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Lahu Immigrants' Attitudes Toward Seeking Mental Health

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Abstract

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MS, Walden University, 2021

MBA, Fresno Pacific University, 2017

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The Lahu immigrants experience some of the highest social, physical, and psychological distresses among the Southeast Asian cultural groups. However, they are often underrepresented in studies related to the mental health systems. Barriers such as cultural stigma, religious ideologies, transportation, language, and cultural interpretation of health and illness hinder them from accessing mental health care services. Studies on the Lahu immigrants in context of mental health do not seem to exist in local or scientific journals. To address this gap, an ethnographic, phenomenological study was conducted to explore the lived experiences of the Lahu immigrants in relation to their attitudes, beliefs, and perceptions toward seeking mental health services, including their attitudes, beliefs, and perceptions toward mental health professionals/systems. The socioecological model and health belief model were used to inform the structure of this study. Nine participants were recruited and interviewed at a church. Data analysis was performed using Quirkos software by coding the findings through a tree coding method (i.e., priori codes). The results indicated that language barrier, lack of transportation, and cultural influences are major barriers to accessing mental health services among the Lahu immigrants. The results also revealed the need for culturally appropriate health education among the Lahu community, including education about the Lahu immigrants for mental health professionals and practitioners to provide culturally appropriate mental health services. Having cultural knowledge and providing culturally appropriate mental health services are vital to achieve a positive social change among the Lahu community.

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Dedication

This dissertation is dedicated to my wife, Jenny Singkeovilay, who provided unwavering support, encouragement, motivation, and being there from throughout this process. She pushed me to achieve more than what I thought was ever possible in life. To my parents, Choy and Namor Singkeovilay, despite enduring the war, encampment, and persecution, they managed to bring our family across the globe to America and put me in a position to achieve what I thought was impossible. Without their courage, determination, and strong will, achieving higher education would only be a dream.

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Last but not least, I would like to thank my brother-in-law, Dr. Cha See, for being there for me throughout my educational journey. He inspired me to pursue higher education and supported me through my dissertation process. I am profoundly indebted to him for his support.

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Chapter 1: Introduction to the Study

Access to mental health services is paramount to promoting health and wellness and sustaining a standard of living. Such services become especially important for racial and ethnic minorities, such as Lahu immigrants who lived through the traumatic experiences of the Vietnam War and encampment to sustain their health and wellness Corrigan et al., 2018). Corrigan et al. (2018) stated that in 2011, 59.6% of people were diagnosed with mental illness such as anxiety, depression, schizophrenia, and bipolar disorder, all of which are disabling illnesses that can affect people's quality of life, including the way how they live, behave, and interact with others. In a more recent study by the National Institute of Health (NIH, 2022) reveals that one in five adults in the United States lived a mental illness ranging from mild to server symptoms. Additionally, Corrigan et al. stated that people who are socially disadvantaged and with mental illness may be discouraged from seeking mental health services due to various reasons such as stigma, stereotype, and discrimination.

However, despite the impact of mental health plays in people's everyday lives, there is a lack of information in literature on the Lahu people in the context of mental health. This lack of information on the Lahu immigrants demonstrated a gap in the literature and underrepresentation in the research community. Bruce et al. (2019) stated the need for research to evaluate health disparities among racial and ethnic minority groups to guide decision making and promote health and wellness. The authors emphasized that health disparities may differ between populations and the importance of understanding the differences faced by each population (Bruce et al., 2019).

The Lahu immigrants represent one of the largest ethnic groups that migrated from the County of Laos behind Hmong, Mien, and Laotian in Tulare County, California (see Arax, 1999). However, they are underrepresented in the health care systems in that there is a lack of mental health professionals that speak the Lahu language, which, in turn, poses a barrier not only for the native Lahu speakers in seeking mental health services but as well as call into question the validity of diagnosis due to the language barrier (Kim et al., 2015). Kim et al. (2015) emphasized that this situation is a major factor in the underutilization of services and misdiagnoses. This lack of representation often misleads the public, including mental health professionals and practitioners to misidentify the Lahu people as other SEA ethnic groups such as Chinese, Hmong, or Laotian.

When it comes to providing mental health services, Weng and Spaulding-Givens (2017) emphasized the importance of providing culturally appropriate mental health services, particularly when working with ethnic minority groups, such as the Lahu immigrants who lived through the traumatic experiences of the Vietnam War and encampment prior to coming to the United States. A study by Ganesan et al. (2011) revealed that South Asian or Southeast Asian patients had more mental health diagnoses when compared to other ethnic groups. Similarly, a local study conducted by the Asian American Coalition (AAC, 2001) revealed that most Asian Americans were diagnosed with posttraumatic stress disorder (PTSD) and major depressive disorder (MDD).

To address this gap in the literature, I explored the lived experiences of the Lahu immigrants living in Tulare County, California in terms of their attitudes, beliefs, and

perceptions toward seeking mental health services. I aimed to provide a better understanding of the unique characteristics of the Lahu immigrants to assist mental health professionals and practitioners to provide culturally appropriate mental health services and address their needs. The following sections are discussed in detail: problem statement, purpose of the study, significance of the study, background of the study, theoretical model, research questions, nature of the study, possible types and date sources, and analytic strategies.

