ABSTRACT

FACTORS ASSOCIATED WITH PSYCHOLOGICAL DISTRESS AMONG OLDER VIETNAMESE ADULTS

By

Quynh Chi Pham

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The purpose of this thesis was to examine the factors associated with psychological distress among older Vietnamese adults. Utilizing information from secondary data called the California Health Interview Surveys (CHIS), a quantitative research method was completed for this study. The study explored levels of psychological distress with several factors including demographic characteristics, language use and proficiencies of patients, patients' understanding of rights to request for an interpreter during doctor visits, number of visits to doctors' offices, language used by doctors during consultation (English, Vietnamese, or other), and lastly, quality of interaction with doctors.

The result of this study indicated significant relationships among several factors and the level of psychological distress among older Vietnamese adults. These factors, include: demographics, patients' understanding of rights to an interpreter, number of doctor visits, language used by doctors during consultation, and doctor-patient communication.

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Committee Members:

Janaki Santhiveeran, Ph.D. (Chair)
Venetta Campbell, Psy.D.
Lisa Jennings, Ph.D.

College Designee:

Nancy Meyer-Adams, Ph.D.

By Quynh Chi Pham

B.S., 2010, University of California State, Fullerton

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CHAPTER 1

INTRODUCTION

Asians are the fastest growing population compared to other racial groups, over the last decade from year 2000-2010. The U.S Census Bureau (2012) reported that out of 308,745,538 million people in the United States, 4.8% or about 17,320,826 million of them are Asians. A person who identifies as Asian can be from countries located in the Far East, Southeast Asia, or the Indian subcontinent; such countries include: Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine islands, Thailand, and Vietnam (U.S Census Bureau, 2012).

Chinese immigrants have migrated to America since the late 1800s. Subsequently, other Asian people started to join the melting pot. Along these lines, the Vietnamese immigrants are part of an Asian group that has emerged over the past 35 years (Quyen, Sorkin, Mangion, Gandek, & Hays, 2008). Quyen et al. (2008) identified the first wave of Vietnamese refugees as people who came to America after he fall of Saigon through the 1980s to the late 1990s, and the second wave included the Vietnamese "boat people"--those who also tried to flee the country in small fishing boats to resume their religious rights and freedom. There are more than 1,743,433 million people living in the United States who identify as Vietnamese alone or in combination with another race or ethnic group. The state of California is home to 37.3% of the Vietnamese population who live in the United States (U.S Census Bureau, 2012).

Most of the first wave of Vietnamese people came to America in their adulthood. After 30 years, this generation transitioned into older adults and joined the baby boomers in America. Older Vietnamese adults have the disadvantage of cultural differences and language barriers that make it difficult for them to adapt to normative aging. Quyen et al. (2008) found that older Vietnamese refugees have more difficulty adjusting to the indigenous culture and the language compared to the second generation of Vietnamese adults who happened to be born in America. Linguistic differences create a visible gap between generations. Lack of language skills increases the psychological distress that in turn, discourages Vietnamese older adults from expressing their medical needs, which can lead to unreported or undiagnosed mental illnesses or medical problems (Quyen et al., 2008).

Purpose of the Study

The purpose of this study was to examine the factors that contributed to psychological distress among Vietnamese elderly between the ages of 55 and 85. The study explored several factors including (1) demographic characteristics, (2) language use and deficiencies (English fluency and difficulty in understanding and communicating with doctors), (3) right to use an interpreter, (4) number of visits to doctor's office, (5) language doctor used during consultation (English, Vietnamese, or other), and finally, (6) quality of interaction with doctors.

Research Questions

The researcher attempted to answer the following questions: (1) How are demographic characteristics (gender and age) associated with level of psychological distress? (2) How are English use and deficiencies associated with psychological

distress? (3) What is the difference between the Vietnamese older adults who knew their rights for interpreters during doctor visits compared to those who did not in their level of psychological distress? (4) For individuals who visited a doctor within the last year, what was their level of psychological distress? (5) What was the language used by the doctor when speaking to respondents (English, Vietnamese, or other) and what was the level of psychological distress of the respondents? (6) How is the quality of interaction with doctors associated with psychological distress?

Definition of Terms

Psychological distress includes two foremost areas: Depression and Anxiety (Zhang & Chen, 2014).

Depression: Which includes the feeling of sadness, loneliness, or hopelessness (Zhang & Chen, 2014).

Anxiety: Being tensed, feeling irritable, and experiencing excessive worries (Zhang & Chen, 2014).

Quality of interaction: Physicians making eye contact, being aware of the patient's feelings and sensitivities, identifying patient's problems, clarifying misinterpretations, acknowledging and respecting patient's beliefs, showing compassion, providing feedback, and lastly physicians need to clearly inform patients of the alternatives of their treatment plans, especially if they involve changes in lifestyle (Main, Buchbinder, Porcheret, & Foster, 2010)

CHAPTER 2

LITERATURE REVIEW

The following literature review will present the current research on topics related to psychological distress among Vietnamese older adults. This chapter will explore how demographic characteristics, Post Traumatic Stress Disorder (PTSD; previous trauma with war and violence before they migrated to the United States), cultural differences such as stigmas and beliefs, family and social support, linguistic barriers, the use of medical interpreter services, and quality of care (communication between patients and doctors) influence their psychological distress.

Demographics and Psychological Distress

Birman and Tran (2011) compared Vietnamese males and females in their study of anxiety and depression, which are important variables related to psychological distress. Through a snowball sampling of Vietnamese refugees, the data was collected from 212 Vietnamese respondents ages 55 and older, who lived in the United States. Respondents received an incentive of $15 when they answered the questionnaires. The researchers identified a negative correlation between social support and life satisfaction with respect to depression and anxiety among both males and females. Men are more likely to experience psychological distress, whereas women are more likely to experience anxiety (Birman & Tran, 2011).

In another study, Lien, Thapa, Rove, Kumar, and Hauff (2010) identified a negative correlation between participants who suffered from PTSD resulting from violent events and war prior to living in the United States and resultant association with psychological distress. The research consisted of 7,607 immigrants from different countries, ages 40 to 70, of whom 39.5% were Vietnamese. Lien et al. also found that there were significant differences in distress scores between males and females; men reported experiencing higher psychological distress due to increased exposure to violence and traumatic events compared to women (Lien et al., 2010).

