Impact of cultural change and acculturation on the health and help seeking behaviour of Vietnamese-Australians

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Declaration

I declare that this thesis contains no material which has been accepted for the award to the candidate of any other degree or diploma and that to the best of my knowledge and belief it does not contain any material previously published or written by any other person except where due reference is made in the text.

Thai Ohtsuka
16 May 2005
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Abstract

This study investigated the influence of cultural change and acculturation on health-related help seeking behaviour of Vietnamese-Australians. Using convenience sampling, 94 Vietnamese-Australians, 106 Anglo-Australians, and 49 Vietnamese in Vietnam participated in the study. Beliefs about health and health-related help-seeking behaviours were assessed through measures of common mental health symptoms, illness expression (somatisation, psychologisation), symptom causal attributions (environmental, psychological, biological), and choice of help seeking (self-help, family/friends, spiritual, mental health, Western medicine, Eastern medicine). Vietnamese-Australian data was compared with that of the Anglo-Australian and Vietnamese-in Vietnam. Results revealed that the help seeking behaviours and health-related cognitions of Vietnamese-Australians, while significantly different from those of Anglo-Australians, were similar to those of Vietnamese in Vietnam. Specifically, both Vietnamese groups were less likely than Anglo-Australians to somatise and psychologise or attribute the cause of symptoms to environmental, psychological or biological causes. However, the two Vietnamese groups were not different from each other in their style of illness expression or in their symptom causal attributions. The Vietnamese-Australians reported experiencing more mental health symptoms than the Vietnamese in Vietnam but fewer than the Anglo-Australians. In relation to help seeking, the Anglo-Australians chose self-help more than the Vietnamese, but there were few other differences between the cultural groups.

To investigate the influence of acculturation on health-related beliefs and help seeking behaviour, Vietnamese-Australians were compared according to their modes of acculturation (integration, assimilation, separation, and marginalisation). Generally, results showed a distinct pattern of response. Those with high levels of acculturation towards the Australian culture (the integration and the assimilation) were found to be most similar (in that they scored the highest in most areas measured) to the Anglo-Australians, while few differences were found between the separated and the marginalised groups. Further, cultural orientation was a powerful predictor of help seeking. In that, original cultural orientation predicted selection of help seeking from Western and Eastern medicine, whereas, the host cultural orientation was a more robust predictor of the other variables. However, neither cultural orientation predicted
preference for mental health help. Finally, the study found that, although the combination of symptom score, modes of illness expression, and symptom causal attribution were strong predictors of choice of help seeking of Vietnamese-Australians, acculturation scores further improved predictive power. The results were discussed in terms of the various limitations and constraints on interpretation of this complex data set.
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CHAPTER 1: INTRODUCTION

OVERVIEW

Help seeking is an effective and adaptive behaviour and a fundamental problem-solving strategy. It enables individuals to maximise their resources through sharing the resources of others. For example, sick people may seek help to access medical services and to mobilise their social support. Help seeking can maximise the likelihood of receiving correct treatment. Further, it enhances the ability to cope with illness or incapacity, thereby reducing stress and improve better overall well-being.

Despite heightened levels of stress as a result of migration and the accompanying adjustment process (Berry, 1990), many immigrants do not seek help (Klimidis et al., 1999) from professional services when they need it. This lack of health service utilisation is attributed to the differences in health beliefs and practice, which often confound communication between new migrants from culturally and linguistically diverse background and service providers in the host culture.

Indeed, culture plays a significant role in shaping health beliefs and practices (Kirmayer, 1989; Kleinman, 1980; Triandis, McCusker, & Hui, 1990). In culturally plural societies such as Australia that offer diverse health care services, cultural differences tend to be more apparent at the early stage of the help seeking process (Angel & Thoits, 1987; Lin, Tardiff, Donetz, & Goresky, 1978). Once reaching the referral point (e.g., making contact with general medical practitioners), help seeking cognitions and behaviours of people from diverse cultural backgrounds tend to become more uniform. Contacts with health care professionals often introduce new sources of information which may significantly change an individual’s health beliefs and practices, making them more in line with those held by people in the mainstream. Therefore, an understanding of the cognitive process before contact with health care professionals takes place is crucial to evaluating the impact of culture on help seeking behaviour.

The initial stage of the help seeking process may also be influenced by cultural change. Previous studies have demonstrated that cultural contacts lead to changes in many areas of a person’s life (Berry, 1990, 1999; Berry & Kim, 1988) including health beliefs and practices (Klonoff & Landrine, 1994; Landrine & Klonoff, 1994b; Quah & Bishop, 1996). The present study was an investigation of the influence of culture and
cultural change (acculturation) on Vietnamese-Australians’ help seeking cognitions with respect to common mental health symptoms, in particular those associated with anxiety and depression.

The first aim of the current study was to examine whether Vietnamese-Australians’ help seeking cognitions were different from people in their county of origin, the Vietnamese in Vietnam, and majority people in their current host country, the Anglo-Australians. Factors related to help seeking such as symptom experience, symptom causal attributions, illness expression, and help-seeking selections were explored in the study. These key concepts are briefly introduced below and discussed in detail in Chapter 3. The second aim of the current investigation was to investigate if help seeking cognitions were influenced by acculturation. Concepts of acculturation are briefly introduced below and will be discussed in more detail in Chapter 4. The third aim of the current study was to identify whether acculturation and help seeking measures could predict the selection of sources of help among Vietnamese-Australians.

STUDY PLAN

There were three major stages of analysis. Firstly, between-group comparisons of three cultural groups (Vietnamese-Australians, Anglo-Australians, and Vietnamese in Vietnam) were conducted on the dependent variables of interest, that is, those comprising the model of help seeking. This model involved assessment of symptoms experienced (of anxiety and depression), and the extent to which participants used somatisation (the tendency to focus on bodily symptoms) or psychologisation (the tendency to focus on psychological symptoms). Modes of illness expression, variations in beliefs about the causes of various symptoms, and types of help sought when such symptoms occur were also assessed.

The focus of the current study was mental health (anxiety and depression) rather than physical health, because this aspect of health behaviour was the area in which cultural differences in symptom recognition, beliefs about illness and help seeking were expected to be greatest. Symptom recognition measures included the notions of somatisation and psychologisation, that is, the extent to which bodily/physical symptoms or psychological symptoms are recognised as problematic and inimical to health. Measures of beliefs about the causes of symptoms included assessment of
causal attributions, that is, the extent to which participants believed that their symptoms were attributable to environmental, psychological, or biological causes. Help-seeking was assessed across six sources: self-help (self-reliance), family and/or friends, spiritual sources, mental health professionals, Western medicine, and Eastern medicine.

The patterns of acculturation of the Vietnamese-Australian sample were defined using the bi-dimensional approach to acculturation proposed by Berry (1990). The extent of adoption of the Australian culture (Australian-ness) and the extent of maintenance of the culture of origin (Vietnamese-ness) were measured for the Vietnamese-Australian sample. The two acculturation dimensions were expected to predict help seeking preferences. Specifically, scores on the independent scales of Vietnamese-ness and Australian-ness were used as independent variables in multiple regression models to predict various aspects of health beliefs and help-seeking. These included measures of symptoms experienced, somatisation, psychologisation, environmental attributions, psychological attributions, biological attributions, and the extent to which the various help sources were to be utilised. The current study also tested multiple regression models to predict choices in help seeking using help seeking variables (symptoms, illness expression, and causal attributions) and acculturation (Vietnamese-ness and Australian-ness) as independent variables.

Finally, the Australian-ness and Vietnamese-ness scores were used to define four modes of acculturation for the Vietnamese-Australian group: marginalisation, assimilation, separation, and integration (Berry, 1990). Acculturation groups were then compared on the help-seeking variables, and hypotheses based on the acculturation literature were tested.

THEORETICAL FRAMEWORK

A MODEL OF THE HELP SEEKING PROCESS

The fundamental focus of this study is on how people seek help when they experience symptoms of illness. On the basis of work by Angel and Thoits (1987), Kleinman (1980), Pescosolido (1992) and Ryan and Pintrich (1998) it was postulated that help seeking is a process rather than a single planned behaviour. This process is described as involving three stages: symptom recognition, decision to seek help, and choice on course of action (Karabenick, 1998), each of which is influenced by culture
(Angel & Thoits, 1987; Kirmayer, Young, & Robbins, 1994; Kleinman, 1980). Figure 1 shows a modified model of a help seeking process based on the work of Angel and Thoits (1987), Kleinman (1980), Ryan and Pintrich (1998), and Pescosolido (1992). The problem recognition phase concerns the notion that help seeking is triggered by the realisation of the need to seek assistance, which is based upon subjective evaluation of the severity of the problem and the type of symptoms experienced. The ‘decision to seek help’ phase posits that, once an individual has decided to seek help, he or she would draw on beliefs about the causes of the presenting problem to reach a decision as to an appropriate course of action. The ‘choice of course of action’ phase posits that individuals select helpers who match their causal explanations. For example, an individual who attributed symptoms to biological causes might be more likely to seek help from a medical practitioner than from a spiritual helper, whereas a person who attributed their problem to a ‘lack of will-power’ would be more likely to seek help from peers, family, spiritual helpers, or to turn inwards to self-help.

Figure 1. Three stage model of help seeking

**Problem Recognition**

The first stage in the help seeking process involves problem recognition - when the person categorises changes to their physical or mental state as either “normal” or “abnormal”. According to Angel and Thoits (1987), an inference of the severity of the problem occurs when the change in sensations is unpleasant, intense or prolonged. Individuals vary in the extent to which they monitor their internal changes. Some minimise their symptoms and are passive about help seeking. Others amplify them and actively seek help.
Self-monitoring and the evaluation of bodily and mental experiences can be significantly influenced by culture and by the individual’s reference groups (Angel & Thoits, 1987). In other words, the normality or abnormality of a physical or mental experience can be assessed by comparing it with the average health status of one’s reference group. A person’s reference group may include family, friends, colleagues, and people in the wider community. The reference group sets a standard for evaluating symptoms. For example, in many cultures, hearing the voice of a ‘significant other’ who died is considered ‘normal’ as a part of the healing process (Helman, 1994). Some affective states, considered in the West as depressed, may be considered ‘normal’ in Buddhist cultures (Obeyesekere, 1985). The more common an abnormal state is in one’s reference group, the less likely it is to be considered significant and therefore worthy of help-seeking (Angel & Thoits, 1987). When a disorder is perceived as serious, then help is more likely to be sought. However, when a serious health condition is deemed socially undesirable (such as psychiatric illness), help is less likely to be sought (Angel & Thoits, 1987). In addition, past research indicates that individuals who closely monitor their internal feeling states (Rickwood & Braithwaite, 1994) and those who are open to confiding in others about their mental health problems (Rickwood & Braithwaite, 1994; Tijhuis, Peters, & Foets, 1990) are more likely to seek help.

People from different cultures may differ in the early stage of help seeking process due to several reasons. First, there may be variation in people’s experience of the problem. For example, anxiety and depression are two of the most common mental health problems which, it is argued, are often more readily recognised by people from Western backgrounds than by those from non-Western backgrounds. In one culture, these illnesses may be recognised by their professionally defined classifications (i.e., anxiety and depression), while in others, they are recognised only by specific symptoms (e.g., sad, worried, headache, etc.). Second, different culture can ascribe different meanings to illnesses. Anxiety and depression, considered mental illness in one culture and requiring medication and psychotherapy, are considered as resulting from either an imbalance of the ecological system (Chen & Swartzman, 2001; Hinton, Chen, Du, & Tran, 1993; Hinton, Hinton, & Tran, 2003) or as a part of life which requires endurance as a coping strategy in another culture. Third, culture may influence the extent to which people are willing to disclose certain symptoms (particularly affective symptoms)
because of perceived stigma or other negative consequences associated with those symptoms (Angel & Thoits, 1987; Kleinman, 1980). Cultures which encourage individualism may not only readily acknowledge but also magnify symptoms, whereas cultures which encourage collectivism may minimise or dismiss them (Kleinman, 1980, 1986, 1988). Finally, culture also influences the way in which health problems are expressed or presented in help seeking situations. It has often been found that, while people from Western cultures are practiced and adept at using psychological terms (psychologisation) to express their distress, people from non-Western societies tend to express their distress through bodily symptoms (somatisation) (Kirmayer & Young, 1998; Kleinman, 1980; Kleinman & Kleinman, 1985; Nguyen, 1982a). Following from that, people from non-Western cultures also tend to somatise their symptoms when they seek help (Kleinman, 1980; Nguyen, 1982a).

**Decision to Seek Help**

Once changes in physical or mental states have been recognised as problematic, individuals elicit causal explanations for their illnesses to facilitate their selection of appropriate sources of help seeking. Illness causal attributions can be categorised into environmental, psychological, and biological factors. Environmental attributions refer to beliefs that natural environmental factors such as wind, dust, temperature, poor housing etc. are the causes of the symptom. Psychological attributions refer to the belief that symptoms experienced arise from psychological factors such as stress (e.g., pressure from financial or relationship problems), personality, or cognitive styles. Biological attributions refer to the belief that symptoms are caused by physiological/biological malfunctioning caused perhaps by to genetic inheritance, disease, germs, viruses, etc. Individuals are likely to seek out caregivers who offer assistance in ways that match their explanatory models. Many studies have shown that beliefs about the nature and cause of a particular illness will directly determine when and what kinds of help people seek (Akighir, 1982; Cameron, Leventhal, & Leventhal, 1993; Leventhal & Diefenbach, 1991; Sue & Sue, 1987; Swartzman & McDermid, 1993). For example, studies have found that individuals who attribute problems to internal dispositional (psychological) causes are more likely to utilise mental health services than those who attribute their symptoms to external/situational factors (Robbins, 1981, 1983; Robbins & Kirmayer, 1991). Similarly, those who attribute their
symptoms to physical disease are more likely to seek help from physicians than are those who dismiss, minimise or deny the significance of their distress (Barsky & Klerman, 1983; King, 1983; Stoeckle & Barsky, 1980).

**Choices on Course of Action**

As indicated above, once they have reached a conclusion on the cause of the problem and acknowledged the need to seek help, individuals consider appropriate sources for help seeking. Selection of the helping source tends to reflect the person’s familiarity with the health care system.

Three sources of health care/help which exist in all cultures have been termed the popular, the folk, and the professional sectors (Kleinman, 1980). The popular sector consists of individuals, their families and their social networks. This sector is considered the largest source of health care and it is through this source that most symptoms of illness are treated (Angel & Thoits, 1987; Kleinman, 1980). Folk medicine consists of non-professionals who practice various forms of healing, including both ‘sacred’ and secular forms (Kleinman, 1980). Examples are shamanism, ritual practices, herbalism, traditional surgical and manipulative treatments, special systems of exercise and exorcism (Kleinman, 1980; Sharp, 1994). The professional sector consists of the organised healing professions. In Western societies, they include mental health and biomedicine practitioners. In non-Western societies such as China and Vietnam, they include both traditional Chinese medicine and Western biomedicine. In these cultures, mental health services are only available in the form of institutions/asylums (Dinh, Ganesan, & Wazler-Morrison, 1990). Nevertheless, the boundaries between the three sectors are not always clear. For example, the popular sector may employ some of the healing practices carried out by the folk sector; traditional (Chinese) medicine is treated as part of the mainstream professional health sector in China, but in Western societies, it may be considered as folk or an alternative form of medicine. Selection of the source of help thus depends on an individual’s knowledge of what is available, their comfort with those sources, and their actual availability.

**THE INFLUENCE OF CULTURE ON HELP-SEEKING PROCESS**

The three cultural groups participating in the current study are Anglo-Australians, Vietnamese-Australians, and Vietnamese in Vietnam. The second focus of the study is to compare cultures with respect to their health beliefs and health-related
help seeking, and to examine the effects of acculturation on these variables. It was hypothesised not only that there would be differences between these three groups’ help seeking cognitions, but that cultural change also influences patterns of help seeking. That is, the experiences of adapting to a new culture, and the modes of adaptation adopted (such as integration, assimilation, separation, and marginalisation, as proposed by Berry (1990), will in turn shape health care behaviour, values and beliefs. The Vietnamese-Australian sample in this study was used to explore this possibility.

Acculturation is a concept with an important role in understanding the health outcomes and behaviour of migrant populations. In the host country, people from migrant backgrounds face two choices in adapting to their new environment – whether to maintain their culture of origin’s beliefs and practices or to adapt to the beliefs and practices of the host society. This choice is available across many life domains including the domain of health care. Simultaneous consideration of these two health related choices in the host society allows for four individual strategies or options: assimilation, separation, integration, and marginalisation (Berry, 1990). The assimilation strategy dictates the adoption of the health beliefs and practices of the host culture and the abandonment of the health beliefs and practices of the culture of origin. The separation strategy dictates the maintenance of the health beliefs and practices of the culture of origin and the rejection of the health beliefs and practices of the host culture. The integration strategy allows both the adoption of the health beliefs and practices of the host culture as well as the maintenance of the health beliefs and practices of the culture of origin. Finally, the marginalisation option represents idiosyncratic health beliefs and practices, which reflect health beliefs and practices of neither the host culture’s nor the culture of origin. Acculturation strategies and their outcomes in the health and help-seeking domains were a major focus of this study.

THE VIETNAMESE IN AUSTRALIA

A third major focus of the study was to further the understanding of the Vietnamese-speaking community in Australia. According to the Australian Bureau of Statistics (2002), by 2001, the Vietnamese community was ranked the fourth largest cultural group by country of birth in Australia (after the UK, Ireland, and Italy). The community comprises approximately 156,581 people of whom 102,210 are of Vietnamese ancestry and 41,230 are of Chinese-Vietnamese ancestry. Of the 150,160
Vietnamese born in Vietnam, only about half indicate the ability to speak English. The main religions of the Vietnamese are Buddhism and Taoism, followed by Confucianism, Christianity (mainly Roman Catholic) and indigenous sects including Cao Dai and Hoa Hao. New South Wales has the largest number of Vietnamese-Australians with 63,020 followed by Victoria (56,680), Queensland (11,570) and South Australia (10,490).

Migration Characteristics

The migration characteristics of Vietnamese in Australia could be classified into five groups. The first group of Vietnamese, estimated between 700 and 2500, were residents in Australia before 1975. They included international students, war orphans adopted by Australian families, and wives of Australian military personnel who had served in Vietnam (Department of Immigration and Multicultural and Indigenous Affairs, 2003). The second group was part of the first wave of refugees who fled the country before the North Vietnamese Army took control over the South on April 30th 1975. This group came from socially and economically advantaged sectors of society.

In general, the second group of Vietnamese migrants were predominantly urban, middle-class, well-educated Vietnamese, and had more ties to Western societies (Nguyen, Messe, & Stollak, 1999; Nguyen & Peterson, 1993). Due to their contact and cooperation with Americans during the war, most of the first-wave refugees were airlifted and evacuated by sea from Vietnam (Nguyen et al., 1999). Most of these over 200,000 first-wave refugees were resettled in the United States but many were also accepted by Australia and Canada.

The third group of Vietnamese migrants are commonly known as “boat people” although the majority of them escaped Vietnam by land. After the official reunification in 1975, Vietnamese refugees continued to flee Vietnam to avoid prosecution and political unrest. This group includes ethnic Chinese who were prosecuted and expelled by the government during the anti-capitalist campaign in 1978 and the Sino-Vietnamese War in 1979. Many refugees suffered atrocities during their escape and were victims of torture, starvation, malnutrition, assault, rape, or robbery, with many children witnessing these atrocities (Chung & Bemak, 1998; Matsuoka, 1993). People from this group came from a wider socioeconomic spectrum, and were generally less educated, and had less previous exposure to the West. More than 90% of the second-wave of
Vietnamese refugees did not speak English (Beiser & Hyman, 1997; Chung, Bemak, & Okazaki, 1997). It has been suggested that the first wave, when compared to the second wave of refugees, experienced fewer post-migration adjustment problems due to the differences in their pre-migration experiences (Nguyen, 1982a, 1982b).

The fourth group of Vietnamese migrants arrived to Australia under the Family Reunion Scheme. They include family members (the elderly parents, spouses, and dependent children) of the Vietnamese migrants who arrived earlier. The last group of Vietnamese residing in Australia include migrants sponsored by Vietnamese-Australians as well as sojourners such as international students and exchange visitors.

According to the Department of Immigration and Multicultural and Indigenous Affairs (2003), between 2001 and 2003, a turnover of over 5,000 Vietnamese from Vietnam arrived in Australia each year on temporary visas. The majority came for purposes such as studying, visiting, social and cultural exchange, and business and governmental assignments. The dynamics of the Vietnamese community’s pathways to Australia has significant implications for their mental health status and adaptation in the host country. Those who left their home country voluntarily are more likely to experience better health and less migration and acculturative stress than those who were forced to leave the country as refugees.

Pre- and Post-Migration Stress

Major life change such as migration can cause tremendous stress. The level of stress varies depending on the type of migration (voluntary vs. involuntary) (Berry, 1990; Berry & Kim, 1988). In addition, Vietnamese refugees (the main migrant group) experience worse health than many other refugee groups (Stutters & Ligon, 2001).

Both before and during emigration, all refugees experience stressful conditions and events that are devastating for many and extremely difficult for most. In addition, the environment after emigration is likely to be filled with extreme stressors. Refugees are forced to adapt to a new country which is often quite different from their own, whilst simultaneously grieving the multiple losses due to the upheavals from their homeland. Clinical and empirical studies have reported that cultural, linguistic, and value differences add further stress and hinder the process of adaptation (Gong-Guy, Cravens, & Patterson, 1991; Le-Doux & Stephens, 1992; Mayadas & Elliott, 1992). Vietnamese refugees in the United States, however, have been found to experience more severe
levels of anxiety and depression when compared with other refugee groups such as the Somali refugees or the refugees from the Former Yugoslavia (Stutters & Ligon, 2001).

Because of the severity and duration of stressors both before and after emigration, many refugees develop serious mental health difficulties (Kinzie, 1993; Weisaeth & Eitinger, 1993; Williams & Berry, 1991). Most of the evidence citing such problems experienced by the Vietnamese comes from research studies of clinical populations. These studies have reported high prevalence rates of posttraumatic stress disorder (PTSD), depression, and anxiety (Cheung & Lin, 1997; Kinzie, 1981, 1993; Kinzie, Boehnlein, Leung, & Moore, 1990; Kinzie & Manson, 1983; Kroll, Habenicht, Mackenzie, & Yang, 1989; Nguyen, 1982a, 1982b). For instance, Kinzie et al. (1990) found that 71 percent of clinic patients were diagnosed with PTSD, and 81 percent were diagnosed with depression. Mollica, Wyshak, de Marneffe and Khuon (1987) reported a 50 percent prevalence rate of PTSD and a 71 percent prevalence rate of mixed anxiety and depression. Kroll et al. (1989) diagnosed only 14 percent of the patients as having PTSD but found a prevalence rate of 73.3 percent for depression amongst refugees. Nguyen (1982a) found that the clinical symptoms of 56 Vietnamese patients included anxiety (18%), depression (39%), anxiety with marked depressive features (10.5%), psychosis (16%), and adjustment reactions (16.5%). A study of the long-term effects of trauma on the mental heath and rates of disability of 1413 Vietnamese living in Sydney found that about 8% of these adults had mental health disorders as defined by the International Classification of Mental and Behavioural Disorders,ICD-10 (Steel, Silove, Phan, & Bauman, 2003). The most common finding from Vietnamese clinical samples is that patients/clients tended to describe their discomfort using somatic terms (Cheung & Lin, 1997; Lin, 1981; Matkin, Nickles, Demos, & Demos, 1996; Williams & Berry, 1991). Popular symptoms included headache, insomnia, palpitation, aches and pains, dizziness, fatigue, poor memory and poor concentration.

*Vietnamese Culture and Health Care Practices*

The Vietnamese originated in southern China about 3,000 years ago and gradually moved southward into the Red River Valley in northern Vietnam and, eventually, to the Mekong River Delta in the South (Buttinger, 1958). Vietnamese culture is influenced by two major sources Chinese and Western (e.g. French and American). The influences of the Chinese extended over a thousand years through the
form of domination (from between 111 B.C. to the 10th Century A.D. and then again from 1407 to 1428). European cultural influences began in the 18th Century, but intensified in 1853 when the French began the process of conquest which culminated in 1883. Vietnam was then officially colonised by the French until 1954 (Huard & Durand, 1994). From 1954 to 1975, the country was divided in half. In the north of the 17th parallel, the Democratic Republic of Vietnam was supported by communist countries such as the People’s Republic of China, and USSR. In the south, the Republic of Vietnam was supported by a number of Western countries such as the United States of America and Australia.

As the result of long-term foreign domination, Vietnamese health care practices are greatly influenced by the Chinese and to lesser extent by Western biomedicine. Particularly, the influence of the Chinese cultural practices and beliefs has had a significant impact on the Vietnamese model of health care practices. These practices and beliefs include an amalgam of beliefs in Confucianism, Taoism, and Mahayana Buddhism which dictate order, harmony, and pragmatism. Vietnamese strictly follow the Confucian ideas of filial piety and ancestor worship wherein interpersonal relationships are carefully regulated. Buddhism, well integrated into the interpersonal, social life of Vietnam, is often practised together with Taoism, worship of historical heroes, local beliefs, and even Christian religious elements. Both Confucianism and Buddhism emphasise the virtue of obedience, order and modesty and discourage the display of strong emotions in public. Buddhism emphasises the attainment of enlightenment through experiential learning to overcome ego and desire which are believed to exasperate suffering in life. Confucianism, more a way of life than a religion, advocates a code of ethics that upholds hierarchy and obedience and stresses the worship of ancestors. Taoism seeks to achieve harmony and perfection by allowing things to assume their natural course. This philosophy advocates taking no unnatural action, thereby achieving conformity to the Tao or "the Way" (Nguyen, 1985). These beliefs are often cited as “Asian”. (Andary, Stolk, & Klimidis, 2003). The manifestation of these religions and philosophies on the health beliefs and practices of people from Chinese-influenced cultures will be presented in Chapter 2.

Western medicine was introduced to Vietnam by the French in the 19th Century. With the encouragement of the colonial authorities, medical doctors were regarded with high prestige. Their status was often equated with gifts from God enabling them to save
people’s lives (Dinh et al., 1990). They exemplified wisdom, good judgement, and dignity. However, for the majority of Vietnamese, the health professionals were rather remote and aloof, since Western biomedicine, only available through hospital and community health clinics, was unaffordable or unattainable for the majority of population (Dinh et al., 1990). Mental health services were also introduced by the French in the form of asylums where profoundly disturbed patients were taken and administered electric convulsive therapy by “wardens.” (Dinh et al., 1990). This treatment reinforced the stigma already associated with mental illness arising from traditional beliefs.

Overall, the traditional Vietnamese lay models of health have been formed as a confluence of significant Chinese influences and a lesser influence by Western biomedicine. In Australia, Western biomedicine is the dominant form of health care and is widely available through Vietnamese-speaking and English-speaking doctors. Although ready access to Western medicine may further influence Vietnamese migrants’ health care models, little is known about Vietnamese migrants’ health beliefs and practices, including the extent to which they have been influenced by traditional Chinese medicine and Western biomedicine. The pathways through which Vietnamese migrants seek help for common mental health problems need to be identified.

RESEARCH QUESTIONS

The current research sought to investigate the following questions:

- How does help seeking differ between Vietnamese-Australians, Anglo-Australians, and the Vietnamese in Vietnam?
- How does help seeking differ among individuals within a bi-cultural cultural group, the Vietnamese-Australian community?
- How does acculturation influence the help seeking cognitions and behaviours of Vietnamese-Australians?
- What factors (severity of symptoms, somatisation, psychologisation, environmental causal attributions, psychological causal attributions, and biological causal attributions) predict help seeking selections among Vietnamese-Australians?
**Brief Description of Independent Variables**

**Culture.** Cultural identity, or ethnicity, has been the most common cultural indicator in cross-cultural research. In typical cross-cultural comparative studies, two or more ethnic groups are compared for quantitative differences on dependent variables related to topics such as disease prevalence or pattern of service utilisation (Kazarian & Evans, 2001; Lin et al., 1978). The current study used a similar approach to identify how people of the culture in transition (Vietnamese-Australians) are different from people of their original culture (the Vietnamese in Vietnam) and people of the dominant culture in their new host country (Anglo-Australians).

**Australian-ness** and **Vietnamese-ness.** The current study proposes conceptualisation of acculturation based on the bi-dimensional approach. In the bi-dimensional theory, acculturation is defined on two dimensions: (a) host culture orientation and (b) heritage culture orientation. Host culture orientation measures the extent of adaptation towards the host culture (Australian culture). Heritage culture orientation measures the extent to which immigrants retain and maintain their culture of origin (Vietnamese culture). Past studies have found acculturation towards the host culture is positively correlated with psychological health (Nguyen et al., 1999), and preference for Western medicine (Quah & Bishop, 1996). Stronger retention of culture of origin behaviours and values predicts poorer health, and preference for Eastern medicine (Quah & Bishop, 1996). In the current study, Australian-ness and Vietnamese-ness were assessed and their roles in health behaviour and help-seeking were evaluated.

**Acculturation strategies/modes.** The most widely accepted approach to acculturation has been the multidimensional approach proposed by John Berry (1990). Berry’s approach conceptualises acculturation as falling into four categories. The assimilation category includes people who are eager to adopt the culture of the host country and show a diminishing interest in their culture of origin. The separation group includes those who do not adapt to the host culture and maintain the ways of their culture of origin, often against difficulties. The integration group includes people who embrace both the new culture and the original culture. The marginalisation group includes those who do not adapt to the new culture but neither do they maintain the behaviours and values of their culture of origin.
Berry and Kim (1988), and Berry (1990) have reported that the integration mode is associated with lower levels of acculturative stress than the marginalisation and separation strategies. Those who choose the assimilation strategy show intermediate levels of acculturation stress. Although the multidimensional approach of acculturation is widely recognised in cross-cultural research, and acculturation of Vietnamese in various host countries has been extensively studied by John Berry and his associates in the International Comparative Studies of Ethnic Yought (ICSEY) project (http://www.ceifo.su.se/icsey/icsey.html), the relationships between different strategies and help seeking have not previously been studied.

Brief Descriptions of Dependent Variables

Symptoms. The symptom score is a measure of participants’ mental health status based on common mental health symptoms such as anxiety and depression. Help seeking is initiated by the ability to recognise disturbing symptoms and by the subjective experience of symptom severity. These in turn can influence the cognitive process which leads to actual help seeking. Accordingly, participants’ symptom scores were used to investigate how general mental health status influences choices of help seeking. Further, because symptom score can be used to measure levels of psychological adjustment, this measure was also used in the current study to investigate the extent of psychological adjustment of Vietnamese-Australians compared to other cultural groups. The relationship between levels of psychological adjustment and Vietnamese-Australians’ modes was also analysed.

Somatisation and psychologisation. These variables assessed participants’ modes of illness expression. Somatisation refers to the tendency to focus on bodily sensations which lead to expression of personal and social distress through bodily complaints and medical help seeking. Psychologisation refers to the tendency to focus on the intrapsychic process. It is often associated with the use of psychological or emotional terminology to express distress (Kleinman & Kleinman, 1985) and help seeking for mental health issues. Although somatisation is a common mode of illness expression in many cultures (Kirmayer, Robbins, & Paris, 1994; Kleinman, 1980, 1982, 1986, 1988; Kleinman, Eisenburg, & Good, 1978; Kleinman & Kleinman, 1985; White, 1982), it has often been found to be a more frequently used mode of distress expression by people from non-Western cultures. Kleinman (1980) among others found that
Chinese patients expressed depression and other psychological problems predominantly through a somatic idiom. Some studies (e.g., Kinzie & Manson, 1983; Lin, Carter, & Kleinman, 1985; Nguyen, 1982a) have found this to be also the case for the Vietnamese. This propensity to use a somatic idiom (e.g., “I have a headache” instead of “I am worried”) to cope with distress is an adaptive coping strategy in cultures in which mental illness is severely stigmatised. According to previous studies (e.g., Kleinman, 1980, Nguyen, 1982a), somatisers come from cultures which discourage expression of emotional problems (e.g. Chinese, Japanese, Vietnamese), which attribute the causes of symptoms to situational and biological factors and in which it is normal to seek external help (e.g. from family members or friends, religious or community leaders, and medical practitioners). Psychologisers, however, tend to attribute the cause of problems to psychological factors, and are more likely to rely on self-help or seek assistance from psychologists or other mental health professionals.

**Symptom Attribution**

Attribution is defined as the explanation given for the cause of various symptoms. In the current study, three primary types of attribution, environmental, psychological, and biological, were discussed.

