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Preferences for Depression Help-Seeking among Vietnamese American Adults

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Abstract

Culture impacts help-seeking preferences. We examined Vietnamese Americans' help-seeking preferences for depressive symptoms, through a telephone survey (N=1,666). A vignette describing an age- and gender-matched individual with depression was presented, and respondents chose from a list of options and provided open-ended responses about their help-seeking preferences. Results showed that 78.3% would seek professional help, either from a family doctor, a mental health provider, or both; 54.4% preferred to seek help from a family doctor but not from a mental health provider. Most (82.1%) would prefer to talk to family or friends, 62.2% would prefer to look up information, and 50.1% would prefer to get spiritual help. Logistic regression analysis revealed that preferences for non-professional help-seeking options (such as talking to friends or family, looking up information, and getting spiritual help), health care access, and perceived poor health, were associated with increased odds of preferring professional help-seeking. This population-based study of Vietnamese Americans highlight promising channels to deliver education about depression and effective help-seeking resources, particularly the importance of family doctors and social networks. Furthermore, addressing barriers in access to care remains a critical component of promoting professional help-seeking.

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Compliance with Ethical Standards

The authors declare that they have no conflicts of interest. All study procedures performed in studies involving human participants were in accordance with the ethical standards of the institution and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. All study procedures were approved by the University of California San Francisco Institutional Review Board, and all study participants provided informed consent.

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Keywords

help-seeking; depression; Vietnamese Americans; mental health

Introduction

Depression is a leading cause of disability worldwide, and lack of timely help-seeking contributes to the burden of illness (World Health Organization, 2012). The mental health literacy framework seeks to promote help-seeking by increasing knowledge and recognition of mental health issues on a community-wide basis (Jorm et al., 1997). Although this promising strategy has garnered increasing attention over the past two decades across numerous population groups around the world, mental health literacy was initially conceptualized from, and still largely maintains, a Western perspective of mental illness and help-seeking. A culturally informed framework for mental health literacy that considers the cultural complexities relevant to Asian groups, including cultural variations in preferences for help-seeking, is needed (Na, Ryder, & Kirmayer, 2016; Picco et al., 2016). For example, while it is well documented that Asian Americans as a whole tend to underutilize professional mental health services in relation to their level of need (Abe-Kim et al., 2007; Alegria et al., 2008; Meyer, Zane, Cho, & Takeuchi, 2009; Sue, Cheng, Saad, & Chu, 2012), less work has emphasized understanding personal preferences for help-seeking and handling mental health problems. Understanding preferences is needed to develop community education and outreach efforts that address mental health issues in ways that are culturally relevant and acceptable. In this study, we examine help-seeking preferences for depression among Vietnamese Americans.

The racial category “Asian American” includes national origin groups that are highly distinct in language, culture, and history. As a group, Vietnamese Americans’ health and culture are shaped primarily by the Vietnam War and the multiple waves of refugees and immigration resulting from the end of the war in 1975. Approximately 85% of Vietnamese American adults are foreign-born and 60% have limited English proficiency (Pew Research Center, 2012). Vietnamese Americans have faced unique pre- and post-migration stressors that have impacted their mental health; this largely includes experiences of war-related trauma, posttraumatic stress, resettlement challenges, and acculturative stress (Birman & Tran, 2008; Leung, Cheung, & Cheung, 2010; Ramos, Jones, Shellman, Dao, & Szeto, 2016). A population-based study of Vietnamese refugees in Australia found that greater exposure to trauma was associated with psychiatric disorders (Steel, Silove, Phan, & Bauman, 2002). In the United States, high rates of clinical depression have been reported among Vietnamese refugees in community and primary care settings, ranging from 30% (Leung et al., 2010; Tran, Manalo, & Nguyen, 2007) to 50% (E. H.-B. Lin, Ihle, & Tazuma, 1985). War-related trauma has been a pervasive and deeply rooted theme in Vietnamese history, affecting not only the mental health of older generations who have directly experienced war-related traumatic events, but also affecting younger generations through intergenerational transmission of trauma (Maffini & Pham, 2016). For example, a cohort study of Vietnamese refugees and their children in Norway reported that paternal mental health, particularly symptoms of posttraumatic stress at the time of resettlement, was

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predictive of children's mental health symptoms more than 20 years after resettlement (Vaage et al., 2011).

