic location the sample was recruited from and the small sample size. The sample was recruited from only one agency in San Francisco, CA. Because of the significant AA/PI history and population in San Francisco, the city has more social services with AA/PI specific outreach than other cities. Participants affirm that ease of access to agencies in the community, Medi-Cal acceptance and Chinese-speaking clinicians of ethnic match were all positive factors in their experience. This finding mirrors a study by Snowden, Masland and Ciemens (2006) who found agencies that accept Medi-Cal and who had bilingual clinicians were the most salient factors in providing greater access for AA/PIs to mental health services in the Los Angeles County area.

However, key findings on institutional strengths does not suggest institutional barriers no longer exist, but rather, reinforce the value of institutional factors in reducing underutilization of mental health services. The sample was recruited on the criteria that they must have received or are currently receiving services. All four participants are currently in long-term treatment. Therefore, barriers for AA/PIs who never had any services or dropped out prematurely were never addressed in

recruitment. Examples of possible institutional barriers that may exist are long

waiting lists, limited acceptance of private insurance, and lack of language services

in other languages than just English, Spanish, Cantonese and Mandarin.

Social support

The last key finding from this study revealed the significance of social support

from parents and friends (with the exception of extended family members) in

treatment retention. Three participants shared about the value of disclosing to friends.

They described receiving overall acceptance, emotional support and work-shift

flexibility for appointments. Disclosing to friends may have also reduced the stigma

towards mental health issues and treatment,

> P1: I just told one friend, my boss. She is very nice. She give me a lot of
> support. ...I told her because [my family] spend a lot of time with my boss and
> co-worker. And so they know about my daughter, like this and like that. So
> when I have to not work, like go to appointments, I tell her.

> P2: I told my close friends. They know I go to a therapist and they help me feel
> a little better. Sharing with them makes me feel better and they are helpful to
> me. They support me and I support them.

Although there is limited empirical research on the relationship between social

support to treatment retention, a review of previous literature by Kim, Sherman and

Taylor (2008) suggests AA/PIs benefit more from social support that involves less

personal disclosure of emotional distress. Their finding does not devalue the role of

social support, but rather suggests the implications in degree of disclosure. For

example, social support can exist without the need of disclosure of personal

problems.

Kim, Sherman and Taylor (2008) distinguished two types of social support,

explicit and *implicit* support. They define explicit support as eliciting awareness, aid

or comfort by disclosing personal stressors to social networks. Implicit support is

elicited without disclosure of personal stressors, for example, feeling supported by

being in the company of others. Kim, Sherman and Taylor (2008) suggest AA/PIs

may feel more comfortable with implicit support without concerns about "losing

face" from revealing too personal of stressors.

With this theoretical framework, participants in this study may have received

explicit support from parents and friends and regulated implicit support from

extended relatives to sustain some support. Participants actively disclosed their

treatment to friends to gain support. However, they purposely withheld disclosure to

relatives for stated reasons of avoiding shame and preventing rumors. Support from

relatives may come in the form of continued "harmonious" relationship without one

being overly concerned or critical of the other (Kim, Sherman & Taylor, 2008).

Limitations of the Research

One of the major limitations of this study was recruitment methods. The

recruitment method was time-consuming and solely dependent on agency and

clinician involvement, decreasing my influence of direct recruitment. By choosing

agencies under the rubric of the Department of Public Health (DPH), I unknowingly

entered a bureaucratic approval process that proved time-consuming and costly. I

had scheduled agency recruitment in advance but because of a delay in obtaining a

human subjects approval from the department director, my timeline to go to agencies

was delayed by more than a month. This led to a shortened recruitment process

which severely limited this study.

Another limitation in the recruitment process was an over-reliance on support

from clinicians. This weakness in design limited my influence on recruitment.

Because I did not have the authority to approach clients at agencies, clinicians were

fully responsible for identifying and approaching potential participants. Henceforth,

they were the most crucial part in recruitment. Therefore, engaging clinicians to

invest effort in my study was largely dependent on my presentations.

I may have also miscalculated clinician bias in recruitment methods. I

presented at two agencies in which I had professional past affiliations. My

relationship may have influenced their willingness to support my study. For example,

all four participants were recruited from the agency I was actively affiliated with at

the time. I also had more direct contact to the clinicians at these two agencies

compared to the limited contact I had with the other two agencies which reinforces

the existence of clinician bias.