**Environmental attributions.** These are defined as the extent to which the causes of symptoms are attributed to environment factors. For example, disease/illness may be attributed to natural phenomena such as wind, dust, and temperature, or to man-made environmental factors such as poor housing or lack of air circulation. In the current study, this type of attribution is of particular interest as it is related to traditional Chinese illness explanatory models. These traditional models attribute the causes of illness to imbalances of complimentary elements in ecological systems (e.g., yin and yang, hot and cold) or exposure to an element causing affliction (e.g. being “hit” by a poisonous wind). These environmental causal explanations have been found to be endorsed by people from cultures with Chinese cultural orientations (Quah & Bishop, 1996) including the Vietnamese (Barrett, 1997; D. Hinton et al., 2003). It was expected that endorsement of this type of causal attribution would be associated with help seeking from Eastern medicine.

**Psychological attributions.** These refer to the tendency to attribute the causes of illness to psychological factors. They include ascription of illness to negative thoughts
or emotions related to a variety of problems (financial, relationship, personality, etc.). Benign symptoms attributed to one’s own personality characteristics are more likely to be dealt with by ‘self-help’ strategies, or simply ignored. Symptoms or problems that are attributed to personal or psychological factors are also more likely to prompt a search for psychological assistance (Robbins & Greenley, 1983). Those who attribute the causes of their problem to these factors were expected to be more open to seeking help from mental health professionals than those who rarely make psychological attributions. Cross-cultural studies, however, have indicated that the relationship between this variable and help seeking tends to be inconsistent between cultural groups. In Western culture, psychological attributions may be related to help seeking from mental health professionals, whereas in non-Western cultures, such attributions may lead to preference for help seeking from informal sources such as family or friends (Lin, Inui, Kleinman, & Womack, 1982).

**Biological attributions.** These attributions reflect Western biological models of illness. This type of illness explanation involves attribution of the causes of symptoms to physical, biological, or genetic factors. Armstrong and Swartzman (1999) compared illness causal attributions between ‘Western’ Canadians and Asian Canadians (Chinese, Vietnamese, and Taiwanese) and found Asian participants endorsed items indicative of traditional beliefs in Chinese medicine, whereas Western participants endorsed biomedical causes more strongly than did the Asians. In the current study, it was expected that those who are more familiar with the Western biomedical model of illness (e.g., Anglo-Australians and Vietnamese-Australians who were more adapted to Australian culture) would adopt this explanation more often than others who are not.

**Sources of Help**
The current study analysed six sources of help which were defined as follows.

**Self-help.** This source refers to the extent participants rely on themselves. Symptoms which are considered not to be severe may simply be ignored or dealt with by the individual themselves. It was expected that a low symptom score would predict the use of this source of help.

**Family and/or friends help.** This source of help refers to the extent to which participants turn to family members or friends for help. People from collective societies (e.g., Vietnam, China, Japan) are more likely to function as part of the group (Nguyen
et al., 1999). When encountering problems, they are more likely than people from more individualistic societies to rely upon family members and friends for help. It was expected that Vietnamese in Vietnam and Vietnamese-Australians who scored high on Vietnamese-ness would be more likely to select this source of help.

**Spiritual help.** This refers to the extent to which participants seek help from spiritual sources. This source of help or guidance includes assistance from religious leaders (e.g., monks and priests), transcendental power (e.g., God, Buddha), and supernatural sources (spirits, spirits of ancestors, etc.). Cultures which believe in the holistic approach to health tend to explain the cause of their problems not only by recourse to social and biological factors but also by spiritual sources (Landrine & Klonoff, 1994b). Spiritual help is assessed in order to find out about the extent to which participants use the ‘folk sector’ of health care (more details in Chapter 2). Past studies of the use of this causal explanation have tended to describe it as people’s “superstitious” tendency. However, causal explanations which lead to help seeking from spiritual sources may include logical acceptance of the doctrine of “karma” or causal repayment of own good/bad deeds, or salvation through good deeds. Although the supernatural is invoked in health care in every culture (Eisenbruch, 1990; Murdock, Wilson, & Fredrick, 1980), it believed that people from non-Western cultures, due to the absence of mental health service in their country, may use this source of help more than people in Western countries. It was expected that Vietnamese in Vietnam and Vietnamese-Australians who strongly retain their heritage culture would prefer seeking help from these sources more than others.

**Mental health help.** This measure indicates participants’ willingness to seek help from mental health professionals. Professionals included in this group of helpers include psychiatrists, psychologists, counsellors, and psychotherapists. Vietnamese have often been found to have negative attitudes toward mental health services and therefore may accept such services only when experiencing a serious episode of mental illness (e.g., psychosis, attempted suicide or schizophrenia) (Andary et al., 2003; Duong-Ohtsuka, 2003; Tran, 1996). In cultures where mental health problems are highly stigmatised (e.g., China, Vietnam, etc.), common symptoms of anxiety and depression may be minimised, dismissed, displaced or somatised (Kirmayer, Young et al., 1994; Kleinman, 1980; Nguyen, 1982a; Robbins & Kirmayer, 1991). However, in cultures where mental health services are readily available and mental health problems
are less stigmatised (e.g. Australia), these symptoms may be more easily recognised and mental health help may be indicated as a treatment of choice. Past studies have often reported the under-utilisation of mental health services by many ethnic communities (e.g., Lin, Inui et al., 1982; Sue & Morishima, 1982). The lack of mental health service utilisation among the ethnic communities may be attributed to many factors such as cultural barriers, stigma, and the unavailability of services. However, the use of alternative sources of help may better account for it. For example, Lin and colleagues discovered a distinctive pattern of help seeking behaviour of people from Asian, Anglo/Europeans, and Mexican-Americans. They found that before reaching specialised mental health services, the Anglo/European group actively sought help from varied social and health care services (e.g. GPs, psychologists, counsellors, psychotherapists). By contrast, they found that Asian families would play an active role in the management of the problem. The Mexican Americans, however, did not receive help from either of those sources; rather, they were passively transferred between legal agencies before being referred to psychiatric care. Subsequently, in the current study, it was expected that Vietnamese-Australians would prefer help from family and friends more than people from the Anglo/European backgrounds. However, due to their access to the Australian health care system, Vietnamese Australian may rely on these informal sources of help less than the Vietnamese in Vietnam do. Specifically, within the Vietnamese Australian community, those who are more adapted to the Australian culture (strong host culture orientation) are more likely to seek help from mental health professionals for mental health related issues than those who are not (low host culture orientation). Conversely, the tendency to count on family and social network for help may remain strong as long as people retain their traditional values and beliefs (strong heritage culture orientation).

Western medicine help. This measure indicates the extent of preference for Western biomedicine as a source of help. Professionals included in this source of help are general medical practitioners and medical specialists. Chung and Lin (1994) reported that migration tends to change Asian people’s pattern of health service utilisation once they have migrated to Western countries. That is, migrants from societies where traditional health services are widely utilised (e.g. Vietnamese, Vietnamese-Chinese, Hmong, Cambodians, Mien) when migrated to the United States, used more Western medical services compared to those remained in their country of
origin. Phan (2000) also found the preference of Western medicine was prominent in a sample of Vietnamese in Australia. Her study found that within a twelve month period, all of 158 Vietnamese carers of psychiatric patients (100%) living in New South Wales had accessed medical services provided by Vietnamese-speaking general practitioners. Because people from Chinese-influenced cultures use somatisation more frequently as a way of expressing distress and because of the easy access to Western biomedicine care in Australia, Vietnamese-Australians are believed to have a strong preference for this source of health care and possibly even over-utilise it. Subsequently, it was expected that Vietnamese-Australians with strong host culture orientation (higher Australian-ness scores) would indicate more positive preference for help from Western biomedicine health care sources than those with lower host culture orientation (lower Australian-ness scores). In addition, it was expected that Western biomedicine would be accessed far more frequently than mental health assistance by Vietnamese-Australians.

Easter medicine help. This variable represents preference for Eastern medicine as a helping source. Professionals practicing this approach include Chinese medicine practitioners, herbalists, and acupuncturists. Quah and Bishop (1996) found that Chinese-Americans with Chinese cultural orientation would be more likely to describe diseases using Chinese health concepts and thus more likely to seek help from traditional Chinese medicine practitioners. Chung and Lin (1994) as well as Phan (2000) found that the increased use of Western medicine help does not necessarily result in the decline in the use of traditional medicine help. Rather, people tend to continue to use the dual health care system. Phan in particular reported that more than 50% of Vietnamese-Australian interviewed sought help from herbalists. Thus, it was expected that Vietnamese with strong heritage culture orientation (higher scores on Vietnamese-ness) would prefer Eastern medicine as a treatment of choice.

An Outline of the Data Analytic Strategy for the Current Study

Preliminary statistical procedures used to analyse data in the current study included reliability analysis to establish internal consistency of measures and factor analysis to confirm the structure of the acculturation scale. The main statistical procedures were multivariate analysis of covariance (MANCOVAs), univariate analysis of covariance (ANCOVAs), and multiple regression analyses.
MANCOVAs and ANCOVAs were used to investigate if mean scores of dependent variables (symptom, modes of illness expression, symptom causal attributions, and help seeking selections) were different across cultures (Anglo-Australians, Vietnamese-Australians, and Vietnamese in Vietnam), and between acculturation groups (integration, assimilation, separation, and marginalisation) within the Vietnamese-Australian sample. Multiple regression techniques were employed to test if cultural orientations (Vietnamese-ness and Australian-ness) could predict variables of help seeking (symptoms, illness expressions, symptom attributions, and help seeking selections). Finally, multiple regression analyses were used to identify independent predictors of help seeking selections and to demonstrate that the inclusion of two measures of cultural orientation (Vietnamese-ness and Australian-ness) could improve the precision of prediction models of help seeking choices.

OUTLINES OF THESIS CHAPTERS

This thesis contains four major sections: the literature review, method, results, and discussion sections. Following this chapter are the three chapters reviewing the literature relating to the current investigation. Chapter 2 provides an overview on the relationship between culture and health. Variations on health concepts and practices between Western and non-Western cultures are examined. Chapter 3 introduces help seeking models and posits that help seeking is a process which is influenced by culture. The major focus of this chapter is to acknowledge how people from different cultures recognise and express everyday stress, explain the causes of problems, and choose types of treatment/helping sources. Chapter 4 argues that acculturation is an important concept to understand the health of people from migrant backgrounds and acculturation strategies can facilitate better health behaviour and outcomes. Chapter 5 outlines the study’s aims and hypotheses. Chapter 6 describes the methodology used to investigate the research questions. Chapter 7 presents the results/findings of the current investigation. Chapter 8 offers a broader discussion of the implications of the current findings in promoting better health care practices for people from the Vietnamese community in particular and people from migrant backgrounds in general. The limitations of the current study and future directions for research are also discussed.
CHAPTER 2: CULTURAL VARIATIONS IN HEALTH BELIEFS AND PRACTICES

It has been suggested that health beliefs and practices in culturally diverse Western societies are embedded in the Western tradition (Kazarian & Evans, 2001). However, a culturally diverse society also means a medically plural society, for it is composed of cultural groups with widely different healing traditions and attitudes to health beliefs and practices. Without an appropriate understanding of the role of culture on health conceptualisation, the health care needs of patients whose belief systems deviate from those of service providers will continue to be unmet. This chapter provides an overview of the relationships between culture and health. In particular, cultural differences in health conceptualisation will be discussed in terms of Eastern/Western models of illness, differences between sectors of health care, differences between the lay and the professional models, and differences based on value systems (individualism and collectivisation).

DEFINING HEALTH

More than 50 years ago, the World Health Organization (WHO, 1948) defined health as “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity”. According to the WHO, health is a state of well-being and individuals are held primarily responsible for maintaining it. However, in reality, health and well-being cannot be achieved or maintained without provision of adequate support services that ensure positive changes in the external environment as well as individual knowledge and practice. Health and Welfare Canada views health in a much broader sense. They defined health as “a resource which gives people the ability to manage and even change their surroundings…a basic and dynamic force in our lives, influenced by our circumstances, our beliefs, our culture and our social, economic and physical environments” (Health and Welfare Canada, 1986, p.3, quoted in (Kazarian & Evans, 2001). This definition of health has been praised for its comprehensiveness and proactive approach. It emphasises the determinacy of psychological and social factors on health. It encompasses both individualistic and collective views of health. Most
importantly, rather than viewing health as an individual trait, this definition places
greater emphasis on individual-environment interactions. The Health and Welfare
Canada (1988) claimed that health in this sense is dependent on not only the physical
surroundings (both natural and artificial) but also on the social, cultural, regulatory, and
economic conditions and influences that impact on people’s every life. While sound in
their concepts, quantification of these definitions however is difficult.

**MEASURING HEALTH**

Up to date, the most widely quoted quantitative definition of health is “the
absence of disease”. Subsequently, studies of health outcomes often rely on symptom
checklist to measure health status. That is, good health is indicated by the absence of
symptoms and poor health by the presence of symptoms. Common psychometric
measures of health symptoms often used are the *Diagnostic and Statistical Manual of
Mental Disorders* (DSM: 1994) and The ICD-10 Classification of Mental and
Behavioural Disorders (ICD: 1992). Measures such as the Hopkins Symptom
Checklist-25, Symptom Checklist-90—Revised (Derogatis, 1994; Derogatis, Kipman,
& Covi, 1973) are often used to assess the presence of various illnesses. Since most of
available measures and both of the classification systems were developed in the United
States or the United Kingdom with normative data collected in these countries, cross-
cultural validity of these measures is often questionable. According to Derogatis
(1994), the generalisability of psychological decisions should always be tested in the
local context before being accepted as valid.

In cross-cultural research, the translating of questionnaire measures is a common
protocol. To ensure some form of equivalence in research protocols, questionnaires
must be not only translated but also back-translated (Brislin, 1970). This procedure
involves taking the protocol in one language, translating it to the other, and having
someone else translate it back to the original. If the back-translated version is
equivalent to the original, some form of equivalence is established. Still, equivalence in
words does not necessarily mean semantic equivalence. Due to different concepts and
expressions of health and illness, the same words being used in the two languages may
carry different meanings depending on the culture.

Another problem that occurs frequently in cross-cultural research is response
sets. Response set refers to a cultural tendency to respond a certain way on tests or
response scales that is reflective more of the cultural tendency than of the meaning of the actual scale. For example, on a 7-point Likert-type scale ranging from 1 to 7, Asian participants may express their views using the section around the middle point (4) such as 3 or 5, whereas Western participants may do the same using the extreme ends of the scale such as 1 or 7. These differences of ratings reflect a broader cultural influence rather than the rating of a particular statement. Whereas some cultures encourage their members to be unique and individualistic, others discourage people from being different. Cultural differences thus may result in different uses of response alternatives on questionnaires or in interviews. Some cultures may encourage extreme responses on rating scale; others may reinforce responses around the “middle” or “lower end” of the scale.

DEFINING CULTURE

The definition of culture is complex and also difficult to operationalise. According to Alarcon (1995) who surveyed the literature on the definition of culture, there are approximately 200 definitions of culture. However, in traditional scientific research, culture has been defined largely by objective traits such as geographical region, race, language, and religion (Armstrong & Swartzman, 1999). From a different perspective, Giger and Davidhizar (1999) argued that culture is a metacommunication system which is distinguished by non-physical traits. Nonetheless, for the definition of culture to become more viable and adaptable to many different groups, Triandis (1972) recommends that culture be defined on subjective features such as shared beliefs, values and ideas. In short, culture needs to be defined from sociopsychological perspectives (Matsumoto, 1994). To meet the criteria of a cultural group, a group of individuals must share some subjective experiences and pass on these experiences to other new members of the group. Subjectively defined, culture consists of shared elements “that provide the standards for perceiving, believing, evaluating, communicating, and acting among those who share a language, a historic period, and a geographic location” (Triandis, 1996).

Culture is not a static concept. Rather, it is a dynamic process arising out of shared ethnicity, religion, beliefs, language, knowledge, values, meanings and rules (Alarcon, 1995; Triandis, 1996). Culture is constantly defined and re-defined through
social interactions. This constant evolving process enables members of a given society
to communicate, live, work, anticipate and interpret each other’s behaviour and motives.
Consequently, culture shapes and guides the behaviours and the expectations of
individuals. According to (Mezzich, Kleinman, Fabrega, & Parron, 1996), cultural
codes are submerged beneath consciousness; only when we are deprived of culture do
we become aware of it.

MEASURING CULTURE

Culture, despite being defined as a sociopsychological construct, is difficult to
operationalise for research purposes. Studies on the links between culture and health
have adopted two approaches. These are the cross-cultural comparative (also called the
packaged) approach and the “unpackaged or decomposed” approach (Kazarian &
Evans, 2001). The cross-cultural comparative approach has dominated research in
psychology. Ethnicity and race are the two most common cultural indicators used in
cross-cultural comparative studies. A search of the PsychInfo database using racial and
ethnicity as key words found a total of 34,558 articles using racial and 11,246 using
ethnicity as cultural indicators for comparative study. Typically, two or more racial or
ethnic groups are compared cross-racially or cross-culturally for quantitative differences
on dependent variables related to topics such as in disease prevalence and pattern of
service utilisation.

The use of race and ethnicity in cultural research has received much criticism.
Firstly, it questions the relevance of “minority” health research in a multitude of cultural
groups in multicultural societies. These types of research often imply differences of
health perceptions between professionals and people from particular cultures. Kazarian
and Evans (2001) argued that application of these constructs thus tends to raise
questions of relevance, scepticism and mistrust. Secondly, the use of race and ethnicity
as independent variables has been criticised as being unreliable indicators of group
membership. Instead, Phinney (1996) suggested the use of cultural values and practices
(e.g., collectivism), ethnic identity, and status within the larger society as the way to
measure culture. There are also concerns about erroneous inferences drawn from the
use of race and ethnicity. These occur when differences in dependent variables are
attributed to race or ethnicity rather than alternative explanations (e.g., poverty,
biological, or social factors). Despite these shortcomings, without a way to measure
culture on the sociopsychological levels, researchers have to ‘trade off’ the ability to adequately study cross-cultural differences. However, interpretation of research findings using race, ethnicity, or nationality as cultural indicators, should take into consideration limitations regarding the discrepancy between the qualitative definition of the term and the quantitative operationalisation used in the research.

A much preferred approach in cross-cultural research is the “unpacked” approach. This involves the use of psychological constructs to identify dimensions of cultural variations. Popular constructs such as individualism/collectivism (Hofstede, 1980) and acculturation (Berry, 1990) are commonly used for this purpose. The current study taps into both of these constructs. For the first construct, relative inferences can be made by comparing differences between individualist groups (Anglo-Australians), collectivists (Vietnamese in Vietnam) and people who are in the cultural transition process and expected to face both cultural orientations (the Vietnamese-Australians). The extent to which people acquire either one cultural dimension or the other, however, can be further understood from an acculturation perspective. Considering its influential role in migrants’ adaptation process, many ethno-specific studies have often employed the concept of acculturation to investigate in-group differences. The concept of acculturation and its associate outcomes will be further discussed in Chapter 4.

CULTURAL VARIATIONS IN HEALTH CONCEPTS AND PRACTICES

Cultural researchers have noted fundamental differences between the health beliefs and practices of people from individualist/egocentric cultures and those held by collectivist/sociocentric cultures (Landrine & Klonoff, 1994b). According to Baumann (2003), egocentric cultures are largely those of Europeans and North Americans. These cultures appear to favour the biomedical model of disease and illness, which emphasises mind-body duality. In contrast, sociocentric cultures draw few distinctions between mind-body, religious, medical, spiritual, emotional, and social processes. Variations in health concepts and practices within and across cultures can be examined from three perspectives: (a) the variations among the three overlapping heath care sectors (popular, folk, and professional) within a given society; (b) variations among medical models (East/Chinese vs. West); and (c) variations between professional and lay models of illness. Each of these is discussed in turn.
**VARIATIONS BETWEEN HEALTH CARE SECTORS**

**The Popular Sector**

In every society, the health care system generally consists of three overlapping sectors. The popular sector includes lay or everyday theories and practices of health acquired from family, social networks, and the community. Being the largest part of the health care system, the popular sector provides initial diagnosis and often this is where the major part of illness is treated (Angel & Thoits, 1987; Kleinman, 1980). Home health care may involve dietary changes and special foods, traditional herbs and medicines, cupping and massage, religious practices, and biomedical interventions. For example, in Western cultures, a cold might be treated with a popular remedy such as a hot lemon drink and honey or chicken soup, which is believed to have restorative effects to health. In some Asian cultures, “coining” (scratching the forehead/temples/neck/back with a coin) can help alleviate symptoms caused by “poisonous wind”. Wind illness is described as a state of illness in which the body’s elements are out of balance. Asian beliefs about the causes of illness will be discussed further in Chapter 3.

**The Folk Sector**

The folk or the traditional health care sector consists of the non-professional, non-organised health care sector. According to Kleinman (1980) and Sharp (1994), this sector includes a wide range of practices with blurring boundaries between the sacred and the secular. The folk sector of health care comprises many components. Some folk theories and practices are closely related to professional sources, but most are related to popular sources. Practitioners in the folk sector may include iridologists, charismatic healers, herbalists, and masseurs (Parsons, 1990). Typical practices carried out in this sector of health care include shamanism, ritual practices, herbalism, traditional surgical and manipulative treatments, special systems of exercise and exorcism. Lefley, Sandoval, and Charles (1998) argue that: “Traditional healers’ skills range from knowledge of appropriate medicinal herbs to modes of negotiation with powerful spirits…Most models of traditional healing, whether for somatic, psychological, social or spiritual ailments, incorporate a supernatural or religious element…Treatment typically involves some imbalance in life forces that can be corrected only by invoking appropriate counter-forces or by ritualistic fulfilling of religious obligations…In treating mental or emotional problems, most traditional
healing systems require the intercession of supernatural powers.” (p. 88). While the folk healers treat a person as an “organic” whole, their practice gives credence to the importance that violations of values may play in the illness (Kirmayer, Robbins et al., 1994). Kleinman et al. (1978) posits that the primary concern of folk healers is the treatment of the illness experience. Subsequently, while folk healers may treat illness effectively, they may not recognise or treat specific diseases.

The Professional Sector

The third sector of health care is the professional sector. According to Kleinman (1980), this sector includes the “organized healing professions … (which practice) modern scientific medicine (p. 53)”. This sector provides officially sanctioned health concepts and practices. In Western societies, biomedicine has gained professional dominance over other health care approaches. However, the term “professional sector” has generated some controversy as some traditional healers may also be considered as professionals. In some cultures, however, this professional sector may include the professionalised indigenous medical systems. In particular, traditional Chinese medicine has been widely accepted in China and Vietnam. India has Ayurvedic medicine and some Muslim countries have Galenic-Arabic medicine (Kleinman, 1980). As the topic of the current study is Vietnamese-Australians who are likely to have been predominantly influenced by the traditional Chinese medicine models, specific cultural differences in health beliefs and practices will focus on those differences found between the Australia’s dominant model of health care, Western biomedicine, and traditional Chinese medicine.

VARIATIONS BETWEEN THE LAY AND THE PROFESSIONAL MODELS OF ILLNESS

In clinical practice, variations in health concepts and practices are particularly apparent when one contrasts those held by the professional service providers and those held by the patients. Specifically, issues often arise from the differences in illness explanatory models held by health care professionals and patients. Professional explanatory models focus on investigating five major aspects of the illness. They include the cause, the time and mode of onset of symptoms, the pathological changes in the body, the course of the illness (including both the severity and type of sickness –
acute, chronic, impaired) and the treatment (Kleinman, 1980, p.105). While health professionals focus on disease (the malfunction, or pathology of a body organ or system), patients tend to focus on the experience of being unwell. Due to this difference in focus, health professionals and clients tend to hold different illness explanatory models.

Lay explanatory models are drawn not only from the professional sector of health care but also from the popular and the folk sectors (Kleinman, 1980). Lay models of illness posit that illness is shaped by cultural factors governing perception, labelling, explanation, and valuation of the experience (Kleinman, 1980). Thus, an explanatory model will include the beliefs, concerns and expectations people have about their illness experience. Lay explanatory models provide multi-causal explanations of personal disorder, involving social, psychological, affective and physical factors, which together constitute a biopsychosocial model (Kirmayer, 1989; Kleinman, 1980). According to Helman (1994), the lay illness explanatory model comprises four elements – the individual, the natural world, the social world, and the supernatural world.

Individual-centred explanations of illness hold the identified patient responsible for his or her own illness. Social explanations attribute the cause of illness to factors such as social conflicts, social stress, and supernatural forces (Helman, 1994). Natural explanations include infection, stress, deterioration, or accidents (Murdock et al., 1980). Supernatural explanations include mystical causes (e.g., fate, magical contagion), animistic (e.g., loss of soul, angry spirits) and magical causes (e.g., witchcraft, sorcery, exorcism). Although generalisations across regions or cultural groups are difficult to make, it has been suggested that supernatural and social theories of illness tend to predominate in non-Western or collectivist societies whereas natural and individual-centred illness theories tend to predominate in Western individualist societies (Helman, 1994; Kleinman, 1980).

Kleinman (1980) compared Chinese and American lay models of illness in a cross-national study and observed distinctly different models (see Table 1 for summary). Although the experience of affective states is universally attributed to psychobiological origins, culture influences how it is processed, perceived, felt, labelled, and evaluated (Kleinman, 1980). The cognitive coping process may vary in type and pattern of use across cultures. In Chinese culture, suppression, lack of differentiation, minimisation, displacement, and somatic substitution are employed as
the dominant coping mechanisms. Among middle-class Caucasians in the United States, however, the cognitive coping mechanism entails predominantly expression, differentiation, and vigilant focusing. Subsequently, in Western medically plural society, while the professional/Western biomedicine explanatory model and the lay explanatory model are not likely to vary a great deal for lay people from Western backgrounds (Armstrong & Swartzman, 1999), people from non-Western cultures are likely to subscribe to quite different illness models.

Table 1
Cognitive coping process in Chinese and American cultures (Kleinman, 1980, p.174)

<table>
<thead>
<tr>
<th>Cultural influences on:</th>
<th>Chinese (middle-class) Americans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perception of stimuli as stressors, and relative ranking of stressors</td>
<td>Primary concern with interpersonal stimuli</td>
</tr>
<tr>
<td>Perception, labelling and valuation of affects</td>
<td>Recognition and expression of strong or dysphoric affects are disvalued. As a result, there is lack of experience in precisely defining, labelling, and communicating about affects.</td>
</tr>
<tr>
<td>Pattern of affective experience and of experience of affective disorders</td>
<td>Vegetative idiom</td>
</tr>
<tr>
<td>Lay and indigenous folk treatment approaches</td>
<td>• Family-based • External oriented clinical reality (somatic and interpersonal)</td>
</tr>
<tr>
<td>Evaluation of therapeutic efficacy</td>
<td>Interpersonal and somatic criteria</td>
</tr>
</tbody>
</table>

Nevertheless, distinct discrepancies between the clinical and lay explanatory models may result in a mismatch between the health needs of the lay population and the services provided by professionals. Divergent explanatory models, based on different cultural perspectives and social roles, can lead to problems in clinical settings.
(Westermeyer, 1987, 1989). According to Minas (1990), due to cultural differences, which embody differences in illness explanatory models, mental health clinicians may: (a) interpret clients’ culturally appropriate beliefs and behaviour as psychopathology; (b) interpret psychopathology as culturally-based beliefs or behaviours; (c) fail to detect psychopathology, misinterpreting the severity of psychopathology, either overestimating or underestimating its severity; (d) provide incorrect classification of psychopathology leading to an incorrect diagnosis; and (e) fail to appreciate the significance of psychopathology to the patient and the patient’s family. To summarise, failure to recognise clients’ models of illness may lead to misunderstanding, loss of clients and poor treatment outcomes.

VARIATIONS BETWEEN MEDICAL MODELS OF ILLNESS

The Western (or biomedical) and the traditional Chinese medical models of illness are two dominant models often cited to explain the cultural differences in health care practices between people from Western culture and Asian cultural backgrounds. Whereas the biomedical model is predominantly a paradigm of Western culture, traditional Chinese medicine is a paradigm that has been popular in many Asian countries (such as China, Japan, Hong Kong, Taiwan, and Vietnam). Although the two models are believed to embody basic characteristics of Western and Asian societies’ health care systems, both practices co-exist and are practiced in both cultures.

The Western Biomedical Model

The Western biomedical model of health and illness operates on two principles: reductionism and materialist assumptions. According to Engel (1977), the reductionist paradigm postulates that biochemical processes play a dominant role in illness formation. Meanwhile, the materialist paradigm asserts that individuals are physical beings and that, therefore, their existence and functions can be explained solely by reference to their physiology, anatomy, and biochemistry. Subsequently, this model formulates that illness results from disruption of biological structures (or physiological process) caused by some physical or chemical factors.

The cause or causes, whether viral, bacterial, or other, are referred to as pathogens which are seen as the root of all physical and medical diseases. Cardiovascular disease, for example, has been linked to specific pathogens such as clotting from lipids and cholesterol. The biomedical model of disease has also
influenced psychology’s view of abnormal behaviour and psychopathology. Traditional psychological approaches view the origin of abnormal behaviour as residing within the person. Such abnormalities may result from lack of gratification or over-gratification of basic, instinctual processes (as suggested by Freudian psychoanalytic theory), faulty brain chemistry or from learned responses (as suggested by classical or operant conditioning) (Matsumoto & Juang, 2004).

The traditional biomedical model of health in both biomedicine and psychology has had a profound influence on treatment approaches. Intervention focuses on the identification of medical or psychological pathogens. Thus, to treat the disease is to manipulate these pathogens. Specifically, treatment requires correction of the physical material and/or the introduction of chemical agents into the body (Engel, 1977). Medical treatment and traditional psychological approaches focus on intervention with the person. This model (in its extreme form) excludes any aspects which do not involve biological or chemical manipulations, such as social, cultural, psychological, or behavioural dimensions of illness. It should be noted that there are proponents for a Western medical model that involves the interplay of biological, psychological, and social aspects of the person's life, called the biopsychosocial perspective (Engel, 1977). However, this model has been slow to gain acceptance in Western medical practice while the materialistic biomedical model continues to be the dominant model of health care practices (Blount & Bayona, 1994; Dowrick, May, Richardson, & Bundred, 1996).

The Traditional Chinese Medical Model

The traditional Chinese model suggests a different concept of health and illness. Unlike the biomedical model, the traditional Chinese medical model views health not only as the absence of negative states but also as the presence of positive ones. The essence of health is determined by the balance between the self, nature and the individual’s various roles in life.

The philosophical basis for traditional Chinese medicine and health concepts is that human beings live between heaven and earth (i.e., macrocosm) and that they in turn constitute a miniature universe (microcosms) (Chen & Swartzman, 2001). Accordingly, well-health is believed to be achieved by maintaining the body in harmony with internal psychological functions as well as external social and ecological conditions. Specifically, an individual’s physical well-being is determined by the balance between
yin (negative energy) and yang (positive energy) which rest within the five elements in the universe. These elements include Fire, Wood, Earth, Water and Metal. The five elements are connected with and interact with each other. Each element may facilitate or inhibit the function of another element within its level. For example, water facilitates the growth of wood, which in turn, facilitates the power of fire. Earth (or soil) can inhibit the movement of water, which in turn may inhibit fire. These five elements are symbolic representations of emotional, physical, interpersonal/societal, and ecological presentations (Table 2). The correct balance of the five elements is believed to result in good health (or one’s well being). Disruption to the harmony of these elements, on the other hand, is presumed to result in ill health. Interventions thus aim at restoring the natural balance of the individual to the universe (Chen & Swartzman, 2001; Hoang & Erickson, 1985; Phan & Silove, 1999).