Dinh, Yamada, and Yee (2009) utilized the Vietnamese Depression Scale (VDS) to explore the depression level within the Vietnamese community. The scale covered questions that applied specifically to Vietnamese cultural contexts. The study included 180 adults, ages 18 to 87, who had lived in the United States for an average of 9 years. Highly trained bilingual interpreters conducted interviews with respondents that covered criteria on the VDS, respondents' social demographics, as well as past experiences before migrating to the United States (Dinh et al., 2009). Researchers found that there was a positive relationship between age and depressive symptoms. Younger respondents were less likely to report having depressive symptoms compared to adults and older adults (Dinh et al., 2009). They also found a positive correlation between age and violent traumatic past experiences. Older adults were more likely to report feeling depressed due to such past experiences (Dinh et al., 2009).

Mental Health Stigma and Barriers among Vietnamese Older Adults

Fancher, Ton, Le Meyer, Ho, and Paterniti (2010) conducted a qualitative study to examine depression among Vietnamese American patients. A semi-structured interview

was conducted with 11 Vietnamese participants. The researchers asked about the barriers that the Vietnamese community encountered when accessing mental health services. The interview was conducted by native Vietnamese speakers who were professionals in their respective field such as sociologists, internists, and psychiatrists. Participants were either diagnosed with a mental illness, had family members as a patient, or were a mental health care provider themselves. The study identified the following barriers: (a) negative stigma and saving face; (b) social roles in the family; (c) healing, traditional and Western medical beliefs; and (d) language and cultural differences (Fancher et al., 2010).

Under these four categorized themes researchers were able to identify that Vietnamese participants were more likely to deny signs and symptoms of mental illness when in public in order to preserve face for their family (Fancher et al., 2010). The participants had fear of being labeled as "crazy" when diagnosed with mental illnesses (Fancher et al., 2010). Participants also reported viewing depression and mental illness as a social and family disruption rather than as an individual health problem. The study also revealed the Vietnamese participants' beliefs that anti-depressants and other Western medications will damage their body if taken for a prolonged period; as a result, they tended to seek traditional herbal treatments instead (Fancher et al., 2010).

To further identify the Vietnamese population's attitudes toward seeking mental health services, Nguyen and Anderson (2005) worked with 148 Vietnamese adults. The respondents had all been residing in the United States for more than 8 years. The researchers identified factors such as stigma, mental health beliefs, help seeking behaviors, alternatives, and self-disclosure among the Vietnamese participants. The researchers found that 97.3% of Vietnamese adults reported that they had never visited a

psychologist, and 100% of the respondents reported they had never seen a psychiatrist within the past 3 years (Nguyen & Anderson, 2005). There is a positive correlation reported among the following variables: individuals who self-disclosed and their likelihood to seek mental health services. There was also a positive correction between support from family and community and pursuing mental health services (Nguyen & Anderson, 2005). Many studies discovered that with the stigmas and traditional beliefs regarding mental illnesses, many Asians were more likely to view a person with mental health ailment as being possessed by an evil spirit rather than as a person simply with mental health issues, which in turn discouraged them from seeking help (Nguyen & Anderson, 2005).

Sorkin, Pham, and Quyen (2009) attempted to analyze mental health service access among minority ethnic groups in California. The study was a collection from a secondary data comprised of 1,215 Asians, of whom 161 of them were Vietnamese, ages 55 and older. In the study, Sorkin and colleagues ultilized the Kessler 6 (K6) to identify the level of psychological distress among the respondents. Researchers found that 21.2% of Asian Americans reported experiencing more mental distress than non-Hispanic Whites (14.4%). The study also indicated that they were less likely to report and to get access for help. Older adults ages 75 and older were 40% less likely to report feeling distressed compared to adults ages 55 to 64. Asian older adults with symptoms suggestive of severe mental health problems were much less likely to report asking for help than any other racial group (Sorkin et al., 2009).

In another study, Sorkin, Tan, Hays, Mangione, and Ngo-Metzger (2008) utilized the California Health Interview Surveys (CHIS) data to identify self-reported health

rating among Vietnamese older adults; the database included 359 participants ages 65 and older. Questions regarding mental health status were explored in the study (Sorkin et al., 2008). They found that 95% of Vietnamese older adults lack much needed access to referrals due to their mental health issues. Vietnamese older adults also needed professional assistance to help with mental health and emotional problems such as anxiety and depression. Seventy percent of the respondents received no information regarding mental health education from their respective primary care physician (Sorkin et al., 2008**).**

Social Context and Psychological Distress

A study conducted by Masood, Okazaki, and Takeuchi (2009) determined that there was a correlation between family and psychological distress among Asians. The study was comprised of 164 participants identified as of Asian ancestry, ages 18 and older. The researchers utilized the Kessler Psychological Distress Scale (K10) to measure the psychological distress caused by burnout, anxiety, depression, hopelessness, sadness, and tiredness. The researchers measured the psychological distress among individuals in terms of three factors, which included (1) family support, (2) extended family/friends support, and (3) demographics. Masood and colleagues also found that women reported having more anxiety compared to men when it came to facing family problems. Furthermore, both males and females scored higher on the distress scale when they had little or no family support compared to their respective counterparts who received more family support (Masood et al., 2009).

Zhang and Chen (2014) explored the association between social support, social leisure (exercise, community participation) and psychological distress among older Asian

adults ages 60 and older. Researchers assessed 292 participants at random geographic and economic stratification. The study covered aspects of social leisure and family support. The five indicators used to measure levels of psychological distress included: anxiety, fear, loneliness, hopelessness, and uselessness. Results showed that there was a significant negative relationship between social leisure and psychological distress. Respondents who reported higher participation in social activities also reported lower levels of psychological distress (Zhang & Chen, 2014). The study also indicated a major difference between participants with higher social support compared to those with lower levels of support from friends and family. Participants with higher social support from friends and family were less likely to report feeling distressed (Zhang & Chen, 2014).