A limitation in sample criteria for this study was the fact that participants had to be able to read, speak, and understand conversational English. This criterion excluded a third of AA/PIs who are non-English speakers (U.S. Census, 2000). Many clinicians at the agencies informed me that this criterion excluded the majority of their AA/PI clients. Therefore, this criterion may have limited the number of clients clinicians could approach overall.

Another limitation was the lack of alternative plans to recruitment. I limited myself to only one method which was clinician dependent. An alternative recruitment plan for future research would be utilizing a snowball sampling method. Another option would be to widen the criteria range to include all types of mental health services rather than just community mental health.

And finally, a significant limitation of this study is the small sample size for a qualitative study with n=4. The sample is too small to be representative of AA/PIs who have received or are currently receiving mental health services which also limits the findings to be generalizable.

Strengths of the Research

Despite the limitations, this study has significant strengths. The extensive recruitment methods allowed me to recruit AA/PI participants with first-hand

experience in accessing mental health services in the community. This study detracts

from most empirical research which are conducted at universities with college-level

students by assessing attitudes and help-seeking behaviors. While most research on

socio-cultural barriers to treatment often analyze quantitative data, this study

collected qualitative narrative experiences in both encountering *and* managing

socio-cultural barriers. This study not only identified barriers from AA/PI

perspectives but also identified factors for AA/PIs to overcome or manage these

barriers. Despite the small sample, many findings of this study are supported by

previous empirical research and suggest salient implications for community mental

health AA/PI outreach.

Implications for Social Work Practice and Policy

This research study provides valuable implications for social work practice as it

projects the voices of AA/PIs in community mental health treatment that are often

silenced, ignored, or ostracized. This study successfully captures rich AA/PI

narrative perspectives of the barriers they encountered. These participants have not

only identified socio-cultural barriers, but also emphasized the role institutional

factors play in providing access and engagement for AA/PIs to engage in therapy.

This adds value to the role of institutions and asserts how they can positively affect

marginalized communities.

The study's findings can influence AA/PI outreach protocols and techniques for agencies. Outreaching to parents may be beneficial as parents may prioritize family needs over individual needs. Findings also suggest parents may indirectly benefit from and be motivated to engage in their children's treatment. Further research on the role of stigma may also be worthy to explore in future studies with AA/PIs. Acknowledging that stigma can manifest socially and within the self can normalize stigma and educate AA/PIs in managing potential stigma. The role of *explicit* and *implicit* support for AA/PIs should also be considered in supporting and retaining them in treatment.

Conclusion

This exploratory qualitative research study is an attempt in illuminating the AA/PI narrative experience in accessing mental health services. Unlike previous empirical studies conducted with university students, this study focused on hearing community voices directly in order to gain insight into how AA/PIs view mental health. Participants provided rich data through their unique perspectives. Their insight reinforces the significant role institutions play in soliciting and engaging potential clients. This study also offers suggestions in how to negotiate barriers for AA/PIs who have not accessed mental health treatment yet. I hope this study will encourage more qualitative research in AA/PI communities to tap into the relevant

wealth of AA/PI narratives.

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Appendix A

Human Subjects Review Approval Letter

January 26, 2010

William Lee

Dear William,

Your revised materials have been reviewed. You have done a thoughtful and careful job and all is now in order. You did a very nice job shortening the Consent and making it much less burdensome. We are happy to give final approval to your most interesting study. We do have one request. In the information to the staff members, please delete the last sentence telling them not to coerce their clients. They could experience that request as pretty insulting.

Please not the following requirements:

Consent Forms: All subjects should be given a copy of the consent.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requests may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Mariko Ono, Research Advisor

Appendix B

Agency Approval Letters

City and County of San Francisco	**Deborah L. Sherwood, Ph.D.**
Department of Public Health	**Director of Research, Evaluation**
COMMUNITY PROGRAMS	**& Quality Management**
COMMUNITY BEHAVIORAL HEALTH SERVICES	1380 Howard St, 5th Floor

San Francisco, CA 94103

Ph: 415-255-3435   Fax: 415.255-3567

Deborah.Sherwood@sfdph.org

February 22, 2010

Dear Mr Lee:

On behalf of Barbara Garcia, Director of Community Programs, this letter serves as
your approval   to recruit 10 – 12 clients at RAMS, Sunset, and Southeast for a
study on sociocultural barriers to access to care .   It is understood that the Directors
of each of these agencies must also approved the recruitment.