Table 2

<table>
<thead>
<tr>
<th></th>
<th>Wood</th>
<th>Fire</th>
<th>Earth</th>
<th>Metal</th>
<th>Water</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organs</td>
<td>Liver</td>
<td>Heart</td>
<td>Spleen</td>
<td>Lung</td>
<td>Kidney</td>
</tr>
<tr>
<td>Face</td>
<td>Eye</td>
<td>Tongue</td>
<td>Mouth</td>
<td>Nose</td>
<td>Ear</td>
</tr>
<tr>
<td>Body</td>
<td>Nerve</td>
<td>Blood</td>
<td>Muscle</td>
<td>Skin</td>
<td>Bone</td>
</tr>
<tr>
<td>Emotions</td>
<td>Anger</td>
<td>Joy</td>
<td>Worry</td>
<td>Grief/sad</td>
<td>Fright/fear</td>
</tr>
<tr>
<td>Taste</td>
<td>Bitter</td>
<td>Sour</td>
<td>Sweet</td>
<td>Pungent</td>
<td>Salty</td>
</tr>
<tr>
<td>Seasons</td>
<td>Spring</td>
<td>Summer</td>
<td>Between seasons</td>
<td>Autumn</td>
<td>Winter</td>
</tr>
<tr>
<td>Directions</td>
<td>East</td>
<td>South</td>
<td>Middle</td>
<td>West</td>
<td>North</td>
</tr>
<tr>
<td>Environmental factors</td>
<td>Wind</td>
<td>Heat</td>
<td>Dampness</td>
<td>Dryness</td>
<td>Cold</td>
</tr>
<tr>
<td>Colour</td>
<td>Green</td>
<td>Red</td>
<td>Brown</td>
<td>White</td>
<td>Black</td>
</tr>
</tbody>
</table>

According to this model, physical health is determined by both internal and external factors. Contrary to the biomedical model, the Chinese health beliefs model posits that physical and psychological states are an integral part of the same system of the body, both of which are subject to external influences. These influences may be changes in seasons, weather, and other natural conditions such as wind, cold, heat, moisture, and dryness (Hinton et al., 2003; Kaptchuk, 1983).
The internal factor attributes ill health to psychological causations (Chen & Swartzman, 2001). Emotions and physical activities are believed to function in a complementary manner in which disruption of one aspect will lead to disruption of the other. For example, dysfunctions of the heart may lead to coma, insomnia, amnesia, dream-disturbed sleep, poor memory, and mental derangement. Dysfunctions of the kidney, which may be caused by excessive sexual activity, may lead to dizziness, fear, and feverish sensation. Dysfunctions of the liver may manifest in irritability and anger, and problems of the spleen are associated with desire and excessive thinking (Hammer, 1990). The relationship between physical and psychological functions are presumed to be bi-directional and transactional in nature (Lin, 1981). Physical dysfunction of an organ may cause emotional problems and emotional disturbances, in turn may be the origins of physical problems. For example, dysfunction of the liver may result in irritability. Overindulgence or excessive intake of alcohol and tobacco may cause accumulation of heat in the liver, and further lead to a bloated sensation in the head, a headache, red eyes, a bitter taste in the mouth, and a flushed face. Excessive grief, sadness, and “over-thinking” may cause dysfunction of the spleen and stomach (Hammer, 1990).

The Chinese health beliefs model also posits that physical health is not only governed by emotional functioning, but also subjected to socio-ecological influences. Good health is attained when a person is psychologically well-balanced and lives in harmony with social and ecological conditions. Ecologically, there are six external determinants of health. They include wind, cold, fire or heat, dampness, dryness, and hotness. Among these, wind and fire are believed to have the most pervasive effect on health (Chen & Swartzman, 2001).

According to Gwei-Djen and Needham (1980, cited in Hinton et al., 2003), the rationales behind the “wind illness” is that “poisonous wind” may enter the body through the body’s orifices, causing blockage of the circulation of “Qi” between body areas. “Qi” can roughly translate as air, which is considered to be an inner vital energy. To help remove the blockage, various techniques can be used. Professional Chinese medicine practitioners often employ acupuncture. This is a treatment technique where a fine needle is inserted into certain vital point of the body, rotated, and removed. Upon the removal of the needle, various sensations are said to be felt due to the flux of “Qi” being released. This helps restore the flow of “Qi”. Other ‘wind release’ techniques
which can be prescribed for home treatment, include: “coining wind” (scratching “open” the surface of the skin using a coin and mentholated ointment), “steaming wind” (the patient is covered in steam from boiled herbs, which cause the skin’s pores to open and induces sweating), cupping (a cup or glass is heated with a flame then pressed on the skin to create a vacuum suction which pulls the skin/air from the body), and moxibustion (a burning herb, moxa, is placed briefly against the skin).

Exercise and diet are other factors which can help maintain good health. Physical exercise is considered important because it helps with the flow of “Qi” and the development of strength in the body. According to Chen and Swartzman (2001), diet is important because it is presumed to affect the function of the stomach and the spleen, which are believed to be responsible for transforming food into “Qi” and blood. Irregularity in the quality and quantity of food intake thus may disrupt the body harmony. Too much “cold” or yin types of food (e.g. raw foods, many types of fruits or leafy green vegetables) may constrain the yang aspect of the spleen which produces internal cold dampness and thus result in abdominal pain, diarrhoea, or weakness. Likewise, “hot” or yang types of food (e.g., fatty and greasy food, alcohol, sweets, ginger etc.) can produce dampness and heat/fever. To correct the imbalance of yin and yang, foods or herbal medicines may be prescribed.

VALUE ORIENTATIONS AND HEALTH COMMUNICATIONS

According to Kleinman (1986) and Kleinman and Kleinman (1985), cultural rules govern illness behaviour and people learn “approved” ways of being ill. While illness conceptualisation is largely influenced by medical models of illness, the experience and expression of illness is determined by the individual’s value orientation. Conceptualisations of the self and the relationship between the self and social group are particularly important in people’s health care practices. These value differences can be demonstrated through the differences between Western/biomedicine and Eastern/Chinese medicine. The former model dominates individualist societies, and the latter is popular in collectivist societies.

Conceptualisations of individualism and collectivism came from a study by Hofstede (1980). In search for meaningful subjective dimensions of culture, Hofstede (1980, 1991) conducted a study of personal values of 117,000 individuals from 50
countries. From these data, he identified four cultural dimensions. They include Individualism-Collectivism, Power Distance, Uncertainty Avoidance, and Masculinity-Femininity. Of all the subjective dimensions/constructs of culture that have been examined, the individualismollectivism construct is recognised as having the highest face validity (Ward, Bochner, & Furnham, 2001) and perceived as most reliable and accounts for the most variance among cultures (Triandis, 1996). Subsequently, this cultural dimension has received the greatest empirical attention in cross-cultural studies (Triandis, Chan, Bhawuk, Iwao, & Sinha, 1995; Ward et al., 2001).

The fundamental concept of individualism-collectivism lies in the relative importance in social relationships. Individualism-collectivism manifests within the self and one’s relationships with others. Individualism-collectivism orientation defines the meaning attached to the self (self construal). People from collectivist cultures tend to define the self as an aspect of a collective (e.g., the family or the clan) whereas those from individualistic cultures tend to define the self as independent and autonomous (Armstrong & Swartzman, 1999; Chen & Swartzman, 2001; Ward et al., 2001). Hofstede’s original study found European and North American countries tended towards the individualist end of the continuum, whereas, Asian and Latin American countries fell on the collectivist end. Countries such as the United States, Australia, and Great Britain were the first three highest ranked countries on the individualist end. Countries such as Guatemala, Ecuador, Panama, Indonesia, Pakistan and Taiwan ranked higher on collectivist end. China (Kazarian & Evans, 2001) and Vietnam (Dinh et al., 1990) are also categorised as having a collectivist cultural orientation.

SUMMARY

In pluralistic multicultural societies, the wide variation of health beliefs and practices poses a challenge for the quality of health care. The Western biomedical model focuses from an analytic perspective on the “objective” biological processes underlying diseases and illness. Health problems are often regarded as an episodic deviation caused by micro-level, natural, etiological agents, such as genes, viruses, bacteria, and hormones. The traditional Chinese medical model focuses on achieving a holistic balance in health care. Health is achieved and maintained when a person lives in harmony with social and ecological conditions and attains an inner psychological
balance. Whereas individualists hold themselves responsible for their health problems, collectivists view health issues in terms of their significance for collective well-being and functioning. Explanatory models of illness provide an insight into the individual experience of illness. Culturally incompatible models of illness not only prevent people from seeking help, but also when they do, incompatible models of illness (between the lay and the professional models) may result in an unsatisfactory experience of the clinical encounter for both the client and the professional. Failure to recognise the incompatibilities of illness models is thus problematic and reduces the quality of health care. In the next chapter, a more detailed description of issues related to illness explanatory models and cross-cultural health care practices will be discussed.
CHAPTER 3: A MODEL OF HELP SEEKING

Help seeking behaviour is, essentially, a selection of available sources of help. There are a number of factors which individuals rely upon to help guide these choices. This chapter provides an overview of the literature on four of these factors: namely, symptom recognition, modes of illness expression, the perceived cause of the illness, and the types of help available for selection. Specifically, it was postulated that help seeking cannot be initiated if symptoms were not considered as warranted for help seeking. The choices people make when help seeking depends on their experience of mental health issues as physical or psychological symptoms. Choices of helping sources can also depend on the way people conceptualise the cause or causes of their problems. Finally, because the relative importance and availability of each helping source varies across cultures/societies, people’s choices of these sources tend to depend on their familiarity with the health care system. Consequently, this chapter presents discussion in terms of (a) help seeking sources, (b) symptom recognition, (c) modes of help seeking, and (d) illness/symptom attributions.

HELP SEEKING SOURCES

According to Kleinman (1980), choices on source of help can be drawn from three health care sectors which exist in any society: the popular sector consists of members of social networks (families and friends) and patients themselves, the folk sector consists of traditional healers, and the professional sector include practitioners of biomedicine (Good, 1987; Kleinman, 1980; Ware, Christakis, & Kleinman, 1992). (For more details on these sectors, see Chapter 2). Each sector can function independently; however, often patients can access more than one sector or all sectors at any given period of an illness episode.

Help Seeking in the Popular Sector

The popular sector is considered the largest part of the health care system where initial diagnosis and treatment are carried out (Angel & Thoits, 1987; Kleinman, 1980). In societies where access to professional help is limited, individuals tend to rely on themselves, their families, and members of their social circle for care. Cultures vary in
the extent to which people use home health care initially or exclusively. For example, studies have reported that up to 90 percent of urban Taiwanese (Kleinman, 1980), 57 percent of poor Salvadorans (Ferguson, 1986), and more than 70 percent of mothers in Burkina Faso (Sauerborne, Nougata, & Diesfeld, 1989) initially used home health care. However, studies have also found a considerably lower use rate of home health care in other areas of the world: 39 percent in Guatemala (Cosminsky, 1987), 29 percent in Sri Lanka (Caldwell, Gajanayake, & Peiris, 1989) and 20 percent in Ethiopia (Kloos et al., 1987). Regardless of the extent to which home health care is used, it is not clear if help seeking occurs in the same manner for both mental and physical health since the literature lacks a clear distinction between the two.

Qualitative studies with migrant and refugee populations have found that people tend to turn to family, friends, and/or religious sources for help for the psychological aspect of distress (Christensen, 1987; Moon & Tashima, 1982; Nishio & Bilmes, 1987; Ying, 1990). Ying (1990) for example, asked 40 Chinese-American women to assess the cause of a woman’s described problem in a vignette designed to cover symptoms of major depression and to recommend appropriate coping strategies. The majority of participants conceptualised the problems as psychological and suggested that the woman should rely on herself, family or friends. Those who conceptualised her problem as a physical disorder recommended that the subject of the vignette should consult a doctor. Studies with Vietnamese and Japanese samples also found that self-reliance, family and friends and religious solace were preferred coping strategies in dealing with mental breakdown (Lam & Kavanagh, 1996; Narikiyo & Kameoka, 1992; Pham, 1986).

*Help Seeking from the Traditional and Professional Health Care Sectors*

More detailed information regarding the types of help sought can reveal a wide range of traditional and professional helping sources people use in response to illness. Phan (2000) interviewed 158 Vietnamese-Australians caregivers of mentally ill patients in New South Wales about the types of help they sought over the previous 12-month period. She found that all participants had used services provided by local Vietnamese-speaking general practitioners (100%), and that about half of the participants also used some form of traditional help (Asian naturalists, spiritual healers, witchcraft doctors, herbalists, and folk healers), as well as mainstream psychiatric hospital facilities (50%)
and community services (>30%). The study did not offer an explanation of the sequential steps these individuals went through before obtaining specialised help; nor did it identify the role of health concepts in the choice of help. It did, however, provide an indication of the persistent use of traditional healing practices in a Western based health care society and the popularity of each form of help in this cultural group.

**Help Seeking Pathways**

The use of home health care does not necessarily mean that it is the only source from which people obtain help in response to an illness episode. Often the use of home health care is followed by consultation with traditional healers and/or biomedical practitioners. Studies in many parts of the world, e.g., China (Kleinman, 1980), Mexico (Salgado de Snyder, Diaz-Perez, Maldonado, & Bautista, 1998); Nepal (Subedi, 1989), Nigeria (Erinosho, 1977), have demonstrated that patients usually turn first to home remedies, then to traditional healers, before turning to biomedical health services for treatment as the last resort. After home remedies have been found to be ineffective, non-Western beliefs about the cause of the illness are likely to lead to treatment being sought from the folk or the traditional sector of the health care system. In contrast, Western illness causal beliefs are likely to lead to help being sought from professional Western medical practitioners (Kleinman, 1980; Stephenson, 1995). However, it is also common for treatment to be sought from both sectors, either in sequence, or simultaneously (Angel & Thoits, 1987; Kirmayer, Robbins et al., 1994; Kleinman, 1980; Stephenson, 1995).

Cultural variations in typical pathways to help seeking can be demonstrated through a qualitative study by Lin et al. (1978). The study compared pathways to help seeking by Chinese, Anglo-Saxons/Middle Europeans, and Native Canadian psychiatric patients in Canada. The Chinese patients were found to delay professional help seeking for prolonged periods of time at the initial period of the help seeking pathway. Their families played a dominant role in managing their problems. Chinese-Canadian patients were often isolated within their homes and allowed few interpersonal contacts. Markedly advanced psychotic symptoms were tolerated if they were not excessively violent or disruptive. When external help was sought, family physicians were their first source of contact. Referrals to psychiatric services were often made by family doctors. The Anglo-Canadian and the Middle European Canadian patients were much more
active in seeking professional help. Their family were involved but played a less active
role in managing patients’ problems. They were referred by their families or self-
referred to multiple sources of social, medical and mental health agencies before arrival
at the current host service. Native Canadian patients, however, were referred by persons
other than family members and themselves and “transferred passively” between social
and legal agencies.

SYMPTOM RECOGNITION

Recognition of symptoms which indicate signs of illness is essential to the
initiation of help seeking (Angel & Thoits, 1987; Ware et al., 1992). Although not
systematically investigated, there has been much conjecture that ethnic and cultural
groups differ on what they perceive to be a mental health problem (Fabrega, 1993;
Fabrega, Ulrich, & Cornelius, 1993; Sue, 1994). Whether changes in bodily or mental
states are considered as symptomatic depends on the local cultural definition of disease

There are several basic factors which allow individuals to recognise the need for
help. According to Kirmayer (1989), these include (1) evidence of a degree of pain,
suffering or emotional distress that commands attention; (2) their behaviour is
troublesome or threatening to others; (3) their behaviour fits a pre-existing category of
distress; and (4) their behaviour contravenes group norms or is sufficiently unusual to
provoke a re-examination of existing norms. The first two forms tend to be consistent
cross-culturally (Kirmayer, 1989; Kleinman, 1980; Westermeyer, 1987, 1989), the latter
two, however, depend crucially on knowledge of cultural categories and expectations.

Cultural variations in the recognition of health, however, may be less prominent
in severe forms of mental illness. Major psychiatric disorders such as schizophrenia,
depression, and bipolar affective disorders tend to have similar appearance in all
societies and can be detected in all cultures (Marsella, Sartorius, Jablensky, & Fenton,
1985; Sartorius et al., 1986; Westermeyer, 1987, 1989). However, it could be argued
that minor psychiatric symptoms can be recognised against cultural norms. According
to Westermeyer (1987), culturally mediated experiences of mental conditions as
supernatural can be readily distinguished from psychotic symptoms. That is, psychotic
symptoms tend to (a) not receive family and social support, (b) last longer than a few
hours or days, (c) disrupt socially appropriate, productive and coping behaviour, (d) result in a loss of self-esteem or social prestige, (e) co-occur with other psychopathological signs and symptoms, and (f) include culturally incongruent content. Apart from the duration and severity components, these criteria also emphasise the importance of sociocultural context in the assessment of the illness.

Recognition of symptoms is, however, less clear for milder forms of mental illness. Kirmayer (1989) argued that the role of cultural prescription in illness explanation, attitudes and practices may show a clearer distinction in milder forms of emotional distress, especially those with co-morbid biologically patterned disorders. For example, anxiety and depression are found to be the most common psychological disorders in many countries. A study by the World Health Organization (WHO) on psychological disorders in primary care (Sartorius, Ustun, Lecrubier, & Wittchen, 1996) with 25,000 consecutive adults in 14 countries found that the commonest disorders were depressive disorders (11.7%) and anxiety disorders (10.5%), with 4.6% having both. However, prevalence rates for anxiety and depression tend to vary across cultures. Becker and Kleinman (1991), for example, reported that based on standard criteria and diagnostic interviews of clinical depression, studies have found that depression rates in the North American Epidemiological Catchment Areas vary from 4.6 to 6.5%. In various studies in India they ranged from .15 to 3.3%. In Africa, they reached the highest rate of 14.3% for men and 22.6% for women. These differential findings underline the need to be wary of assumptions about the cross-cultural validity of the concept of depression and anxiety and of associated epidemiological instruments.

Anthropological research has suggested that models of mental health and illness based on studies of patients in Western psychiatric settings cannot be generalised to non-Western societies (Jenkins, Kleinman, & Good, 1991). In studies of Chinese medical practices, Kleinman (1980, 1982) reported that, while no formal diagnosis of depression exists in the Chinese diagnostic vocabulary, the majority of patients diagnosed as “neurasthenic” present with symptoms that can be recognised as the physiological concomitants of depression (e.g., dizziness, headaches, appetite and sleep disturbances and lethargy). Indeed, cross cultural studies have often found that many patients from non-Western cultures tend to experience and express milder forms of distress primarily with physical symptoms. Subsequently, although some form of anxiety and depression may be found in all cultures, it may not be valid to equate forms
of the illness manifested primarily in psychological terms with illness experienced primarily in somatic terms.

MODES OF HELP SEEKING

Somatisation and Psychologisation

Accounts of cultural variations in help seeking behaviour tend to emphasise the use of somatisation and psychologisation as modes of help seeking. In general, somatisation is defined as the experience and expression of psychosocial and emotional distress through physical symptomatology (Becker & Kleinman, 1991; Kleinman, 1986, 1988; Miranda & Nunoz, 1994). It also describes a pattern of illness behaviour, especially a style of clinical presentation, in which somatic symptoms are presented to the exclusion of emotional distress and social problems. Kleinman and Kleinman (1985), in particular, define somatisation as the expression of personal and social distress in an idiom of bodily complaints and medical help-seeking.

Psychologisation, however, has a different focus. Broadly defined, psychologisation is a mode of expression that explicitly refers to indigenous theories of the mind, self and emotion (Kirmayer, 1989; Kirmayer, Dao, & Smith, 1998). Typical psychologisers are characterised as people with physical or social origins of distress who focus on the emotional aspects of experience. Kleinman (1980) proposes that while somatisation is a legitimate idiom of distress in most non-Western societies, he believes that many people in the West, especially those who are from educated middle-class background, are emotionally expressive and tend to psychologise their stressful experiences. As the result, they are less likely to somatise social and emotional distress. Instead, psychologisation is more likely to be used as mode of illness expression.

Somatisation as an Universal Mode of Help Seeking

Somatisation is recognised as a universal mode of help seeking behaviour (Miranda & Nunoz, 1994; Nguyen, 1982a; Parsons & Wakeley, 1991). Analyses of patients presenting complaints in primary health care settings indicated a high incidence of psychosomatic symptoms which often are associated with anxiety and depression. Burrows and Vine (1994), for example, found that between 38% and 45% of those who did not receive a medical diagnosis when seeking help from primary health care
providers were found to have a psychiatric disorder - mostly anxiety or depression, or both. Other studies in primary care settings suggest that between 50% to 95% of psychiatric patients initially presented with somatic complaints or "somatisation" (Goldberg, 1995). In general, these presentations are characterised by physical symptoms (often more than one) that are vague and difficult to explain in terms of organic disease. Further, typical symptoms presented were fatigue, gastrointestinal complaints, dizziness, joint pain, weight loss, chest pain and headache, etc. Although rates of somatisation are inconsistent across studies, these differences may be due to lack of recognition of the role of ethnicity in influencing modes of help seeking.

According to Kirmayer et al. (1998), somatisation can function as a psychophysiological process or as a sociolinguistic process. When somatisation is described in terms of psychophysiological process, it refers to a group of psychiatric disorders (somatoform disorders in DSM-IV) where psychological conflicts are transformed or transduced into bodily symptoms (often including medically unexplained and functionally somatic symptoms). As such, somatisation is a common form of illness expression. When somatisation is described in terms of a sociolinguistic process, it refers to a cultural specific idiom of expression. Kirmayer and colleagues (Kirmayer et al., 1998; Kirmayer & Young 1998) argues that somatic symptoms serve as cultural idioms of distress in many ethnocultural groups and that, if misinterpreted by health care professionals, somatic symptoms may lead to unnecessary diagnostic procedures or inappropriate treatment. Differences in symptom expression thus reflect cultural styles of expressing distress that are influenced not only by cultural beliefs and practices but also by familiarity with health care systems and pathways to care.

**Reinforcers of Somatisation**

The biomedical health care system, because of its orientation towards somatic disease, its management of symptoms by biomedical investigations and somatic treatments, may in itself act as a powerful reinforcer of somatisation. Unfamiliar with mental health diagnosis and treatment, people from many migrant groups or ethnocultural groups tend to associate it with severe forms of mental disorders (Duong-Ohtsuka, 2003; Kirmayer et al., 1998). Accustomed to health care provided in the primary health care settings, where the focus is usually on physical illness, and concerned about the stigma attached to mental health problems, people tend to
deemphasise the psychosocial aspects of their distress. The lack of health professionals from similar ethnic backgrounds amongst immigrant communities may further contribute to the use of somatisation (Draguns, 1995, 1996a, 1996b; Phan, 2000). For example, Draguns (1996b) argues that in dealing with ethnic groups in North America, the cultural context in which the cultural background of the therapist, predominantly white, is widely different from the background of patients could encourage communication of physical rather than psychological symptoms. In most cases, the presentation of somatic symptoms does not necessarily mean that patients do not experience psychological symptoms, but simply that the patients are reluctant to make psychological symptoms the focus of their professional help seeking.

Kirmayer and Sir Mortimer (1991) estimated about 75% of primary care patients with major depression or panic disorders, present to primary care with exclusively somatic symptoms. About 10% of those with such somatic presentation however, persistently denied any connection between somatic symptoms and nerves or worries (Kirmayer, Robbins, Dwarkind, & Yaffe, 1993). Characteristics of patients with somatic presentations have been found to be distinctive from those with somatoform disorders. For example, Bridges, Goldberg, Evams, and Sharpe (1991), found that patients making somatised presentation resembled those making psychosocial presentations in having increased body consciousness and hypochondriasis. They differed from psychosocial presentation patients mainly in their negative attitudes towards psychiatric illness.

Another explanation on the use of somatisation as mode of expression is that many traditional theories of medicine, particularly in countries such as India, Southeast Asia, indigenous peoples in North America, Australia and New Zealand, take a holistic approach in which somatopsychic rather than psychological aspects of disease are emphasised (Cheung & Lin, 1997; Cheung, 1987; Groleau & Kirmayer, 2004; Kinzie & Manson, 1983; Kleinman, 1980, 1988; Matkin et al., 1996; Nguyen, 1982a; Phan & Silove, 1999). Angel and Thoits (1987) explained the somatic presentation of psychiatric disorders among Mexican Americans as: “At the broadest level, health consists of a physical and an emotional component which are only partly differentiated. The more traditional the culture, the less differentiation there will be between physical illness and psychological disturbance” (p.484). Draguns (1995, 1996a, 1996b) argues that culture may encourage sensitivity to either psychological or physiological
processes, and the report of somatic symptoms may reflect the socio-cultural norms for illness. Koss (1990) suggests that physical complaints may have an adaptive social function and may form a link between the individual, the social, and the political sphere. Kawanishi (1992) also cautions that the physical complaints of Asians have been decontextualised by being studied within a Western frame of reference. He suggests that in many Eastern cultures, the display of emotions in social interactions is not desirable. The expression of somatic symptoms may also reduce the stigma of mental illness and legitimise entry into the mental health care system. Thus, the expression of somatic rather than affective symptoms among non-Western patients seems to be related to many cultural factors rather than to an intrinsic deficit.

The use of somatisation as a mode of illness expression does not necessarily mean that people’s experience of distress is exclusive only to physical symptoms. Indeed, people usually experience bodily and emotional distress at the same time (Kirmayer, 1989). Studies on the relationship between somatisation and psychologisation have found that these two dimensions are not the opposite ends of a continuum. Rather they are alternative modes of expressing distress and may occur simultaneously (Kirmayer, 1989; Vassend, 1989). Beiser and Hyman (1997), in their study of Southeast Asians, found two independent factors, somatic distress and depressive affect, evidence against the stereotype of the inability of Asians to “psychologise” in expressing their emotions.

ILLNESS/SYMPTOM CAUSAL ATTRIBUTIONS

Lay models of illness are important in guiding choices between available treatments (Kleinman, 1980). According to Leventhal and Diefenbach (1991), patients’ illness representation is based on distinct components which in turn determine coping in which help seeking behaviour plays a major role. Kleinman (1980) proposes several questions to elicit these components in clinical settings. He posits that there are five major questions which are important to ask at any illness event. These questions aim to elicit (a) the cause of the problem; (b) the timing and mode of onset of the symptoms; (c) the pathophysiological manifestation of the problem; (d) the course of the illness in terms of severity, acuteness, or chronicity; and (e) the type and length of treatment.
Among these five components of the illness explanatory factor seems to receive the most attention in cross cultural studies.

Shiloh, Rashuk-Rosenthal, and Benyamini (2002) reviewed the illness-cognition literature and found there are about 140 possible perceived causes of illness. However, the categorisation of these causes is not always consistent. Shiloh et al. (2002) categorised causes of illness into three main branches of environmental causes (e.g., air pollution, contact with sick persons), behavioural causes (caffeine intake, exercise), and hidden causes (genetic/biological causes such as heredity, mystical causes such as God’s punishment, and psychosocial causes such as hypochondriasis or bad work conditions).

Cultural theories of illness, however, categorise causal attributions in different ways. Based on anthropological studies of 139 traditional societies across the world, Murdock et al. (1980) have proposed two major categories of illness causation: natural and supernatural causations. Natural causation can be further distinguished into Western and non-Western theories. Western theories of natural causation may include infection, stress, organic deterioration (e.g., old age, hereditary defects), accident (unintended physical injury), and overt human aggression (physical injury inflicted by another person). Non-Western theories of natural causation may include ideas derived from the traditional Chinese medical model which emphasizes imbalance of the negative and positive energy (yin/ âm vs. yang/ dương), nerve weakness, loss or blocking of vital energies, loss of vital essences (as in semen loss), and being “hit” or “caught” by a “poisonous” wind. Supernatural theories of causation can be further divided into mystical, animistic, and magical causes of illness. Mystical causation includes beliefs that illness is caused by fate (due to astrological influence, fate, predestination, or bad luck), ominous sensation (e.g., dreams, sights, sounds or sensation), contagion (e.g. caused by contact with a supposedly polluting object, substance or person), or violation of a taboo or moral injunction. Animistic causation involves beliefs that illness is due to the behaviour of personalised supernatural agents - for example, that the soul may be lost or possessed by a ghost, spirit, or god. Magical causation involves beliefs that illness has been caused by covert action of envious, offended or malicious human being who have used sorcery or witchcraft or that someone with an evil soul has projected his/her malicious wish onto the targeted person through his/her “evil eye”.
Although both natural and supernatural illness causal attributions exist in all societies, cultural differences can be found in the extent to which each dimension is endorsed compared to other dimensions. For example, Bhugra, Corridan, Rudge, Leff, and Mallett (1999) found people from Asian backgrounds were more likely to see the cause of mental illness in spiritual or religious terms or to regard it as unacceptable behaviour, whereas “whites” were more likely to see mental illness as a possible cause. Similarly, Landrine and Klonoff (1994b) found the people from “minority” group (Blacks, Latinos, and Asian/Pacific Islanders) rated supernatural forces as more important causes of illness than did the “whites”. The limitation in the theory of natural/supernatural causal attributions explaining illness behaviour is that it excludes the roles of cultural health belief models and social relationships which are presumed to more strongly differentiate across-cultures.

Robbins and Kirmayer (1991) suggest that to identify cultural differences in causal explanations, subjects/stimulus used to elicit attributions should be symptom specific rather than general illness. They argue that in predicting health behaviour such as patterns of self-care, propensity to visit a doctor, delay in help-seeking, compliance with therapeutic regimes, and success in coping with chronic illness, past studies have failed to demonstrate the importance of causal attributions. The reason for this failure may be due to the crucial distinction between attributions of the cause of illness compared to attributions of the cause of symptoms. Diseases with established labels and diagnosis (such as diabetes, breast cancer, heart disease, schizophrenia, etc.) often already imply a specific cause, timeline, probable outcome and appropriate treatment. Klonoff and Landrine (1994) found that culture plays an insignificant role in causal explanation when specific illnesses were used (e.g. headache, hypertension, AIDS, the common cold, diabetes, and lung cancer). In contrast, symptoms generally occur before a self or professional diagnosis has been made. They are often experienced as a mix of confusing sensations, and are therefore open to a variety of interpretations. Causal attributions for these unlabelled symptoms may be more predictive of illness behaviour than are attribution of illness.

In predicting professional help seeking, Robbins and Kirmayer (1991) argue that normalising/environmental, psychological, and somatic factors are considered important in predicting illness behaviour. Biological and somatic causal explanations, however tend to be associated with help seeking from biomedical practitioners. They posit that
symptoms, when they first appear, are often normalised by being attributed to situational factors such as environmental irritants, fatigue, overexertion, lack of sleep or dietary indiscretion. Only when such a normalising attribution is realised as insufficient, will symptoms be attributed to a dispositional source such as physical disease, excessive worry, or constitutional weakness. They suggest that symptoms which are believed to originate from somatic or psychological causes are more likely to be dealt with by biomedical practitioners. In proposing these dimensions, the researchers show a clear bias toward biomedical orientation in their analysis.

Cross-cultural studies reveal Western patterns of causal attributions are not shared by many cultures. In particular, situational or contextual factors, while being underestimated by from the Western medical model, are strongly endorsed by people from many Asian cultures (Kirmayer, Young et al., 1994). The fact that traditional Eastern models of illness place an emphasis on the environmental factor in conceptualising health is assumed to imply different help seeking by people from these cultures to people from Western cultures. An investigation into symptom attributions by Vietnamese mental health outpatients in Massachusetts in the United States found that 30 percent of the patients attributed the causes of their symptoms as “hit by the wind” (see Chapter 2). All of these patients, however, met the DSM-IV criteria for panic attack (Hinton et al., 2003). That is, while people from Western cultures may discount symptoms which they attributed to environmental factors, people from Eastern cultures may magnify the importance of this factor and actively seek help.

Dispositional factors of illness attribution also have different help seeking implications for people from non-Western cultures. The general trend indicates that people from non-Western cultures tend to seek informal help for symptoms associated with psychological causes (Lam & Kavanagh, 1996; Moon & Tashima, 1982; Pham, 1986; Ying, 1990). For symptoms which are perceived as having biological origin, medical help is most often preferred. For example, Cheung (1987) investigated the relationship between problem conceptualisations and the type of help sought among 247 outpatients at Chinese psychiatric clinics. The study found three patterns of help seeking. The first group consisted of the outpatients who conceptualised their initial problems in purely psychological terms and were more likely to use self-directed psychological coping methods, delay initial professional consultation and approach mental health professionals. The second group, which consisted of people who used
somatic concepts only, was least likely to approach mental health professionals initially or anytime during their previous consultation history and tended to use other resources to cope with their problems. The third group, comprising people who conceptualised their problems in mixed terms, approached professional help early and accessed psychiatric resources the earliest among the three groups. Similar results were reported by Ying (1990) in a study exploring explanatory models of major depression among recently arrived Chinese-American immigrant women. The study found that those who conceptualised problems as having a psychological base tended to turn to family and friends for help, whereas those who attributed them to physical causation were more likely to seek out medical services, whether from the folk or the traditional sector of the health care system (non-Western beliefs about the cause of the illness) or biomedicine practitioners (Western causation beliefs) (Fosu, 1989; Kleinman, 1980; Stephenson, 1995).