Kim, Bryant, and Parmelee's (2012) study focused on serious impairments from psychological distress between different racial and ethnic groups. The study focused on 36,098,038 older adults, ages 65 and older; 13.8% of the participants were identified as Asian, and of these, 7.8% were Vietnamese. The psychological distress impairments in the areas of individuals' work and family support were examined. The researchers revealed that older Asian adults who reported having higher involvement with friends and family were less likely to experience psychological distress (Kim et al., 2012).

Chang, Natsuaki and Chen (2013) used the National Latino Asian American Study (NLAAS) data to identify the importance of family support and mental health service utilization among Asian Americans. Data included 2,554 Latino and 2,095 Asian American respondents. Seventy percent of the respondents were born outside of the United States and 25% of the Asian American respondents were Vietnamese. According to Chang et al.'s study, 75% of Asian Americans needed mental health services, but less

than one-quarter of those individuals actually sought professional services. First generation (older) Asian Americans often reported experiencing higher family and cultural conflict; this population is also less likely to seek mental health services in their lifetime compared to younger second and third generations (Chang et al., 2013).

Wu, Chi, Plassman, and Guo (2010) conducted a quantitative study to examine the correlation between social support and depressive symptoms among Asian older adults. Researchers utilized the Center for Epidemiologic Studies Depression Scale (CES-D) in their study of 554 participants, ages 70 and older. A random sampling list was collected from the Social Welfare Department. Respondents participated in a face-to-face interview that lasted 45 minutes. Participants' social support was measured and compared to their CES-D score. Results illustrated that there is a significant correlation between low CES-D score and older adults who live by themselves. There was a significant positive association of CES-D scores with the level of social and family support (Wu et al., 2010).

Leong, Park, and Kalibatseva (2013) applied the NLAAS data to examine the risk factors that contributed to psychological distress among immigrants. Among the 2,095 study participants ages 65 and older, only 520 were Vietnamese. The purpose of the study was to measure the association of Limited English Proficiency (LEP), family cohesion, social support, and family conflict to analyze the connection of psychological risk factors (Leong et al., 2013). The researchers found that family conflict contributed to higher psychological distress. Asian Americans who had higher family conflict were more likely to experience lifetime distress and depressive disorder (Leong et al., 2013). The researchers also found that 95% of immigrants who have a low level of family

cohesion are more likely to develop depressive symptoms (Leong et al., 2013).

Psychological Distress and Limited English Proficiency

Gee and Ponce (2010) conducted a study to examine the association between LEP and quality of life among six Asian groups. The six groups included older adults from Filipino, Chinese, Japanese, Korean, and Vietnamese respondents. Nine hundred and thirty eight Vietnamese immigrants reported having the lowest quality of life compared to other Asian groups (Gee & Ponce, 2010). Forty three percent of Vietnamese respondents reported having poor quality of health (Gee & Ponce, 2010). The researchers found that there is a significant association between LEP and poor health. Fifty two percent of the Vietnamese respondents reported having LEP (Gee & Ponce, 2010).

Ding and Hargraves (2009) conducted a study to examine how LEP related to unhappiness, depression, and anxiety among the participants. One-sixth of the 29,510 participants were older adults ages 65 and older. The participants were adult immigrants who were not born in the United States. The researchers categorized participants into two groups: (a) participants who had no problem understanding their primary care physicians and (b) participants who had trouble speaking and understanding their doctor. They found that immigrants with language barriers reported a much higher percentage of unhappiness (32.42%), compared to immigrants who did not have such language barriers (8.84%). Immigrants with language barriers also had a higher level of depression (19.29%) and anxiety (12.29%) compared to the respective levels of immigrants who did not have the same struggle (6.27% and 4.04% respectively). The researchers also found that immigrants with language barriers are most likely to report poorer health (40.09%) compared to those without language barriers (16.34%; Ding & Hargrave, 2009).

Kim et al. (2011) explored the association of LEP with inequalities in health status and utilization of healthcare services among minority immigrants by using the CHIS. Researchers collected data from 1,745 individuals ages 60 and older, of which 13.3% of them were Vietnamese. The participants were divided into three groups: (1) individuals with LEP, (2) English Proficient (EP), who spoke English and other languages at home, and (3) individuals who spoke only English (OE). The number of Asians with LEP was significantly higher in the older adult population when compared to younger adults with English proficiency (Kim et al., 2011). The researchers found that Asian respondents with LEP were more likely to have difficulty communicating with their doctors. These same respondents also reported having trouble following the instructions their doctor provided (Kim et al., 2011). Asian older adults with LEP reported having poorer health reports and more psychological distress when compared to respondents with EP and EO respondents (Kim et al., 2011).

Using the NLAAS data, Le Meyer, Zane, Cho, and Takeuchi (2009) explored the usage of mental health services among Latino and Asian Americans with psychiatric disorders. Trained bilingual interviewers examined 368 Asian Americans (19.8% were Vietnamese) who had one or more mental disorders. The researchers utilized the World Mental Health Survey from the World Health Organization Composite International Diagnostic Interview to identify mental health status and usage of respondents. LEP was also assessed during the study. Results showed that Asian Americans who were born in the United States were more likely to utilize mental health services compared to non-U.S. born Asian American participants with LEP (Le Meyers et al., 2009). The older an

individual was when he or she arrived in the United States, the higher the likelihood (95%) that he or she would not use mental health services (Le Meyer et al., 2009).

Kim et al. (2010) examined the impact of LEP on mental health service usage among older adults with psychiatric disorders. Researchers utilized the NLAAS analysis and collected data from 249 Latinos and 123 Asian Americans. There were only 34 Vietnamese. The study was conducted through face-to-face interviews and scheduled telephone interviews. The questions in the interview identified participants' health status, mental health services usage, and psychiatric disorders such as anxiety, mood, and substance disorders. To be selected for this study, participants had to be diagnosed with one or more psychiatric disorders.

Major depressive disorders were more prevalent among Latinos (49.4%) and Asians (47.2%); only 19.4% of Asian older adults reported receiving some form of mental health service (Kim et al., 2010). Kim and colleagues (2010) found that none of the participants with LEP reported using the crisis hotline. Asian respondents were less likely to seek mental health services compared to Latino respondents.

Zhang, Hong, Takeuchi, and Mossakowski (2012) conducted a study to measure the effect of LEP on psychological distress among immigrants. Researchers utilized NLAAS data, which included 520 Vietnamese participants. The Kessler Psychological distress K10 was used to measure the degree of psychological distress including feeling of burnout, anxiety, depression, hopelessness, sadness, and tiredness.