Many Vietnamese Americans tend not to seek professional mental health services even when experiencing significant problems. The 2002–2003 National Latino and Asian American Study (Alegria et al., 2004)—currently the only nationally representative epidemiologic study of Asian Americans—showed that less than half of Vietnamese Americans with probable psychiatric disorders used any mental health-related services, including specialty mental health and general medical services (Abe-Kim et al., 2007). According to a 2011 needs assessment survey conducted in Santa Clara County, California—a county with a high proportion of Vietnamese Americans—40% of Vietnamese adult respondents reported that emotional problems interfered "some" or "a lot" with work and relationships in the past 12 months. Of those who reported that emotional problems interfered "a lot," 76% did not perceive a need to see any type of health professional (Santa Clara County Public Health Department, 2011). This may be in part due to concerns regarding stigma and "face," or the importance of the respect of others (Fancher, Ton, Le Meyer, Ho, & Paterniti, 2010), but also important cultural variations in conceptualizations of mental health and expressions of psychological distress (Silove, Steel, Bauman, Chey, & McFarlane, 2007). For example, Vietnamese refugees in Australia reported greater physical disability from posttraumatic stress compared to the general Australian sample that reported greater mental disability (Silove et al., 2007).

Given relatively low rates of professional help-seeking for mental health problems, there is a need to examine a broader range of help-seeking preferences, beyond professional mental health care. This is the first step towards informing the development of effective and culturally appropriate strategies for mental health promotion and community education on mental health issues. In this study, we examined professional and non-professional help-seeking preferences for depression among a population-based sample of Vietnamese American adults, drawn from two geographic areas of the U.S. We focused on depression because it is one of the most common mental health problems. A survey of Medicare beneficiaries reported that a greater proportion of Vietnamese Americans screened positively for depression (21%) compared to other Asian American groups (ranging from 13%-18%), including Asian Indians, Chinese, Filipinos, Japanese, and Koreans (Centers for Medicare and Medicaid Services Office of Minority Health and Health Services Advisory Group, 2017). Moreover, in a clinical sample of Vietnamese Americans seeking professional mental health services, nearly two-thirds (62%) reported depression as the primary reason for help-seeking (Akutsu & Chu, 2006). Our study goals were twofold: to examine the range of personal help-seeking preferences for depression, and to examine factors associated with professional help-seeking preferences for depression.

Methods

Study data were derived from a population-based telephone survey conducted by researchers at the University of California San Francisco, as part of a larger health promotion study among Vietnamese Americans (T. T. Nguyen et al., 2010). To summarize, respondents were recruited from two metropolitan areas with a relatively high population of Vietnamese

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Americans: the San Francisco Bay Area and the Greater Washington DC area. A list of 55 Vietnamese surnames was used to obtain a simple random sample of telephone numbers in listed directories. This is an established method of obtaining a representative sample in this population (T. T. Nguyen et al., 2010; V. M. Taylor, Nguyen, Hoai Do, Li, & Yasui, 2011), as the 55 surnames account for over 95% of Vietnamese living in the U.S. (Lauderdale & Kestenbaum, 2000; Swallen et al., 1998). Respondents were eligible to participate if they (a) self-identified as Vietnamese, Vietnamese American, or Chinese-Vietnamese, (b) were aged 18 to 64, (c) resided in either geographic area, and (d) were able to respond in Vietnamese or English. The study was approved by the university institutional review board, and data were collected between February and June 2011.

The surname method yielded an initial sample of 12,063 telephone numbers. Of these, 3,768 (31.2%) were ineligible to participate (e.g., did not meet inclusion criteria or the telephone number was invalid) and 5,994 (49.7%) could not be reached or screened for eligibility during the study period. From the 2,301 reachable and eligible households, 1,666 respondents (72.4%) provided consent, completed the survey, and are included in the current analysis. Of the remaining 635 respondents who were not included in the study, 521 (22.6%) were not available for the study period and 114 (5.0%) refused participation. Computer-Assisted Telephone Interview (CATI) surveys were conducted by 14 trained bilingual interviewers. More detailed sampling information is published elsewhere (Chu et al., 2017).

Measures

Sociodemographic characteristics included age, gender, marital status, educational level, language proficiency (English and Vietnamese), number of years living in the U.S., employment status, health insurance coverage status, and self-reported general health.

