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Help-Seeking Behavior Among Southeast Asian Refugees

Rita Chi-Ying Chung
National Research Center on Asian American Mental Health
University of California, Los Angeles

Keh-Ming Lin
Department of Psychiatry and Research
Center on the Psychobiology of Ethnicity
Harbor-UCLA Medical Center

This study examined the help-seeking behavior of Vietnamese, Cambodians, Lao, Hmong, and Chinese-Vietnamese refugees and compared the help-seeking patterns employed by these groups in their native country with those currently used after resettlement in the United States. There were three major findings: (1) intergroup differences in help-seeking behavior were found in Asia and also in the United States. In Asia, Vietnamese were more likely to utilize Western medicine and the Hmong least likely to do so. In the United States, Cambodians were more likely to utilize mainstream services and again the Hmong were less likely to do so; (2) for all groups there was a dramatic change from prominently utilizing traditional medicine in their home country to a higher usage of mainstream services in the United States; (3) regardless of the significant increase in the use of Western medicine, traditional medicine continued to be important for all five Southeast Asian refugee groups after resettlement. Furthermore, subjects from all five groups reported the use of a dual health care system both in Asia and the United States. The implications of these findings for community services and health care providers are discussed.

Since 1975, over 1 million Southeast Asian refugees have been resettled in the United States. As has been the case with other groups of displaced persons, research conducted in the past two decades has demonstrated that Southeast Asian refugees often experience difficulties in re-adjustment (Beiser, Turner, & Ganesan, 1989; Lin & Masuda, 1983; Lin, Masuda, & Tazuma, 1982; Lin, Tazuma, & Masuda, 1979; Owan et al., 1985), and are at a greatly increased risk for the development of serious psychiatric disorders (Kinzie, Tran, Breckenridge, & Bloom, 1980; Kinzie, Frederickson, Ben, Fleck, & Karls, 1984; Mollica & Lavelle, 1988). The psychiatric care of refugee clients poses significant challenges to the mental health care system. One of the major issues in this regard has been the often substantial discrepancy in the cultural conceptualization of mental health problems between Southeast Asian refugees and mental health professionals. Researchers have reported that most Southeast Asian refugees are unfamiliar with Western mental health concepts (Kinzie, 1985; Lin & Masuda, 1983), and are still deeply influenced by a multitude of indigenous cultural beliefs and practices that significantly affect the symptom presentation, conceptualization, and the help-seeking behavior of this group

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(Van Deusen, 1982; Vignes & Hall, 1979). Such culturally shaped beliefs and practices profoundly influence clients' coping mechanisms, utilization of services, satisfaction, and other clinical outcomes (Borkan, Quirk, & Sullivan, 1991; Kleinman, 1988a, b; Weiss, et al., 1992). An adequate understanding of these issues thus is crucial for providing effective mental health care for Southeast Asian refugee clients.

With a few remarkable exceptions (Kinzie, 1985; Tung, 1983), health beliefs and help-seeking behavior have not been the focus of research attention in regard to Southeast Asian refugees. However, their clinical significance can be easily inferred from studies conducted in other populations. Recent studies have consistently indicated that, contrary to the beliefs of most health care professionals, alternative or unconventional health methods continued to be extensively utilized in many communities, including mainstream Western societies. For example, based on findings from their recent study, Eisenberg and associates (1993) estimated that one in three persons in the U.S. adult population used alternative care. Very often they combined conventional treatment with alternative healing methods. In many cases, this is done without the awareness of their medical practitioner. Nearly half of those using alternative medicine self-treated and were not under the supervision of either a medical doctor or a provider of alternative medicine. The importance of the alternative healing system is also reflected by the fact that the "out of the pocket" expenses for the purchase of these services are quite substantial, approaching the total cost of regular outpatient services.