Results indicated that Asians with LEP were more likely to be Chinese, Vietnamese, female and married or individuals with lower levels of education and income (Zhang et al., 2012). Vietnamese individuals with LEP were reported to have

significantly higher levels of psychological distress and to experience more discrimination compared to Vietnamese individuals with EP or EO (Zhang et al., 2012). LEP contributed highest psychological distress, overall above any other factors such as discrimination and low socioeconomic status among Asians (Zhang et al., 2012)

Use of Medical Interpreters and Psychological Distress

A descriptive and explorative study by Hadziabdic, Heikkilä, Albin, and Hjelm (2009) analyzed the perceptions of individuals who used professional interpreter services within the past 6 months. The researchers conducted 1 hour semi-structured interviews with 10 women and seven men, ages 26-75. The goal was to measure the satisfaction with respect to how they viewed their interpreters. Researchers discovered that respondents reported feeling easygoing and satisfied when their interpreter showed professionalism such as respect, neutrality, and maintenance of confidentiality (Hadziabdic et al., 2009). A desirable professional interpreter respondent was perceived as someone with simple knowledge of healthcare, as evidenced by their facility with medical terminology (Hadziabdic et al., 2009).

Leng, Changrani, Tseng, and Gany's (2010) study focused on the detection of depression by using the Remote Simultaneous Medical Interpreting (RSMI), an over-voice system that helps interpret medical questionnaires, as compared to the absence of any type of translation system for patients with LEP. The study was composed of 742 participants, including Asian participants. LEP patients who scored positive on the Beck Depression Inventory-Fast Screen (BDI-FS) agreed to utilize the RSMI during the consultation with their physician, rather than requesting for an interpreter or a family member as translators. In their findings, Leng et al. found that without interpreters, 31%

of Asians were less likely to be diagnosed with depression. When applying RSMI to the study; researchers found the gap was reduced to 27% for Asians who were diagnosed with depression. Asian respondents with LEP were able to respond better with the RSMI system (Leng et al., 2010).

Flynn et al. (2013) examined the health patterns of adults who required interpreter services (IS). Through a medical electronic record, 82,490 older adult participants were studied, who entered either through Express Care (EC) or through the Emergency Department (ED). Fifty eight percent (n = 36,525) of 63,525 patients were female. Among 1,566 patients who required interpreter services, 12% or 182 were Vietnamese (Flynn et al., 2013). Their findings demonstrated that patients who require IS were mostly female (62.5%). Patients who required IS (37.5%) were less likely to be diagnosed with mental health illness than patients who did not need IS (63.8%; Flynn et al., 2013).

Rosenberg, Richard, Lussier, and Shuldiner (2011) observed the subject of conversation among 16 older adult patients with their interpreters, whether they were professional interpreters (PI) or family members as an interpreter (FI) during consultations with their primary care doctor. The researchers utilized MEDICODE as a descriptive tool to cover the discussions during visits. MEDICODE included six themes, which covered different perspectives of health care such as follow-ups, explanations, drug management and usage, patients' rights, and lastly, discussions about emotional and mental health problems. Results revealed that psychological issues such as depression, anxiety, and PTSD were not addressed during consultations when the patient used their own family member as an interpreter (Rosenberg et al., 2011). Patients reported

professional interpreters were more likely to discuss emotional issues during visits; furthermore, interpreters were able to explain and clarify mental health disorders. Professional interpreters were 42% more likely to discuss issues about mental health to patients compared to 4% of patients who used FIs (Rosenberg et al., 2011).

August, Nguyen, Ngo-Metzger, and Sorkin's (2011) intended to identify the correlation between patient-physician communication and language concordance regarding mental health needs. The CHIS secondary data analysis was used to collect data from 1,346 Latinos and 1,614 Asian Americans (175 were of Vietnamese descent), ages 55 and older. Based on a series of questions of how well individuals understand when they are communicating with their doctors, the measurements for language concordance were divided into the following categories: (a) spoke English at home and did not have trouble understanding the doctor, (b) spoke another language different from their doctor but had no trouble understanding English, and (c) spoke another language, had trouble understanding when the doctor spoke English and often required someone to translate. Discussions and questions with doctors to raise concerns regarding psychological distress and mental health problems with respondents were also measured (August et al., 2011). August and colleagues found that language discordant Asians who have trouble understanding their doctors were less likely to discuss mental health needs with their physicians compared to respondents who could speak English and had no problem understanding their doctor. Language discordant Latinos reported using more mental health services and discussing more mental health related topics compared to language discordant Asians (August et al., 2011).

A cross- sectional study by Green et al. (2005) examined the correlation between the quality of healthcare among LEP immigrants who use interpreter services or language concordance. The study included 2,715 Chinese and Vietnamese respondents collected from 11 healthcare agencies in the community. Self-reported surveys from participants who measured communication with their doctor, along with an overall health rating, were evaluated for this examination. The researchers revealed that patients who use interpreter services were more likely to share information regarding their mental health status during consultation, and patients who rated excellent or good when communicating with their interpreters were also more likely to report receiving better health care (Green et al., 2005). The study also found that patients who used interpreters were more likely to ask questions about medical information (30.1%) and mental health (25.3%) compared to 20.9% and 18.2%, respectively, of patients who used language concordance (Green et al., 2005).

Patient-Doctor Communication and Mental Health

Schenker, Stewart, Na, and Whooley (2009) explored the association between depressive symptoms and patient-doctor communication. A cross-sectional analysis was comprised of 703 participants who reported how patient-doctor communication influenced their medical and mental morbidity. To access different levels of patient-doctor communication, researchers utilized the Explanations of Condition and the Responsiveness to Patient Preferences scale. Researchers also used the Patient Health Questionnaire to identify patients' depressive symptoms. Schenker et al. found participants who reported poor communication with the doctor were more likely to be female and Asian; furthermore, 50% of participants who reported having poor doctor-

patient communication also reported increasing symptoms of depression (Schenker et al., 2009).