We would like to receive the results of your study once concluded, so that our
system may learn from research efforts with our clients.

Wishing you success in your research!

Deborah Sherwood, Ph.D.
Director, Research, Evaluation, and Quality Management
Community Behavioral Health Services

rams
richmond area multi-services, inc.   community mental health

November 25, 2009

Smith College
School for Social Work
Lilly Hall
Northampton, MA 01063

To Whom It May Concern:

As the Chief Executive Officer of Richmond Area Multi-Services, Inc. (RAMS), I want to indicate our considerable interest and support in working with William Lee to conduct his MSW thesis and research project at this agency, while also pending approval by Smith College School for Social Work's (SSW) Human Subject Review Committee (HSR) and San Francisco Department of Public Health (SFDPH) – Community Behavioral Health Services (CBHS). SFDPH CBHS does not have a Human Subjects Review Board and, therefore, requests that Smith College School for Social Work's (SSW) Human Subject Review Committee (HSR) perform a review of the proposed research project.

Pending approval and implementation, RAMS, Inc. would abide by the standards related to the protection of all participants in the research approved by Smith College SSW HSR Committee. RAMS understands the proposed research project to be a qualitative study of the Asian American/Pacific Islanders (AA/PI) experience of access to community mental health treatment; the goal is to learn about AA/PI clients' perceptions of their experience and explore the socio-cultural barriers they may encounter in accessing treatment.

Sincerely,

Kavoos G. Bassiri, LMFT, CGP
President & CEO

City and County of San Francisco   **Southeast Child Family Therapy Center**
Department of Public Health   100 Blanken Avenue.
COMMUNITY BEHAVIORAL HEALTH SERVICES   San Francisco, CA 94134
Website: dph.net   Tel: (415) 330-5740 Fax: (415) 330-9120

11/23/09
Smith College
School for Social Work
Lilly Hall
Northampton, MA 01063

To Whom It May Concern:

Southeast Child Family Therapy Center (SECFTC) gives support for William Lee to
conduct his research in this agency. The City and County of San Francisco
Department of Public Health Community Behavioral Health Services (CBHS) does
not have a Human Subjects Review Board and, therefore, request that Smith College
School for Social Work's (SSW) Human Subject Review Committee (HSR) perform
a review of the research proposed by William Lee. We will give full permission to
William Lee to conduct research in our agencies after his research proposal is
approved by Smith College SSW HSR Board and signed off by CBHS.

SECFTC will abide by the standards related to the protection of all participants in
the research approved by Smith College SSW HSR Committee and will retain all
responsibility for the individuals involved in the study.

Sincerely,

Program Director
Maryanne Mock, LCSW
Southeast Child Family Therapy Center
100 Blanken Avenue
San Francisco, CA 94134

<div align="center">Appendix C</div>

Informed Consent Letter

Dear Potential Participant,

My name is William Lee, a graduate student at Smith College School for Social Work in Northampton, MA. I am asking for your participation to conduct a research study for my MSW (Masters in Social Work) thesis. I am doing research on how Asian Americans/Pacific Islanders (AA/PI) experience seeking professional mental health services. This study will also explore possible difficulties in accessing these services. I want to gain direct insight from these experiences and use this information for possible publication and presentation.

You are being asked to participate in this study because you meet the following requirements:

- You identify yourself as Asian Americans/Pacific Islander;
- You are at least 18 years of age;
- You are able to read, understand and speak conversational English;
- You have received or are currently receiving professional mental health services.

You will take part in a 45-60 minute interview for research. You can choose the time and place of the interview for your convenience—either in-person or over the phone. The in-person interview can take place at your agency or a public venue. I will record and transcribe the data myself on a computer. No other person will transcribe the data.