The utilization of "unconventional" healing methods is expected to be even more prominent in ethnic minority communities. Research on other refugee and immigrant groups has documented a strong tendency for members of these groups to continue to rely on traditional medicine and healing methods, and to underutilize mainstream services. This is especially true in the area of mental health, possibly due to cultural barriers, stigma, and the unavailability of services (Higginbotham, Trevino, & Ray, 1990; Lin, Inui, Kleinman, & Womack, 1982; Sue & Morishima, 1982). For example, studies on Mexican Americans (Higginbotham et al., 1990) have found that a large proportion of those surveyed frequently utilized *curanderismo* (folk medicine). As a consequence of the use of curanderismo, Mexican Americans tend to delay seeking medical care, often until the condition becomes critical. Those who use curanderismo were more likely to be males, foreign born, less educated, and with Spanish as their primary language. They also typically expressed dissatisfaction with mainstream services (Higginbotham et al., 1990).

Similar to their Mexican-American counterparts, Asians also show a tendency to use traditional medicine such as herbs and traditional healers. Chinese medicine is often used in addition to or in combination with Western medicine (Lin & Lin, 1978; Smith, 1982). Chinese in New York City's Chinatown showed a high prevalence of "shopping around" for medical care (Chan & Chang, 1976). This involved not only visiting different physicians within the Western medical system, but also sequential or simultaneous use of Western and traditional Chinese medicines. Chinese herbs were also used heavily as a form of self-treatment, because they were believed to have health-promoting and preventative qualities. The frequency of utilizing Chinese medicine was positively correlated with the age of respondents and negatively correlated with the number of years the respondents have been in the United States. Older females who were recent immigrants with little education were more likely to use Chinese medicine. In contrast, young American-born males with higher education used significantly less Chinese medicine than

others. Acculturation evidently played a part in the preference of Western methods. English-speaking ability, occupation, health insurance, and religion were not significantly related to the usage of Chinese medicine (Chan & Chang, 1976; Lin & Lin, 1978).

Although it is important to attain an adequate understanding of the health beliefs and help-seeking behaviors of the Southeast Asian refugees by service providers, empirical research in this regard has been scarce. In order to begin to bridge this gap, this study examines the help-seeking behavior of five Southeast Asian groups—Vietnamese, Cambodians, Lao, Hmong, and Chinese Vietnamese—and investigates the differences in the help-seeking behavior in their home country and in the United States.

Method

Data for this study were originally collected by the California Southeast Asian Mental Health Needs Assessment project (Gong-Guy, 1986). It is one of the largest statewide community studies ever conducted on Southeast Asian refugees.

Sample

The participants in the study consisted of adults between the ages 18 to 68 (median age 35), drawn from Southeast Asian refugee communities residing in nine counties in the state of California. The counties accounted for 90% of the Southeast Asian refugee population in the state of California. The sample ($N = 2,773$) consisted of Vietnamese ($N = 867$), Cambodians ($N = 590$), Lao ($N = 723$), Hmong ($N = 302$), and Chinese Vietnamese ($N = 291$). The respondents have lived in the United States for an average of 6.1 years. The Vietnamese were the most highly educated and the Hmong were the least educated. Cambodians and Hmong reported the lowest level of literacy in their own language and in English. When the respondents were asked their occupation prior to leaving their native countries, nearly half (48%) indicated no occupation. This was due to a large proportion (60%) of the women in the sample who were homemakers and reported that they had no occupation. The most common occupations indicated for each group were: military for the Vietnamese; farming/fishing for Cambodians, Lao, and Hmong; and sales/clerical for the Chinese Vietnamese. Over half (53%) of the respondents were originally from urban areas in Southeast Asia. Urban was defined as a city whose population is greater than 20,000 and rural was defined as towns or villages with fewer than 20,000 residents. Table 1 gives a detailed description of the demographic characteristics of each of the five groups.

Variables Examined

Help-seeking behavior in Asia and the United States. To examine differences in help-seeking behavior in their native countries and the United States, the respondents were asked: When you had a health problem while you were in Vietnam/Laos/Cambodia, did you go to a traditional practitioner (that is, healer and spiritualist), Eastern practitioner (that is, herbalist and acupuncturist), or Western medical doctor (that is, those who practice the Western form of medicine)? The same question was repeated with "in the United States" replacing the Asian country.