Chung et al. (2000) investigated doctors' diagnoses for psychological distress among their minority patients. To identify the degree of psychological distress among 91 Asian participants, doctors asked about emotional or psychiatric problems during medical visits; then the results were matched with their patients' Epidemiological Studies Depression Scale (ESD-S) scores (Chung et al., 2003). The (ESD-S) demographic questionnaire was used for this research. Physicians identified 67.0% of Asian participants scored negative on the ESD-S, and 17.2% of Asians participants scored positive on the ESD-S (Chung et al., 2003). The study indicated that poor doctor-patient communication prevents the detection of psychological distress among minority groups that in turn affect patients' quality of care (Schenker et al., 2009).

A cross sectional study by Street, Gordon, and Haidet (2007) explored the communication and perception of illness among patients and physicians. Twenty-nine physicians and 270 patients participated in this study. Patient-doctor communication was categorized into three sets of measures. The first set of patient-doctor communication included patients' evaluations to investigate whether the physician was (1) informative, (2) supportive, and (3) engaged in partnership communication with patients. The second set measured patients' involvement in the communication. Lastly, researchers used the Roter Interaction Analysis System (RIAS; Roter & Larson, 2002) to measure the effectiveness of interactions between patients and physicians during consultations. The RIAS scale also helped to measure patients' level of depression and emotional distress (Street et al., 2007).

Results revealed that physician's opposing sentiments of sympathy and contentiousness during consultations affect communication distress (Street et al., 2007). Physicians reported that they communicated better with patients who were active during the meeting. They also reported that older adult patients needed longer consultation time with their primary care physicians, especially patients with mental health issues (Street et al., 2007).

Ngo-Metzger et al. (2007) identified the importance of English concordance and interpreters utilization for patients with LEP. A cross-sectional survey collected data from 2,746 Chinese and Vietnamese participants who were receiving care at 11 health care centers. Researchers examined patients' knowledge on the subject of health and personal care that was taught by their doctors. They also measured patient rating on their doctor, and the availability of interpreters provided by the clinics. Results indicated that language discordant patients were less likely to receive health education compared to patients with language concordant providers (Ngo-Metzger et al., 2007). Language discordant respondents who reported not receiving enough interpersonal care from providers also scored low when rating their providers (Ngo-Metzger et al., 2007). Patients who received interpreter services at the clinics were more likely to rate their physicians lower. Patients with language concordant providers reported the best outcome (Ngo-Metzger et al., 2007).

Summary

Only two studies (Birman & Tran, 2008; Lien et al., 2010) explored the psychological distress among male and female respondents. They also reviewed the associations between war, traumatic violent events and psychological distresses on male

respondents. Only one study (Dinh et al., 2009) focused on the aspect of age and psychological distress. Several studies (Nguyen & Anderson, 2005; Fancher et al., 2010) helped to identify the stigmas and barriers regarding mental health within the Vietnamese community that could lead to undetected and untreated cases.

Several studies (Sorkin et al., 2008; Sorkin et al., 2009) demonstrated that the majority of Vietnamese older adults were unfamiliar with the symptoms of mental illness and their lack of resources and information. Using different methods, multiple studies (Chang et al., 2013; Chou & Chi, 2003; Kim et al., 2011; Kim et al., 2012; Leong et al., 2013; Masood et al., 2009; Wu et al., 2010) identified the correlation between social support and psychological distress. Only one study (Chang et al., 2013) included the generation differences among the participants.

Several studies (Leng et al., 2010; Rosenberg et al., 2011) identified the benefit of interpreters for patients with LEP, but only one (Street et al., 2007) was able to find the correlation between patients with LEP need for interpreters and patients' psychological distress. Several studies (Chung et al., 2000; Schenker et al., 2010) emphasized the importance of doctor-patient communication, but only one (Street et al., 2007) could identify physician's actions that correlated to patients' distress. Researchers identified statistics illustrating why communication is crucial to mental health services. Many studies (Chung et al., 2003; Ngo-Metzger et al., 2007; Schenker et al., 2009; Street et al., 2007) identified the importance of interpreter services for LEP respondents but only one study (August et al., 2011) utilized the VSD.

A majority of studies reviewed in this chapter focused on the Vietnamese population (Nguyen & Anderson, 2005; Birman & Tran, 2008; Chang et al., 2013;

Fancher et al., 2010 ; Flynn et al., 2013; Gee & Ponce, 2010; Green et al., 2005; Lien et al., 2010; Leong et al., 2013; Le Meyer et al., 2009; Kim et al., 2010; Kim et al., 2011; Kim et al., 2012; Ngo-Metzger et al., 2007; Sorkin et al., 2009; Sorkin et al., 2008; Zhang et al., 2012). Some assessed only Chinese participants (Schenker et al., 2009; Wu et al., 2010; Zhang & Chen, 2014). Other studies focused on Asians in general (August et al., Chung et al., 2000 ; 2011; Ding & Hargraves, 2009; Hadziabdic et al., 2009; Leng et al., 2010; Masood et al., 2009; Rosenberg et al., 2011; Street et al., 2007).

In this current study, the researcher will explore the psychological distress among 200 Vietnamese older adults, ages 65 and older. The researcher will examine how demographic characteristics, PTSD (pre-trauma with war and violence before immigrated to the United States), cultural differences such as stigmas and beliefs, family and social context, linguistic barriers, the use of medical interpreter services, and the quality of care (communication between patients and doctors) are associated with psychological distress. Distinctive factors create different levels of psychological distress, this research will examine the most significant factors.

CHAPTER 3

RESEARCH METHODS

Design and Methodology

The purpose of this exploratory quantitative research was to examine the factors associated with the level of psychological distress that serves as barriers for Vietnamese older adults to access mental health services. The following factors include: (1) difficulty communicating with primary care physicians for patients with LEP, (2) numbers of doctor visits, (3) demographic characteristics, (4) number of visits to doctor's office, (5) language the doctor used during consultation, and (6) patients knowing their rights to a professional interpreter during doctor visits that are associated with patients' level of psychological distress.