To assess help-seeking preferences for depression, interviewers read a clinical depression vignette. The vignette, originally developed by Jorm et al. (1997), was adapted by the research team for cultural relevance; it was piloted with 12 Vietnamese-speaking men and women with ages ranging from 20s to 70s in the San Francisco Bay Area. The adapted vignette depicted an individual who was age- and gender-matched to the respondent, and used a gender-neutral name in Vietnamese ("Linh"). The script was as follows: "I would like to read you a hypothetical story: [Mr./Ms.] Linh is about your age. [S/he] has been feeling unusually sad for the last few weeks. [S/he] is tired all the time and has trouble sleeping. [S/he] has lost [her/his] appetite, becomes irritable easily, and no longer enjoys doing things [s/he] used to enjoy. [S/he] has trouble concentrating. Even day-to-day tasks seem too much for [her/him]. If you were in [her/his] situation, what would you do? I will read you a list of actions; please tell me whether or not you would do each of the following." The seven answer choices included "do nothing about the situation," "talk to your family or close friends," "look up information, for example from the Internet or a book," "get spiritual help, for example go to church or temple," "see a psychiatrist or a mental health counselor," "see your family doctor," and "do something else." Respondents could endorse multiple options, and those who selected "do something else" were prompted to further provide an open-ended response.

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Analysis

The distribution of responses were examined and summarized. Two authors (JEKM and JYT) content-analyzed the open-ended responses provided by participants who selected "do something else." The first author developed the initial categories and coded responses into these categories. The second author refined the categories, and using an iterative process, both authors simultaneously reviewed the coding until consensus was reached on all responses. Multivariable logistic regression analysis was used to examine factors associated with the binary outcome of preferring professional help-seeking for depression, operationalized as seeking help from a specialty mental health provider (i.e., see a psychiatrist or a mental health counselor) and/or a general medical provider (i.e., see your family doctor). We combined these two types of professional help-seeking, as there were very few respondents who preferred seeing a mental health provider exclusively. As independent variables, the model contained demographic characteristics, including geographic location, gender, age, English and Vietnamese language fluency, education level, self-reported health, and health care access variables (i.e., insurance coverage status and having a usual source of health care), and the non-professional help-seeking preferences.

Results

Participant Characteristics

Table 1 displays the sociodemographic characteristics of the study respondents. Over half were women, and the mean age was 48 years ($SD = 12$). Most respondents were born in Vietnam, married, employed either full-time or part-time, had health insurance coverage, and had a usual source of health care (or a regular place to go to for health care). Over two-thirds reported limited English fluency, and respondents most often reported that their health was "good" or "fair."

Help-Seeking Preferences

Table 2 displays the frequencies of participants' help-seeking preferences for depression. Talking to family or close friends was most commonly preferred, followed by seeing a family doctor, looking up information, and getting spiritual help. Less than a quarter of the participants preferred to see a psychiatrist or a mental health counselor. Nearly half (46.8%, $n = 779$) selected doing nothing, but even among them, 95.6% selected other responses with the most frequent responses being talking to family or close friends (79.5%) and seeing a family doctor (75.0%). On average, participants endorsed 3.7 responses ($SD = 1.4$, range = 0–7, median and mode = 4). Very few respondents (5.5%) selected only one response, and 1.1% did not select any response. Of those who selected one or more responses, only 2.1% exclusively selected that they would do nothing about the situation. In other words, 97.9% indicated that they would seek some type of help or do something else about the situation.

In terms of professional help-seeking preferences, 78.3% selected seeing a family doctor and/or a mental health professional (data not shown in Table 2). One in five (21.7%) preferred to see both a family doctor and a mental health provider. Among the 23.9% preferring to see a mental health provider, 90.7% simultaneously indicated that they would see a family doctor. Over half (54.4%) preferred to see a family doctor but not a mental

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health provider, and very few (2.2%) preferred to see a mental health provider but not a family doctor.

One-third of participants also indicated they would "do something else." These 553 participants gave a total of 845 open-ended responses, with a mean of 1.5 responses (SD = 0.8, range = 1–5, median and mode = 1) per participant. As summarized in Table 3, the most frequent response category was related to engaging in exercise or sports to deal with depression, followed by hobbies or other activities. For other open-ended responses that did not fit into any major category, we grouped them by whether participants' responses were specific or non-specific. Only three respondents specifically mentioned that they would engage in negative coping strategies related to substance use, and we note that the majority of the non-specific responses were goal-directed towards making changes (e.g., "change life habits").

Factors Associated with Professional Help-Seeking Preferences

The results from the logistic regression analysis in Table 4 showed that factors related to health care access (i.e., health insurance coverage and having a usual source of care) were associated with increased odds of preferring professional help-seeking from a mental health provider and/or a family doctor. Preferring non-professional help-seeking options, such as talking to family or close friends and looking up information, were also associated with increased odds of preferring any professional help-seeking. Individuals who selected "do something else", however, were about half as likely to prefer professional help-seeking compared to those who did not select that option.