There are possible risks if you participate in this study. You may feel uncomfortable with some interview questions as they may recall some difficult experiences in your life. This study may also be beneficial to you. You may gain insight on how cultural values influence how and why you seek mental health services. Your thoughts and experiences may also help develop knowledge about Asian Americans/Pacific Islanders in mental health services for both clinicians and social service agencies. If you participate in the study, you will be given $25 in cash. The $25 in cash will be yours to keep even if you decide to withdraw from the study during the interview.

Throughout your participation in this study, I will assure confidentiality of your identity. All identifying information will be kept separate from the interview data. All data will be kept in a locked cabinet for up to three years as required by Federal guidelines, and destroyed when it is no longer needed. Stories and quotes will be carefully disguised to protect your identity.

Your participation is fully voluntary. You may refuse to answer any questions. You may choose to withdraw from the study at any moment during the interview or up to 30 days after the interview. All material collected following your withdrawal will be destroyed. If you have any questions about this study or your involvement, please contact me before signing this form. If you have any additional questions or wish to withdraw after the study, you can reach me at XXXXXXX or XXXXXXXX. If at any time you have questions or concerns about your rights as a research participant, contact the Smith College School for Social Work Human Subjects Review Committee at **(413) 585-7974.**

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

_____

NAME OF PARTICIPANT (please print)

_____

SIGNATURE OF PARTICIPANT

_____

DATE

William Lee

Smith College School of Social Work
Lilly Hall
Northampton, MA 01060

Please keep a copy of this form for your own records. Thank you for your participation.

Contact Information

If you decide to participant in the study, please sign and date the Informed Consent form and fill out the contact information below. Mail both the Informed Consent form and the Contact Information in the attached pre-paid envelope addressed to William Lee. **You are not required to inform the person who introduced this packet whether you want to participate or not.**

If you decide <u>not</u> to participant in the study, please discard this packet at your own time. You do not need to return it to the person who gave it to you.

What is the best way to reach you to schedule an interview?

Phone (Day): _____

Phone (Evening): _____

Email: _____

I will contact you in a week after I receive your reply.

Note: This information along with the informed consent will be kept in a secure location separate from the interview data.

Appendix D

Recruitment Materials

Recruitment Instructions for Clinicians

Hi, my name is William Lee, a 2nd-year MSW student at Smith College. With the support of your agency, I will be conducting a research study that involves voluntary participation from your clients. The following points will describe the study and provide instructions for your involvement. Thank you so much for your participation!

• Object of the research

My MSW thesis project is a qualitative study of Asian American/Pacific Islanders (AA/PIs) who have received or who are currently receiving community mental health services, and their experience to access these services. The purpose of this study is to illuminate the narrative experience of AA/PI individuals and explore the possible sociocultural barriers they may have *encountered* and possibly *overcame* in accessing community mental health services. This study aims to provide narrative research of AA/PI clients for the social work profession and toward clinical practice, particularly geared to the AA/PI community. In addition, this study will be utilized for possible presentations or publication.

• Nature of participation for the study

I will engage participants in a 45-60 minute interview either in person or over the telephone, (whichever method they prefer). The in-person interviews will take place at the agency or a place in which they feel comfortable which we can both safely access (i.e., a coffee shop, park or a public venue during the day). Participants will also be given $25 in cash for participation.

Sample questions:
- **What were your initial thoughts about mental health services?**
- **Was there anything from yourself or social environment that held you back to seek services?**
  - o **Possible cultural and social themes that may come up:** Family. Finances. Shame. Stigma to services. Lack of knowledge of treatment. Time commitment. Language. Other cultural factors.

- **Despite these themes, what motivated you to seek services anyway?**

• Risks and benefits to participation

- Risks to participation may include feelings of distress and/or discomfort that may arise from the interview questions.
- Benefits to participation may include helping develop knowledge about Asian Americans/Pacific Islanders in mental health services for both clinicians and the community.
- Participants will also be given $25 in cash for participation.

• Your role

Please identify clients who meet the following four criteria to approach for the study:

    a.) Participants must identify as Asian American/Pacific Islander;
    b.) Participants are 18 years of age or older;
    c.) Participants can read, understand and speak conversational English;
    d.) Participants are receiving or have received mental health treatment.

I will not ask participants to disclose diagnosis or type of treatment received.