Data Collection

The California Health Interview Survey (CHIS; 2012) secondary database was utilized for the current study. CHIS recruited the largest state sample conducted by the UCLA Center for Health Policy Research (UCLA-CHPR). The CHIS (2012) data sample estimated the number of adults in most counties and minority groups within counties with smaller populations. The data also represented California's non-institutionalized population living in households, characterized in terms of sex, age, race, ethnicity, and rural-urban residence. A random digit dial (RDD) telephone survey of landline and cellular telephone data was collected in the state of California, between June

2011 and January 2013. CHIS (2012) interviewed only one adult in each household. The questionnaires were translated into multiple languages to extend the adaptation into cross-cultural differences. The questionnaires covered languages including English, Spanish, Mandarin, Cantonese, Korean, Khmer, and Vietnamese.

Sample

The researcher applied a non-probability method and a purposive sampling procedure selecting 200 Vietnamese who lived in California at the time of CHIS Adult in 2011-2013. The sample was comprised of 200 older adults who self-identified themselves as Vietnamese, between the ages of 55 to 85.

Social Work Ethics

Areas compacted with extended numbers of Vietnamese residents were highly sampled. Telephone numbers associated with specific surnames drawn from telephone directories helped to increase the sample size for Vietnamese households. An average interview took about 35 minutes to complete.

Data Retrieval Form

The study utilized a secondary data, which was retrieved from the 2012 California Health Interview Survey data files (Appendix A). This study extracted data for 20 variables that were used to analyze the above research questions. The variables included the demographic characteristics of male and female, age, country of birth, self-reported Vietnamese, English language proficiency, language spoken at home or with friends, and language use for television, radio, or newspaper.

Ratio variables included: how many times have you seen the doctor in the past 12 months. Interval variables included: how often doctors listen carefully, how often a

doctor explains clearly what to do, (never, sometimes, usually, or always), what language a doctor speaks to you? (English or other languages). Dichotomous variables (Yes or No) included: Did you know that in California you have the right to request an interpreter during your doctor visits, did you know that before today? During your last doctors visit did you have a hard time understanding them? Did the doctor speak English or your preferred primary language? Did you need someone else to help understand or translate what the doctor said? Do you feel comfortable talking to your professional about your personal problems?

Data Analysis

The researcher was able to compare the following independent variables: English use and deficiency, quality of interactions with physicians, number of doctor visits, being able to comprehend information from the doctors, and understanding the right to an interpreter with a ratio level dependent variable, and language the doctor spoke during visits. The study included serious psychological distress as an dependent variable. The researcher applied independent sample t-tests and correlation to test the research questions. In addition, the researcher ran the frequencies for all variables.

Limitations of the Study

Limitation existed within the design of this research. There were various limitations pertaining to the population collected from CHIS database. Vietnamese immigrants are scattered all over the United States but merely a small segment of the population was selected for the study. The sample was collected from only one adult per household; the data then categorized the adult according to the appropriate age to fit this study.

Even when information was obtained from the CHIS database, researchers considered the factors that were excluded from the questionnaire such as personal history, family background, family support, and medical history. These elements were not fully addressed through the variables used in this study. Furthermore, it is impossible for the survey to detect social bias. Cultural differences and negative stigmas against mental health services among the Vietnamese community may not have been revealed throughout this study. Limited personal information shared with strangers also hindered the results of the study.

CHAPTER 4

RESULTS

Univariate Results

The study sample consisted of 265 adults who identified themselves as Vietnamese. There were 111 (41.9%) males and 154 (58.1%) females. The respondents were 55 years and older (Table 1). Ninety-six (36.3%) respondents were 55 to 64 years, 105 (39.7 %) were 65 to 74 years, 54 (20.4%) were 74 to 84 years, and 10 (3.8%) were 85 years.

The study found that 213 (80.4%) reported not speaking English well and 52 (19.6%) respondents reported not at all speaking English well. Only 4 (1.5%) indicated that their doctor never listened to them carefully, 17 (6.4%) stated that their doctor only listened to them sometimes. Ninety-nine (37.4%) respondents indicated that their doctor usually listened to them and 145 (54.7%) Vietnamese respondents reported that their doctor always listened to them.

Only 12 (4.5%) respondents revealed that their doctors never took the time to explain to them clearly about what they need to do and 14 (5.3%) reported that only sometimes their doctor took the time to explain health condition or treatment to them. Furthermore, 107 (40.4%) indicated that their doctor usually took the time to explain things to them, and 132 (49.8%) indicated that their doctor has always taken the time to explain clearly what they can do about their health.

The study found that 140 (52.8%) respondents knew that it is their right to request an interpreter during doctor visits, while 125 (47.2%) respondents did not know that they have the right to request for an interpreter during doctor visits.

Only 24 (9.1%) Vietnamese respondents reported visiting their primary care doctor within the past twelve months, while 241 (90.0%) indicated that they had not been to the doctor within the past twelve months.

Only 38 (14.3%) respondents reported that their primary care doctor only spoke in English when speaking to them, 221 (83.4%) respondents reported that their doctors spoke to them in Vietnamese. Six respondents (3.3%) reported that their doctor spoke to them in other languages.

TABLE 1. Demographics (N = 265)

Variables	*f*	%
Age		
55-64	96	36.3
65-74	105	39.7
75-84	54	20.4
85+	10	3.8
English Use and Proficiency		
Not well	213	80.4
Not well at all	52	19.6
How Often Does Your Doctor Listen Carefully to You		
Never	4	1.5
Sometimes	17	6.4
Usually	39	37.4
Always	145	54.7

TABLE 1. Continued

How Often Doctor Explain Clearly What You Need to do About Your Health		
Never	12	4.5
Sometimes	14	5.3
Usually	107	40.4
Always	132	49.8
Individuals Who Knows Their Right to Request an Interpreter During Doctor Visits		
Yes	140	52.8
No	125	47.2
Have Contacted Their Doctor's Office within the Past 12 Months		
Yes	24	9.1
No	241	90.0
What Language the Doctor Spoke to You?		
English	38	14.3
Vietnamese	215	83.3
Others	6	3.3

Bivariate Results

Demographic Characteristics and Psychological Distress

Table 2 showed an association between age and psychological distress. The study found a weak, negative correlation between age and level of psychological distress (r = -.187; p = .002).

Table 3 showed the difference between males and females in their psychological distress. There was no significant difference between males and females in regards to their psychological distress, t (263) = 1,370, p =. 172.