HELP SEEKING AND ACCULTURATION

Previous studies have found acculturation to be an important variable when addressing culture differences in help seeking behaviour (Atkinson & Gim, 1989; Solberg, Choi, Ritsma, & Jolly, 1994). One possible reason is that acculturation levels may be related to psychosocial adjustment and thus the need for help (Sue, 1994). Another rationale is that during the process of cultural change as the result of migration and assimilation into the host society, health related beliefs and practices are altered. These changes may be more prominent for those who came from different value-orientated societies. For example, amongst Vietnamese-Australians, acculturation may result in a shift from more traditionally Chinese orientated health beliefs and practices to the more scientific Western health orientated beliefs and practices dominant in Australian society. Such health acculturation is likely to result in a changing pattern of health care seeking.

A review of the literature specifically pertaining to help seeking for mental health issues suggests that more acculturated individuals were more likely to express a preference for an Anglo-American counsellor over an Asian-American counsellor (Hom, 1998). Especially, greater acculturation toward the host culture predicts more positive attitudes toward seeking professional psychological help (Leong, Wagner, &
Tata, 1995; Ly, 2002; Tata & Leong, 1994; Ying & Miller, 1992; Zhang & Dixon, 2003) and greater use of mental health services (Tabora & Flaskerud, 1997). People who are less acculturated may continue to use alternative remedies from herbalists, acupuncturists, fortune-tellers, or ministers (Al-Issa, 1993; S. Sue, 1994; Sue & Morishima, 1982).

A few studies have approached help seeking in a more comprehensive manner. Quah and Bishop (1996) examined the relationship between illness cognition, cultural orientation, and the help seeking behaviour of Chinese-Singaporean students and their parents in the United States. The study found that participants who scored high on Chinese cultural orientation were more likely to attribute “internal imbalance,” “blocked qi,” “excessive cold,” or “excessive heat” as causes of illness, and that they were more likely to seek help from traditional Chinese medicine professionals. Conversely, the participants who scored low on Chinese orientation tended to believe more in physical attributions and were less likely to consult a practitioner of Eastern medicine. Consequently, individuals who tend to ascribe diseases to physical causes indicated greater likelihood of seeking help from a physician. It would be difficult to judge, however, if this study adequately investigated participants’ biomedical models of illness explanation since this model was measured using a single item – “caused by a virus”. Moreover, the researchers also found that cultural orientation, independent of its relationship to illness concepts, was positively related to seeking help from a traditional Chinese medicine practitioner. However, because the study only focussed on measuring Chinese orientation, it was impossible to establish if acculturation towards the American society played a role in illness cognition and subsequent choices in help seeking.

Armstrong and Swartzman (1999) adopted a similar approach. They improved, however, on the measurement of illness attributions by examining Asians’ (Chinese, Chinese from Hong Kong, Taiwanese, and Vietnamese) and Westerners’ satisfaction with medical care in Canada. To assess causal attributions, their study employed items which represent the biomedical and the traditional Chinese medical models in the list of causal attributions. Further, unlike Quah and Bishop (1996) who measured acculturation from a uni-directional/one-dimensional approach from perspective of Chinese culture, acculturation orientation was changed to host culture in the Armstrong and Swartman (1999) study. The researchers found that both acculturation and causal attribution played significant roles in determining satisfaction with care. Asian
participants in particular were found to endorse the traditional Chinese medical causal attribution model, whereas Western participants endorsed the biomedical model. Moreover, this study suggested that these traditional beliefs mediated the cultural differences in satisfaction with medical care. That is, the extent to which a participant endorsed items indicative of traditional Chinese beliefs explained the difference in satisfaction with Western medical care between the Western and the Asian groups and also accounted for satisfaction differences between the more acculturated and the less acculturated. In short, the stronger participants’ traditional Chinese views were, the less satisfied they were with Western medical care. Although the research focussed on physical illness/symptoms, its findings may be extendable to mental health symptoms.

SUMMARY

This chapter postulated that help seeking essentially involves choices in helping sources. Four factors which help determine these choices are modes of symptom expression, causal attributions for symptoms, available sources of help, and acculturation. The earliest step in the help seeking process involves individual recognition of physical or psychological symptoms and their subsequent illness expression.

Two modes of symptom expression commonly presented in clinical settings are somatisation and psychologisation. Although somatisation is arguably a universal mode of help seeking, it has often been found that people from non-Western cultures, especially Chinese influenced cultures, tend to use it exclusively in professional help seeking situations. Psychologisation, however, is a more common characteristic of people from Western cultures.

The second influence on help seeking is the way in which people attribute a cause to symptoms which concern them. Three causal attribution styles important in considering help seeking behaviour include environmental attributions, psychological attributions, and biological attributions. It has been shown that people who attribute the cause of their symptoms to environmental factors would be more likely to seek help from Eastern medicine. People from Western cultures would be more likely to seek help from mental health professionals for symptoms attributed to psychological causes. In contrast, people from non-Western cultures would more likely to seek informal
sources of help (family, friends, religious sources). Finally, biological causation tends to lead to help seeking from Western medicine.

The third factor posits that choice in help seeking depends also on the availability of helping sources. The absence, or scarcity, of professional mental health services in most non-Western cultures, has meant that people tend to rely on themselves, family or social networks for help with psychological problems. The choice between Western biomedicine and Eastern/Chinese medicine also depends on cultural patterns on the use of services. People from Asian cultures may be more likely to prefer traditional Chinese medicine, whereas, people from Western cultures may prefer biomedicine.

Finally, acculturation has been found to be an important mediator of help seeking. The extent to which an immigrant chooses to retain the health beliefs, and practices of their heritage culture and the extent to which they adopt the beliefs of their host culture, both have a significant impact on health outcome measures (such as help seeking patterns or satisfaction with care). Despite the significant role of acculturation in help seeking behaviour, little is known of its relationship with the variables influencing choices of help seeking addressed in this chapter. Before examining the dynamics of these help seeking variables between Anglo-Australians and Vietnamese-Australians, the next chapter introduces a theoretical background on the concept of acculturation.
CHAPTER 4: ACCULTURATION

Migrating from one culture to another (e.g., from a collectivistic to an individualistic culture or from an Eastern to a Western culture) inevitably influences a person’s cultural orientation. How it does so, depends on the way in which the immigrant reconciles the two types of cultural values. Previous chapters have demonstrated that culture shapes illness behaviour, and that changes in culture therefore tend to result in modification of health care practices (including help seeking behaviour). Although previous research has demonstrated the importance of the role of acculturation in adaptation and health outcomes, few researchers have investigated how it influences help seeking cognition. Further, existing help seeking literature has operationalised acculturation using a uni-dimensional approach which is problematic in itself. Although the current understanding of acculturation has shifted to a bi-dimensional conceptualisation, there is no single instrument which has been found adequate in measuring acculturation. In search of a better understanding of acculturation and its influences on help seeking behaviour, this chapter reviews the conceptualisation of acculturation. A particular focus of this chapter will be the strengths and weaknesses of existing scales measuring acculturation.

GENERAL DEFINITION

Numerous definitions of acculturation have been put forth, most of which built from the early explication of the construct provided by anthropologists (Redfield, Linton, & Herskovits, 1936): "Acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups" (p. 149). More specifically, acculturation can be defined as an ongoing process whereby emotions, cognition, and the behaviour of persons from one culture are modified as the result of first-hand contact with persons from a different culture or cultures (Berry, 1984, 1990; Berry & Kim, 1988; Berry, Trimble, & Olmedo, 1986; Maclachlan, 1997; Ward, 1996). This cultural modification can be viewed as a learning process in which individuals adopt attitudes, values and behaviours of another culture in
areas such as language familiarity and usage, cultural heritage, ethnic pride, ethnicity, and interethnic distance (Padilla, 1980).

Berry (1990) emphasises that acculturation may be "uneven" across domains of behaviour and social life. For example, one may seek economic assimilation (in work), linguistic integration (by way of bilingualism), and marital separation (by endogamy). Consequently, the operationalisation of acculturation has varied depending on the areas under investigation. Existing acculturation scales (Berry, Kim, Power, & Young, 1989; Cuellar, Arnold, & Maldonado, 1995; Felix-Ortiz, Newcomb, & Myers, 1994; Harris & Verven, 1996; Landrine & Klonoff, 1994a; Suinn, Richard-Figueroa, Lew, & Vigil, 1987) have incorporated different elements of acculturation. For instance, Berry et al. measured acculturation attitudes; Cuellar and colleagues included language, ethnic identity, and ethnic interaction factors on their instrument; Landrine and Klonoff included cultural beliefs and practices, socialisation, traditional food preparation and consumption, possession of cultural items, attitude, and cultural superstitions; and Suinn and colleagues included reading/writing/cultural preference, ethnic interaction, affinity for ethnic identity and pride, generation identity, and food preference factors in their acculturation measurement.

**TWO CONCEPTUALISATIONS OF ACCULTURATION**

Although acculturation has been identified as an indicator of refugees' or immigrants' cultural adjustment, theoretical differences in defining acculturation and understanding the acculturation process do exist. Nevertheless, the conceptualisation of acculturation has evolved from a uni-dimensional to a bi-dimensional paradigm.

**Uni-Dimensional Paradigm**

Within the uni-dimensional approach of acculturation, there evolved two levels of conceptualisation. The unidirectional and the bi-polar uni-dimensional approaches.

**The uni-directional/uni-dimensional model**

The early conceptualisation of acculturation was based on a unidirectional/uni-dimensional approach. It proposed that acculturation is a process through which individuals give up their traditional cultural values and behaviours and weaken their ethnic identities as they take on the values and behaviours of the dominant social
structure (Suinn et al., 1987; Ward, 1996). Acculturation is often described as an assimilative process where minority individuals acquire the behaviours and values of the host society (e.g., Franco, 1983). It is often referred to in terms of high versus low acculturation (or acculturated vs. not acculturated) - where high acculturation indicates assimilation into the host society and low acculturation indicates maintenance of the ethnic culture. In this model, one’s ethnic culture is measured against the host culture, and the implication is that one can be either Vietnamese or American (for example). (See Figure 2)

![Figure 2. A unidirectional model of acculturation](image)

**The bipolar/uni-dimensional model**

Like the unidirectional model, acculturation under this framework also places individuals in a position where they have to choose between culture of their origin and the culture of the host society. However, the bi-polar model allows for a middle ground between the two identities. That is, individuals who identify with both cultures are considered as bicultural (see Figure 3).

![Figure 3. Bipolar model of acculturation](image)

Although this model better explains the concept of acculturation, the bipolar model is criticised because it fails to differentiate between a “true” versus “mock” bicultural (Nguyen et al., 1999). A “true” bicultural is one who is well integrated into the two cultures, while a “mock” bicultural is one who is alienated or marginalised
from both cultures (Szapocznik, Kurtines, & Fernandez, 1980). The problem with the bipolar model is that it can only report the ‘‘biculturality’’ in terms of equal involvements. It cannot, however, distinguish how involvements in each culture are equivalent—whether they are equally high (i.e., a true bicultural) or equally low (i.e., a mock bicultural or marginalised person). Yet, such distinctions are important because they capture the concept of being culturally at ease while living in a new society.

There are also further problems with the uni-dimensional approach of acculturation. One of the criticisms is that it assumes mutually exclusion (Rogler, Cortes, & Malgady, 1991). It assumes that a strong ethnic identity is not possible among those who become involved in the mainstream society and that, as acculturation into the host society increases, a concomitant decrease or weakening of ethnic ties must also occur (Phinney, 1990). Although this type of mutual exclusive relationship between the host and the heritage cultures may exist, critics argue that acculturation does not have to be an ‘‘either-or’’ relationship. Individuals can be highly involved in both cultures (e.g., they can be fluent in both ethnic and host languages), and a strengthening of one culture does not require a weakening of the other. The second problem of this model is its bias toward the dominant culture. Its conceptualisation suggests that a ‘‘good’’ group is those who assimilate to the host culture and that a ‘‘bad’’ group is those who maintain their ethnic traditions (Dona & Berry, 1994). This conceptualisation is problematic because it implies that the ideal goal for all minority individuals is to relinquish their ethnicity and become like the host culture, and that a failure to do so indicates a sense of weakness and inadequacy. However, the importance of adhering to the dominant culture has been countered by immigrants who have carved a ‘‘native’’ environment in their new community or who have preserved their ethnic identity over time and across contexts (Oetting & Beauvais, 1990). The uni-dimensional model is also criticised as faulted because it does not reflect the dynamic of current multicultural/multiethnic societies (Nguyen et al., 1999).

The Bi-Dimensional Paradigm

In contrast to the uni-dimensional model of acculturation, the bi-dimensional model suggests that cultural involvements are not necessarily polar opposites and that they can and should be measured separately (e.g., (Dona & Berry, 1994; Oetting & Beauvais, 1990). The bi-dimensional model asserts that the extent to which individuals
maintain their culture of origin and the extent to which they adopt the culture of the host society can be assessed independently. Individuals can have either strong or weak identifications with both their own and the host culture. A strong relationship with one culture however does not automatically imply a weak relationship or low involvement with the other culture (Phinney, 1990). In contrast to the uni-dimensional approach, the bi-dimensional approach allows assessment of acculturation according to orthogonal domains (Figure 4).

Figure 4. The bi-dimensional model.

The most sophisticated conceptualisation of acculturation to date is the one proposed by John Berry (Berry, 1984, 1990, 1995, 1998, 1999; Berry & Kim, 1988; Berry et al., 1989; Berry et al., 1986). Berry based his conceptualisation on two focal questions: First, “is it considered of value to maintain one’s identity and characteristics?” and second, “is it considered of value to maintain relations with larger society?” He then derived four acculturation attitudes (integration, assimilation, separation, marginalisation) based on responses to these questions. Assimilated individuals are those who have relinquished their cultural heritage and identity and adopted the culture and identity of the country of settlement. Separation represents the opposite of Assimilation in that the individual maintains his/her culture of origin and refuses to adopt the host culture. Integration-orientated individuals maintain a strong
identity with their heritage culture but, at the same time, are motivated to establish sustained links with the other culture. Marginalisation represents loss and alienation in which the person rejects both their culture of origin and the culture of settlement (see Figure 5). These modes of acculturation, nevertheless, are not rigid boundaries. It is assumed that people may experience more than one mode at some time in their lives. Further, people in the same family may adopt different modes of acculturation.

Is it considered to be of value to maintain one’s identity and characteristics?

<table>
<thead>
<tr>
<th>“YES”</th>
<th>“NO”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated</td>
<td>Assimilated</td>
</tr>
</tbody>
</table>

Is it considered to be of value to maintain relationships with larger society?

<table>
<thead>
<tr>
<th>“YES”</th>
<th>“NO”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separated</td>
<td>Marginalised</td>
</tr>
</tbody>
</table>

Figure 5. Formulation of bi-dimensional conceptualisation of acculturation

MEASURING ACCULTURATION

Past studies have operationalised acculturation in divergent ways: with either a single index; with uni-dimensional-bipolar scales such as the Suinn ASIA (Suinn et al., 1987) and the ARSMA (Cuellar, Harris, & Jasso, 1980); with bi-dimensional scales measuring independent cultural domains (e.g., Acculturation Index: Ward & Kennedy, 1994; Cultural Identity Scale: Felix-Ortiz et al., 1994; Acculturation Scale for Vietnamese Adolescents: Nguyen et al., 1999; or with bi-dimensional scales measuring modes of acculturation directly (e.g., Acculturation Attitudes Scales: Berry et al., 1989; The East Asian Acculturation measure: Barry, 2001; the AHIMSA Acculturation Scale: Unger et al., 2002). Measuring acculturation with such different approaches has tended to produce somewhat contradictory and conflicting research findings.

Single-Item Indices

Several single-item indices have been used by researchers to measure acculturation. These include generation status (Inclan, 1983), language preference (Ortiz & Arce, 1984), years of host country residence (Dressler & Bernal, 1982), participation in host culture (Ranieri & Klimidis, 1994). The use of a single item as a
form of measurement is problematic because its content validity may be questioned. That is, a single factor cannot fully accounts for the multifaceted complexities of acculturation. Rather, it can only be used as a proxy measure where acculturation is implied rather than ascertained.

**Uni-Dimensional Measures**

The majority of measures used in the acculturation literature are based on bipolar models. These scales include a wide range of ethnic groups (e.g., Cubans, Greeks, Mexicans, Koreans, African-Americans, Southeast Asians, etc.) and most are psychometrically sound (e.g., the Suinn-Lew Asian Self-Identity Acculturation Scale; the Acculturation Rating Scale for Mexican Americans). Despite their strengths, however, these bipolar models are not immune from conceptual problems. An example of conceptual issues can be found in the Suinn-Lew Asian Self-Identity Acculturation scale, which is one the most widely used measures of acculturation for Asian populations. The Suinn-Lew ASIA scale assesses language, identity, friendship choice, behaviours, generation status, and attitudes, and is based on the assumption that acculturation is a uni-dimensional construct ranging from “low acculturation,” indicating an Asian identification, to “high acculturation,” indicating a Western identification, with a midpoint representing a “bicultural” identification. Although the Suinn-Lew ASIA Scale has garnered increasing empirical attention and shows much promise as a research instrument, it has been criticised because it does not distinguish between different Asian ethnic groups and does not assess a range of acculturation behaviours and situations. Moreover, it does not adequately recognise that individuals may display varying patterns of acculturation in different situations. Acculturation may be better described as a composite profile rather than a unitary phenomenon or single-scale score. From a clinical perspective, the Suinn-Lew-ASIA Scale has a severe limitation because it does not flag marginalised immigrant or ethnic minority individuals (i.e., individuals who have difficulty fitting into host and native cultures) who, according to Berry (1990), may be particularly vulnerable to psychological distress. Note that the Suinn-Lew ASIA Scale was developed based on a scale specifically designed for the Mexican population – the Acculturation Rating Scale for Mexican American (Cuellar et al., 1980). Although the ARSMA has been revised to incorporate the new bi-dimensional conceptualisation of acculturation (Cuellar et al.,
1995), the Suinn-Lew ASIA Scale retains its original uni-dimensional conceptualisation from the original ARSMA and continues to offer a basis of acculturation measurement in studies of Asian groups. Despite the limitations in conceptualisation, the scale still is one of the most popular measurement scales of acculturation for Asian populations.

**Bi-Dimensional Measurements**

Berry’s framework of acculturation, particularly his use of categorical approaches, has received increased attention over the past decade. Berry and his colleagues have relied on three methods to assess acculturation attitudes (Ward & Rana-Deuba, 1999). Acculturation attitudes can be measured by the preference rankings of the four acculturation strategies through the use of vignettes, the assessment of attitudes toward host and co-national communities as a basis for classifying research participants into one of the four acculturation groups (Dona & Berry, 1994), and the simultaneous measurement of the four acculturation attitudes via separate subscales (Berry et al., 1989).

In his original measure of acculturation – the Attitudes Acculturation Scale, Berry measured acculturation attitudes directly rather than computing them from the two dimensions (e.g., Berry et al., 1989) His scales have strong psychometric properties and have been widely tested in different countries, with different ethnic groups (Berry et al., 1989). However, Berry’s scales have been criticised for several reasons: (a) the items were double-barrelled (i.e., they conveyed more than one piece of information); (b) the scales were lengthy, taxing, and “ipsative”; and (c) infeasible correlations between the attitudes raised concerns for construct validity (Dona & Berry, 1994; Nguyen et al., 1999; Ward & Rana-Deuba, 1999) and the four scale approach is largely unsuitable for multivariate analyses, most of which requires orthogonal measures based on the assumption that measures would show no correlation between them \( (r = 0) \) (Ward & Rana-Deuba, 1999). Although Dona & Berry (1994) have addressed some of these limitations in later instruments by measuring the two dimensions directly (others who take this approach are Nguyen, Messe & Stollak, 1999; Ward & Rana-Deuba, 1999). However, acculturation research, in line with Berry’s own preference, has still employed direct measurement of the four attitudes.

Although acknowledging Berry’s influential conceptualisation of acculturation, other researchers are not fully satisfied with his choice in measuring acculturation.
Instead of measuring the four modes of acculturation directly, they have derived scales which allow the independent assessment of both heritage and host cultural orientation. Some of these measures include the Acculturation Index (Ward & Kennedy, 1994), the Cultural Identity Scale (Felix-Ortiz et al., 1994), the East Asian Scale Measure (Barry, 2001), the Khmer Acculturation Scale (Lim, Heiby, Brislin, & Griffin, 2002), and the Acculturation Scale for Vietnamese Adolescents (Nguyen et al., 1999). Cuellar and his colleagues (1995), also influenced by the movement toward bi-dimensional conceptualisation of acculturation, have subsequently updated the original uni-dimensional scale ARSMA (Cuellar et al., 1980) to the bi-dimensional scale ARSMA-II (Cuellar et al., 1995) to measure Mexican cultural orientation and American cultural orientation. The combination of the two scores on cultural orientation is used for categorisation of modes of acculturation.

There have been various attempts to propose modes of acculturation based on the two cultural orientation scales. One of such attempts includes Cuellar et al. (1995) ARSMA-II, which still carries the legacy of uni-dimensional conceptual limitation. On ARSMA-II, although the two cultural orientations were measured “independently,” categorisation of acculturation still requires computation of a single acculturation score by subtracting the Mexican cultural orientation score from the Anglo cultural orientation score. Negative results were then assigned to acculturation modes associate with Mexican culture and positive scores were assigned to Anglo-American culture. Inadvertently, this technique set acculturation back to a uni-dimensional style of conceptualising acculturation. Further, it still failed to identify individuals who are marginalised.

The more convincing approach to categorisation of acculturation strategies is recommended by Dona and Berry (1994). To address some of the criticisms of their previous measure of acculturation, Dona and Berry recommended the use of mid-point split technique in which cut-off scores for categorising acculturation modes are defined by mid point on each dimension (e.g., 3 in a range between 1 to 5). A similar approach has been adopted by other researchers. However, median scores were used as the cut-off criterion instead (e.g. Lim et al., 2002; Neto, 2002; Ward & Rana-Deuba, 1999). Both techniques allow the categorisation of any culture orientation as “high” or “low”. The integration mode is assigned when both cultural orientation are scored ‘high’, the marginalisation mode is assigned when both scores are ‘low’, the assimilation mode is
when score of host culture orientation is ‘high’ and score of heritage culture orientation is ‘low’, and the separation mode is assigned when score of heritage culture is ‘high’ and score of host culture is ‘low’. The use of mid-point split or median split has advantages as well as limitations. The first approach is believed to result in a “purer” classification scheme and affords greater cross-sample comparisons (Lim et al., 2002; Ward & Rana-Deuba, 1999). The second approach relies on a relative within-sample classification scheme and has some limitations for cross-sample comparisons (Neto, 2002; Ward & Rana-Deuba, 1999).

PREDICTORS OF ACCULTURATION

Research has shown that individual differences do exist in acculturation. For example, the relationship between acculturation level and individuals' demographic characteristics such as age (Liebkind, 1996), length of residency in the host country (Jiobu, 1988; Szapocznik, Scopetta, Kurtines, & Aranalde, 1978), and immediate home, school, or work environment (Sodowsky & Wai, 1997) have been examined. In examining cultural factors that affect the psychological functioning of Southeast Asian refugee adolescents, Lee (1988) observed that their adjustment to the host country depended on the length of stay in the host country, the age of arrival at the time of immigration, the compatibility of their country of origin to the host community, their parents' acculturation levels, and the school environment. Jiobu (1988) confirmed the role of length of residency in the host country in acculturation and found that the longer immigrants had lived in the host country, the more acculturated they became. Similarly, Szapocznik et al. (1980) concluded that acculturation was unidirectional in that, with time, immigrants became more acculturated but not less.

From the bi-dimensional perspective, there are a number of variables which predict acculturation strategies. Berry et al. (1989) found that people who favour integration and separation strategies tend to have higher education and socioeconomic status compared to those who adopt assimilation and marginalisation. Assimilation can be predicted from greater participation in the host society such as reading newspapers, having friends from the host culture, and being less interested in maintaining the heritage culture. Separation can be predicted from less identification with the host society and more heritage cultural maintenance (e.g., less English use, and having more
in-group friends) together with lower education and socio-economic status. Integration can be predicted by greater usage of host culture language and newspaper reading, more involvement in the host society’s clubs and organisations, in conjunction with ongoing interest in maintaining ethnic identity. Berry also found that age and greater time in the host culture predicted assimilation.

HEALTH OUTCOMES OF ACCULTURATION

According to Ward et al. (2001), Berry’s four modes of acculturation by virtue of being categorical data, may be less effective in predicting cross-cultural outcomes than the two dimensions of cultural identity, culture of origin and host culture. Nevertheless, outcomes of acculturation are viewed as indicators of effective functioning. Although the benefits of adjustment are well recognised, substantial variation in defining adjustment has been documented. Some assessed outcomes of acculturation as the ability to manage psychological (intercultural) stress, ability to communicate effectively, and ability to establish interpersonal relationships (Hammer, Gudykunst, & Wiseman, 1978). Others argue for the importance of self-maintenance of psychological well-being, interpersonal interactions with host nationals, and appropriate cognitive dispositions such as values and attitudes (Black & Mendenhall, 1990; Mendenhall & Oddou, 1985). Nevertheless, all theorists recognise the important roles of physical and psychological well-being as well as behavioural competence.

The relationship between acculturation and various measures of stress and well-being have been substantially investigated. Studies with native peoples and immigrants have documented a positive relationship between integration, assimilation, and adjustment. In contrast, separation and marginalisation are related to psychological maladjustment and psychosomatic problems (Berry, Kim, Minde, & Mok, 1987; Berry, Wintrob, Sindell, & Mawhinney, 1982; Schmitz, 1992). There is an argument and some empirical evidence to suggest that the integration option, maintaining both one’s own ethnic traditions and contacts with the host culture, affords the best psychological outcomes; whereas, marginalisation leads to the worst psychological outcomes (Berry et al., 1987; Phinney, 1990; Ward, 1996). For example, Rumbaut (1991) found, in his longitudinal study on Southeast Asian refugees in the United States, that the level of distress decreased over time but that biculturalism (integration) emerged as a significant
predictor of low levels of distress at the later period. Sam and Berry (1995) found a consistent relationship between marginality and emotional distress amongst young Third World immigrants in Norway.

SUMMARY

This chapter examines the acculturation literature in search for a meaningful explanation of help seeking behaviour. Over the past decades, acculturation has evolved from the uni-dimensional conceptualisation to a bi-dimensional conceptualisation. The uni-dimensional conceptualisation equates acculturation with assimilation. The bi-dimensional conceptualisation, however, emphasises cultural pluralism. Although the current trend in acculturation has come to accept the latter form, none of the help seeking studies have incorporated the theoretical advance of the bi-dimensional approach into their measurement of acculturation. Further, acculturation has been measured in different ways, with single-item, uni-dimensional-bipolar scales, or with bi-dimensional modes of acculturation. Subsequently, studies of the relationship between acculturation and outcomes (health beliefs and help seeking included) have yielded conflicting results. Nevertheless, given the influential role of acculturation on the process and outcomes of psychological and socio-cultural adjustment, further examination of the relationship between acculturation and help seeking behaviour seems warranted.
CHAPTER 5: AIMS AND HYPOTHESES

AIMS

The main aim of the present study was to investigate the influence of culture and cultural change on the health-related help seeking behaviour of Vietnamese-Australians. Specifically, it aimed to investigate the health-related help seeking behaviour of Vietnamese-Australians from two perspectives. One perspective focussed on cross-cultural differences. It sought to compare Vietnamese-Australians to the Vietnamese in Vietnam (their culture of origin) and to the majority of people in the host culture (Anglo-Australians). The second perspective focussed on investigating individual differences among Vietnamese-Australians regarding their health beliefs and behaviour, based on their mode of acculturation. Central to the Vietnamese Australian experience is the acculturation process to Australia (the host culture) and its effect upon the maintenance of aspects of Vietnamese culture (the heritage culture). It has been argued that this acculturation process differs from one person to another, reflecting individual choice, and that the modes of acculturation predict Vietnamese-Australians’ health beliefs and practices. The aims of the current study also included the development of acculturation scales to assess the heritage- and host-culture orientations of Vietnamese-Australians in order to achieve a better understanding of health cognitions, beliefs, and behaviour. It was expected that acculturation orientation would have both a direct effect on help seeking and an indirect effect via the illness explanatory model adopted. Therefore the current study also aimed to investigate whether the acculturation of Vietnamese-Australians predicted their help seeking cognitions and whether it influenced the predictive power of illness explanatory models in people’s choices of help seeking. According to Kleinman (1980), lay illness explanatory models are a set of ideas about an episode of sickness that guide individuals with choices among available treatments. The current study tested whether variables included in the model predict choices of help seeking.
HYPOTHESES

*Hypothesis 1: Differences between culture groups*

It was predicted that patterns of help seeking would vary across cultural groups. Specifically,

1a. Vietnamese-Australians would be report lower levels of psychological adjustment compared to Anglo-Australians and the Vietnamese in Vietnam.

1b. The Anglo-Australians would score the highest, the Vietnamese in Vietnam would score the lowest, and the Vietnamese-Australians would score intermediate on psychologisation. Between groups differences on somatisation were explored.

1c. The Anglo-Australians would score the highest on biological attributions and psychological attributions and the lowest on environmental attribution. In contrast, the Vietnamese in Vietnam would score the highest on environmental attributions and the lowest on biological attributions and psychological attributions. The Vietnamese-Australians would report intermediate levels of three sources of causal attributions.

1d. The Anglo-Australians would indicate the highest preference for self-help, mental health help and Western medicine help; whereas the Vietnamese in Vietnam would score the highest on preference for obtaining help from family and/or friends, spiritual help sources and Eastern medicine professionals. The Vietnamese-Australians would score intermediate on preference on all sources of help.

*Hypothesis 2: Differences between acculturation groups/modes*

It was hypothesised that help seeking tendencies (assessed by symptom score, modes of illness expression, symptom attributions, and help seeking choices) would be influenced by acculturation, and participants’ help seeking tendencies would vary according to their modes of acculturation. More specifically,

2a. The integrated and assimilated Vietnamese-Australians would be more psychologically adjusted (fewer symptoms of anxiety and depression) than the separated and marginalised groups.

2b. The assimilated and the integrated would be higher on psychologisation than the separated and the marginalisation. Also, differences between groups on somatisation were explored.
2c. The assimilated and integrated would be more likely to attribute to psychological and biological causes than the marginalised and separated groups. Also the integrated and separated more likely to attribute to environmental causes than assimilated and marginalised groups.

2d. The assimilated and integrated groups were predicted to prefer self-help, mental health help, and Western medicine help more than the separation and the marginalisation groups. Separated and integrated groups were more likely to seek help from family/friends, spiritual sources, and Eastern medicine in comparison with the assimilated and marginalised groups.

**Hypothesis 3: Predicting help seeking of Vietnamese-Australians from cultural orientation**

Vietnamese-Australians’ help seeking tendency could be predicted from their acculturation (assessed by Australian and Vietnamese cultural orientations). Specifically,

3a. Australian-ness would predict better psychological adjustment whereas Vietnamese-ness would predict poorer adjustment,

3b. Australian-ness and Vietnamese-ness would predict the use of somatisation as a mode of illness expression but only Australian-ness would predict psychologisation,

3c. Vietnamese-ness would predict environmental attributions, and Australian-ness would predict psychological and biological attributions,

3d. Australian-ness would predict choices of self help mental health help and Western medicine help; whereas Vietnamese-ness would predict family and/or friend help, spiritual help, and Eastern medicine help.

**Hypothesis 4:** Illness explanatory models (assessed by symptom severity, mode of illness expression, and symptom attributions) would predict all choice of help seeking sources for Vietnamese-Australians.

**Hypothesis 5:** Cultural identifications (Vietnamese-ness and Australian-ness) would improve the predictive power of the illness explanatory model in predicting help seeking choices.
CHAPTER 6: METHOD

PARTICIPANTS

A total of 248 individuals (88 men, 160 women and 1 of unknown sex) participated in the study. Participants were selected from three cultural groups. The Vietnamese-Australian group included 94 participants who self-identified as Vietnamese, born in Vietnam, or have at least one parent born in Vietnam (28 men and 66 women). The Anglo-Australian group included 106 people who self-selected as Anglo-Australian (47 men and 59 women). This group also included people whose either one or both parents were “European”. The Vietnamese-Vietnam group included 49 Vietnamese in Vietnam (13 men, 25 women, 1 of unknown sex). ANOVAs showed significant age differences between the three culture groups, $F(2,245)=20.34, p<.001$, with the Vietnamese-Australians ($M=36.96, SD=14.54$) being were significantly older than both the Anglo-Australians ($M=26.61, SD=9.28$) and the Vietnamese in Vietnam ($M=30.98, SD=8.57$). Fifty-three percent of Vietnamese-Australians, 62% of Anglo-Australians, and 60% of the Vietnamese in Vietnam either completed or were enrolled in tertiary education. Eighty-four percent of Anglo-Australians, 61% of Vietnamese-Australians and 87% of the Vietnamese in Vietnam were employed casually, part-time, or full time. Forty-nine percent of Anglo-Australians indicated that they had ‘no religion’, 25% were Catholics and 8% reported their religion as other Christian. For Vietnamese-Australians, 46% were Buddhists, 17% Catholics, and 18% had ‘no religion’. A quarter of the Vietnamese in Vietnam indicated that they had ‘no religion’, 19% were Buddhists, and 5% were Catholics.