• Instructions

1.) Let clients know the purpose of this study: to learn about their experiences in accessing community mental health services and if they encountered any difficulties along the way. Participation is 100% voluntary. Participants will also be given $25 in cash for participation.

2.) If clients are interested, please give clients the **Informed Consent Packet (3 pages)** which includes: informed consent form, contact information sheet, and self-addressed stamped envelope.

3.) Let clients know they are **not required** to inform you of their willingness to participate. Do not allow them to return the packet if they are not interested; they must discard it at their own time to ensure confidentiality.

4.) If clients **are interested** in the study, they can sign the consent form, complete the contact information sheet and mail both in the provided self-addressed stamped

envelope.

If clients are **not interested** in the study, they must discard it at their own time.

5.) Please direct all questions and concerns outside of this description form to me. My contact information can be found in the informed consent form.

If you have any questions or concerns, you can reach me at XXXXXXXXX or XXXXXXXXXXXX.

Thank you for your participation!

Asian Americans. Mental health services. Share your experience!

Would you like to be compensated $25 for your time?

Seeking Asian Americans adults who have received or
currently receiving mental health services for a 1 hour interview.
<u>Interviews are done in person or over the phone to your convenience.</u>

The study would like to learn about your experience in possible
barriers to accessing mental health services.
Your experience is valued!

**If interested, please ask for an informed consent packet
or contact William Lee.
Call XXXXXX or email XXXXXXXX.**

Appendix E

Interview Guide

These interview questions serve as a guide for the semi-structured format of the
interviews. I will focus on the possible sociocultural barriers an AA/PI individual
may encounter in their effort to seek mental health treatment, as well as the steps
they took, if any, to overcome them.

Demographic questions
1.) What is your race/ethnicity?
2.) What is your current age?
3.) Where were you born?
  → What generation are you?
  → When did you immigrate to the U.S.?
4.) Where do you currently live? Which part of the city do you live in?
5.) How long have you lived in the Bay Area?
6.) How long have you been in treatment?
7.) How long have you been in treatment at this agency?
8.) What is your marital status?

Interview questions (priority)
1.) What were your initial thoughts about mental health services?
  • What was your understanding of it? Or what did you envision?

2.) How were you referred to these services?
  • **Possible themes that may come up:** Friends. Family. Professional.
    Community. Self. Other.
  (Explore possible themes.) Possible follow-up questions:
    → More than one referral source?
    → What did they say?
    → How did they say it?

**3a.) Was there anything from yourself or social environment that held you back
to seek services?**
  • **Possible cultural and social themes that may come up:** Family. Finances.
    Shame. Stigma to services. Lack of knowledge of treatment. Time commitment.

Language. Other cultural factors.

(Explore possible themes. Can provide examples if they ask to clarify).

Possible follow-up questions:
  →Ask to define themes.
  → Any other possible themes that were not brought up?

3b.) Despite these themes, what motivated you to seek services anyway?

4a.) Was there anything from the agency/agencies that held you back to seek services?
- **Possible institutional themes that may come up:** Location of agency (distance, community surroundings). Insensitive person on phone. Negative first-impression of staff. Staff was culturally insensitive. Lack of AA/PI staff/clinicians. Too many AA/PI staff/clinicians. Physical agency felt too foreign. Long waiting time. Intake format too personal. Lack of appropriate services to community.

(Explore possible theme. Can provide examples if they ask to clarify.)

Possible follow-up questions:
  →Ask to define themes.
  → Any other possible themes that were not brought up?

4b.) Despite these themes, what motivated you to seek services anyway?

5.) Did you delay seeking community mental health services?
- How long was the delay?

6.) Did you tell your family or friends? When did you tell them? How was the experience?
- What was your expectation of their reaction?
- What was their actual reaction?

7.) Did you consider an alternative treatment?
- **Possible themes of:** Medical providers. Non-western medicine. Rituals. Family/home.

- Did you actually seek the alternative treatment? Was it before or after mental health treatment?

8.) What kept you in community mental health services?
- **Possible themes of:** Language. Clinician. Cultural competency. Progress in treatment.

9.) How do you think your agency is serving you as an Asian American?

<u>**(Lower priority question)**</u>
10.) Would you recommend mental health treatment to your family or friends?