TABLE 2. Age (N = 265)

Variables	r	p
Age vs. Psychological Distress	- .187	.002

TABLE 3. Gender (N = 265)

Variables	N	*Mean*	*SD*	t	*df*	p
Males	111	1.69	3.316	-1.370	263	.172
Females	154	2.38				

English Use and Proficiency and Psychological Distress

An independent group *t*-test was conducted to analyze the association between English use and psychological distress (Table 4). There is no significant association between how well respondents spoke English and their psychological distress, t (263) = -1.053, p =. 084.

Language Doctor Spoke and Psychological Distress

The study found that there was a statistically significant difference between doctors who spoke to them in Vietnamese and doctors who used other languages in respondents' psychological distress t (263) = -3.755, p = < 005). Respondents who reported having a medical doctor who spoke to them in English were more likely to experience more psychological distress (M = 4.11; SD = 5.78) compared to respondents who reported that their physician spoke to them in Vietnamese (M = 1.69; SD = 3.432).

Knowing Rights for Interpreters and Psychological Distress

There was a significant difference between respondents who knew their right to an interpreter and those who did not know their right to an interpreter during doctor visits in their psychological distress t (263) = -3.077, p < .002). Respondents who did not know (M = 2.88; SD = 4.690) their right to an interpreter during doctor visits are more likely to suffer from psychological distress compared to respondents who knew their right to request for interpreters (M = 1.39; SD = 3.138).

Doctor Visitation within the Past Year and Psychological Distress

Table 5 shows that there was a significant difference in psychological distress between respondents who reported contacting the doctor's office and those who did not contact the doctor's office within the past twelve months t (263) = 1.977, p < . 049).

TABLE 4. Language Barriers (N = 265)

Variables	*N*	*Mean*	*SD*	*t*	*df*	*p*
English Use and Proficiency						
Not Well	213	1.96	3.716	-1.053	263	.293
Not Well at all	52	2.62	5.045			
Language Spoken by Doctor						
English	221	1.69	3.432	-3.755	263	.005
Vietnamese	44	4.11	5.780			
Knowing the Right to An Interpreter During Doctor Visits						
Yes	140	1.39	3.138	-3.077	263	.002
No	125	2.88	4.690			

TABLE 5. Contacted Doctor for Medical Questions in the Past 12 Months (N = 265)

Variables	*N*	*Mean*	*SD*	*t*	*df*	*p*
Contacted Doctor within the Past 12 Months						
Yes	24	3.63	6.020	1.977	263	.049
No	241	1.94	3.735			

Respondents who reported contacting their doctor's office (M = 3.63; SD = 6.020) were more likely to experience psychological distress compared to respondents who did not contact their doctor's office within the past twelve months (M = 1.94; SD = 3.735)

Quality of Interaction with Doctor and Psychological Distress

A moderate inverse correlation (r = -.123; p = .046) was found between how often the doctor listens to their patients and the patients' psychological distress (Table 6). Respondents who reported having their doctors listen to them often were less likely to experience psychological distress. Results also indicated that there was a negative correlation (r = -.117; p = .057) between having their doctors explain things clearly to them about their health and psychological distress. The relationship is only approaching significance.

TABLE 6. Quality of Care versus Psychological Distress (PD) (N = 265)

Variables	r	p
Doctor Listens to you vs. PD	-.123	.046
Doctor Explains to you vs. PD	-.117	.057

CHAPTER 5

DISCUSSION

Summary of Findings and Comparison to Prior Literature

The study sample consisted of 265 adults ages 55 to 85. Among those participants, 41.9% of them were Vietnamese males and 58.1% are Vietnamese females. The study found a weak negative correlation between the level of psychological distress and age. Younger adults reported having higher levels of psychological distress compared to older adults. This is contrary to the findings of Ding et al. 2009, which found a positive relation between age and depressive symptoms among Vietnamese participants.

In this study, there was no significant association between gender and the level of psychological distress. Yet in another study, men reported having higher levels of psychological distress due to past exposures of war, violence, and traumatic events compared to women (Birman &Tran, 2008; Lien et al., 2010). Perhaps, different types of psychological distress should be explored for a more accurate measure.

The current research suggests no association between English use and respondents' level of psychological distress. However, the current study found a difference in levels of psychological distress between respondents whose doctor reciprocally communicated with them in Vietnamese compared to respondents whose doctor communicated to them in English.

Two studies examined the association between participants with Limited English Proficiency (LEP) and their quality of life (Ding & Hargraves, 2009; Gee & Ponce, 2010). Various studies identified the lack of mental health utilization among Vietnamese respondents with LEP (Kim et al., 2010; Kim et al., 2011; Le Meyer et al., 2009). Only one study measured the effect of LEP on psychological distress among Asian immigrants. Many researchers identified the effect of LEP among Asian immigrants but neglected to explore the possibilities of how to decrease problems such as shortage of mental health usage and poor patient-doctor communication. LEP is a factor that attributed towards many problems among the Vietnamese population, yet it has not been explored enough.

The present study discovered a significant difference between respondents who know their rights and these who do not know their rights to an interpreter in relation to their psychological distress. The level of distress was higher among individuals who reported not knowing their rights to request for an interpreter compared to a lower level of distress reported by individuals who knew their rights during doctor visits. Leng et al. 2010 identified the benefit of having interpreter devices for patients at doctor's offices. Studies recognized the importance of having professional interpreters during doctor visits for individuals with LEP (Flynn et al., 2013; Green et al., 2005; Rosenburg et al., 2011). These studies emphasized the likelihood that patients with professional interpreters asked questions regarding their health and shared concerns about their mental health. None of the studies examined the relationship between respondents' access to professional interpreters and their level of psychological distress.

This study revealed the importance of patient-doctor communication with aspect to the quality of care patients received and their degree of psychological distress. The

results demonstrated a moderate correlation between how often respondents' doctors listened to them and their level of psychological distress. Furthermore, the study also revealed a negative correlation between having doctors who explained things carefully during visits and the degree of psychological distress among respondents. The findings were consistent with the literature that healthier communication between the patient and doctor enhances the quality of care for the patient (August et al., 2011; Chung et al., 2000; Ngo-Metzger et al., 2007; Schenker et al., 2009; Street et al., 2007).