On a 5-point Likert-type scale (1= very poor health to 5= very good health), the majority of Anglo-Australians were in ‘good’ health ($M=4.09, SD=.78$), most Vietnamese-Australians felt that they were in a ‘fair’ health ($M=3.27, SD=.88$), and most of the Vietnamese in Vietnam were either in a ‘fair’ or ‘good’ health ($M=3.42, SD=.76$). Only 18% of Anglo-Australians, 23% of Vietnamese-Australians, and 26% of the Vietnamese in Vietnam were seeking professional help for health-related matters at the time of the survey. Despite only 24 people reporting poor health, there were 49 people seeking health-related help at the time of the survey. The majority of help seeking was related to physical symptoms ($n=42$) and only seven cases were for
psychological problems. Out of 30 people who answered the help seeking status question, 23 stated that they were seeking help from Western medicine practitioners, 6 sought help from mental health professionals, and one was seeking help from an Eastern medicine specialist. Also, only 11% of the Vietnamese in Vietnam had access to a regular family doctor while more than half of the Anglo and Vietnamese Australian participants indicated that they had such access.

Background Characteristic of Vietnamese-Australians

Of the 94 Vietnamese-Australians who participated in the study, more women than men were found in each acculturation group (marginalisation – 23 women, 10 men, assimilation – 10 women, 4 men, separation – 11 women, 8 men, and integration – 22 women, 6 men). One-way ANOVAs showed significant differences between the groups in terms of age ($F(3,90)=10.19$, $p<.001$). Scheffé post hoc tests indicated that the separation ($M=43.37$, $SD=12.42$) and marginalisation ($M=42.91$, $SD=14.55$) groups were significantly older than the integration ($M=32.11$, $SD=13.23$, both $p<.05$) and assimilation groups ($M=23.93$, $SD=5.60$, $p<.01$ and $p<.001$, respectively).

About half of the Vietnamese-Australians participants had either completed or were enrolled in tertiary education. About 29% of participants indicated that they spoke ‘some’ English at home. Twenty-five percent did not speak the English language at home at all. Twenty-three percent spoke ‘very few’ English words. Seventeen percent spoke English ‘often’ and only 9% spoke English ‘very often’ at home.

One-third of Vietnamese Australian participants were working full-time, 14% were working part-time, 10% were employed on a casual basis, and 4% were retired. About one-third of participants were either students or ‘not employed.’

Forty-seven percent of participants were married and 9% were in de facto relationships, while 32% were single (never married), 11% either separated or divorced, and 3% were widowed.

The majority of Vietnamese Australian participants were long-term residents of Australia. Approximately 30.9% indicated that they had lived in Australia for the past ten to fifteen years. Another 26.3% had resided in the country for between 15 to 20 years while 17.9% had been in Australia for 5 to 10 years. A small percentage (10.5%) was considered new to the country because they had only been in Australia for between one to five years. Five people (5%) indicated that they had arrived in Australia in the
past 12 months. Only one person (1%) had been in Australia for more than 25 years. The majority of the participants (89%) were born in Vietnam, four were born in Australia, two born in Singapore, and one each was born in New Zealand and Thailand.

MEASUREMENTS

In the current study, the survey included several parts designed to assess demographic information, acculturation, symptoms of anxiety and depression, symptom expression (psychologisation and somatisation), symptom attributions, and help seeking choices. The survey package is included in appendix A. To improve the reliability and face validity of scales presented in the survey, the appropriateness of its format, and its readability, the survey package was assessed by a reference group consisting of five Anglo-Australian postgraduate students, three psychology academics, and two Vietnamese family counsellors. The language in the survey was then modified and simplified for better understanding by the lay people based on recommendations from reference group members. The questionnaire was then translated into Vietnamese by the researcher who is a qualified translator and interpreter by the National Accreditation Authority for Translator and Interpreter (NAATI-II), checked for its precision and expression by a Vietnamese bilingual family counsellor/writer, and back-translated into English by a Vietnamese-Australian PhD (business) student. Finally, the two versions of the questionnaire (in English and Vietnamese) were cross-checked by a senior accredited translator/interpreter (NAATI-Level III). The Vietnamese language version of the questionnaire was pilot-tested with six Vietnamese-Australians (two professionals and four lay persons).

The demographic information section (Part 2) of the questionnaire comprised 15 demographic items identifying participants’ age, gender, length of stay in Australia, occupation, employment status, education level, place of birth, parents’ place of birth, marital status, number of children, whether participants have a regular family doctor, a 5-point Likert-type rating scale on general health status, and whether participants were seeking help for any of their health symptoms.

Symptom checklist (Part 1). A checklist of 24 symptoms (9 of anxiety and 15 of depression) was used to measure participants’ levels of psychological adjustment. Depressive symptoms were derived from the Vietnamese Depression Scale (Kinzie et
al., 1982) and anxiety symptoms were obtained from the Hopkins Symptom Checklist – 25 (Mollica & Lavelle, 1988).

The VDS is a 15-item, self-report questionnaire which resembles English-language instruments such as the Beck Depression Inventory (Beck, Rial, & Rickels, 1974) and the Zung Self-Rating Depression Scale (Zung, 1965). The scale was developed based on a combination of the Vietnamese perception of lowered mood and behaviours consistently observed in Vietnamese patients and symptoms relative to the Western concept of depression (especially described in the DSM-III). The scale pays special attention to the cross-cultural differences in the expression of depressive symptoms characteristic of Vietnamese perceptions. The VDS has been validated on the basis of DSM-III criteria and been found a reliable scale with a sensitivity of 91 percent and a specificity of 95 percent (Lin, Ihle, & Tazuma, 1985). The original VDS measured symptoms using 3-degree continuum style. Scores above 13 (of a possible maximum 34) were found to discriminate significantly between clinically depressed and non-depressed Vietnamese.

Adjustment symptoms were also derived from the Hopkins Symptom Checklist - 25 (Mollica et al., 1987). The scale was originally developed by (Derogatis et al., 1973) and was adapted for use with Vietnamese and other Indochinese refugees by Mollica and colleagues to measure symptoms of anxiety and depression. The scale contains ten anxiety symptoms and 15 depression symptoms. The original scale measured items using the four-point Likert scale ranging from 1 (not at all) to 4 (extremely). Mean scores above 1.75 indicate clinically significant levels of anxiety.

Both the HSCL-25 and the VDS have been found to be reliable and have been used extensively with Vietnamese refugees (Felsman, Leong, Johnson, & Felsman, 1990; McKelvey, Mao, & Webb, 1992; McKelvey & Webb, 1995). Subsequently, all symptoms from both scales (40 items) were combined and assessed for their use in the current study. The initial step involved deleting repeated items (e.g., “headache” vs. “headache, limb ache and back ache”; “sad and bothered” vs. “sad” and vs. “bothered”). Further item reduction was carried out on recommendation from the reference group. The final checklist comprised 24 symptoms (9 anxiety symptoms from the HSCL-25, depressive symptoms were 8 items from the VDS and 7 items from the HSCL-25). The scale was found most reliable for the Vietnamese-Australian sample (Cronbach's alpha = .96), followed by the Anglo-Australians (alpha = .86) and least reliable for the
Vietnamese in Vietnam (alpha = .53). To maintain consistency in measuring style, all symptoms were measured using a 4-point Likert-type scale ranging from 0=not at all, 1=a little, 2=quite a bit, to 3=extremely. Only the total score was used to assess participants’ levels of psychological adjustment. A possible score range was from 0 to 72. Higher scores on this scale indicate poorer levels of psychological adjustment.

The Vietnamese-Australian Acculturation Scale (Part 3) was developed for the current study. It comprises 16 items addressing 7 acculturated areas which were designed to measure Vietnamese-Australians’ orientation towards Vietnamese and Australian cultures. The scale adapted a number of components from existing cultural measures. The language competency (speaking, reading and writing), and the ethnic interaction (friends and acquaintances who are Vietnamese or Australians) were adapted from the Suinn-Lew Asian Self-Identity Acculturation Scale (Suinn et al., 1987). The ethnic identity question was adapted from (Berry et al., 1989) attitudes scale. In assessing existing scales (e.g., Suinn-Lew ASIA), items measuring cognitive and behaviour aspects of acculturation (e.g., choice of clothing, listening to the radio, participating in festivals, etc.) were summarised into three dimensions: knowledge of custom and tradition, values and beliefs of custom and tradition, and actual practise of custom and tradition. An item specific to help seeking, the preference of helper (preferring Vietnamese vs. Australian helpers) was an original measure included by the author. Items were measured using 5-point Likert-type scales ranging from 0=not at all, 1=a little, 2=adequate, 3=fluent, and 4=very fluent. For the question items that require numerical quantification, 5-point Likert-type scales ranging from 0=0%, 1= up to 25%, 2 = up to 50% 3 = up to 75%, 4=100% were used. The total of eight items per each scale yielded two scores: the Vietnamese cultural orientation (Vietnamese-ness), and the Australian cultural orientation (Australian-ness). Vietnamese-ness is calculated by summing the scores of eight items on Vietnamese reference. Australian-ness is the sum of eight items on Australian reference. The possible range of these cultural orientation scores was from a minimum score of 0 to a maximum of 32. Both scales were found highly reliable in the current study (Cronbach’s Alpha = .95 for both scales).

Symptom Causal Attributions (Part 5). Originally, the 24 distress/adjustment symptoms were used to elicit symptom causal attribution and help seeking selections. This process was deemed as strenuous by several participants at the early stage of the data collection. Subsequently, the numbers of symptoms on this scale were reduced.
Symptoms with low reliability from the analyses with the first batch of 81 data sets were removed from the scale. The symptoms finally selected to elicit causal attributions and help seeking selections comprised seven most reliable affective symptoms and seven most reliable somatic symptoms.

Symptom Causal Attributions scale comprised three subscales: the environmental, psychological, and biological. The environmental causal attributions scale measured the extent to which participants attributed the cause of symptoms to environmental factors such as the wind, dust, and temperature, or man-made environmental factors such as poor housing. These environmental attributions were assessed in the current study because they were expected to relate to traditional Chinese illness explanatory models. Traditional Chinese illness models often explain the causes of illness as due to imbalances of ecological systems (e.g., yin and yang, hot and cold, “hit” or “caught” by a poisonous wind). The psychological attributions subscale measured the tendency to attribute the causes of illness to psychological factors. These may included ascription of illness to thoughts or emotions-related to a variety of problems (financial, relationship, personality, etc.). The biological attributions subscale measured attribution of the causes of symptoms to physical, biological, or genetic factors. The 14 symptoms were rated on their likelihood to be caused by environmental factors, psychological factors, and biological factors using a 4-point Likert type scale (0=Extremely unlikely, 1=Unlikely, 2=Likely, 3=Extremely likely). The three causal attribution scores were calculated by summing rating of the 14 symptom for each of the three sources of attribution. Higher score indicated higher likelihood of causal attribution. All three scales, except the environmental attribution scale for the Vietnamese in Vietnam (Cronbach’s alpha=.47), were found highly reliable with Cronbach’s alphas ranging from .84 to .94.

Help Seeking Selection (Part 4). The same 14 symptoms used to elicit causal attribution were also used to assess participants’ help seeking preference. There were six sources of help which included self-help (self-reliance or ignoring the symptoms), family and friends, spiritual helpers (e.g., spiritual leaders, God, spirits, etc.), mental health professionals (psychologists, psychiatrists, counsellors), Western medicine, (e.g., family doctors, GPs, and specialists), and Eastern medicine (herbalists, acupuncturists, etc.). Preferences for each source of help were measured by 4-point Likert-type scales varying from 0= ‘extremely unlikely’, 1= ‘unlikely’, 2= ‘likely’, 3=‘extremely likely’. 
The higher scores represent the higher degrees of preference for obtaining help from a particular source. The measure regarding sources of help yielded highly reliable Cronbach’s alphas ranging from .86 to .97.

**Part 6** contains two scales. The Private Body-Consciousness Scale (PBC: Miller, Murphy, & Buss, 1981) was used to measure the extent to which participants employ somatisation as a mode of illness expression. It is a five-item scale measuring participants’ tendency to notice common bodily sensations (somatisers). The scale rates body consciousness on a 5-point Likert-type scale ranging from 0=never to 4=always. Higher scores indicate a stronger tendency to somatise. It has a test-retest reliability of .69 and correlates significantly with measures of somatic symptom reporting (Robbins & Kirmayer, 1986). The current study found the PBC reliabilities with Cronbach’s Alphas ranging from .68 to .92 between the three cultural groups.

The Private Self-Consciousness Scale (PSC: Fenigstein, Scheier, & Buss, 1975) was used to measure the extent to which participants used psychologisation as mode of illness expression. It is a 10-item scale which identifies individuals who tend to be aware of their inner thoughts and feelings (psychologisers). Each scale was rated on a 5-point Likert-type scale ranging from 0=never to 4=always. Higher scores represent a stronger tendency to psychologise. The PSC has a test-retest reliability of .79 and a Pearson correlation of .32 with a physical symptom checklist (Pennebaker & Skelton, 1978). A similar scale has been employed as a measure of introspectiveness or psychological-mindedness in studies of illness behaviour (Hansell & Mechanic, 1985). The PSC was found reliable for the current study with Cronbach’s Alphas ranging from .72 to .80 between the three cultural groups.

**Part 7. Cognitive-Somatic Anxiety Questionnaire** (Schwartz, Davidson, & Goleman, 1978). This questionnaire measured participants’ tendency to experience anxiety as somatic distress or as cognitive distress. It comprises seven cognitive symptoms and seven somatic symptoms. Results yield two scores, one representing the degree to which the respondent experiences somatic symptoms when anxious (somatisers), another measuring cognitive symptoms when anxious (psychologisers). Each symptom statement was rated on 5-point Likert-type scale ranging from 0=never to 4=always. Because several participants reported finding it difficult to understand some statements in this scale, which contains double negatives (e.g., I feel like I am losing out on things because I can’t make up my mind soon enough), data gathered
using this scale was considered unreliable and subsequently excluded from further analysis.

PROCEDURE

Ethics approval for the current study was sought and approved by the Human Research Ethics Committee of Swinburne University of Technology in September 2001. Data was collected in Vietnam and Australia. In Australia, the survey was distributed to the community and student populations using both a face-to-face approach and posting on the Internet. Three hundred surveys were distributed (240 in Australia and 60 in Vietnam). The return rate was 68% for Australian samples and 93% for the Vietnamese in Vietnam sample. Various helpers were recruited through the researcher’s social and professional network (with prior written permission from places such as medical clinics, Chinese herbalist shops and counselling agencies) to help with the distribution of the questionnaire. Helpers were given an instruction sheet specifying procedure requirements for the distribution of the questionnaire. Prospective participants were given a package containing the project information letter, a consent form, the five-page questionnaire, and a reply paid envelope. In Vietnam, a total of 60 surveys written in Vietnamese were distributed in the North, Central, and South of the country by the researcher and a helper (who worked in Vietnam as a tour leader). All survey packages contained project information, a consent form, the questionnaire, and a return envelope. Participants were asked to return the survey to the distributor in the sealed envelope provided. Although 56 questionnaires were returned, only 49 useable questionnaires were analysed as seven questionnaires were incomplete.

Prospective participants were given a short verbal explanation of the research project and were asked to read the project information letter, which explained the purpose of the study using plain language. Participants who completed the survey (in English or Vietnamese) on the spot were asked to sign an informed consent form before slotting the answered package into a box provided. Those who wished to complete the survey at home were given a self-stamped envelope with a return address. Participants were also asked to assist the data collection process by using the snowball recruiting method. Those who agreed were given extra kits consisting of questionnaires, information sheets, consent forms, and self-addressed envelopes.
The survey, together with the project information page, was also posted on the Internet for data collection. An invitation to participate was posted on the Swinburne University’s webpage. The researcher also emailed an invitation and the URL link to the survey to friends and acquaintances. The survey was anonymous in that they were not required to reveal their identity and could drop out (by closing the website) at any time. All responses to the Internet based questionnaires were downloaded and merged with the data collected using questionnaires which were typed in a data file. A total of 51 participants responded to the Internet based questionnaire. However, 15 participants were excluded from the final analysis as their questionnaires were incomplete (due to early drop-out).
CHAPTER 7: RESULTS

STRUCTURE OF DATA ANALYSIS

Data was screened for outliers and normality. Appendix B shows a table of skewness and kurtosis. Two sets of group data were analysed. Set 1 contained data from all three cultural groups (N=249) which included the Anglo-Australians (AA, n=106), the Vietnamese-Australians (VA, n=94), and Vietnamese in Vietnam (VV, n=49). Set 2 was a subset of the group data containing only the Vietnamese-Australians sample (N=94). Data set 1 was used to investigate differences between the three cultural groups on dependent variables. Data set 2 was used to explore differences between the four groups of acculturation (integration, assimilation, separation, and marginalisation). Statistical procedures employed to compare cross-cultural and cross-acculturation group differences were Multivariate Analysis of Covariance (MANCOVA) and Analysis of Covariance (ANCOVA) with age as a covariate in all comparative analyses. Age was controlled because both between group and within group analyses showed that participants were not evenly distributed in terms of age (as reported in Method Chapter). In addition, age was significantly correlated with all dependent variables which indicated that it was potentially related to these outcome variables. Group comparisons on illness expression (somatisation and psychologisation) and help seeking choices were also controlled for symptoms. It was expected that the tendency to pay more attention to bodily or mentally sensations may lead to more symptom reporting, or alternatively, the more symptoms actually experienced, the higher the likelihood they would be expressed (psychologically, or somatically) and so the greater the perceived need to seek help.

Data set 2 was also analysed to predict help seeking cognition and behaviour of Vietnamese-Australian sample. Multiple regression analyses were used to investigate the predictive property of the two cultural orientations, Vietnamese-ness and Australian-ness, in predicting help seeking variables of symptom scores, illness expression scores, symptom causal attributions, and help seeking choices). Further Multiple Regression Analyses were also carried out to identify independent predictors of help seeking choices.
PREMILINARY ANALYSIS

RELIABILITY OF MEASURES

Reliability analyses were carried for scales used in the study, for the whole group (N= 249) and separately for the three cultural groups. Table 3 shows the Cronbach’s alpha reliability of all calculated variables for each cultural group and for the total sample.

Table 3
Reliability (Cronbach’s alpha) of measures

<table>
<thead>
<tr>
<th>Scales</th>
<th>Anglo-Australian (N=106)</th>
<th>Vietnamese-Australian (N=94)</th>
<th>Vietnamese-Vietnam (N=49)</th>
<th>Overall (N=249)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acculturation Scales:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australian-ness</td>
<td>-</td>
<td>.95</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Vietnamese-ness</td>
<td>-</td>
<td>.95</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Symptom Scales:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>.75</td>
<td>.90</td>
<td>.40</td>
<td>.87</td>
</tr>
<tr>
<td>Depression</td>
<td>.81</td>
<td>.94</td>
<td>.43</td>
<td>.91</td>
</tr>
<tr>
<td>Total symptoms</td>
<td>.86</td>
<td>.96</td>
<td>.53</td>
<td>.94</td>
</tr>
<tr>
<td><strong>Modes of Illness Expression:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatisation</td>
<td>.68</td>
<td>.92</td>
<td>.68</td>
<td>.91</td>
</tr>
<tr>
<td>Psychologisation</td>
<td>.77</td>
<td>.80</td>
<td>.72</td>
<td>.92</td>
</tr>
<tr>
<td><strong>Symptom Causal Attributions:</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental</td>
<td>.90</td>
<td>.93</td>
<td>.47</td>
<td>.94</td>
</tr>
<tr>
<td>Psychological</td>
<td>.90</td>
<td>.92</td>
<td>.84</td>
<td>.94</td>
</tr>
<tr>
<td>Biological</td>
<td>.94</td>
<td>.90</td>
<td>.87</td>
<td>.94</td>
</tr>
<tr>
<td><strong>Help Seeking Choices:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Help</td>
<td>.96</td>
<td>.98</td>
<td>.93</td>
<td>.97</td>
</tr>
<tr>
<td>Family/friends</td>
<td>.86</td>
<td>.92</td>
<td>.87</td>
<td>.90</td>
</tr>
<tr>
<td>Spiritual</td>
<td>.91</td>
<td>.87</td>
<td>.85</td>
<td>.89</td>
</tr>
<tr>
<td>Mental Health</td>
<td>.91</td>
<td>.89</td>
<td>.88</td>
<td>.90</td>
</tr>
<tr>
<td>Western Medicine</td>
<td>.87</td>
<td>.86</td>
<td>.86</td>
<td>.86</td>
</tr>
<tr>
<td>Eastern Medicine</td>
<td>.92</td>
<td>.89</td>
<td>.88</td>
<td>.90</td>
</tr>
</tbody>
</table>

Table 3 shows the reliability of scales ranged from .40 to .97. All scales were highly reliable for the Anglo-Australian and the Vietnamese-Australian groups (α>.68). However, the reliability of several scales was inadequate for the Vietnamese in Vietnam sample (α<.50). Some of these scales were subsequently excluded from the data.
analysis for the Vietnamese in Vietnam cultural group. Scales selected for the three cultural groups’ comparative data analysis included the total symptom score, somatisation, psychologisation, environmental attributions, psychological attributions, biological attributions, and all six sources of help seeking choices. Note that acculturation scales were relevant to the Vietnamese-Australian sample only.

To determine if these help seeking measures were different between people from the same culture group and if they could be influenced by participants’ cultural orientations, further investigations were conducted with data from the Vietnamese-Australian sample only. Data for the Vietnamese-Australian sample (N=94) was used for analysis focusing on the influence of acculturation on the dependent variables. The following section includes preliminary analyses which (1) checks the factorial validity of the Vietnamese-Australian Acculturation Scale; (2) identifies participants’ cultural orientations towards Vietnamese culture (Vietnamese-ness) and Australian culture (Australian-ness), (3) identifies participants’ modes of acculturation (integration, assimilation, separation, and marginalisation), and (4) verifies the relationship between measures.

**ACCULTURATION OF VIETNAMESE-AUSTRALIANS**

*Factor Analysis of the Vietnamese-Australian Acculturation Scale*

To test construct validity of the acculturation scale, a factor analysis was carried out to verify two underlying components within the scale. The results of a principal-components factor analysis using Varimax rotation are presented in Table 4.
Table 4
Items and factor loading for the Vietnamese-Australian Acculturation Scale

<table>
<thead>
<tr>
<th>Items summary</th>
<th>Factor loading</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Australian-ness</td>
<td>Vietnamese-ness</td>
</tr>
<tr>
<td>Australian Identity</td>
<td>.90</td>
<td>.01</td>
</tr>
<tr>
<td>Australian values and beliefs</td>
<td>.90</td>
<td>.22</td>
</tr>
<tr>
<td>Knowledge of Australian culture</td>
<td>.88</td>
<td>.11</td>
</tr>
<tr>
<td>Speaking English</td>
<td>.87</td>
<td>.09</td>
</tr>
<tr>
<td>Australian friends and acquaintances</td>
<td>.86</td>
<td>-.05</td>
</tr>
<tr>
<td>Read and write English</td>
<td>.85</td>
<td>.14</td>
</tr>
<tr>
<td>Prefer Australian helpers</td>
<td>.81</td>
<td>.24</td>
</tr>
<tr>
<td>Australian behaviour</td>
<td>.75</td>
<td>.20</td>
</tr>
<tr>
<td>Speaking Vietnamese</td>
<td>.13</td>
<td>.89</td>
</tr>
<tr>
<td>Knowledge of Vietnamese culture</td>
<td>.20</td>
<td>.88</td>
</tr>
<tr>
<td>Vietnamese friends and acquaintances</td>
<td>.15</td>
<td>.88</td>
</tr>
<tr>
<td>Vietnamese values and beliefs</td>
<td>.29</td>
<td>.87</td>
</tr>
<tr>
<td>Vietnamese identity</td>
<td>.08</td>
<td>.87</td>
</tr>
<tr>
<td>Vietnamese behaviour</td>
<td>.29</td>
<td>.87</td>
</tr>
<tr>
<td>Read and write in Vietnamese</td>
<td>-.07</td>
<td>.86</td>
</tr>
<tr>
<td>Prefer Vietnamese helpers</td>
<td>-.01</td>
<td>.70</td>
</tr>
</tbody>
</table>


Results showed only two factors, one associated with the Vietnamese cultural orientation (Vietnamese-ness) and one with Australian cultural orientation (Australian-ness), were extracted (eigen values >1). These two factors together explained 75.62% of the total variance in the acculturation scale. Table 4 shows that all Vietnamese or Australian cultural items were loaded with their respective dimension with factor loadings of above .70, and there were no cross loadings of greater than 0.29.

Acculturation Orientations: Australian-ness and Vietnamese-ness

Factor analysis results validated that items included in the acculturation scale formed two orthogonal dimensions, namely, the Australian-ness score (Factor 1) and the Vietnamese-ness score (Factor 2). Reliability analysis revealed that Cronbach’s alphas of .95 were obtained for both acculturation measures (see Table 3). A paired sample t-test showed that scores on Vietnamese-ness \( M=13.52, SD=8.30 \) were significantly higher than scores on Australian-ness \( M=6.72, SD=6.71 \), \( t(91)=7.22, p<.001 \), indicating that Vietnamese-Australians identified with Vietnamese culture substantially more than with Australian culture. The two acculturation scores were later used to
predict health-related measures. That analysis will be described in detail in a later section.

Classification of Acculturation Responses

Classification of the four acculturation modes can be achieved when heritage cultural orientation and host cultural orientation scales are subjected to a bipartite split (Dona & Berry, 1994). There are two approaches, however, to splitting the identification scales. The scale midpoint ($Md = 16$ for both host and co-national identification) or the median score ($Md = 13$ in a range of 2 to 30 for heritage culture orientation, and $Md = 5$ in a range of 0 to 24 for host cultural orientation) were selected as the cut-off criterion. Specifically, the integration mode was assigned when both cultural orientation scores were greater than the cut-off point. The marginalisation mode was assigned when scores were equal-to or less than the cut off on both cultural orientations. Assimilation signified a greater score for host culture orientation and an equal-to or lower score for heritage cultural orientation. The separation mode was assigned when the score for heritage cultural identification was greater than the cut-off score and the score for the host culture was equal-to or lower. Since the midpoint split approach is said to be preferable for cross-sample comparisons (Dona & Berry, 1994) and the median split approach for relative comparison within a group (Ward, 1999; Ward & Rana-Deuba, 1999), both approaches were undertaken with this sample, and compared.

The scale’s midpoint split resulted in 47 (50%) participants being classified as marginalised, 38 (38.3%) as separated, 7 (7.4%) as assimilated, and 4 (4.3%) as integrated. This, unfortunately, did not permit further meaningful comparisons across the four acculturation groups. In contrast, the median split techniques resulted in 35% of Vietnamese-Australian participants falling into the marginalisation category ($n=33$), 30% into the integration category ($n=28$), 20% in the separation category ($n=19$), and 15% in the assimilation category ($n=14$). Based on these more even classifications, responses were then grouped into the four acculturation groups. Analysis of differences within-groups was then carried out according to these groups of acculturation. Figures 6 and 7 show results of classification using midpoint split and median split techniques.
Figure 6. Acculturation classifications based on scale midpoint splitting technique (N=94).

Figure 7. Acculturation classifications based on sample median splitting technique (N=94).
**Relationship between Measures**

To assess relationships between measures prior to hypothesis testing, Pearson correlation coefficients were calculated. These measures included acculturation variables (Australian-ness and Vietnamese-ness), and health seeking variables (symptom score, somatisation, psychologisation, environmental attributions, psychological attributions, biological attributions, self-help, family and/or friends help, spiritual help, mental health help, Western medicine help, and Eastern medicine help).

Results indicated that acculturation variables correlated significantly with almost all of the health care seeking variables. Correlation coefficients ranged from .03 (Vietnamese-ness and spiritual help) to .61 (Australian-ness and somatisation). Because the symptom score, somatisation, psychologisation, and three causal attributions were intended to be used as independent variables in predicting help seeking selections in later section, correlations between these variables were also assessed. As high correlations between predictor variables suggest potential multicollinearity, independent variables with $r \geq .80$ were noted and one of these was excluded from further regression analyses. Table 5 shows that the correlation between somatisation and psychologisation was equal to .80. Previous analyses indicated that somatisation was a more common mode of illness expression endorsed by all participants than psychologisation. Subsequently, somatisation was retained and psychologisation was excluded from regression models.
Table 5
Correlations of acculturation and help seeking variables (N=94).

<table>
<thead>
<tr>
<th></th>
<th>V-ness</th>
<th>A-ness</th>
<th>SS</th>
<th>Som</th>
<th>Psych</th>
<th>EA</th>
<th>PA</th>
<th>BA</th>
<th>SH</th>
<th>FFH</th>
<th>SpH</th>
<th>MH</th>
<th>WH</th>
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</thead>
<tbody>
<tr>
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<tr>
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<td>.29**</td>
<td>.48**</td>
<td>-</td>
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<tr>
<td>Som</td>
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<td>.66**</td>
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<td>Psych</td>
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<td>.57**</td>
<td>.80**</td>
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<td>EA</td>
<td>.29**</td>
<td>.57**</td>
<td>.61**</td>
<td>.66**</td>
<td>.65**</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>PA</td>
<td>.24*</td>
<td>.43**</td>
<td>.70**</td>
<td>.67**</td>
<td>.64**</td>
<td>.74**</td>
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<td>.57**</td>
<td>.70**</td>
<td>.71**</td>
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</tr>
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<td>.26*</td>
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<td>.45**</td>
<td>.46**</td>
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<td>.33**</td>
<td>.63**</td>
<td>.51**</td>
<td>.56**</td>
<td>.74**</td>
</tr>
</tbody>
</table>

Notes. A-ness = Australian-ness; V-ness = Vietnamese-ness; SS = Symptom Score; Som = Somatisation; Psych = Psychologisation; EA = environmental attributions; PA = Psychological attributions; BA = Biological attributions; SH = Self-help; FFH = Family and/or friends help; SpH = Spiritual help; MH = Mental health help; WH = Western medicine help; EH = Eastern medicine.

** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).
DIFFERENCES BETWEEN CULTURAL GROUPS

The following describes result findings which compared group differences between the Vietnamese-Australians, the Anglo-Australians and the Vietnamese in Vietnam regarding their psychological adjustment, modes of illness expression, symptom attributions, and help seeking selection.

Psychological Adjustment

A one-way ANCOVA (with age as a covariate) was performed to test Hypothesis 1a (if the Vietnamese-Australians experience more symptoms of psychological adjustment compared to the Anglo-Australians and the Vietnamese in Vietnam). The results showed a statistically significant main effect of culture, $F(2,241)=60.90$, $p<.001$, but not age. A priori planned contrasts (Simple and Difference) showed that the Anglo-Australians ($M=.65$, $SD=.30$) scored significantly higher than both the Vietnamese-Australians ($M=.27$, $SD=.39$, $p<.001$) and the Vietnamese in Vietnam ($M=.05$, $SD=.08$, $p<.001$) on symptom score. Between the two Vietnamese groups, the Vietnamese-Australians scored significantly higher ($p<.001$). These results indicated that the Vietnamese-Australians admitted to being less psychologically adjusted than the Vietnamese in Vietnam, however they reported fewer symptoms than the Anglo-Australians.