Discussion

Understanding cultural preferences for help-seeking is an initial step towards developing effective community education and outreach efforts for mental health promotion in culturally diverse populations. This population-based study of Vietnamese Americans examined a range of help-seeking preferences for depression including both professional and non-professional venues. The findings showed nearly 98% of all participants would seek help or do something for symptoms of depression, and that most would seek help from family and social networks or from health professionals. In terms of professional help-seeking, most preferred to see a family doctor, and less than one-quarter preferred seeing a psychiatrist or a mental health counselor. The findings presented here highlight the important roles of social networks and family doctors in the process of help-seeking and dealing with mental health problems.

Contrary to the limited research available in the literature, almost all of the participants in this survey would seek help or do something for depressive symptoms. Explanations for this difference may include the fact that we used a case scenario with symptoms rather than ask about depression directly, thus removing possible stigma preventing people from seeking help. This was presented as a hypothetical scenario rather than the respondent responding directly to his or her own situation, and respondents could choose multiple options. However, our findings also raise the possibility that the assumption that Vietnamese

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Americans do not recognize or seek help for depressive symptoms may be erroneous, or at the very least, have changed over time.

Across cultures, relying on social support is a frequently preferred and effective strategy to cope with stressors (H. S. Kim, Sherman, & Taylor, 2008). However, there are some cultural variations in its meaning, use, and value (Chang, Chen, & Alegría, 2014; H. S. Kim et al., 2008). Prior research has found that Asian Americans, compared to European Americans, tend to prefer implicit social support that is focused on the awareness of the existence of a social network, rather than directly seeking advice (S. E. Taylor et al., 2004). One study reported that Asian American participants experienced greater psychological and biological stress reduction from this implicit (e.g., focusing on belongingness to valued social groups) versus explicit support (e.g., directly seeking advice from close others) (S. E. Taylor, Welch, Kim, & Sherman, 2007). This may be due to the cultural emphasis on maintaining intergroup harmony, which discourages overburdening others with one's problems (Chang, 2014). Although the current data do not provide information about the type of social support that Vietnamese Americans would seek for depression, the findings do suggest that leveraging social networks is a promising area for efforts aimed at mental health promotion. A key component of mental health literacy involves the ability to effectively identify and support others who are struggling with mental health problems (Jorm, 2012). As talking to family and friends was the most commonly preferred strategy, this finding has implications in developing and testing culturally tailored community mental health literacy programs.

Emphasizing community mental health requires consideration of cultural conceptualizations of mental health and treatment for mental health problems. In Vietnamese communities, depression may be perceived as personal weakness (Fancher et al., 2010) and is often viewed as similar to other more severe and more stigmatized mental illnesses such as schizophrenia. In this study, most participants preferred to see a family doctor over a mental health professional, which may be associated with the stigma of mental health problems. Thus, alongside stigma reduction efforts, it is important to acknowledge the possibility that Western conceptualizations of depression and models of depression treatment are incongruent with the cultural norms and values of many Vietnamese Americans. Qualitative research has indicated that Vietnamese community members tend to view depression as problems associated with social functioning (e.g., unable to work) versus a mental health problem (Fancher et al., 2010). In terms of mental health treatment, particularly psychotherapy, one study found that Asian American participants (including Vietnamese Americans) experiencing moderate to serious psychological distress tended to perceive psychotherapy as less credible, and self-disclosure to a therapist as less helpful, than White American counterparts, and these factors partly explained racial/ethnic differences in help-seeking intentions (J. E. Kim & Zane, 2016).

Another possible explanation for preferring to see family doctors is cultural variations in expression of distress, such that Vietnamese individuals may experience depression primarily through somatic symptoms, which would influence help-seeking preferences (Niemi, Målqvist, Giang, Allebeck, & Falkenberg, 2013). Furthermore, the lack of access to a culturally and linguistically congruent mental health provider may play a role. As primary care settings can be effective in treating depression (Linde et al., 2015), healthcare providers

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who are not specifically trained as mental health professionals may benefit from increasing awareness of help-seeking preferences of Vietnamese Americans and members of other diverse groups, and to dialogue with patients about depression in culturally acceptable and non-stigmatizing ways (Epstein et al., 2010; Fancher et al., 2010). Family doctors play another key role through appropriate referrals to specialty mental health services (e.g., through primary care and behavioral health integration). This may enhance individuals' perceptions of credibility and helpfulness of mental health services, given that the recommendation originated from one's preferred source of professional help-seeking and access is more convenient. Nonetheless, with over 80% of respondents willing to seek help from health professionals and with the association between health insurance and preferring to seek help from professionals, we underscore the need for improved access to care. Structural factors, such as insurance coverage and financial access, remain important barriers to care that must be addressed through the broader policy discourse (Snowden & Yamada, 2005).