Analyses

Data reduction. Frequencies were calculated for the three different health care categories (traditional practitioner, Eastern practitioner, and Western doctor) utilized in Asia. Overall, approximately 50% of the respondents reported utilizing Western medicine

Table 1
Demographic Characteristics

	Vietnamese (N = 867)	Cambodians (N = 590)	Lao (N = 723)	Hmong (N = 302)	Chinese Vietnamese (N = 291)
Females	359	300	300	138	142
Males	508	290	423	164	149
Median age	32	36	37	35	35
Years in U.S.	6.6	4.7	6.3	6.8	6.6
Years of education in Asia	11	6	7	3	8
Literate in own language (% fair or better)	96	67	82	38	78
Occupation in homeland					
% military	12	8	11	24	10
% professional/technical occupation	11	5	8	5	4
% sales/clerical	9	5	9	3	12
% blue collar services	10	3	6	3	4
% farming/fishing	5	34	18	28	6
Urban/rural background					
% urban	63	43	52	16	88
% rural	35	45	46	83	9
English language proficiency					
% cannot speak English	8	39	16	32	17

only, 8% utilized traditional practitioners only, 9% utilized Eastern practitioners only, and approximately 30% used a combination of the three health care systems. These were collapsed into two categories: (1) Western medicine only, and (2) traditional medicine, including all the other categories (utilization of either traditional or Eastern methods only, or in combination with Western methods).

Group comparisons. Logistic regressions were used to examine the intergroup differences between the Vietnamese, Cambodians, Lao, Hmong, and Chinese Vietnamese in their help-seeking behavior in Asia and the United States. Because different respondent characteristics might be related to, and thus confound help-seeking behavior, these characteristics (age, gender, educational level, and English proficiency) were entered in the regression analyses as controlling variables. Five separate logistic regression analyses were performed using the same variables but alternating each group as the baseline group.

Results

Help-Seeking Patterns in Asia

The results of the five regressions were similar in terms of the significant controlling variables. Therefore only the variables used in the analyses with the Vietnamese as baseline will be shown in the table, along with the results of the intergroup differences. Table 2 shows the estimated effects (odds ratio) and significance of each variable, controlling for the effects of all other variables for help-seeking behavior in Asia with the Vietnamese as baseline. The results showed that, across all five regressions, respondents with a high level of English proficiency, those who have received formal education, and younger respondents were more likely to utilize Western medicine in their home country.

Table 2
Estimated Effects (Odds

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Table 2
Estimated Effects (Odds Ratio) for Help-Seeking Variables Predicting Utilization Behavior in Asia

	Exp(B)
Variables[1]	
English proficiency (1 = excellent, 5 = very bad)	1.07***
Education level (0 = no education, 18 = Ph.D.)	.75***
Age	.99**
Gender (0 = males, 1 = females)	1.14
Ethnic group comparisons - Vietnamese (N = 867) baseline	
Cambodian (N = 590)	.70**
Lao (N = 723)	.82
Hmong (N = 302)	.10***
Chinese Vietnamese (N = 291)	.46***
Cambodian baseline	
Lao	1.18
Hmong	.14***
Chinese Vietnamese	.66**
Lao baseline	
Hmong	.12***
Chinese Vietnamese	.56***
Hmong baseline	
Chinese Vietnamese	4.68***

[1] Variables analyzed with Vietnamese as baseline group.
*$p < .01$; **$p < .001$; ***$p < .0001$.