Modes of Illness Expression

To investigate Hypothesis 1b (if the Anglo-Australians would score the highest, the Vietnamese in Vietnam would score the lowest, and the Vietnamese-Australians would score intermediate on psychologisation) and to explore if there were differences between the three cultural groups in somatisation, a one-way MANCOVA with age and symptom score as covariates was conducted with both psychologisation and somatisation entered as dependent variables. Table 6 shows means and standard deviations of somatisation and psychologisation scores.
Table 6
Mean (SD) somatisation and psychologisation scores by cultural groups (N=249)

<table>
<thead>
<tr>
<th>Cultural Group</th>
<th>Somatisation</th>
<th>Psychologisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>2.64 (.67)</td>
<td>2.31 (.64)</td>
</tr>
<tr>
<td>VA</td>
<td>1.39 (.95)</td>
<td>1.14 (.82)</td>
</tr>
<tr>
<td>VV</td>
<td>1.32 (.67)</td>
<td>.96 (.42)</td>
</tr>
</tbody>
</table>

Notes: ***p<.001, **p<.01, *p<.05

The MANCOVA results showed a statistically significant main effect of culture, Wilks’ Lambda =.80, F(4,432)=12.49, p<.001 and symptoms, Wilks’ Lambda=.78, F(2,216)=30.68, p<.001, but not age. Follow-up ANCOVAs revealed a statistically significant culture effect as well as a significant symptom score covariance on both somatisation scores (F(2,217)=14.94, p<.001 and F(1,217)=58.52, p<.001 respectively), and psychologisation scores (F(2,217)=24.34, p<.001 and F(1,217)=38.90, p<.001, respectively).

A priori planned contrasts (Simple and Difference) found the Anglo-Australians’ scores on somatisation and psychologisation were significantly higher than both the Vietnamese-Australians and the Vietnamese in Vietnam (all p<.001). No differences were found between the Vietnamese-Australians and the Vietnamese in Vietnam. These results indicated that the Anglo-Australians somatised and psychologised significantly more than both the Vietnamese-Australians and the Vietnamese in Vietnam, even controlling for their greater number of expressed symptoms. However, Vietnamese in Australia or Vietnam were not different in their style of illness expression.

Pearson correlations analyses showed symptom scores correlated significantly with both somatisation (r(224)=.66, p<.001) and psychologisation (r(223)=.65, p<.001), indicating that more the symptoms experienced, the higher levels of somatisation and psychologisation.

**Symptom Causal Attributions**

To test Hypothesis 1c (if the Anglo-Australians score the highest on biological and psychological attributions and the lowest on environmental attributions; the Vietnamese in Vietnam score the highest on environmental attributions and the lowest on biological and psychological attributions; and the Vietnamese-Australians score intermediate on the three sources of attributions), a one-way MANCOVA (with age as a
covariate, culture as the independent variable, and three sources of attributions as the dependent variables) was performed. Table 7 shows cultural group scores for each source of attribution.

Table 7
Mean (SD) symptom causal attributions scores by cultural groups (N=249)

<table>
<thead>
<tr>
<th>Attributions</th>
<th>AA</th>
<th>VA</th>
<th>VV</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment</td>
<td>1.44 (.67)</td>
<td>.60 (.61)</td>
<td>.40 (.28)</td>
<td>62.04***</td>
</tr>
<tr>
<td>Psychological</td>
<td>1.92 (.64)</td>
<td>.98 (.60)</td>
<td>.86 (.37)</td>
<td>65.78***</td>
</tr>
<tr>
<td>Biological</td>
<td>1.29 (.78)</td>
<td>.73 (.49)</td>
<td>.61 (.41)</td>
<td>28.56***</td>
</tr>
</tbody>
</table>

Notes: ***p<.001, **p<.01, *p<.05

The MANCOVA results showed a statistically significant main effect of culture (Wilks’ Lambda = .56, F(6, 404)=23.60, p<.001) as well as a significant effect of age as a covariate (Wilks’ Lambda = .94, F(3, 207)=4.72, p<.01).

ANOVA tests found significant main effects of culture group on environmental attributions, psychological attributions, and biological attributions (see Table 7). A priori planned contrasts (Simple and Difference) revealed the Anglo-Australians’ scores on all three sources of attributions were significantly higher than both the Vietnamese-Australians and the Vietnamese in Vietnam (all p<.001). No significant differences were found between the two Vietnamese groups.

ANOVA results found that the effect of age as a covariate was only statistically significant for biological attributions, F(1,209)=4.49, p<.05. The correlation between age and biological attributions was only statistically significant only for the Anglo-Australians (r(92)=.38, p<.001), with older Anglo-Australians attributing the cause of symptoms to biological factors more than younger ones.

In sum, the Anglo-Australians attributed the causes of symptoms to all sources significantly more than both the Vietnamese-Australians and the Vietnamese in Vietnam. The two Vietnamese groups indicated no significant differences on their attribution tendencies.
**Help Seeking Selections**

To investigate Hypothesis 1d (if the Anglo-Australians would score the highest preference for self-help, mental health help and Western medicine help; the Vietnamese in Vietnam would score the highest on family and/or friends help, spiritual help and Eastern medicine help; and if the Vietnamese-Australians would score intermediate on preference on all sources of help), a one-way MANCOVA procedure with age and symptom score as covariates, all six sources of help as dependent variables, and culture (group) as an independent variable, was conducted. Table 8 shows mean ratings of the extent of helper preference for six sources of helping for Anglo-Australians, Vietnamese-Australians, and Vietnamese in Vietnam.

Table 8
Means (SD) helper preference scores by culture groups (N=249)

<table>
<thead>
<tr>
<th>Helping Sources</th>
<th>AA</th>
<th>VA</th>
<th>VV</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Help</td>
<td>1.77 (.95)</td>
<td>1.02 (.90)</td>
<td>1.02 (.61)</td>
<td>5.49**</td>
</tr>
<tr>
<td>Family/Friends</td>
<td>1.09 (.59)</td>
<td>.71 (.60)</td>
<td>.69 (.39)</td>
<td>1.16</td>
</tr>
<tr>
<td>Spiritual</td>
<td>.44 (.56)</td>
<td>.40 (.49)</td>
<td>.33 (.35)</td>
<td>.98</td>
</tr>
<tr>
<td>Mental Health</td>
<td>.51 (.56)</td>
<td>.42 (.43)</td>
<td>.56 (.40)</td>
<td>6.53**</td>
</tr>
<tr>
<td>Western Medicine</td>
<td>.67 (.54)</td>
<td>.70 (.45)</td>
<td>.65 (.42)</td>
<td>1.53</td>
</tr>
<tr>
<td>Eastern Medicine</td>
<td>.48 (.61)</td>
<td>.46 (.47)</td>
<td>.48 (.42)</td>
<td>1.66</td>
</tr>
</tbody>
</table>

Notes: ***p < .001, **p < .01, *p < .05

The MANCOVA results showed statistically significant main effects of culture, Wilks’ Lambda=.86, F(12,412) = 2.61 p < .01). Both age, Wilks’ Lambda=.86, F(6,202) = 5.61, p < .001 and symptoms, Wilks’ Lambda=.84, (F(6,202)=6.66, p<.001 were found to be statistically significant covariates.

Follow-up ANCOVA demonstrated a significant main effect of culture only on self-help and mental health help (see Table 8). A priori planned contrasts (Simple and Difference) indicated that the Anglo-Australians scored significantly higher on self-help than both the Vietnamese-Australians (p<.01) and the Vietnamese in Vietnam (p<.05). However, on mental health help, both the Anglo-Australians and the Vietnamese-Australians scored significantly lower than the Vietnamese in Vietnam (both p<.01). No differences were found on other sources of help (family and friends, spiritual, Western medicine, and Eastern medicine) among the three cultural groups. These
results indicated that the Vietnamese-Australians, the Anglo-Australians, and the Vietnamese in Vietnam reported differences only in their choices of self-help, and mental health help, but did not differ on family and friends, spiritual, Western or Eastern medicine help. That is, the Anglo-Australians reported that they were more likely to use self-help strategies than people from both the Vietnamese groups. The Vietnamese in Vietnam however indicated that they would be more likely to seek help from mental health sources compared to both the Anglo-Australians and the Vietnamese-Australians. The cultural groups showed no differences in their preference on other types of help seeking.

In addition, age as a covariate was statistically significant for spiritual help ($F(1,211)=18.22, p<.001$), mental health help ($F(1,211)=15.79, p<.001$), Western medicine help ($F(1,211)=13.25, p<.001$), and Eastern medicine help ($F(1,211)=7.32, p<.01$). Correlations indicated a positive relationship between age and all of these helping sources: spiritual help ($r(221)=.19, p<.01$), mental health help ($r(221)=.21, p<.01$), Western medicine help ($r(225)=.25, p<.001$), and Eastern medicine help ($r(219)=.20, p<.01$). The older the participants the greater the likelihood that they would seek help from spiritual helpers, mental health professionals, Western medicine practitioners, or Eastern medicine.

Symptom score was also found statistically significant covariate on all help seeking sources – self help ($F(1,211)=4.46, p<.05$), family and friends help ($F(1,211)=17.61, p<.001$), spiritual help ($F(1,211)=24.49, p<.001$), mental health help ($F(1,211)=26.03, p<.001$), Western medicine help ($F(1,211)=16.90, p<.001$), and Eastern medicine help ($F(1,211)=12.59, p<.001$). Pearson correlations showed a statistically significant positive relationships between symptoms and all of these helping sources. These suggested that the more symptoms experienced, the higher the likelihood help would be sought from all sources.

**SUMMARY**

In summary, the comparisons between the three cultural groups found the Anglo-Australians were scoring significantly higher on all variables than Vietnamese-Australians and Vietnamese in Vietnam. That is, compared to the Vietnamese-Australians and Vietnamese in Vietnam, the Anglo-Australians reported more symptoms. They registered higher tendencies to both somatise and psychologise. They
attributed causes of listed symptoms to all three sources, environmental, biological and psychological, to a greater extent than the Vietnamese groups. Finally, the Anglo-Australians reported they were more likely to be self-reliant (self-help) than Vietnamese in either group. The Vietnamese in Vietnam, while indicating fewer psychological adjustment problems than the Anglo-Australians and the Vietnamese in Australia, however, reported that they would be more likely to seek help from mental health professionals. The Vietnamese in either country were not different in somatisation, psychologisation, symptoms attributions, or choice of help seeking sources (with the exception of mental health help seeking as described above). No differences were found between the three cultural groups on their choices of help from the following sources: family and friends, spiritual, Western medicine, and Eastern medicine.

Results also found older participants were more likely to seek help from spiritual helpers, mental health professionals, Western medicine practitioners, and Eastern medicine practitioners than younger participants. Further, the more symptoms people experienced, the more they somatised and psychologised and the higher the likelihood they would seek help from all available sources of help.

DIFFERENCES BETWEEN ACCULTURATION GROUPS

Data obtained from the Vietnamese-Australian sample (N=94) were analysed. Analyses in this section aimed to investigate within-group differences on help seeking variables among the Vietnamese-Australians. Participants were classified into four types of acculturation, integration, assimilation, separation, and marginalisation using the median splitting technique. Comparative data analyses were then carried out to test hypotheses regarding participants’ level of psychological adjustment, modes of illness expression, symptom causal attributions, and help seeking choices.

Psychological Adjustment

One-way ANCOVAs (with age as a covariate, acculturation (group) as an independent variable, and symptom score as a dependent variable) were carried out to test Hypothesis 2a (if the integrated and assimilated Vietnamese-Australians would score fewer symptoms of anxiety and depression than the separated and marginalised groups). Results showed a statistically significant main effect of acculturation on the
symptom score, $F(3,88)=6.13, p<.01$. Further, a priori planned contrasts (Simple, Difference, and Special designed) showed that the integration group ($M=.52, SD=.44$) scored significantly higher than all other three groups - the assimilation group ($M=.22, SD=.34, p<.05$), the separation group ($M=.12, SD=.22, p<.01$), and the marginalisation group ($M=.16, SD=.35, p<.001$). These results indicated that the integrated Vietnamese-Australians reported more psychological adjustment problems than the other acculturation groups. No differences were found between other groups in terms of their levels of psychological adjustment.

**Modes of Illness Expression**

To test Hypothesis 2b (if the assimilated and the integrated would score higher on psychologisation than the separated and the marginalisation) and to explore acculturation group differences on somatisation, one-way MANOVAs (with age and symptom score as two covariates, acculturation as an independent variable, and both somatisation and psychologisation as dependent variables) were carried out. Table 9 shows means and standard deviations for somatisation and psychologisation scores.

<table>
<thead>
<tr>
<th></th>
<th>Integration</th>
<th>Assimilation</th>
<th>Separation</th>
<th>Marginalisation</th>
<th>$F$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somatisation</td>
<td>2.40(1.05)</td>
<td>1.29(.81)</td>
<td>.80(.57)</td>
<td>1.06(.51)</td>
<td>14.42***</td>
</tr>
<tr>
<td>Psychologisation</td>
<td>2.00(.86)</td>
<td>1.00(.70)</td>
<td>.41(.43)</td>
<td>1.03(.42)</td>
<td>16.86***</td>
</tr>
</tbody>
</table>

Notes: ***$p<.001$, **$p<.01$, *$p<.05$

The MANCOVA results showed significant main effects of acculturation (Wilks’ Lambda=.52, $F(6,158)=10.10$), and significant covariation of symptom score (Wilks’ Lambda=.62, $F(2,79)=24.45, p<.001$), but not age. Follow-up ANCOVAs found statistically significant results for both acculturation and symptom score on somatisation ($F(3,80)= 15.17, p<.001$ and $F(1,80)=46.72, p<.001$, respectively) and psychologisation ($F(3,80)=16.87, p<.001$, and $F(1,80)=26.33, p<.001$, respectively). A priori planned contrasts (Simple, Difference, and Special designed) showed the integration group’s scores on somatisation and psychologisation were significantly higher than all the other three groups (all $p<.001$). The other difference found was
between the separation and the marginalisation groups, with the former scoring significantly lower on psychologisation, \( p < .001 \). These results meant that the integration group somatised and psychologised more than people who endorsed other modes of acculturation. The marginalisation group was also found to psychologise more than the separation group (but less than the integration group).

Pearson correlation showed statistically significant positive relationships between symptom score and both somatisation and psychologisation (Table 5). These indicated that, as with the total group, higher symptoms scores were associated with higher the levels of somatisation and psychologisation among the Vietnamese-Australians.

Symptom Causal Attributions

To test Hypothesis 2c (if the assimilated and integrated would score higher than the marginalised and separated groups on psychological and biological causes; and if the integrated and separated would score higher than the assimilated and marginalised groups on environmental causes), one-way MANCOVA tests (with age as a covariate, acculturation as an independent variables, and all three sources of causal attributions as dependent variables) were carried out. Table 10 shows means and standard deviations of attribution scores by acculturation groups.

Table 10
Means (SD) attribution scores by modes of acculturation (N=94)

<table>
<thead>
<tr>
<th>Source</th>
<th>Integration</th>
<th>Assimilation</th>
<th>Separation</th>
<th>Marginalisation</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental</td>
<td>1.20(.70)</td>
<td>.61(.49)</td>
<td>.26(.15)</td>
<td>.37(.33)</td>
<td>12.78***</td>
</tr>
<tr>
<td>Psychological</td>
<td>1.57(.63)</td>
<td>.83(.69)</td>
<td>.50(.29)</td>
<td>.90(.36)</td>
<td>11.77***</td>
</tr>
<tr>
<td>Biological</td>
<td>1.23(.64)</td>
<td>.67(.41)</td>
<td>.50(.21)</td>
<td>.59(.32)</td>
<td>11.02***</td>
</tr>
</tbody>
</table>

Notes: ***\( p < .001 \), **\( p < .01 \), *\( p < .05 \)

Results of the MANCOVAs showed a statistically significant main effect of acculturation, Wilks’ Lambda=.53, \( F(9,172)=5.66, p<.001 \), but not age. Follow-up ANCOVAs found significant group differences on environmental attributions, psychological attributions, and biological attributions (see Table 10). A priori planned contrasts (Simple, Difference, and Special designed) revealed that the integration
group’s scores on all three sources of causal attributions, environmental, psychological and biological, were significantly higher than the other three groups (separation, assimilation, and marginalisation, all $p < .001$). The other difference found was between the separation and the marginalisation groups, with the former group scoring significantly lower on psychological attributions ($p < .05$). This meant that the integration group attributed the causes of symptoms to all three sources more than other groups. In addition, the separated group was less likely than the marginalisation group to explain the causes of symptoms to psychological origins.

Help Seeking Selections

To test Hypothesis 2d (if the assimilated and integrated groups would score higher than the separation and the marginalisation groups on self-help, mental health help, and Western medicine help; and if the separated and integrated groups would score higher than the assimilated and marginalised groups on family/friends help, spiritual help, and Eastern medicine help), one-way MANCOVAs (with age and symptom score as two covariates, acculturation as an independent variable, and six sources of help as dependent variables) were carried out. Table 11 shows mean and standard deviations of all helper preference scores by acculturation groups.

Table 11
Mean (SD) help seeking selection scores by modes of acculturation ($N = 94$)

<table>
<thead>
<tr>
<th></th>
<th>Integration</th>
<th>Assimilation</th>
<th>Separation</th>
<th>Marginalisation</th>
<th>$F$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-help</td>
<td>1.55 (.95)</td>
<td>1.04 (1.12)</td>
<td>.09 (.24)</td>
<td>1.12 (.62)</td>
<td>7.27***</td>
</tr>
<tr>
<td>Family/Friends</td>
<td>1.23 (.58)</td>
<td>.71 (.60)</td>
<td>.26 (.21)</td>
<td>.61 (.52)</td>
<td>5.18**</td>
</tr>
<tr>
<td>Spiritual</td>
<td>.70 (.58)</td>
<td>.15 (.39)</td>
<td>.01 (.04)</td>
<td>.44 (.44)</td>
<td>7.12***</td>
</tr>
<tr>
<td>Mental Health</td>
<td>.69 (.52)</td>
<td>.17 (.21)</td>
<td>.30 (.21)</td>
<td>.42 (.45)</td>
<td>2.68</td>
</tr>
<tr>
<td>Western Medicine</td>
<td>1.15 (.53)</td>
<td>.40 (.20)</td>
<td>.43 (.24)</td>
<td>.68 (.36)</td>
<td>10.02***</td>
</tr>
<tr>
<td>Eastern Medicine</td>
<td>.89 (.56)</td>
<td>.21 (.21)</td>
<td>.55 (.33)</td>
<td>.27 (.35)</td>
<td>10.19***</td>
</tr>
</tbody>
</table>

Notes: ***$p<.001$, **$p<.01$, *$p<.05$

Results of the MANCOVAs showed, significant main effects of acculturation (Wilks’ Lambda=.31, $F(18,187.16)=4.51, p<.001$), age (Wilks’ Lambda=.80, $F(6,66)=2.72, p<.05$), and a significant covariance with symptom score (Wilks’ Lambda=.31, $F(18,187.16)=4.51, p<.001$).
Followed-up ANCOVA results showed significant main effects of acculturation on five sources of help – namely, self-help, family and/or friends, spiritual help, Western medicine help, and Eastern medicine help, but not mental health help (see Table 11). A priori planned contrasts (Simple, Difference, and Special designed) showed the integration group scored higher than the other three groups on family and/or friends help, spiritual help, Western medicine help, and Eastern medicine help (all \( p < .05 \) or better). On self-help, the separation group scored significantly lower than all other groups (all \( p < .01 \)). Additionally, the separation group scored significantly lower than the marginalisation group on family and friends help, spiritual help, Western medicine help (all \( p < .05 \) or better), but higher on Eastern medicine help (\( p < .05 \)). On mental health help, the only difference found was between the integration and the assimilation with the former scoring higher (\( p < .01 \)). No differences were found between the assimilation and the marginalisation groups. These results indicated that apart from self-help and mental health help, the integration group reported they were more likely to seek help from all sources compared to all other acculturation groups. With respect to mental health help, the integration group was more likely to seek this than the assimilated group. The separation group were less likely than all other groups to use self-help. Compared to the marginalisation group, they were less likely to seek spiritual help and Western medicine, however more likely to seek Eastern medicine help. The assimilated and the marginalised groups were not different in any of their help seeking choice.

Follow-up ANCOVAs found statistically significant main effects of age only on spiritual help seeking selection (\( F(1,71) = 6.56, p < .05 \)). However, Pearson correlation analysis indicated a positive relationship between the two variables, only for the marginalised group (\( r(33) = .37, p < .05 \)). This indicate that the older the marginalised participants, the more likely they were to rely on spiritual sources of help.

Follow-up ANCOVAs also found statistically significant main effects of symptom score on mental health help (\( F(1,71) = 8.12, p < .01 \)) and Western medicine help (\( F(1,71) = 6.35, p < .05 \)). Correlations indicated positive relationships between symptom score and these two help seeking sources – mental health help (\( r(80) = .47, p < .001 \)) and Western medicine help (\( r(83) = .44, p < .001 \)). These indicated that the more symptoms experienced, the higher the likelihood help will be sought from mental health and Western medicine sources.
SUPPLEMENTARY ANALYSIS

This analysis was exploratory, and a response to the somewhat confusing data emanating from the previous comparisons between acculturation groups, in which a median split was used to separate four acculturating groups. In this section, a mid-point split was used, and groups compared. As indicated in a previous section, such a split leaded to most Vietnamese-Australian participants being categorised as marginalised or separated. Only a very small number of integrated \( (n=4) \) and assimilated \( (n=7) \) participants were identified. For the purpose of this analysis, these two groups were collapsed and labelled “Australianised” \( (n=11) \).

Table 12 shows one-way ANOVAs with age (for all analysis) and symptom score (for illness expression and help seeking selections) as covariates indicated that the Australianised group scored higher than the other two groups on seven variables (symptom score, somatisation, psychologisation, environmental attributions, psychological attributions, biological attributions, and spiritual help) and higher than the marginalised on Eastern medicine help.
Table 12 shows that this pattern of finding was not dissimilar to that obtained with median split analysis in that the more Australianised groups scored higher on most variables and there were few differences between the separated and marginalised groups.

**SUMMARY**

Comparative data for the four acculturation groups (marginalisation, assimilation, separation, and integration) showed the integrated Vietnamese-Australians generally scored higher than Vietnamese-Australians who adopted other modes of acculturation, for most areas measured. Specifically, the integrated individuals reported more symptoms of anxiety and depression. They were more likely to somatisate and

<table>
<thead>
<tr>
<th></th>
<th>Australianised</th>
<th>Separated</th>
<th>Marginalised</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Symptoms</strong></td>
<td>.67(.32)</td>
<td>.31(.41)</td>
<td>.15(.32)</td>
<td>9.20***</td>
</tr>
<tr>
<td><strong>Illness expression</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatisation</td>
<td>2.84(.92)</td>
<td>1.36(1.03)</td>
<td>1.12(.60)</td>
<td>4.34*</td>
</tr>
<tr>
<td>Psychologisation</td>
<td>2.31(1.03)</td>
<td>1.07(.90)</td>
<td>.97(.47)</td>
<td>3.25*</td>
</tr>
<tr>
<td><strong>Causal attributions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental</td>
<td>1.50(.62)</td>
<td>.55(.54)</td>
<td>.38(.29)</td>
<td>23.25***</td>
</tr>
<tr>
<td>Psychological</td>
<td>1.67(.45)</td>
<td>.93(.74)</td>
<td>.81(.39)</td>
<td>8.69***</td>
</tr>
<tr>
<td>Biological</td>
<td>1.33(.47)</td>
<td>.76(.57)</td>
<td>.57(.29)</td>
<td>12.05***</td>
</tr>
<tr>
<td><strong>Help seeking selections</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Help</td>
<td>1.59(.97)</td>
<td>.85(1.16)</td>
<td>.98(.65)</td>
<td>1.08</td>
</tr>
<tr>
<td>Family/friends</td>
<td>1.29(.48)</td>
<td>.71(.70)</td>
<td>.58(.48)</td>
<td>1.95</td>
</tr>
<tr>
<td>Spiritual</td>
<td>.80(.67)</td>
<td>.24(.44)</td>
<td>.34(.42)</td>
<td>4.36*</td>
</tr>
<tr>
<td>Mental health</td>
<td>.60(.63)</td>
<td>.42(.39)</td>
<td>.37(.40)</td>
<td>.06</td>
</tr>
<tr>
<td>Western medicine</td>
<td>.91(.54)</td>
<td>.73(.55)</td>
<td>.63(.36)</td>
<td>.01</td>
</tr>
<tr>
<td>Eastern medicine</td>
<td>.78(.61)</td>
<td>.64(.46)</td>
<td>.28(.35)</td>
<td>6.54**</td>
</tr>
</tbody>
</table>

Notes: ¹=Significantly greater than both separated and marginalised groups, ²= Significantly greater than the marginalised group only. # = Age as covariate, ## = Age and symptom score as covariates. *p<.05, **p<.01, ***p<.001
psychologise, and to attribute the causes of their symptoms to all three sources of causal explanations to a greater extent than the other groups. Except for self-help and mental health help, the integrated group were also significantly more likely to seek help from all sources of help available. The integrated were more likely than the assimilation to seek mental health help. The separated Vietnamese-Australians were also less likely than all other Vietnamese-Australians to use self-help strategies. Other findings indicated that compared to the marginalised individuals, the separated Vietnamese-Australians were less likely to psychologise, less likely to attribute causes of symptoms to psychological factors, and less likely to seek help from spiritual and Western medicine sources, but more likely to seek Eastern medicine help. The assimilation, separation, and marginalisation groups were not different in their symptom reporting, somatisation, psychological and biological causal attributions. The assimilated and the marginalised were not different in any area measured.

Using a midpoint split analysis of acculturation, a similar pattern emerged with the Australianised scored higher on most variables and few differences found between the marginalised and separated groups.

Further, findings indicated that older Vietnamese-Australians tended to seek spiritual help more than younger ones. In addition, those who scored higher on symptoms somatised and psychologised more. They were also more likely to seek help from mental health and Western medicine sources.

**PREDICTING HELP SEEKING OF VIETNAMESE-AUSTRALIANS**

**PREDICTING HELP SEEKING FROM THE TWO CULTURAL ORIENTATIONS**

To investigate Hypothesis 3 (if help seeking behaviours can be predicted from participants' Vietnamese and Australian cultural orientations), twelve separate multiple regression analyses employing scores of Australian-ness and Vietnamese-ness were used to predict symptom scores, modes of illness expression, symptoms attributions, and help seeking selection. Table 13 shows results of these analyses.
Table 13
Standardised Beta weights of acculturation scores in predicting help seeking variables.

<table>
<thead>
<tr>
<th>Predictors</th>
<th>SS</th>
<th>Som</th>
<th>Psych</th>
<th>EA</th>
<th>PA</th>
<th>BA</th>
<th>SH</th>
<th>FF</th>
<th>SpH</th>
<th>MH</th>
<th>WH</th>
<th>EH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vietnamese-ness</td>
<td>.15</td>
<td>.16</td>
<td>.04</td>
<td>.14</td>
<td>.13</td>
<td>.17</td>
<td>.04</td>
<td>.16</td>
<td>-.06</td>
<td>.21</td>
<td>.35**</td>
<td>.57***</td>
</tr>
<tr>
<td>Australian-ness</td>
<td>.43***</td>
<td>.56***</td>
<td>.56***</td>
<td>.53***</td>
<td>.39***</td>
<td>.45***</td>
<td>.29**</td>
<td>.34**</td>
<td>.27*</td>
<td>.06</td>
<td>.15</td>
<td>.09</td>
</tr>
<tr>
<td>F</td>
<td>14.66***</td>
<td>28.05***</td>
<td>19.90***</td>
<td>20.81***</td>
<td>9.74***</td>
<td>14.85***</td>
<td>64*</td>
<td>8.45***</td>
<td>2.79</td>
<td>2.33</td>
<td>8.46***</td>
<td>22.23***</td>
</tr>
<tr>
<td>Adj $R^2$</td>
<td>.23</td>
<td>.39</td>
<td>.31</td>
<td>.33</td>
<td>.18</td>
<td>.27</td>
<td>.06</td>
<td>.15</td>
<td>.04</td>
<td>.03</td>
<td>.15</td>
<td>.35</td>
</tr>
</tbody>
</table>

Note. SS=symptom score, Som=somatisation, Psych=psychologisation, EA=environmental attributions, PA=psychological attributions, BA=biological attributions, SH=self-help, FF=family and/or friend help, SpH=spiritual help, MH=mental health help, WH=Western medicine help, EH=Eastern medicine help.

***$p<.001$, **$p<.01$, *$p<.05$
Table 13 shows that the multiple regression equation consisting of scores of Australian-ness and Vietnamese-ness together significantly predicted most help seeking variables, except for help-seeking from spiritual or mental health sources. The two acculturation scores together successfully explained 23% of the variance of symptom score, 39% of the somatisation score, 31% of psychologisation, 33% of environmental attributions, 18% of psychological attributions, 27% of biological attributions, 6% of self-help, 15% of family and/or friends help, 15% of Western medicine help, and 35% of Eastern medicine help. However, only the score of Australian-ness was found to be a statistically significant independent predictor for the significant regression equations, with the exception of the equations predicting Western medicine help, and Eastern medicine help. The score on Vietnamese-ness alone was found to be an independent positive predictor of both these variables.

These results indicated that the more Vietnamese-Australians maintain their culture of origin the greater is the likelihood that they will seek help from both Western and Eastern medicine help for symptoms indicative of anxiety and depression. However, the more they identified with the host Australian culture, the greater is the likelihood that they will report poorer levels of psychological adjustment and that they will explain the cause or causes of listed symptoms as having environmental, psychological and/or biological in origins. Therefore, they would be more likely to somatise and psychologise, and would be more likely to use self-help techniques, seek help from family and/or friends and/or seek spiritual sources of help to alleviate symptoms. Neither cultural orientation was found to predict the preference for seeking help from mental health sources. However, Pearson correlation analysis showed that while no significant relationship was found between the Australian cultural orientation and mental health help seeking, positive correlation was obtain for the Vietnamese cultural orientation (r(81)=.23, p<.05). These suggested that the more Vietnamese culturally orientated the individual, the higher the preference for mental health help.

**PREDICTING HELP SEEKING SELECTIONS OF VIETNAMESE-AUSTRALIANS**

To investigate if the symptoms, somatisation, environmental attributions, psychological attributions, and biological attributions could predict help seeking; multiple regression analysis procedures were employed. Six separate regression
analyses were conducted using a set of five predictor variables (symptom, somatisation, environmental attributions, psychological attribution, biological attribution) for each of six criterion variables (self-help, family/friends, spiritual, mental health, Western medicine, Eastern medicine). To further test if the two scores of cultural orientation (Australian-ness and Vietnamese-ness) could improve the predictive power of the first model; Hierarchical Regression Analysis procedure was carried out. Table 14 shows beta weights of each predictor in predicting six choices in help seeking.

Table 14
Summary models of predicting selection of helping sources (N=94)

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Self-Help</th>
<th>Family/Friends</th>
<th>Spiritual</th>
<th>Mental Health</th>
<th>Western Medicine</th>
<th>Eastern Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Model 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SS</td>
<td>-.37*</td>
<td>-.22</td>
<td>-.15</td>
<td>.22</td>
<td>.04</td>
<td>-.11</td>
</tr>
<tr>
<td>Som</td>
<td>.32*</td>
<td>.18</td>
<td>.30(^1)</td>
<td>.12</td>
<td>.06</td>
<td>.11</td>
</tr>
<tr>
<td>EA</td>
<td>-.14</td>
<td>.07</td>
<td>.01</td>
<td>-.34(^1)</td>
<td>.02</td>
<td>.25</td>
</tr>
<tr>
<td>PA</td>
<td>.71(^{***})</td>
<td>.37*</td>
<td>.18</td>
<td>-.01</td>
<td>.05</td>
<td>-.08</td>
</tr>
<tr>
<td>BA</td>
<td>-.04</td>
<td>.26(^1)</td>
<td>.25</td>
<td>.57(^*)</td>
<td>.53(^*)</td>
<td>.40(^*)</td>
</tr>
<tr>
<td>Adj (R^2)</td>
<td>.32</td>
<td>.39</td>
<td>.26</td>
<td>.27</td>
<td>.38</td>
<td>.26</td>
</tr>
<tr>
<td>(F)</td>
<td>7.83(^{***})</td>
<td>10.13(^{***})</td>
<td>5.92(^{***})</td>
<td>6.33(^{***})</td>
<td>10.20(^{***})</td>
<td>6.25(^{***})</td>
</tr>
<tr>
<td><strong>Model 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SS</td>
<td>-.35(^*)</td>
<td>-.23</td>
<td>-.11</td>
<td>.23</td>
<td>.05</td>
<td>-.18</td>
</tr>
<tr>
<td>Som</td>
<td>.28(^1)</td>
<td>.14</td>
<td>.37(^*)</td>
<td>.21</td>
<td>.17</td>
<td>.16</td>
</tr>
<tr>
<td>EA</td>
<td>-.22</td>
<td>.004</td>
<td>.10</td>
<td>-.21</td>
<td>.19</td>
<td>.34(^*)</td>
</tr>
<tr>
<td>PA</td>
<td>.70(^{***})</td>
<td>.40*</td>
<td>.07</td>
<td>-.07</td>
<td>-.02</td>
<td>-.003</td>
</tr>
<tr>
<td>BA</td>
<td>.02</td>
<td>.25</td>
<td>.35(^*)</td>
<td>.60(^{***})</td>
<td>.56(^{***})</td>
<td>.26(^1)</td>
</tr>
<tr>
<td>V-ness</td>
<td>-.24(^*)</td>
<td>-.03</td>
<td>-.20(^1)</td>
<td>.02</td>
<td>.05</td>
<td>.44(^{***})</td>
</tr>
<tr>
<td>A-ness</td>
<td>.18</td>
<td>.14</td>
<td>-.17</td>
<td>-.28(^1)</td>
<td>-.34(^1)</td>
<td>-.25(^1)</td>
</tr>
<tr>
<td>(R^2\Delta)</td>
<td>.06</td>
<td>.01</td>
<td>.05</td>
<td>.04</td>
<td>.06</td>
<td>.18</td>
</tr>
<tr>
<td>Adj (R^2)</td>
<td>.36</td>
<td>.38</td>
<td>.29</td>
<td>.29</td>
<td>.43</td>
<td>.44</td>
</tr>
<tr>
<td>(F)</td>
<td>6.94(^{***})</td>
<td>7.31(^{***})</td>
<td>5.19(^{***})</td>
<td>5.17(^{***})</td>
<td>8.83(^{***})</td>
<td>9.06(^{***})</td>
</tr>
</tbody>
</table>

Notes. SS=Symptom Score; Som=Somatisation; EA=environmental attributions; PA=Psychological attributions; BA=Biological attributions; V-ness=Vietnamese-ness; A-ness=Australian-ness

\(^{***}p<.001, **p<.01, *p<.05; \(^1\)p<0.1\\n
Model 1. Predicting Help Seeking Selection

Hierarchical multiple regression analyses showed the first model successfully explained 32% of the total variance in self help, 39% of the total variance in family and/or friends help, 26% of the total variance in spiritual help, 27% of the total variance
in mental health help, 38% of the total variance in Western medicine help, and 26% of the total variance in Eastern medicine help. All regression equations were statistically significant (See Table 14).