Non-professional preferences, which include talking to friends or family, getting spritiual help and looking up information, were associated with increased endorsement of professional help-seeking. The current results are partly congruent to a previous study examining a representative sample of Asian Americans with psychiatric disorders, reporting that the use of alternative services (e.g., services provided by religious advisors, healer, doctors of Oriental medicine, chiropractors, or spiritualists) was associated with increased utilization of specialty mental health services (Meyer et al., 2009). These initial results add to the existing evidence about the importance of understanding informal networks, particularly faith communities, as important sources of support for mental health problems (Leung et al., 2010). The findings also highlight the possibility that individuals who are motivated to seek help will leverage multiple resources.

One-third of the participants responded that they would "do something else." These participants were less likely to endorse professional help-seeking compared to those who did not select this response. The content analysis showed that many preferred to engage in activities that are generally helpful for symptoms of depression, such as exercising, doing enjoyable activities, and seeking relaxation (Jorm, 2012). This could suggest that relying on these types of self-help strategies reduces the perceived need to seek professional help. Another possibility is that the stigma associated with professional help-seeking may increase preference for self-help methods. This warrants further investigation, as we were unable to assess concerns about stigma in the present study.

Nearly half of the participants responded that they would "do nothing," but this response was not significantly associated with professional help-seeking. Of note, among these individuals, the majority also responded that they would talk to family or friends and see their family doctor. The suggests that while individuals understand the need for getting help for depression, many also would consider passive approaches to dealing with depressive symptoms, such as assuming that problems will resolve on their own (Leung, Cheung, & Tsui, 2012). This might also help explain the broader tendency of Asian Americans to delay seeking help (K. Lin & Cheung, 1999). A plausible methods-related explanation for both the

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null finding and for the high overlap of other responses is the order in which responses were presented to participants, and we acknowledge that an order effect cannot be ruled out.

There are additional limitations to consider. The assessment was based on a hypothetical vignette describing an individual with clinical depression, which we attempted to make more personally relatable and minimize biased responses or refusals due to mental health-related stigma. As these data are self-reported and cross-sectional, we presume that participants' indicated help-seeking preferences would match actual behaviors in similar real-life situations. Many participants selected multiple preferences, and we cannot determine which was the most preferred. Our investigation was to approximate the types of behaviors that one would undertake in similar mental health-related situations, covering both professional and non-professional help-seeking preferences. Our data are also limited, as we do not have information about respondents' personal experiences with depressive symptoms, their use of mental health services, their levels of mental illness and help-seeking stigma, and acculturation-related variables, which would influence help-seeking preferences. Although prior findings have indicated that acculturation does not appear to have a direct effect on help-seeking, it may operate through related variables, such as face concern or adherence to Asian cultural values (Liao, Rounds, & Klein, 2005). It would be informative in future work to assess these areas. In prior studies using similar vignettes (J. E. Kim, Saw, & Zane, 2015), participant misrecognition of depression was associated with lower endorsement of professional help-seeking. Thus it would be important for future work to examine whether accurate depression recognition is associated with various help-seeking preferences in this population.

Effective outreach channels to engage Vietnamese Americans with depression and other mental health needs are currently lacking. These initial findings have implications in informing the next steps to developing such programs. Our results showed that preferring to seek help from non-professional sources was associated with increased likelihood of preferring professional help-seeking, independent of health care access or general health, and particularly, the role of family and friends appears to be crucial. Moreover, culturally acceptable and appropriate mental health outreach programs may emphasize psychoeducation on depression by couching it within a general health education curriculum versus a mental health-specific curriculum. Delivering information through settings that are less formal or community-based, such as through community or lay health workers who are members of the Vietnamese community and have good understanding of cultural sensitivity, as found to be effective in promoting cancer prevention screening and tobacco cessation (Mock et al., 2007; B. H. Nguyen, Stewart, Nguyen, Bui-Tong, & McPhee, 2015; T. T. Nguyen et al., 2009; Tsoh et al., 2015), is also a promising strategy. Moreover, mental health service agencies and providers may consider partnering with community organizations and faith-based communities to establish trusted members of the Vietnamese community as cultural brokers. Overall these findings highlight that leveraging social support, self-help resources, and faith communities are promising outreach channels to deliver education about depression and effective help-seeking resources for Vietnamese Americans. These outreach activities should be conducted alongside broader efforts at the policy level to reduce structural barriers in access to care.