Separate logistic regressions were performed with each group alternating as the baseline to examine intergroup differences. The results showed that after controlling for the confounding variables (age, gender, educational level, and English proficiency) significant intergroup differences emerged. In descending order, the percentage of each group utilizing Western medicine in their home country were Vietnamese (68%), Lao (53%), Cambodians (44%), Chinese Vietnamese (44%), and the Hmong (11%). Results of the logistic regression showed that Vietnamese had significantly higher odds, whereas Hmong had significantly lower odds of those utilizing Western medicine in their home country than did Cambodians, Lao, and Chinese Vietnamese (all $p < .001$). The Vietnamese had a higher probability of utilizing Western health care services in their home country than all the other groups, except for the Lao. No differences were found between the Cambodians and Lao in their utilization of Western health care services in their home country. However, both groups had a higher likelihood of utilizing Western medicine in their home country than the Hmong and Chinese Vietnamese. In turn, the Chinese Vietnamese were more likely to utilize Western medicine than the Hmong. The greatest intergroup difference was between the Hmong and all the other groups. In fact, the Chinese Vietnamese were four times, Cambodians seven times, Lao eight times, and Vietnamese ten times more likely to utilize Western medicine in their home country than the Hmong.[1] No gender differences were found within or between groups. The fact that

[1]These figures are calculated by taking the inverse of the odds ratio shown on Table 2.

there is a substantial overlap in the utilization of traditional and Western medicine in Asia strongly suggests that in general this refugee population, apart from the Hmong, was utilizing a dual health care system in Asia.

Help-Seeking Patterns in the United States

Again, similar results emerged for the five separate logistic regressions with each group alternating as the baseline group. Therefore only the variables used in the analyses with the Vietnamese as baseline will be shown in the table, along with the results of the intergroup differences. The findings (see Table 3) indicated that again younger respondents and those with a high level of English proficiency have a higher probability of utilizing Western medicine in the United States. After controlling for the confounding variables, significant intergroup differences still emerged. In descending order, the percentage of each group seeking Western medicine in the United States were Cambodians (88%), Lao (86%), Vietnamese (76%), Chinese Vietnamese (69%), and Hmong (56%). The results of the logistic regression showed that Cambodians were more likely to utilize Western medicine in the United States, whereas the Hmong were less likely to utilize Western medicine in the United States compared to Vietnamese, Lao, and Chinese Vietnamese. The Lao had significantly higher odds of utilizing Western medicine compared to Vietnamese, Chinese Vietnamese, and Hmong. In turn, Vietnamese were more likely to utilize Western medicine in the United States than Chinese Vietnamese and Hmong, and the Chinese Vietnamese were more likely to seek Western medicine than the Hmong. Once again the greatest disparity in help-seeking behavior in the United States was between the Hmong and the other groups, with the Chinese Vietnamese 1.6 times, Vietnamese 3 times, Lao 7 times, and Cambodians 12 times more likely to utilize Western medicine in the United States than the Hmong. No gender differences were found in the help-seeking patterns in the United States.

As expected there was a significant increase in the utilization of Western medicine in the United States for all groups. For the Cambodians the percentage (88%) of those utilizing Western medicine doubled. For the Hmong the use of Western medicine in the United States was five times greater than in Asia, however, this accounted for only 56% of this group. Surprisingly, 39% of the Hmong reported still utilizing traditional medicine in the United States compared to 25% Chinese Vietnamese, 16% Vietnamese, 7% Lao, and 5% Cambodians. The results indicate that although there is a dramatic increase in the utilization of Western health care services in the United States, traditional methods of health care continue to be important in postmigration. The overlap in the usage of traditional and Western health care methods suggests that all groups, especially the Hmong and Chinese Vietnamese, continued to utilize a dual health care system in the United States.

Discussion

Three major findings emerged from the study: (1) significant intergroup differences were found in the help-seeking patterns between the five groups in both Asia and the United States. In Asia, Vietnamese were more likely and the Hmong least likely to utilize Western medicine. In the United States, Cambodians were more likely to utilize mainstream services and again the Hmong were less likely to do so. (2) After resettlement a similar pattern emerged for all five groups, with a dramatic change in their help-seeking behavior from a dominant use of traditional medicine in Asia to the heavy usage of

Table 3
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Table 3
Estimated Effects (Odds Ratio) for Help-Seeking Variables Predicting Utilization Behavior in U.S.