Total symptoms, somatisation, and psychological attribution, were statistically significant independent predictors of self-help. Psychological attributions were statistically significant independent predictor of family and/or friends help, Biological attribution was a statistically significant independent predictor of mental health help, Western medicine help, and Eastern medicine help.

These results suggested that people who used self-help strategies more were those who experienced fewer psychological adjustment problems, more likely to express illness using somatisation, and tended to explain causes of symptoms through psychological factors. Those Vietnamese-Australians who were more likely to seek help from family and friends were those who were stronger users of psychological attributions. Those who tended to turn to spiritual sources of help were greater somatisers. Greater help seeking from mental health professionals, Western medicine and Eastern medicine was predicted by stronger biological attributions for symptoms.

Model 2: Cultural Orientation and Help Seeking Prediction

To test if acculturation scores could further improve predictive power of previous prediction models, scores of Vietnamese-ness and Australian-ness were added in Step 2 of the regression model for analysis. This produced a significant change only for self-help ($F(2,67)=3.37, p<.05$), Western medicine help ($F(2,67)=3.54, p<.05$), and Eastern medicine help ($F(2,65)=11.29, p<.001$). In addition to existing independent predictors found in Model 1, Vietnamese-ness was found to be a significant negative independent predictor of self-help, and a positive independent predictor of Eastern medicine help. Australian-ness was found to be a negative independent of Western medicine help. These suggested that high Vietnamese-ness and higher levels of environmental attributions predicted greater preference for Eastern medicine. Low Australian-ness and strong biological attributions predicted greater preference for Western medicine. Low Vietnamese-ness, high psychological attributions and lower symptom scores predicted higher levels of self-help preference. External (non self or family/friends) help-seeking was consistently predicted by biological attributions.
RESULT SUMMARY

The first hypothesis: Differences between the Vietnamese-Australians, Anglo-Australians, and Vietnamese in Vietnam.

Hypothesis 1 was partly supported. As expected, findings indicated that, compared to the two Vietnamese groups, the Anglo-Australians were more likely to psychologise, attribute the causes of symptoms to psychological and biological factors and use self-help strategies. Also as expected, the Vietnamese-Australians had higher symptom scores than the Vietnamese in Vietnam. The following results did not support the first hypothesis. Vietnamese-Australians reported fewer symptoms of anxiety and depression than the Anglo-Australians. Vietnamese in Vietnam did not somatise, attribute the cause of their symptoms to environmental factors, or seek help from family/friends, spiritual sources, or Eastern medicine more than the other two groups. Likewise, the Vietnamese-Australians did not report intermediate levels of somatisation, psychologisation, three sources of causal attributions, and six sources of help. Instead, findings generally indicated that the Anglo-Australians scored the highest on most of the variables measured, except for mental health, where the Vietnamese in Vietnam indicated a higher score. The two Vietnamese groups did not differ on modes of illness expression and symptom causal attributions. Few differences on choices of help seeking were found between cultures.

The second hypothesis: Differences between Vietnamese-Australian acculturation groups

Hypothesis 2 was partially supported. As expected, findings indicated that the integrated and the assimilated (as grouped into ‘Australianised’) tended to psychologise, and attribute the cause of symptoms to psychological and biological factors more than the separated and the marginalised groups. Results also indicated that the integrated group, but not the separated group, somatised and attributed the cause of symptoms to environmental factors more than the assimilated and marginalised groups. However, results did not indicate, as had been hypothesised, that the ‘Australianised’ would be better adjusted (fewer symptoms) than the separated and the marginalised groups. None of the hypotheses regarding help seeking choices were supported.
Overall, findings indicated that compared to the separated and the marginalised groups, the ‘Australianised’ Vietnamese-Australians tended to score higher on all variables measured. Specifically, they experienced significantly more symptoms of anxiety and depression, somatised, psychologised, and attributed the causes of symptoms more to all listed sources. On help seeking choices, the marginalised group preferred spiritual help less than the ‘Australianised’. They also were less likely than the separated group to seek Eastern medicine help. On other variables, no differences were found between the separated and the marginalised groups. No differences were found between acculturation groups on other choices of help seeking.

The third hypothesis: Cultural orientations as predictors of help seeking variables

Hypothesis 3 was only partly supported. Specifically, as expected, Vietnamese cultural orientation predicted help seeking from Eastern medicine, and Australian cultural orientation predicted somatisation, psychologisation, psychological attributions, biological attributions, and self-help. However, the Vietnamese cultural orientation did not predict higher symptom scores, somatisation, environmental attribution, help seeking from family/friends and spiritual help as expected. Further, it predicted help seeking from Western medicine. Similarly, the Australian cultural orientation did not predict lower symptom scores, mental health help, and western medicine help. Instead, the Australian cultural orientation predicted higher symptom scores, more environmental attributions and more help seeking from family/friends as well as from spiritual sources.

The fourth hypothesis: Predicting help seeking choices

Hypothesis 4 was fully supported. The hypothesised model, which contained the symptom score, somatisation, and symptom causal attributions, was found to be highly effective in predicting all sources of help seeking choices. Separate analyses showed that self help could be independently predicted by lower symptom scores, higher somatisation, and higher psychological attributions. Family and/or friends help seeking was independently predicted by psychological and biological causal attributions. Seeking spiritual help was independently predicted by somatisation. Seeking mental health help was independently predicted by biological and
environmental causal attributions. Finally, biological causal attribution was found to be the only independent predictor of help seeking from Western medicine and Eastern medicine. Further, all types of help-seeking were significantly associated across the board with higher symptom scores, greater psychologisation and somatisation, and stronger attributions to all causes.

The fifth hypothesis: Role of acculturation in the prediction of help seeking choices

Hypothesis 5 was only partly supported. The study found the two cultural orientations of Vietnamese-Australians significantly improved the predictive power of the previous models only in predicting self-help, Western medicine help, and Eastern medicine help, but not family and/or friends help, spiritual help, or mental health help. Findings suggested that Vietnamese-Australians who identified more with their heritage culture tended to use self help more if they perceived symptoms were not serious and had a psychological cause. Vietnamese-Australians who had a stronger Vietnamese cultural orientation and who, at the same time, attributed the causes of symptoms more to environmental factors were more likely to seek Eastern medicine help for symptoms indicative of anxiety and depression. Those who showed a weaker tendency toward adopting the Australian way of life, however, were also more likely to use Western medicine help in response to the experience of anxiety or depression symptoms, so long as they also perceived these as likely to have biological causes.
CHAPTER 8: DISCUSSION

The results of the current study provide important information for understanding how Vietnamese-Australians experience and deal with common mental health symptoms. Findings described in the previous chapter indicated that Vietnamese-Australians, while significantly different from Anglo-Australians in most areas, still shared many help seeking characteristics with people from their country of origin. Examination into the role of acculturation in help seeking cognitions and behaviour of Vietnamese-Australians revealed that Australianised Vietnamese-Australians shared a similar trend of responses with Anglo-Australians in the study. Further, the current study demonstrated that cultural orientation had an influential role in predicting the help seeking behaviour of people from migrant backgrounds (such as the Vietnamese-Australian community). Especially, the study showed that while the Vietnamese culture orientation of Vietnamese-Australians may provide a useful indicator about the type of help they seek, the process of acculturation to the Australian culture provides deeper insights into their cognitive aspects of help seeking.

In the following discussion, four major trends in the data are presented, followed by a more detailed discussion of group differences on the four health-related help seeking variable groups (symptoms, symptom expression, causal attributions, help-seeking sources). Limitations of the study and implications for research and practice are presented and general conclusions drawn.

MAJOR FINDINGS

THE INFLUENCE OF HOST AND HERITAGE CULTURAL ORIENTATIONS ON HELP-SEEKING VARIABLES

The first pattern that emerged from the current study was the role of cultural orientation, in particular, the influence of the Australian cultural orientation on the various aspects of help seeking among Vietnamese-Australians. The findings of the current study indicated that the Vietnamese cultural orientation only predicted the selection of help seeking from Western and Eastern medicine. By contrast, the
Australian cultural orientation proved a more robust predictor of almost all other variables (the single exception being mental health help). These findings suggest that the Australian cultural orientation of participants provides useful information regarding the likelihood or style of symptom reporting, illness expression, symptom causal attributions and the selection of help options such as self-help, help sought from family/friends, and spiritual sources of help. The important role of host cultural orientation in psychological outcomes has been clearly shown in previous research (Hom, 1998; Leong et al., 1995; Ly, 2002; Tabora & Flaskerud, 1997; Tata & Leong, 1994; Ying & Miller, 1992; Zhang & Dixon, 2003). The findings of the current study underscore these findings regarding the role of cultural orientation in health and help-seeking behaviour. Further, even though the combination of symptom score, illness expression, and symptoms causal attributions was powerful in predicting all choices of help, acculturation further improved the predictive power for the prediction of three of the six sources of help (self-help, Western medicine help, Eastern medicine help).

Converging evidence of the role of the Australian cultural orientation was obtained in both cross-cultural group comparisons and within Vietnamese-Australian acculturation modes comparisons on illness expression and attributions. This evidence further supports the author’s contention regarding the interactive relationships of culture, illness perception and help seeking.

Although contrary to expectations, the heritage cultural orientation of Vietnamese-Australians failed to predict all criterion variables but two. Nevertheless this orientation provided useful information regarding patterns of help seeking. The findings indicated that Vietnamese-Australians who had a greater identification with their culture of origin were more likely to seek help from both Western and Eastern medical sources. This finding was partly supported by Quah and Bishop (1996) who found that heritage cultural identification predicted help seeking from Eastern medicine among Chinese-Americans. However, considering the prestige of Western medicine in Vietnamese culture (Dinh et al., 1990), and Vietnamese people’s tendency to somatise distress, it was not surprising that Western medicine was also selected as a treatment of choice among people who retain a strong cultural identity with their culture of origin.

The high levels of preference for medical (both Western and Eastern medicine) sources of help among those with strong Vietnamese cultural orientation were supported
by a study by Phan (2000). In fact, Phan found that all Vietnamese in her study consulted Western medicine practitioners and more than half of them also consulted Eastern medicine specialists. Considering that the symptoms used to elicit help seeking choices in the current study were psychological in nature, people’s tendency to resort to medical help suggests a strong somatisation tendency among more traditionally orientated Vietnamese-Australians. Further, considering the mild nature of symptoms people reported to have experienced, help seeking from medical health professionals may imply a need to seek reassurance and support through a recognised and socially acceptable professional relationship. Such a need often arises when it is difficult for the patient to confront the underlying problems, especially if they are ambiguous and difficult to diagnose. In this way, patients can avoid the risk of displaying weakness and vulnerability contrary to culturally expected and learned behaviour patterns.

The findings of the current study, however, only achieved part of the original aim of resolving the confusion caused by previous research regarding mental health seeking. Empirical findings linking acculturation to help seeking are rather mixed, reporting positive, negative, or nonsignificant relationships (Atkinson, Lowe, & Matthews, 1995; Gim, Donald, & Scott, 1990; Ly, 2002; Ying & Miller, 1992). The findings of the current study were more in tune with the suggestion that cultural orientation may play a limited role in Vietnamese-Australians’ choice of mental health help seeking.

It appeared that Vietnamese-Australians were not different from Vietnamese in Vietnam in their help seeking tendencies. In that, no differences were found between the two groups on any help seeking related measures, except on choices of mental health help. This could be interpreted as indicating that Vietnamese-Australians’ illness cognitions had not changed despite them being exposed more to the Western health care system (by virtue of being in Australia) compared to the Vietnamese in Vietnam. The similarity between the two Vietnamese groups could be attributed to the high levels of Vietnamese cultural maintenance among the Vietnamese-Australians. Because Vietnamese-Australians identified more with the Vietnamese culture than the Australian culture, they are more like the Vietnamese in Vietnam than the Anglo-Australians in their help seeking. However, this simplistic explanation does not adequately explain the differences among Vietnamese-Australians who adopt different ways of cultural
affiliation towards the Australian and Vietnamese cultures. It was believed that the four acculturation strategies proposed by Berry (1990) would provide further understanding regarding the relationship between acculturation and help seeking. These strategies are discussed in the following section.

**ACCULTURATION STRATEGIES/MODES AND HELP SEEKING**

The current study attempted to investigate the role of acculturation strategies/modes in health-related help seeking cognition and behaviour. Findings revealed that this mission was more challenging than originally expected. Firstly, the classification of modes of acculturation recommended by Berry and Kim (1988) using the mid-point split techniques, resulted in most of Vietnamese-Australians being classified as marginalised or separated with very few classified as integrated or assimilated. The uneven distribution of group membership thus did not allow a meaningful comparative cross-acculturation mode analysis. Instead, a median splitting technique recommended by Ward and Rana-Deuba (1999), which allows a relative grouping to the four acculturation modes was conducted. The comparative analyses resulting from this technique, however, were complex in that no clear pattern of response emerged. However, after further exploration using the mid-point splitting technique, and with those relatively small number of participants who reached the mid-point cut-off required for the Australian cultural orientation (the integrated and the assimilated) grouped into a single ‘Australianised’ group, a clearer pattern was evident. The findings of the Australianised group indicated that it was neither solely the integrated group (as found using the median split method) nor the assimilated group (as hypothesised) but the combination of people in these two groups (the Australianised) whose help seeking characteristics were similar to those of the Anglo-Australians.

In adopting the culture of the host country, Vietnamese-Australians’ help seeking cognitions and behaviours seemed more in tune with the majority in this society. The second pattern emerging from this study was that both the Australianised Vietnamese-Australians and the Anglo-Australians tended to score higher than others on all but one of the areas measured. That is, compared to other groups, they reported that they experienced more symptoms of anxiety and depression and used more somatisation and psychologisation to express their health problems. The Australianised Vietnamese
and the Anglo-Australians attributed causes of symptoms to all sources more, and were more likely to seek help (from most sources) compared to the other groups in the study. One partial explanation of the pattern of higher response rates among the Australianised Vietnamese- and the Anglo-Australians is that all help seeking measures are by their nature, strongly correlated. Indeed, in the current study it was found that all types of help-seeking were significantly associated, across the board, with higher symptom scores, greater psychologisation and somatisation, and stronger attributions to all causes. These results suggested that the more symptoms people experience, the more they somatise, psychologise, and find possible causes of their symptoms, and thus the greater the recognition of the need for help (of any type).

Another possible partial explanation is that cultural bias in the self-reported measures may account for the higher response rates amongst the Anglo-Australians and the more Australianised Vietnamese. It could be argued that the more people identified with the Australian culture, the more likely they were to score higher on the self-reported measures. This is because of a bias of certain culture groups to overstate (or understate) their experiences, beliefs and behaviours. Cross-cultural research has often cautioned that people from some cultures have the tendency to score ‘neutral’ and avoid using the extreme ends of self-report scales (Lee, 1988; Matsumoto, 1994; McKelvey & Baldassar, 1999; McKelvey & Davies, 1999; Tung, 1980). For example, cultural bias in patterns of responding to self report measures amongst Vietnamese were reported in McKelvey and Davies' (1999) study with Vietnamese in Vietnam. In this study, Vietnamese parents were asked to complete the Child Behavior Checklist (Achenbach, 1991) to identify their children’s behaviour and emotional problems and competencies. The study found that parents in Vietnam tended to score lower on the Child Behavior Checklist compared to American parents. Kleinman (1980) suggests that people from Eastern Asian societies (e.g., Chinese) may deny or minimise the experience of affective symptoms, whereas people from Western societies (e.g., Americans) may emphasise or over-report these symptoms. If this pattern of responding is applicable to the current study, it could mean that the Vietnamese were more reluctant to admit health symptoms, or to report the full extent of their experiences. McKelvey and Davies (1999) suggested that normative data is sometimes incompatible between two countries and that different cut-off points may need to be established for Vietnam to distinguish
levels of clinical significance. If this is the case, then the results of a good deal of cross-cultural research, including those of the current study, must be viewed with caution.

However, there are several indications that the differences found in this study were not merely a function of differential response biases (although such biases may have played a part). First, the patterns from the current study were not totally consistent in the direction of Anglo-Australians scoring the highest. In particular, the pattern of preference for help seeking sources did not show Anglo-Australians uniformly choosing all sources at a greater rate than the two Vietnamese groups (see Table 8). Second, the Anglo-Australians’ standard deviations were not consistently higher than those of the Vietnamese groups. In fact, they were quite similar in most cases, suggesting all groups were using similar scale ranges. Third, Cronbach’s alpha reliability measures of all scales but one were adequate for both the Anglo-Australians and the Vietnamese groups, suggesting that participants responded to the scales with understanding. In short, while data from this study must be viewed with caution, there are also some cogent arguments supporting its validity.

**GROUP DIFFERENCES IN HELP SEEKING COGNITIONS**

The third pattern emerging from this study was that the group differences found were mostly on cognitive aspects of help seeking rather than on behaviour. Results from both cultural group comparisons and acculturation group comparisons showed differences generally on symptom score, illness expression, and symptom causal attributions. Only a few differences were found for choices of help seeking. On the help seeking continuum, it is assumed that the earlier stages involve more cognitive aspects and that the ultimate behaviour is the selection of a help seeking source (see Chapter 3). This might mean that while people are uniform in their preferences for help, they may still be under the influence of their culture in the way that they find meanings for symptoms.

Similar to the findings of the current study, McClain (1977) found some inconsistencies between the cognitive and behavioural aspects of help seeking. The researcher compared the health behaviour of traditionally oriented (assumed to be exposed more to traditional healing methods) and more modern-oriented women (assumed to be exposed more to biomedicine) in a Mexican community, and found that
women with both orientations tended to conceptualise disease aetiology and process it in terms of traditional cognitive models. Nevertheless, traditionally orientated women participated partially in a biomedicine treatment approach, and modern-orientated women participated fully. A similar inconsistency has also been found with the Vietnamese. Stephenson (1995) found that Vietnamese-Canadians who did not use traditional medicine (either Chinese or Vietnamese types) were still guided by a conceptualisation of illness which evolved around the notions of hot and cold, and of harmony between Yin and Yang, core tenets of the traditional Eastern medicine. McClain (1977) suggests that this inconsistency exists because behavioural changes proceed faster than cognitive change. It is not a common practice of biomedicine practitioners to explain the aetiology of the disease to their patients. Thus while accepting modern biomedical treatment, people may still resort to their more familiar traditional explanation of their illness to understand it.

SIMILARITY IN CHOICE OF HELP SEEKING SOURCE

The fourth pattern found in help seeking choices reflects a similarity between people in their help seeking behaviour. One explanation for why fewer than expected differences were found in help seeking behaviour/choices could be that the low rates of symptoms may have contributed to the low help seeking in all groups, thus restricting the range of the help seeking variables and limiting the possibility of significant differences between groups. Previous research, which found a higher usage of family and friends help for mental health problems among the Asian population, tended to be conducted with clinical samples where the symptoms had already progressed to an advanced stage. As attitudes towards mild and severe forms of health problems may be significantly different, it could be concluded that help seeking choices for perceived severe symptoms cannot be automatically generalised to milder symptoms. If symptoms were considered as non-problematic, they were more likely to be dismissed or dealt with by the individual rather than requiring external professional help.
SPECIFIC DIFFERENCES ON HEALTH-RELATED AND HELP SEEKING VARIABLES

PSYCHOLOGICAL ADJUSTMENT

Symptoms indicative of different levels of psychological adjustment were found between comparative groups. This finding needs to be seen within the context that participants in the study were generally well adjusted psychologically. The study used the Hopkins Symptom Checklist -25 rating scale (Mollica et al., 1987) in which an average symptom score of 1.75 (ranging from 1 to 4) indicates clinical significance. Thus in the current study, a score of .75 (using a range of 0 to 3) could be used as an indicator of clinically symptomatology. All mean symptom scores obtained from the three cultures were less than .75, indicating that the participants were on an average only experiencing mild level of stress and that they were generally psychologically adjusted. While this result is generally expected from community samples, it should be noted that the low symptom scores do not always mean that there is no distress. In addition, previous research has demonstrated that the reporting of troublesome events and the subsequent use of help seeking services tends to be underestimated in data collected through research surveys (Gourash, 1978; McKelvey & Baldassar, 1999). Thus, the study results need to be viewed in the context of a normal, non-clinical sample with respect to mental health, but a sample that has, nonetheless, potential for and experience of stress and distress.

Contrary to expectations, the findings of the current study indicated that while the Vietnamese-Australians experienced more mental health symptoms than Vietnamese in Vietnam, their symptoms were fewer compared to the Anglo-Australians. While the better indication of health revealed by the Vietnamese in Vietnam sample was as expected in the current study, the real extent of symptoms experienced by this sample population may be underestimated. In interpreting levels of symptoms experienced by the Vietnamese in Vietnam, there are a number of issues which need to be taken into consideration. Firstly, because of the small size of the Vietnamese in Vietnam sample, statistical power to make generalisations about the group may be low. Secondly, the reliability of the symptom scale was just barely adequate for the Vietnamese in Vietnam sample. The reason for this may be that, because the symptom checklist used in the
study was developed with a refugee population in Western countries, it may be less relevant to the experiences of Vietnamese in their home country. Thirdly, as mentioned earlier, due to cultural bias, Vietnamese in Vietnam may deny or dismiss symptoms. For all these reasons, symptoms reported by Vietnamese in Vietnam may be understated in the current study.

Previous studies have suggested that, due to pre- and post-migration experience, migrants may face heightened levels of stress. Other studies have tended to show that immigrant groups have more psychological symptoms than the majority ethnic group (e.g., Aldwin & Greenberger, 1987; Long et al., 1999). Findings of the current study, however, did not find the Vietnamese-Australians to experience more mental health symptoms than the majority group. Instead, the reverse was the case. As discussed previously, the higher symptom score among the Anglo-Australians may be the result of a response bias, however, other explanations are possible. Berry and Kim (1988) present an argument which may better explain this finding. They argue that acculturative experiences do not inevitably bring about a decline in mental health, especially, if there are good supportive structures available in the host country and the immigrant groups maintain cohesion in their new community. For example, Niles (1999) interviewed Greeks and Filipinos in Australia and found the mental health of members of both groups to be only minimally affected by migration experiences. Several researchers (e.g., Lin, Masuda, & Tazuma, 1982; Niles, 1999) argued that a strong sense of cultural identity, support from family and association with members of their own community (both in Australia and in their home country) may be a protective factor against mental health problems among people from immigrant backgrounds. Likewise, the relatively large and cohesive structure of the Vietnamese community in Australia could explain the current research findings regarding their better mental health status.

PSYCHOLOGISATION AND SOMATISATION

Unexpectedly, findings also indicated that the Anglo-Australians and the Australianised Vietnamese-Australians, instead of the Vietnamese in Vietnam and the more Vietnamese-oriented Vietnamese-Australians, somatised (as well as psychologised) more than other groups. One explanation of this unforeseen finding
could be the differential operationalisation of somatisation in the current study in comparison with previous research. Most previous research regarding illness expression of people from Asian cultures has focussed on investigating the use of somatisation only, not psychologisation. Also, somatisation has often been identified through clinical interviews or through a separate somatisation scale derived from the Symptom Checklist 90 (Derogatis, 1994). Because the current study had a different focus (in that it was aimed at investigating the extent to which people somatise as well as psychologise) the scales employed measured both modes of illness expression and might not necessarily measure the same aspects of somatisation as those of previous studies.

Another possible explanation of the higher rates of somatisation among the Anglo-Australians and the Australianised Vietnamese-Australians could be related to the high correlation between somatisation and psychologisation in this study. The more the participants psychologised, the more they somatised, rather than these being relatively independent traits, or alternative modes of symptom expression. Miller et al. (1981) found similar results with 628 men and women in Texas, USA. These researchers argued that an interest in the bodily aspects of oneself tended to be associated with an interest in the psychological aspects. Although somatisation and psychologisation have been conceptualised as distinct personality traits (Kirmayer et al., 1998; Kleinman, 1980; Miller et al., 1981), the high correlation found between these two variables suggests otherwise. Thus in the current study, the Anglo-Australians may have somatised more because they psychologised more, that is, they expressed symptoms more than the other cultural groups. This in turn may relate to the fact that they reported more symptoms in the first place.

**SYMPTOM CAUSAL ATTRIBUTIONS**

In the current study, the higher scores for psychological and biological causal attributions among those who identified more with the Australian culture were as expected. However, their higher score on environmental causal attributions posed a puzzle. It was expected that due to Eastern health beliefs, Vietnamese who were strong in their Vietnamese cultural orientation would endorse this source of causal attribution the most. Again, the conceptualisation of this variable may hold the key to this
unexpected finding. According to Robbins and Kirmayer (1991), common health symptoms when they first appear, are often normalised by being attributed to environmental or non-pathological causes. Only when these explanations are realised as insufficient, then symptoms be attributed to other factors such as biological or psychological factors. However, this theory may not have been the case in cross-cultural settings. For example, Vietnamese have been found to commonly attribute the cause of severe health conditions to environmental sources (e.g., Hinton et al., 1993, 2003). Perhaps, failure to find a higher environmental attribution score among the Vietnamese samples in the current study may relate to the low symptom score. That is, more of the Vietnamese might have attributed the cause of their symptoms to environmental factors if they had actually experienced more symptoms or if their symptoms were more severe.

**CHOICES IN HELP SEEKING**

One of the two patterns of difference revealed in help seeking choice was the higher preference for self-help among the Anglo-Australians. This may indicate that the Anglo-Australians have more health self efficacy, or more personal resources in this domain such as more knowledge, compared to the Vietnamese groups. These resources may include more awareness of the nature of anxiety and depression, and more ideas about treatment options. An analysis of differences in help seeking pathways between cultures by Lin et al. (1978) found that, before mental health symptoms were recognised as severe (requiring specialist interventions), people from Anglo-Saxon/Middle European groups were more active in accessing both social and health care services than other cultural groups. As such, Anglo-Australians would be expected to have more awareness of problems and have more access to resources (e.g., self-help materials and knowledge of available services) and may use these sources more than the Vietnamese. Literature on the Transtheoretical Model of Intentional Behavioral Change (DiClemente & Prochaska, 1998; Prochaska & DiClemente, 1982) suggests that an intentional behavioural change occurs if people believe they have the ability to effect change (high self-efficacy). The Anglo-Australians’ preference for self-help may, therefore, indicate that the levels of their self-efficacy are higher compared to the two Vietnamese groups.
The other difference found was in participants’ choice of mental health help. The Vietnamese in Vietnam were found to prefer this source of help more than people in the other two groups. Despite the lack of Western-style psychological services in Vietnam, Vietnamese in Vietnam reported they preferred these sources of help significantly more than did the Vietnamese-Australians. A possible explanation for this unexpected difference is that Vietnamese in Vietnam may overestimate the ability of mental health professionals and the effectiveness of psychological treatment.

Professional mental health services in Vietnam are provided exclusively through hospitals and tend therefore to be associated with Western medicine. Even though the nature of the mental health service is not clearly understood by the general public in Vietnam, its affiliation to Western medicine may contribute to the optimistic assumption that this source of help is powerful and effective. The second possible reason for the more positive response to mental health help than expected among the Vietnamese in Vietnam is that participants’ responses could have been biased towards the researcher. McKelvey and Baldassar (1999) found similar responses among Vietnamese in Western Australia. Contrary to his expectation, the researcher found that, despite participants’ narrow definition of mental health and lack of knowledge about available services, Vietnamese parents expressed a high level of preference for Western-trained mental health professionals. Researchers (e.g., Gourash, 1978; McKelvey & Baldassar, 1999; McKelvey & Davies, 1999) suggested that respondents’ attempts to please the investigators often reduce the validity of data with respect to presentation of the problem, source of referral, and help preferences.

The lack of differences between the Vietnamese-Australians and the Anglo-Australians in choice of mental health help found in the current study seemed to add further confusion to findings regarding attitudes towards mental health service of the Vietnamese living overseas. For example, a study of Vietnamese in the U.S.A., Atkinson, Ponterotto, and Sanchez (1984) found that, in comparison with mainstream Americans, the Vietnamese have less confidence in the ability of mental health professionals to be of assistance. In Australia, on the contrary, they tended to have higher confidence in such help (Duong-Ohtsuka & Ohtsuka, 2002). These differential findings may indicate attitudes of different population samples. That is, due to differences in their migration history, the 1980s Vietnamese sample may have
significantly different characteristics compared to the Vietnamese sample in the years after 2000. However, these differential findings may also indicate the progress of attitude change over time. A possible explanation for the unexpected finding in the current study could be that similar rates of preference for mental health help among the Vietnamese-Australians and the Anglo-Australians reflects a more realistic understanding of the nature of mental health services and lower levels of expectation regarding this help source by participants from these groups. Nevertheless, further investigation into this matter is needed for this explanation to inclusive.

SUMMARY

In summary, four distinct patterns of findings emerged from current study. The first indicated that cultural orientation, especially, cultural orientation to the Australian culture, is a useful indicator, predictive of the help seeking cognitions and behaviours of Vietnamese-Australians. Secondly, “Australianisation”, which encompasses both the Anglo-Australian and the more Australianised Vietnamese-Australian groups, predicted higher scores on most of the health-related help seeking variables. Thirdly, group differences were mostly found on cognitive rather than on behavioural aspects of help seeking. Finally, there were many similarities between the groups in help seeking choices.

LIMITATIONS

The results of the current study, including the lack of support for several hypotheses, need to be viewed in light of the following limitations. Ideally, further research which overcomes these limitations will enable the full evaluation of arguments in support of the findings of the current study.

A major limitation with the current study was the categorisation of Vietnamese-Australians’ acculturation modes. Within-group data analysis showed that acculturation modes using the median splitting technique provided somewhat contradictory results. The use of the median-split method to classify modes of acculturation was adopted because it enabled a relatively even split of participants into each group, and a large enough sample in each group for meaningful comparison. However, there are problems
with this method. First, although Australian culture and Vietnamese cultural orientations represent independent domains of acculturation, it typically is the case that Vietnamese culture orientation has greater influence than Australian cultural orientation. Consequently, it might be argued that the assignment of research participants to one of the four acculturation categories under these conditions does not represent a pure measurement of integration, separation, marginalisation, and assimilation. Second, considering the possible differences in response bias between Asian and Anglo-Australian groups (Lee, 1988; Matsumoto, 1994; McKelvey & Baldassar, 1999; McKelvey & Davies, 1999; Tung, 1980), it has been argued that it is simplistic to assume that all cultural groups exhibit the full range of acculturation scores and that, therefore, the mid-point of scale scores can be used to operationalise acculturation modes. Third, had the mid-point split been used in this study, most of the participants would have fallen into the marginalised and the separation groups.