Respondents who reported contacting their physicians within the past 12 months for medical questions had a lower level of psychological distress compared to respondents who did not. A majority of the research (Chang et al., 2013; Kim et al., 2010; Le Meyers et al., 2009; Zhang et al., 2012) revealed the difficulty older adults with LEP faced when accessing healthcare services. LEP could be a reason why minority older adults are not contacting their doctors for medical questions, which often leads to higher levels of distress.

Implications to Social Work Practice and Policy

The instruments in this study provided the researcher an opportunity to identify the relationship between LEP and the level of psychological distress among older Vietnamese adults. Studies revealed patients with LEP were less likely to disclose information about mental health status compared to patients who can communicate well with their physicians (August et al., 2011; Green et al., 2005). The gap to detect for psychological distress became wider when patients were reluctant to disclose information and when physicians neglected to investigate patients' mental health status. According to the United States Department of Health and Human Service, one in five adults who

experience mental health issues could recover completely with proper treatment such as medication and therapy. Psychological distress and mental illness are often not explored during doctor visits. The lack of communication during doctor visits can affect the patients' wellbeing.

Untreated psychological distress could lead to major depressive disorders, which in turn might lead to suicidal ideation and even death. The study serves as a tool for professionals to acknowledge their needs when working with LEP patients. As social workers fight against social injustice to ensure equality of services for the general population, there is a need to raise awareness in the medical profession in order to better assist minorities with LEP.

Implications for Multicultural Practice

The Department of Managed Health Care (2014) stated that all health plans must provide interpreters for patients if requested, and that such services are free to patients. The state of California encouraged LEP patients to request interpreters during appointments with primary doctors, and particularly with specialists. The present study shows that a majority of older Vietnamese adults reported not knowing their rights to an interpreter during doctor visits, even though this right is a state law.

Social workers who work with older Vietnamese adults need to be educated and encouraged, similar to any other minorities (NASW, 2014); to exercise their rights to request professional interpreters during doctor visits. Senior centers in the community need to be encouraged to prepare educational events to promote patients' rights. All information need to be distributed through the mail and via posters. Moreover, professionals need to reassure Vietnamese patients that the services will be free of charge

and that health care organizations are responsible for the costs. In addition, it is significant to advocate (NASW, 2014) to the community the importance of professional interpreters and its benefit on patients with LEP. To further reinforce this law, posters and information about patients' rights to request for interpreters will also be displayed at doctor's offices, hospitals, emergency rooms, health care agencies, and mental health agencies.

It is crucial for professionals to acknowledge that there is a shortage of mental health service usage among older Vietnamese adults (Kim et al., 2010; Kim et al., 2011; Le Meyer et al., 2009). Part of being a social worker is to make necessary referrals and to provide resources of services for clients who are in need (NASW, 2014). Professionals who work with the Vietnamese community need to understand that there is a need for resources to mental health services.

Recommendations for Future Research

Part of the literature review in this study explored how cultural stigmas and barriers are a part of the problem that prevent Vietnamese adults from seeking mental health treatment (Fancher et al., 2010; Nguyen and Anderson, 2005; Sorkin et al., 2008). Future researchers should further investigate this population's perspective on mental illness and treatment in order to implement programs that help to decrease the gap between cultural barriers, stigma, and mental health services.

Numerous studies indicate the importance of social support and psychological distress among the Asian population (Chang et al., 2013; Kim et al., 2012; Leong et al., 2013; Masood et al., 2009; Wu et al., 2010; Zhang and Chen, 2014). Respondents who receive more support from family and friends were less likely to experience

psychological distress. Social workers comprehended the importance of human relationships (NASW, 2014) to engage families and friends as allies to help clients through their healing process. This study provides directions for future researchers to explore the benefit of expanding social support for older Vietnamese adults and increasing treatments for patients with mental illnesses.

APPENDIX

DATA RETRIEVAL FORM

APPENDIX

DATA RETRIEVAL FORM

1. What is your age, please? [Range 0-120] _____
2. Are you male or female?
   Male
   Female
   Refused
3. You did not feel comfortable talking with a professional about your personal problems.
   Yes
   No
4. What language do you speak at home?
   English
   Spanish
   Cantonese
   Tagalog
   Mandarin
   Korean
   Asian Indian Languages
   Russian
   Other (Specify:_____)
5. During the past 12 months, how many times have you seen a medical doctor?
   _____
6. How often does your medical doctor listen carefully to you? Would you say
   Never
   Sometimes
   Usually, or
   Always
7. How often does your doctor or medical provider explain clearly what you need to do to maintain your health, would you say
   Never
   Sometimes
   Usually, or
   Always
8. The last time you saw the doctor, did you have a hard time understanding him/her? Yes
   No
9. What language did the doctor speak to you?
   English
   Spanish
   Cantonese
   Vietnamese
   Tagalog
   Mandarin
   Korean

Asian Indian Languages
Russian
Other (Specify:_____)

10. You and your doctor spoke different languages?
    Yes
    No
11. Did you need someone to help you understand the doctor?
    Yes
    No
12. In California, you have the right to get help from an interpreter without charge during your medical visits. Did you know this before today?
    Yes
    No
13. In what country were you born?
    United States
    American Samoa
    Canada
    China
    El Salvador
    England
    France
    Germany
    Guam
    Guatemala
    Hungary
    India
    Iran
    Ireland
    Italy
    Japan
    Korea
    Mexico
    Philippines
    Poland
    Portugal
    Puerto Rico
    Russia
    Taiwan
    Vietnam
    Virgin Islands
    Other (Specify: _____)
14. If you reported you are Asian, what specific ethnic group are you?
    Bangladeshi
    Burmese
    Cambodian
    Chinese

Filipino
Hmong
Indian (India)
Indonesian
Korean
Laotian
Malaysian
Pakistani
Sri Lankan
Taiwanese
Thai
Vietnamese
Other Asian (Specify: _____)

15. Serious Psychological Distress for worst month in the past year (K6 Score)
    Yes
    No
16. Serious Psychological Distress
    Yes
    No
17. Experienced Serious Psychological Distress in the past Year
    Yes
    No
18. Experienced Serious Psychological Distress in the past Month
    Yes
    No
19. How well do you speak English?
    Poor
    Fair
    Fluent
20. Are you Vietnamese?
    Yes
    No
21. English Use and Proficiency
    Well
    Not Well
    Not Well at all

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