	Exp(B)
Variables[1]	
English proficiency (1 = excellent, 5 = very bad)	.77***
Education level (0 = no education, 18 = Ph.D.)	1.02
Age	.99**
Gender (0 = males, 1 = females)	1.05
Ethnic group comparisons – Vietnamese (N = 867) baseline	
Cambodian (N = 590)	3.35***
Lao (N = 723)	2.03**
Hmong (N = 302)	.27***
Chinese Vietnamese (N = 291)	.44***
Cambodian baseline	
Lao	.61*
Hmong	.08***
Chinese Vietnamese	.13***
Lao baseline	
Hmong	.13***
Chinese Vietnamese	.21***
Hmong baseline	
Chinese Vietnamese	1.60*

[1] Variables analyzed with Vietnamese as baseline group.
*p < .01; **p < .001; ***p < .0001.

mainstream services in the United States. (3) However, although there was a significant increase in the use of Western medicine, traditional medicine continued to be important for all groups after resettlement. Furthermore, this refugee population reported using a dual health care system in both Asia and the United States.

The intergroup differences in the utilization of health care services in Asia could be attributed to the degree of exposure to Westernization and the availability of Western medicine. Vietnamese were more likely to utilize Western medicine in their native country than the other groups. This could be partially attributed to Western medical practices introduced to Vietnam by the French colonials. The relatively longer exposure of Vietnamese to the French culture may have made them more familiar with Western medicine. Western influence was also enhanced during the Vietnam war, especially to those who were in contact with Western allies, as well as those who may have been treated by Western medicine in refugee camps. Furthermore, the Vietnamese in this study were highly educated, had a high level of literacy in their own language, only 8% reported they could not speak English, and 63% reported they lived in urban areas in Vietnam.

In contrast, although 88% of the Chinese Vietnamese in this study also lived in urban areas and possibly experienced similar exposure to Westernization as their Vietnamese counterparts, they were, however, less likely to seek Western medicine in Vietnam compared to Vietnamese, and also compared to the Cambodians and Lao. The reason for this is not entirely clear. However, as descendants of recent emigrants from China, they may have been more insulated from direct influence of the French and other

Western cultural influences. The minority status they occupy in Southeast Asia may have contributed to their greater adherence to their traditional Chinese cultural beliefs and values, which in turn influence their preference in traditional over Western health care methods.

Western health professionals were scarce in Cambodia and Laos prior to 1975. Therefore, it was expected that Cambodians, Lao, and Hmong would tend to rely on indigenous healers and folk medicine (Muecke, 1983; Yeatman & Dang, 1980). As expected, the findings showed that the Hmong were the least likely to utilize Western medicine compared to the other groups. Eighty-three percent of the Hmong in this study came from rural areas in Laos and therefore may have little exposure to Westernization and the availability of Western medicine. Also 38% reported a low level of literacy in their own language and a third reported they cannot speak English. Therefore it was not surprising to find a high percentage (85%) of Hmong who reported utilizing traditional medicine compared to the other groups. Just over half of the Chinese Vietnamese (53%) and under half of the Cambodians (48%), 41% of Lao, and 29% of Vietnamese sought similar help in Asia.

Unexpectedly, however, under half of the Cambodians and over half of the Lao reported utilizing Western medicine in their home country. Again, Westernization as a result of the war may be an explanation for this, because 43% of the Cambodians and 52% of the Lao came from urban areas in their home country. Furthermore, the Lao in this study were fairly well-educated, had a high level of literacy in their own language and only 16% reported that they could not speak English. In addition, military occupation was the second most commonly endorsed occupation for this group and 23% reported that they were in blue-collar, technical, or professional occupations in Laos. English proficiency, educational level, and age were also significant predictors for utilizing Western medicine in Asia. The findings suggest that the educated, younger people and those with English proficiency acculturated at a greater pace and therefore sought Western medicine compared to traditional medicine in Asia.