Indeed, further exploration using the mid-point split techniques showed that it was not the integration group alone who scored the highest on most variables (as found when the median split technique was used). Instead a combination of those who scored higher on Australian cultural orientation (the Australianised Vietnamese-Australians) scored the highest. Although a limitation of this splitting technique was that it only allowed the comparisons of three acculturation groups, its results provided a clearer pattern in supporting the role of Australian cultural orientation in help seeking behaviour of Vietnamese-Australians.

The second limitation of the current study was that the samples drawn from the three culture groups might not be a representative sample of people in these cultures. The participants in the current study were recruited using convenience sampling methods. Due to vast differences between the societies, health systems, economies, and education systems, it is difficult to match all three cross-cultural comparison groups on demographic factors. Among the three cultural group samples, the sample of Vietnamese in Vietnam may not be considered as a representative of the general Vietnamese population. The participants in this sample were generally employed in administrative areas (e.g., education, banking, tourism, students). Those who did not volunteer when approached to participate tended to be from trade, artisan, or farming professions. Further, the sample sizes of the cross-cultural groups were not even. The
sample of Vietnamese in Vietnam contained the smallest number of participants (19%), followed by the Vietnamese-Australians (38%) and the Anglo-Australians (43%). Even though the age difference between participants were controlled for both cross-cultural group and cross-acculturation group analyses, the small sample size of the Vietnamese in Vietnam group together with its selection bias may compromise generalisability of the findings of the current study and has made it difficult to interpret the results.

Another limitation is related to the operationalisation of the three sources of causal attributions. According to Robbins and Kirmayer (1991), the three sources of causal attributions presented in help seeking situations are environmental, psychological and biological. However, in the current study, imputed causes may not fit clearly into the three categories nominated. For example, people may be unsure whether ‘stress’ has a psychological or an environmental cause, or whether ‘a chill’ is biological or environmental. The difference in results between the current study and that of Robin and Kirmayer could also be due to differences in stages of help seeking of the study participants. That is, while Robin and Kirmayer’s study assessed causal attributions where help seeking had already occurred, the current study elicited hypothetical behavioural intentions. As such, sources of causal attribution from a community setting such as the current study may require further examination.

Finally, although quantitative analyses did not show evidence of consistent cultural response bias in the data of the current study, there is a possibility that it existed. However, these biases may appear in a more selective manner than can be ascertained through inspection of scale standard deviations and reliabilities. As such, people may respond according to what to be expected of them in one area but not others. For example they may be biased in their symptom reporting, illness expression, and causal attribution, but not in their choice of help seeking. Further, even though the scales were translated (when required), the connotation of concepts may differ in different cultures, therefore they still may not be directly compatible across comparative groups. Interpretations of these cognitive aspects thus may be limited.

IMPLICATIONS AND FUTURE RESEARCH

In studying the help seeking behaviour of people from culturally and linguistically diverse communities, future research needs to further investigate the role
of acculturation, in particular, the methods used to classify modes of acculturation. Ideally, if each cultural group exhibits a full range of acculturation scale scores, the scalar midpoint approach advocated by Dona and Berry (1994) should be used to categorise modes of acculturation. However, as discussed earlier, this method may ignore response tendencies which are affected by sample size for some categories, as occurred in the current study, resulting in small numbers of participants in the “integrated” and “assimilated” groups. Other researchers also found some shortcomings using classifications using the scalar midpoints. Table 15 shows a summary of results from studies which adopt the mid-point techniques.

Table 15
Acculturation modes classified from the mid-point split techniques in cross-studies.

<table>
<thead>
<tr>
<th>Study</th>
<th>Sample population</th>
<th>N</th>
<th>Integration (%)</th>
<th>Assimilation (%)</th>
<th>Separation (%)</th>
<th>Marginalisation (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dona &amp; Berry, 1994</td>
<td>Central American refugees</td>
<td>93</td>
<td>77.4</td>
<td>4.3</td>
<td>18.3</td>
<td>-</td>
</tr>
<tr>
<td>Ward &amp; Rana-Deuba, 1999</td>
<td>International aid workers in Nepal</td>
<td>104</td>
<td>6.7</td>
<td>0.9</td>
<td>79.8</td>
<td>12.5</td>
</tr>
<tr>
<td>The current study</td>
<td>Vietnamese in Australia</td>
<td>94</td>
<td>4.3</td>
<td>7.4</td>
<td>38.3</td>
<td>50</td>
</tr>
</tbody>
</table>

As showed in Table 15, the scalar midpoint splitting techniques resulted in the majority of participants being classified as integrated and no respondents being classified as marginalised in Dona and Berry’s study. In Ward and Rana-Deuba’s study, most of respondents were classified as separated. In the current study, most participants were classified as marginalised or separated. The midpoint split failed to accommodate meaningful cross-group comparisons in the current study (as it also did with the study of Ward and Rana-Deuba). It also failed to produce four discernible acculturation categories in Dona and Berry’s (1994) refugee research. Subsequently, it can be argued that both median and scalar midpoint split techniques are equally useful in acculturation research and that the selection of the most appropriate method is likely
to be influenced by sample-specific characteristics including the migration status of the acculturating group. However, considering the benefits of the mid-point split techniques, it is possible that it might be suitable for the effective classification and comparison of acculturation styles in long-term immigrants. This issue of assessment of acculturation modes should be further explored in future research.

Future research should investigate into the acculturation of majority or other more established ethnic groups and the effects of acculturation attitudes on the behaviour and psychological well-being of these people. It would be of interest to undertake within-culture comparisons of immigrant groups that systematically vary in cultural distance from members of the host culture. Comparisons should also be made across different receiving societies. Systematic variation of open versus closed, loose versus tight, individualist versus collectivist, and monocultural versus multicultural emphasis between the culture of origin of migrants and the host country/society merits further research related to health issues.

The current study sought to differentiate people on type of illness attribution. However, it was interesting to note that the three causal attributions of environmental, psychological and biological were highly correlated. This suggests that, once people nominated one type of cause, they were also more likely to nominate others. Since the type of illness attribution is expected to have a significant implication on the choice of help seeking (Robbins & Kirmayer, 1991), the extent to which people attribute any type of cause may be a more useful indicator of the range of help seeking behaviour they will choose. Individuals tend to seek help based on their preliminary analysis of their problems. If symptoms receive a causative explanation which warrants help seeking, help seeking may be more likely to commence. However, if symptoms receive no attention, they are more likely to be dismissed and help seeking is not likely to occur. As such, the tendency to seek causative explanations for events may have a significant role in help seeking decision making. Thus, it may be useful to further investigate if individuals and cultures differ in whether they seek causative explanations for events.

The inconsistency between the cognitive and behavioural aspects of help seeking is another area which seems to warrant for further investigation. As intention to perform certain behaviour may not always lead to that behaviour being carried out (Ajzen & Madden, 1986), assessment of future help seeking behaviour for symptoms
which may or may not be experienced may not be as accurate as the assessment of past behaviour. It has been suggested that that the connection between reports of troublesome events and the subsequent use of services has been underestimated in data collected through research surveys (Gourash, 1978). To be more accurate in the assessment of help seeking, other researchers have tended to use the retrospective methods (e.g. Anderson, Gunter, & Kennedy, 1963; Lin et al., 1978; Phan, 2000). For example, Anderson et al. (1963) found that people accurately reported the history of their health care when asked specific questions about disease and their efforts to seek help. The researchers argued that this technique may have a special advantage as it focuses on the memory of a specific event and resulting behaviour rather than requiring an unprompted recall of all illnesses and help-seeking efforts. Although these studies focussed on help seeking behaviour for more serious health problems, the same methods should be useful for less severe forms of problems such as anxiety and depression.

CONCLUSION

The current study used an integrative approach in the study of help seeking behaviour. Despite limitations, the breadth of the findings of the current study sheds light on important key aspects of illness cognition and help seeking behaviour of people from migrant backgrounds, in particular, the Vietnamese in Australia. The tremendous ethnic diversity of Australian society today makes the study of cultural differences a matter of practical importance. As demonstrated in the current study, cultures vary in their response to common mental health symptoms. Some of these responses facilitate better psychological adjustment while others may increase social stigma, anxiety or maladaptive illness behaviour.

It has been suggested that norms about help-seeking influence the search for assistance. Understanding of help-seeking norms can orient educational campaigns and outreach programs directed towards counterbalancing the factors that conspire against the effective use of resources and professional services. In order to maximise the effectiveness of such strategies, individual programs can be created for specific audiences.

However, it should be noted that harmony with prevailing cultural values does not always guarantee positive outcomes. Therefore, a culturally sensitive intervention
must not only respect the locally reinforced coping strategies, but must also appreciate
its social implications, taking into account the psychological dynamics of the target
community.
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APPENDIX A

The study survey
Dear Sir/Madam,

We are seeking your participation in our study of health and help seeking of people in our multicultural society of Australia.

It has often been found that people do not always turn to the right professionals when they become unwell. This study aims to investigate how people from different cultures experience distress, interpret health symptoms, and seek help for their health problems. The results of this study shed light on better understanding of help seeking behaviour and help improving health service policies and provisions in a multicultural society. Please find a questionnaire enclosed for this study purpose.

It will take approximately 15-20 minutes to complete the enclosed questionnaire. (Please complete the questionnaire on your own without discussing it with others.) There are no right or wrong answers. The questionnaire simply asks you to select the answers that best reflect your personal views and experiences. Your completion and return of the questionnaire will be taken as your consent for participation. Completed questionnaires can be returned in the reply paid envelope provided.

Your participation in this study is voluntary and your answers will be treated with confidentiality. Your name is not required and your responses will remain completely anonymous. While results from this study may be published, individual anonymity is assured and only group data will be reported in the report.

If you have any questions regarding this questionnaire or the research project, please feel free to contact an investigator on 0402 208 154. If you have any concerns or need information about symptoms described in the questionnaires, please contact your family doctor or the nearest community health centre.

Thank you so much in anticipation.

Sincerely,

Susan Moore (PhD.), Thai Duong-Ohtsuka(GraDipPsych.), Elizabeth Hardie (PhD)
Health and Help-seeking

PART 1

1. Please rate your general health: □Very poor  □Poor  □Fair  □Good  □Very good

2. Are you currently seeking help for any health symptom? □No; □Yes
   What are the symptoms? .................................................................
   Who are you seek help from? ..........................................................

3. List below are some symptoms or problems that people sometimes have. Please check if you have been experiencing these symptoms over the past three months. Please circle the number that most reflect your condition.

0=Never  
1=Sometimes  
2=Often  
3=All the time

<table>
<thead>
<tr>
<th>No.</th>
<th>Symptom</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Faintness, dizziness, or weakness</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
<td>Suddenly scared for no reason</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3.</td>
<td>Heart pounding or racing</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4.</td>
<td>Feeling fearful</td>
<td></td>
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<td></td>
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<tr>
<td>5.</td>
<td>Trembling</td>
<td></td>
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<tr>
<td>6.</td>
<td>Nervousness or shakiness inside</td>
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<tr>
<td>7.</td>
<td>Feeling tense or keyed up</td>
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<tr>
<td>8.</td>
<td>Spells of terror or panic</td>
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<tr>
<td>9.</td>
<td>Feeling restless, can’t sit still</td>
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<tr>
<td>10.</td>
<td>Feeling of being trapped or caught</td>
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<tr>
<td>11.</td>
<td>Feeling blue</td>
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<tr>
<td>12.</td>
<td>Loss of sexual interest or pleasure</td>
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<tr>
<td>13.</td>
<td>Thoughts of ending your life</td>
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<tr>
<td>14.</td>
<td>Feeling of worthlessness</td>
<td></td>
<td></td>
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<tr>
<td>15.</td>
<td>Difficulty falling asleep, staying asleep</td>
<td></td>
<td></td>
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<tr>
<td>16.</td>
<td>Crying easily</td>
<td></td>
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<tr>
<td>17.</td>
<td>Desperate</td>
<td></td>
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<tr>
<td>18.</td>
<td>Downhearted and low spirited</td>
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<tr>
<td>19.</td>
<td>Sad and bothered</td>
<td></td>
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<tr>
<td>20.</td>
<td>Feelings of going crazy</td>
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<tr>
<td>21.</td>
<td>Headache, limb ache, back ache</td>
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<tr>
<td>22.</td>
<td>Shameful and dishonoured</td>
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<tr>
<td>23.</td>
<td>Decreased appetite</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>24.</td>
<td>Easily angry/Irritable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Do you have a regular family doctor? □Yes; □No

5. What is your marital status? □Single/Never married; □Married; □De Facto; □Separated/Divorced; □Widowed

6. How many children do you have? .........................

7. What language(s) do you speak at home? .................................................................

8. (If not English,) about what percent of the time do you speak English at home? ....................%
PART 2  About yourself:

1. Gender: Male/Female
2. Age: ................................(years old),
3. Cultural background: □ Anglo-Australian, □ European, □ Vietnamese, □ Other Asian
4. Place of birth: ........................................................................................................................................
5. (If born outside Australia) Years in Australia: ......................................................(years)
6. Father’s country of birth? ...................................................... Mother: ..............................................................
7. Current occupation: ................................................................................................................................
8. Employment Status: □ Not employed □ Fulltime □ Part-time □ Casual
9. Education level: □ No formal education □ Diploma/TAFE □ Primary □ Undergraduate □ Secondary □ Postgraduate
10. Religion: ...............................................................................................................................................

If you are Anglo-Australian with English as first language, omit Part 3 and turn over to Part 4!

PART 3  We are interested in how you maintain your own culture of origin in the context of multicultural Australia. Please tick (✓) only one box that describes you best.

1- a. How well do you speak Vietnamese?
   □ Not at all…… □ A little………… □ Basic.......... □ Fluent………… □ Very fluent
   b. How well do you speak English?
   □ Not at all…… □ A little………… □ Basic.......... □ Fluent………… □ Very fluent

2 - a. How well do you read and write in Vietnamese?
   □ Not at all…… □ A little………… □ Basic.......... □ Fluent………… □ Very fluent
   b. How well do you read and write in English?
   □ Not at all…… □ A little………… □ Basic.......... □ Fluent………… □ Very fluent

3 - a. What proportion of your close friends and acquaintants are from Vietnamese background?
   □ 0%…………… □ 25%…………… □ 50%…………… □ 75%…………… □ 100%
   b. What proportion of your close friends and acquaintants are Australians?
   □ 0%…………… □ 25%…………… □ 50%…………… □ 75%…………… □ 100%

4 - a. How much knowledge do you have about Vietnamese culture?
   □ 0%…………… □ 25%…………… □ 50%…………… □ 75%…………… □ 100%
   b. How much knowledge do you have about Australian culture?
   □ 0%…………… □ 25%…………… □ 50%…………… □ 75%…………… □ 100%

5 - a. How much of your values and beliefs reflect Vietnamese culture’s values and beliefs?
   □ 0%…………… □ 25%…………… □ 50%…………… □ 75%…………… □ 100%
   b. How much of your values and beliefs reflect Australian culture’s values and beliefs?
   □ 0%…………… □ 25%…………… □ 50%…………… □ 75%…………… □ 100%

6 - a. How much do you actually practice Vietnamese culture’s custom and tradition?
   □ 0%…………… □ 25%…………… □ 50%…………… □ 75%…………… □ 100%
   b. How much do you actually practice the Australian custom and tradition?
   □ 0%…………… □ 25%…………… □ 50%…………… □ 75%…………… □ 100%

7 - a. Do you prefer your health care professionals to be from Vietnamese background?
   □ Not at all…… □ Sometimes…… □ Don’t care…… □ Often…… □ Always
   b. Do you prefer your helpers to be Australians?
   □ Not at all…… □ Sometimes…… □ Don’t care…… □ Often…… □ Always

8 – a. How much can you identify yourself as a Vietnamese?
   □ 0%…………… □ 25%…………… □ 50%…………… □ 75%…………… □ 100%
   b. How much can you identify yourself as an Australian?
   □ 0%…………… □ 25%…………… □ 50%…………… □ 75%…………… □ 100%
PART 4 Source of help. There are 6 groups of people who we often ask for help when we are unwell:

1. Yourself include self-help or ignoring the symptom;
2. Your family or friends;
3. Spiritual helpers such as religious leaders, spirit of ancestors, or gods;
4. Mental health professionals such as psychologists, psychiatrists, counsellors, or psychotherapists;
5. Western medicine practitioners (eg. Family doctors or medical specialists); and
6. Eastern medicine practitioners (eg. Herbalists or acupuncturists).

We are interested to hear how likely it is for you to seek help from each group of these people for specific health condition. Please circle 1 of the 4 numbers (0,1,2,3) used to indicate your level of preference. Please provide your answers for all six sources of help.

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<th>Myself</th>
<th>Family/Friends</th>
<th>Spiritual Helpers</th>
<th>Mental Health Professional</th>
<th>Western Medicine</th>
<th>Eastern Medicine</th>
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<td>2. Suddenly scared for no reason</td>
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<td>6. Feeling tense or keyed up</td>
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<td>14. Easily angry/Irritable</td>
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**PART 5 Causes of symptoms.** There are three possible reasons to the cause of particular health condition:

(1) Environmental causes (e.g., wind, temperature, dust, poor housing etc.);
(2) Psychological causes – (personality, temperament, symptoms originate from financial pressure or relationship problems)
(3) Biological causes – (symptoms have physiological, biochemical or genetic explanations)

We are interest to know your explanations as how likely four factors above to be the causes of each health conditions. Please circle one of the 3 numbers (0,1,2,3) used to indicate your level of preference. Please provide answers for all factors.

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<tr>
<td>2. Suddenly scared for no reason</td>
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<tr>
<td>3. Heart pounding or racing</td>
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<td>4. Trembling</td>
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<td>0 1 2 3</td>
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<tr>
<td>5. Nervousness or shakiness inside</td>
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<td>0 1 2 3</td>
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<td>6. Feeling tense or keyed up</td>
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<tr>
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<tr>
<td>8. Feeling restless, can’t sit still</td>
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<tr>
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<tr>
<td>10. Desperate</td>
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<tr>
<td>11. Difficulty falling asleep, staying asleep</td>
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### PART 6
Following statements describe people’s characteristics. Please circle the number that best describes you for each statement.

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<th>3</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>1. I am sensitive to internal bodily tensions</td>
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<tr>
<td>2. I know immediately when my mouth or throat gets dry</td>
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<tr>
<td>3. I can often feel my heart beating</td>
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<td>4. I am quick to sense the hunger contractions of my stomach</td>
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<tr>
<td>5. I’m very aware of changes in my body temperature</td>
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<tr>
<td>6. I’m always trying to figure myself out</td>
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<tr>
<td>7. Generally, I’m not very aware of myself</td>
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<tr>
<td>8. I reflect about myself a lot</td>
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<tr>
<td>9. I’m often the subject of my own fantasies</td>
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<tr>
<td>10. I never scrutinise myself</td>
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<tr>
<td>11. I’m generally attentive to my inner feelings</td>
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<tr>
<td>12. I’m constantly examining my motives</td>
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<tr>
<td>13. I sometimes have the feeling that I’m off somewhere watching myself</td>
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<tr>
<td>14. I’m alert to changes in my mood</td>
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<tr>
<td>15. I’m aware of the way my mind works when I work through a problem.</td>
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### PART 7
Please continue

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<th>4</th>
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</thead>
<tbody>
<tr>
<td>1. I find it difficult to concentrate because of uncontrollable thoughts</td>
<td></td>
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</tr>
<tr>
<td>2. My heart beats faster</td>
<td></td>
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<tr>
<td>3. I worry too much over something that doesn’t really matter</td>
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<tr>
<td>4. I feel jittery in my body</td>
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<tr>
<td>5. I imagine terrifying scenes</td>
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<tr>
<td>6. I get diarrhea</td>
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<tr>
<td>7. I can’t keep anxiety provoking pictures out of my mind</td>
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<tr>
<td>8. I feel tense in my stomach</td>
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<tr>
<td>9. Some unimportant thought runs through my mind and bothers me</td>
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<tr>
<td>10. I nervously pace</td>
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</tr>
<tr>
<td>11. I feel like I am losing out on things because I can’t make up my mind</td>
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<tr>
<td>12. I become immobilized</td>
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<td>13. I can’t keep anxiety provoking thoughts out of my mind</td>
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<td>14. I perspire</td>
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Thank you very much for taking time to fill out this questionnaire.

Further comment: .................................................................................................................................
### Descriptive Statistics

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<td>30.00</td>
<td>.00</td>
<td>30.00</td>
<td>11.0977</td>
<td>9.55119</td>
<td>.386</td>
<td>.210</td>
<td>-1.239</td>
<td>.417</td>
</tr>
<tr>
<td>Valid N (listwise)</td>
<td>108</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Dear Sir/Madam,

We are seeking your participation in our study of health and help seeking of people in our multicultural society of Australia.

It has often been found that people do not always turn to the right professionals when they become unwell. This study aims to investigate how people from different cultures experience distress, interpret health symptoms, and seek help for their health problems. The results of this study will shed light on better understanding of help seeking behaviour and help improving health service policies and provisions in a multicultural society. Please find a questionnaire enclosed for this study purpose.

It will take approximately 15-20 minutes to complete the enclosed questionnaire. (Please complete the questionnaire on your own without discussing it with others.) There are no right or wrong answers. The questionnaire simply asks you to select the answers that best reflect your personal views and experiences. Your completion and return of the questionnaire will be taken as your consent for participation. Completed questionnaires can be returned in the reply paid envelope provided.

Your participation in this study is voluntary and your answers will be treated with confidentiality. Your name is not required and your responses will remain completely anonymous. While results from this study may be published, individual anonymity is assured and only group data will be reported in the report.

If you have any questions regarding this questionnaire or the research project, please feel free to contact an investigator on 0402 208 154. If you have any concerns or need information about symptoms described in the questionnaires, please contact your family doctor or the nearest community health centre.

Thank you so much in anticipation.

Sincerely,

Susan Moore (PhD.), Thai Duong-Ohtsuka(GraDipPsych.), Elizabeth Hardie (PhD)
Health and Help-seeking

PART 1

1. Please rate your general health: □ Very poor □ Poor □ Fair □ Good □ Very good

2. Are you currently seeking help for any health symptom? □ No; □ Yes

What are the symptoms? .........................................................................................................................

Who are you seek help from? ...................................................................................................................

3. List below are some symptoms or problems that people sometimes have. Please check if you have been experiencing these symptoms over the past three months. Please circle the number that most reflect your condition.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0=Never</td>
<td>1=Sometimes</td>
</tr>
<tr>
<td>1.</td>
<td>Faintness, dizziness, or weakness</td>
</tr>
<tr>
<td>2.</td>
<td>Suddenly scared for no reason</td>
</tr>
<tr>
<td>3.</td>
<td>Heart pounding or racing</td>
</tr>
<tr>
<td>4.</td>
<td>Feeling fearful</td>
</tr>
<tr>
<td>5.</td>
<td>Trembling</td>
</tr>
<tr>
<td>6.</td>
<td>Nervousness or shakiness inside</td>
</tr>
<tr>
<td>7.</td>
<td>Feeling tense or keyed up</td>
</tr>
<tr>
<td>8.</td>
<td>Spells of terror or panic</td>
</tr>
<tr>
<td>9.</td>
<td>Feeling restless, can’t sit still</td>
</tr>
<tr>
<td>10.</td>
<td>Feeling of being trapped or caught</td>
</tr>
<tr>
<td>11.</td>
<td>Feeling blue</td>
</tr>
<tr>
<td>12.</td>
<td>Loss of sexual interest or pleasure</td>
</tr>
<tr>
<td>13.</td>
<td>Thoughts of ending your life</td>
</tr>
<tr>
<td>14.</td>
<td>Feeling of worthlessness</td>
</tr>
<tr>
<td>15.</td>
<td>Difficulty falling asleep, staying asleep</td>
</tr>
<tr>
<td>16.</td>
<td>Crying easily</td>
</tr>
<tr>
<td>17.</td>
<td>Desperate</td>
</tr>
<tr>
<td>18.</td>
<td>Downhearted and low spirited</td>
</tr>
<tr>
<td>19.</td>
<td>Sad and bothered</td>
</tr>
<tr>
<td>20.</td>
<td>Feelings of going crazy</td>
</tr>
<tr>
<td>21.</td>
<td>Headache, limb ache, back ache</td>
</tr>
<tr>
<td>22.</td>
<td>Shameful and dishonoured</td>
</tr>
<tr>
<td>23.</td>
<td>Decreased appetite</td>
</tr>
<tr>
<td>24.</td>
<td>Easily angry/Irritable</td>
</tr>
</tbody>
</table>

4. Do you have a regular family doctor? □ Yes; □ No

5. What is your marital status? □ Single/Never married; □ Married; □ De Facto; □ Separated/Divorced; □ Widowed

6. How many children do you have? .............................

7. What language(s) do you speak at home? ..........................................................

8. (If not English,) about what percent of the time do you speak English at home? ..............................%
PART 2  About yourself:

1. Gender: Male/Female
2. Age: ................................(years old),
3. Cultural background:  □ Anglo-Australian, □ European, □ Vietnamese, □ Other Asian
4. Place of birth: .................................................................................................................................
5. (If born outside Australia) Years in Australia: ...................................(years)
6. Father’s country of birth? ..........................................................................................................................
7. Mother: ...........................................................................................................................................
8. Employment Status: □ Not employed □ Fulltime □ Part-time □ Casual
9. Education level: □ No formal education □ Diploma/TAFE □ Primary □ Undergraduate □ Secondary □ Postgraduate
10. Religion: ...............................................................................................................................................

If you are Anglo-Australian with English as first language, omit Part 3 and turn over to Part 4!

PART 3  We are interested in how you maintain your own culture of origin in the context of multicultural Australia. Please tick (✓) only one box that describes you best.

1- a. How well do you speak Vietnamese?
       □ Not at all…… □ A little…… □ Basic…… □ Fluent…… □ Very fluent
   b. How well do you speak English?
       □ Not at all…… □ A little…… □ Basic…… □ Fluent…… □ Very fluent

2 - a. How well do you read and write in Vietnamese?
       □ Not at all…… □ A little…… □ Basic…… □ Fluent…… □ Very fluent
   b. How well do you read and write in English?
       □ Not at all…… □ A little…… □ Basic…… □ Fluent…… □ Very fluent

3 - a. What proportion of your close friends and acquaintants are from Vietnamese background?
       □ 0% □ 25% □ 50% □ 75% □ 100%
   b. What proportion of your close friends and acquaintants are Australians?
       □ 0% □ 25% □ 50% □ 75% □ 100%

4 - a. How much knowledge do you have about Vietnamese culture?
       □ 0% □ 25% □ 50% □ 75% □ 100%
   b. How much knowledge do you have about Australian culture?
       □ 0% □ 25% □ 50% □ 75% □ 100%

5 - a. How much of your values and beliefs reflect Vietnamese culture’s values and beliefs?
       □ 0% □ 25% □ 50% □ 75% □ 100%
   b. How much of your values and beliefs reflect Australian culture’s values and beliefs?
       □ 0% □ 25% □ 50% □ 75% □ 100%

6 - a. How much do you actually practice Vietnamese culture’s custom and tradition?
       □ 0% □ 25% □ 50% □ 75% □ 100%
   b. How much do you actually practice the Australian custom and tradition?
       □ 0% □ 25% □ 50% □ 75% □ 100%

7 - a. Do you prefer your health care professionals to be from Vietnamese background?
       □ Not at all…… □ Sometimes…… □ Don’t care…… □ Often…… □ Always
   b. Do you prefer your hepers to be Australians?
       □ Not at all…… □ Sometimes…… □ Don’t care…… □ Often…… □ Always

8 – a. How much can you identify yourself as a Vietnamese?
       □ 0% □ 25% □ 50% □ 75% □ 100%
   b. How much can you identify yourself as an Australian?
       □ 0% □ 25% □ 50% □ 75% □ 100%
PART 4 Source of help. There are 6 groups of people who we often ask for help when we are unwell:

1. Yourself include self-help or ignoring the symptom;
2. Your family or friends;
3. Spiritual helpers such as religious leaders, spirit of ancestors, or gods;
4. Mental health professionals such as psychologists, psychiatrists, counsellors, or psychotherapists;
5. Western medicine practitioners (eg. Family doctors or medical specialists); and
6. Eastern medicine practitioners (eg. Herbalists or acupuncturists).

We are interested to hear how likely it is for you to seek help from each group of these people for specific health condition. Please circle 1 of the 4 numbers (0,1,2,3) used to indicate your level of preference. Please provide your answers for all six sources of help.

<table>
<thead>
<tr>
<th>0 = Most unlikely</th>
<th>1 = Unlikely</th>
<th>2 = Likely</th>
<th>3 = Most likely</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Myself</th>
<th>Family/Friends</th>
<th>Spiritual Helpers</th>
<th>Mental Health Professional</th>
<th>Western Medicine</th>
<th>Eastern Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Faintness, dizziness, or weakness</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>2. Suddenly scared for no reason</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>3. Heart pounding or racing</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>4. Trembling</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>5. Nervousness or shakiness inside</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>6. Feeling tense or keyed up</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>7. Spells of terror or panic</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>8. Feeling restless, can’t sit still</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>9. Loss of sexual interest or pleasure</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>10. Desperate</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>11. Difficulty falling asleep, staying asleep</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>12. Sad and bothered</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>13. Headache, limb ache, back ache</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>14. Easily angry/Irritable</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>
PART 5 Causes of symptoms. There are three possible reasons to the cause of particular health condition:

1. Environmental causes (eg. Wind, temperature, dust, poor housing etc);
2. Psychological causes – (personality, temperment, symptoms originate from financial pressure or relationship problems)
3. Biological causes – (symptoms have physiological, biochemical or genetic explanations)

We are interest to know your explanations as how likely four factors above to be the causes of each health conditions. Please circle one of the 3 numbers (0,1,2,3) used to indicate your level of preference. Please provide answers for all factors.

<table>
<thead>
<tr>
<th>Environmental Causes</th>
<th>Psychological Causes</th>
<th>Biological Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eg. Stomach ache</strong></td>
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<td>0 1 2 3</td>
</tr>
<tr>
<td>1. Faintness, dizziness, or weakness</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>2. Suddenly scared for no reason</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>3. Heart pounding or racing</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>4. Trembling</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>5. Nervousness or shakiness inside</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>6. Feeling tense or keyed up</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>7. Spells of terror or panic</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>8. Feeling restless, can’t sit still</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>9. Loss of sexual interest or pleasure</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>10. Desperate</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>11. Difficulty falling asleep, staying asleep</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>12. Sad and bothered</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>13. Headache, limb ache, back ache</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>14. Easily angry/Irritable</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>
### PART 6
Following statements describe people’s characteristics. Please circle the number that best describe you for each statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am sensitive to internal bodily tensions</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I know immediately when my mouth or throat gets dry</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I can often feel my heart beating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I am quick to sense the hunger contractions of my stomach</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I’m very aware of changes in my body temperature</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I’m always trying to figure myself out</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Generally, I’m not very aware of myself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I reflect about myself a lot</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. I’m often the subject of my own fantasies</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. I never scrutinise myself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. I’m generally attentive to my inner feelings</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. I’m constantly examining my motives</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. I sometimes have the feeling that I am off somewhere watching myself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. I’m alert to changes in my mood</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. I’m aware of the way my mind works when I work through a problem</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

### PART 7
Please continue

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I find it difficult to concentrate because of uncontrollable thoughts</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. My heart beats faster</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I worry too much over something that doesn’t really matter</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I feel jittery in my body</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I imagine terrifying scenes</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I get diarrhea</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I can’t keep anxiety provoking pictures out of my mind</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I feel tense in my stomach</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. Some unimportant thought runs through my mind and bothers me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. I nervously pace</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. I feel like I am losing out on things because I can’t make up my mind soon enough</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. I become immobilized</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. I can’t keep anxiety provoking thoughts out of my mind</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. I perspire</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Thank you very much for taking time to fill out this questionnaire.

Further comment: ..........................................................................................................................................................................
...........................................................................................................................................................................................................
...........................................................................................................................................................................................................
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5
<table>
<thead>
<tr>
<th>Descriptive Statistics</th>
<th>N</th>
<th>Range</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std.</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Symptom Score</td>
<td>246</td>
<td>2.00</td>
<td>.00</td>
<td>2.00</td>
<td>.3856</td>
<td>.38939</td>
<td>1.039</td>
<td>.155</td>
</tr>
<tr>
<td>body-consciousness</td>
<td>225</td>
<td>4.20</td>
<td>.00</td>
<td>4.20</td>
<td>1.8896</td>
<td>1.00393</td>
<td>.113</td>
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