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Table 1

Sociodemographic Characteristics of Vietnamese American Adult Survey Respondents (*N* = 1,666)

Sociodemographics	*n*	%
Gender		
Male	693	41.6
Female	973	58.4
Age range		
18–35	222	13.3
36–50	707	42.4
51–64	737	44.2
Nativity		
Born in U.S.	40	2.4
Born in Vietnam	1614	96.9
Other	12	0.7
Marital status		
Single/never married	269	16.2
Married	1294	77.7
Separated/divorced/widowed/other	103	6.2
Highest education level		
Some high school or less	375	22.5
High school	493	29.6
Some college	231	13.9
College graduate or beyond	555	33.3
Limited English fluency	1127	67.6
Vietnamese fluency	1478	88.7
Employment status		
Full-time or part-time	1056	63.4
Homemaker	237	14.2
Unemployed	167	10.0
Other	206	12.4
Has health insurance	1342	80.6
Has usual source of care	1220	73.2
Self-reported health		
Excellent	98	5.9
Very good	162	9.7
Good	679	40.8
Fair	559	33.6
Poor	150	9.0
Geographic region		
East coast (DC Metropolitan Area)	809	48.6
West coast (Northern California)	851	51.1

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Table 2

Help-Seeking Preferences for Depression among Survey Respondents ($N = 1,666$)

Help-seeking preferences	***n***	**%**
Talk to your family or close friends	1367	82.1
See your family doctor	1268	76.1
Look up information (Internet or book)	1036	62.2
Get spiritual help (go to church or temple)	835	50.1
Do nothing about the situation	779	46.8
Do something else	553	33.2
See a psychiatrist or mental health counselor	399	23.9

Note. Respondents were able to select multiple options.

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Table 3

Categories of the 845 responses given by 553 individuals who selected "do something else"

Response Category	*N* (%)	Sample Responses
Exercise or sports-related	226 (26.8%)	*"Exercise"* *"Jogging"* *"Swim"*
Hobbies or activities	170 (20.1%)	*"Do things I like, such as watch movies"* *"Find hobbies"* *"Read books"*
Rest or relax	89 (10.6%)	*"Relax"* *"Work less"* *"Take time off"*
Pray or meditate	48 (5.7%)	*"Pray"* *"Get in touch with spirituality"* *"Have faith in religion"*
Keep busy	48 (5.7%)	*"Keep busy to forget illness"* *"Work"* *"Do house chores"*
Diet or food-related	39 (4.6%)	*"Focus more on nutrition"* *"Change diet"* *"Eat better"*
Connect with others	36 (4.3%)	*"Hang out with friends"* *"Find someone to support and listen to me"* *"Visit relatives"*
Seek help, including use of traditional medicine or other specialist	35 (4.2%)	*"Seek traditional healer"* *"Take herbs"* *"Take medicine"*
Other response, specific	58 (6.9%)	*"Travel"* *"Spend time thinking about my problems"*
Other response, non-specific	95 (11.3%)	*"Change life habits"* *"Positive thinking"* *"Try not to get stressed"*

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Table 4

Summary of logistic regression results of factors associated with seeking professional help from a mental health provider and/or family doctor

Variable	OR	(95% CI)
Poor or fair self-reported health (vs good, very good, or excellent health)	1.38 *	(1.03–1.84)
Has health insurance (vs uninsured)	2.58 *	(1.88–3.54)
Has usual source of care (vs no usual source)	2.02 *	(1.51–2.71)
Selected “do nothing about the situation”	1.12	(0.86–1.46)
Selected “talk to your family or close friends”	2.76 *	(2.03–3.76)
Selected “look up information”	2.44 *	(1.84–3.24)
Selected “get spiritual help”	1.38 *	(1.05–1.81)
Selected “do something else”	0.46 *	(0.35–0.61)

Note. Model included geographic location, gender, age, English and Vietnamese fluency, and education, which were not significant. OR = odds ratio; CI = confidence interval;

*indicates significant OR at $p < .05$