As expected, English proficiency and youth were also significant predictors for utilizing Western medicine in the United States. English proficiency is often a prerequisite for utilizing Western medicine in the United States where many of the mainstream services do not have translators or bilingual/bicultural staff. Although children may act as translators for the family this is not necessarily an effective method of communicating with health care professionals.

Significant gender differences within and between groups in help-seeking behavior in Asia and the United States were not found. However, a pattern did emerge that suggested that for all groups, women tend to utilize more traditional medicine compared to their male counterpart in both Asia and the United States. A partial explanation for this is that refugee women also reported having received less education, and a lower level of literacy in their own language and in English compared to their male counterparts. Furthermore, studies have found that Southeast Asian refugee women report a significantly higher level of distress than refugee men (Chung & Kagawa-Singer, 1993; Mollica, Wyshak, & Lavelle, 1987). Although no significant differences were found in their help-seeking pattern, it is, however, important to take into consideration that there is a tendency for refugee women to utilize traditional methods over Western methods of health care.

Significant intergroup differences were also found in help-seeking behavior in the United States. In fact, these intergroup differences became more extreme after

resettlement. The greatest intergroup disparity in help-seeking behavior was again between the Hmong and the other groups. Cambodians were more likely and the Hmong were least likely to utilize Western medicine after resettlement. Although intergroup differences in help-seeking behavior were found, all five groups exhibited a similar help-seeking pattern. That is, for all groups there was a dramatic change in health care utilization after resettlement, with a significant increase in the utilization of mainstream services. For example, utilization of Western medicine doubled for Cambodians and was five times greater for the Hmong in the United States compared to Asia. The dramatic increase in the heavy usage of mainstream services may reflect the high level of distress displayed by this refugee population due to their premigration experiences, and therefore the need for services. For example, Cambodians were more likely to utilize Western medicine than all other groups. This may be partially explained by the fact that Cambodians as a group exhibit a higher level of distress than other Southeast Asian refugee groups (Chung & Kagawa-Singer, 1993; Mollica et al., 1987).

Although there was a significant increase in the usage of Western medicine for all five groups, the findings also showed that traditional health care methods still continued to be important after resettlement. For example, although the Hmong reported using Western medicine five times more in the United States than in Laos, nearly 40% of the Hmong respondents reported that they still utilize traditional medicine in the United States. A possible explanation for this is that unlike other Southeast Asian refugee groups, the Hmong have strongly resisted acculturation and have strongly maintained their culture (Arax, 1993).

Whereas traditional medicine for Chinese Vietnamese and Vietnamese in the United States may be available through Chinatowns or areas with large Chinese communities, it is at present unclear as to the nature and sources of the traditional health care methods that are utilized by the other refugees. The findings, however, do clearly show that the utilization of traditional medicine in the United States is still highly prevalent for all five groups studied, and suggest that this refugee population utilize a dual health care system in the United States that consists of both traditional and Western health care methods.

One in three Americans also utilize a dual health care system. This group tends to be in the 25–49 age range and includes individuals who have a higher education and income. The main reason for utilizing alternative or unconventional medicine is due to the dissatisfaction with the medical establishment (Eisenberg et al., 1993). In comparison, the utilization of traditional medicine by Southeast Asian refugees is due to cultural conceptions of illness and therefore they seek traditional methods of healing. Regardless of the reasons for seeking traditional or unconventional medicine, both groups tend not to disclose the fact that they are utilizing a dual health care system to their medical practitioners. Many self-treat, therefore using alternative medicine unsupervised.

The data clearly demonstrate an immense need for services by Southeast Asian refugees resettled in the United States. At the same time, the dramatic change in help-seeking behavior also suggests that traditional methods used in Asia may have become less available in the United States. For instance, many Cambodian traditional health care providers, including monks, were killed during the Pol Pot regime. Because of this, for many Cambodians resettled in the United States, Western medicine may be the only alternative.

The findings in this study have important implications for health care providers. One of the questions that needs to be addressed is how effective are the mainstream services in treating the Southeast Asian refugee population. High utilization of mainstream

services does not necessarily reflect effective treatment outcome, especially in view of the high dropout rate from mainstream services exhibited by Asian Americans. Instead, the high utilization may reflect a desperate need for services and not necessarily the satisfaction or preference of health care methods.

Furthermore, health care professionals should not ignore that Southeast Asian refugees utilized, and most likely will continue to utilize, a dual health care system. They must also recognize, acknowledge, and accept the fact that many of them may prefer traditional health care methods. Eisenberg et al. (1993) stated that health care professionals mistakenly assume that their clients do not use unconventional medicine for serious problems and strongly suggested that health care professionals need to ask their clients routinely about the usage of alternative medicine. Eisenberg further stated that failure to communicate may have negative effects. For example, the use of unconventional methods may at times interact with biomedicine in an unpredicted manner, and lead to harmful results.

To understand the needs of this refugee population fully and to begin to provide effective services, health care professionals need to be aware of cultural differences in the conceptualization of mental health and the influence it has on help-seeking behavior and expectations on treatment outcome. It is also necessary to realize how difficult it is for individuals with strong cultural adherence to adjust to the American way of life. An understanding of the circumstances that led this group to arrive in the U.S. as refugees is also necessary as well as the recognition of intergroup differences within this population. Health care professionals should also maintain and strengthen their efforts to deal with linguistic, cultural, and intergroup differences in order to provide effective services.

Southeast Asian refugees are often categorized as one group, and although these different cultural groups share similar characteristics and experiences, differences, however, do exist that should not be ignored. Health care programs need to be specifically tailored to individual groups in order to address these intergroup differences. For example, the Hmong and Cambodians were the less educated and reported the lowest level of literacy in their own language and English. They also had the least exposure to Western ideas and concepts. Although their utilization of mainstream services significantly increased after resettlement, a high percentage also reported utilizing traditional medicine. To reduce the cultural barriers between traditional and Western health care methods this population needs to be better acquainted with Western methods. Outreach and educational programs need to be directed at this group to educate them on Western health care methods, the type and availability of health care services, and to promote the understanding of the Western health care system particularly as it relates to traditional concepts. Many refugees may not know what is available to them; this is especially true for those who have newly arrived and are not familiar with the American health care delivery system.

Lin (1980) stated that cultural barriers to Western methods are not due solely to indigenous health beliefs, but more important, through these concepts and categorization, the Asian culture continues to influence the way symptoms are perceived, expressed, and reacted to. Community leaders need to be identified to assist Western health care professionals in understanding cultural differences in symptom expression and treatment methods used by traditional health care professionals. With this knowledge one can bridge the gap between Western and traditional Asian methods. Understanding of these cultural beliefs is the key to the indigenization of Western health care services in Southeast Asian refugee settings, and the successful planning and provision of culturally appropriate

mental health services for Southeast Asian clients (Lin, 1980). Through understanding and accepting these differences, culturally responsive services can be established.

In summary, significant intergroup differences were found within the Southeast Asian refugee population in their help-seeking behavior in Asia and the United States. After resettlement, all groups displayed a dramatic increase in the utilization of mainstream services. However, there was still a strong preference for traditional methods of health care. The high usage of mainstream services in the U.S. is consistent with studies that have found this population to exhibit a high level of distress due to their premigration experiences, and highlight the need for services by this population. The significant increase in the use of mainstream services may be attributed to the unavailability of traditional health care services in the United States and the dominance of Western health care services in their setting as a major source of health care. The findings clearly showed that the Southeast Asian refugees in this study utilized a dual health care system, which consisted of traditional and Western health care methods.

The findings of this study have direct implications for mental health professionals and services. It is crucial for mental health professionals to acknowledge and accept that Southeast Asian refugee groups may utilize a dual health care system in the United States. To be effective, they must ask their clients about the usage of alternative medicine, as well as attaining knowledge of these traditional methods in order to bridge the gap between Western and traditional techniques. Only then will effective services and successful treatment outcome occur.

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