Problem Statement

The population of the Lahu immigrants in the United States is on the rise; however, there is no study related to their health in terms of mental health, including their attitudes, beliefs, or perceptions toward seeking mental health services. The lack of knowledge regarding Lahu and mental health forces mental health professionals and practitioners to rely on their experiences of health services among general populations, as opposed to cultural-based services, when providing mental health services to the Lahu people (see See, 2014). This, in turn, leads to health disparities among the Lahu population. Gopalkrishnan (2018) and Gopalkrishnan and Babacan (2015) stated that culture is a multilayered concept influenced by a variety of internal and external factors, such as gender, class, religion, language, nationality, social norms, and practices. According to the authors, understanding the unique characteristics of each culture is critical to engage them more effectively (Gopalkrishnan, 2018; Gopalkrishnan & Babacan, 2015). In other words, cultural values, beliefs, and practices held by members of a group influence the way in which they construct their world. Also, Weng and

Spauding-Givens (2017) posited that cultural knowledge is essential for enabling mental health professionals and practitioners working with diverse populations, such as Lahu immigrants, to provide culturally appropriate mental health services. A lack of culturally appropriate mental health services among minority groups such as Asian Americans (e.g., Lahu immigrants) leads to disparities in health care services (Weng & Spauding-Givens, 2017).

In Tulare County, mental health disparities between racial and ethnic groups are becoming a rising concern, specifically among the Lahu immigrants. Compared to other racial and ethnic groups, Lahu immigrants' mental health care access is assumed to be extremely low (ACC, 2001; See, 2014). Concurrently, health risk behaviors such as suicidal ideation and suicidal attempts continue to rise among the Lahu community. According to the American Psychological Association (APA, 2022), suicide was the eighth leading cause of death among Asian Americans, higher than the 11th leading cause of death for all other racial and ethical groups. Among women between the ages of 65 and 84, Asian Americans had the highest suicide rate. On the contrary, Asian Americans had the lowest suicide rate among men compared to other racial and ethnic groups. The APA attributed Asian Americans' suicidal behaviors to mental illness, social factors, and chronic medical conditions, all of which were persistent among the Lahu immigrants due to their traumatic experiences in the Vietnam and Secret Wars and the concentration camp before migrating to America. The common diagnoses of Lahu immigrants are depression (e.g., MDD, persistent depression, and psychotic depression) and PTSD with suicidal ideations/thoughts (discussed in detail in Chapter 2).

Purpose

The purpose of study was to explore the attitudes, beliefs, and perceptions of Lahu immigrants in Tulare County toward seeking mental health services, including their attitudes, beliefs, and perceptions toward mental health care systems. This information is crucial for mental health professionals and practitioners in providing culturally appropriate mental health services to this population. While there are literatures on other Southeast Asian populations (e.g., Cambodian, Chinese, Hmong, Japanese, Laos, and Vietnamese), there is no study conducted on the Lahu population.

Currently, I found only one Ph.D. dissertation related to study on the Lahu related to health care access (see See, 2014) but not specific to mental health and mental health services. Findings from this study may enable mental health professionals and practitioners from the mental health field to effectively work with the Lahu population and address mental health disparities among the Lahu immigrants. Yang et al. (2020) stated that health care systems must improve cultural sensitivity and incorporate cultural solutions in their mental health care services to provide culturally appropriate mental health services. Lee et al. (2010) and Sorkin et al. (2011) also stated that the ethnic and racial diversity of Asian subgroups warrant a deep understanding of the unique characteristics of each population, as well as their understanding, recognition, and attitudes toward seeking mental to address disparities in health services.

Significance

Culture plays a significant role in many aspects of mental health, including how people perceive health and illness, their health-seeking behavior (Gopalkrishnan, 2018),

and their perceptions of practitioners and mental health care systems. Understanding the unique characteristics of this population is paramount for mental health professionals and practitioners working with this population and to effectively engage them. Findings from this study may assist mental health professionals and practitioners in incorporating cultural-based solutions in their mental health care services among this population to promote positive social change. Lor et al. (2017) stated that understanding differences in perceptions of the causes of illnesses and the link between perceived cause and treatment is important to improving mental health care services. Also, Weng and Spauding-Givens (2017) stated that a lack of culturally appropriate mental health services among minority groups such as Asian Americans (e.g., Lahu immigrants) leads to disparities in health care services.

The study was paramount to understanding the unique characteristics of the Lahu population and their attitudes, beliefs, and perceptions toward seeking mental health services. This study was original, as no found study has been carried out on the Lahu population in this arena (i.e., mental health services). In addition to the vital contribution to the literature, this study provides valuable insights for mental health professionals and practitioners regarding the unique characteristics of the Lahu population. Gopalkrishnan (2018) explained that cultural diversity has a "significant impact on the many aspects of mental health, ranging from how health and illness are perceived, health-seeking behavior, attitudes of the consumer as well as the practitioners and mental health systems" (p. 2).

From a social change perspective, I addressed the disparities in mental health and mental health care access among minority groups (see Yang et al., 2020), such as the Lahu immigrants, which may enable mental health professionals and practitioners to work with this population more effectively. Yang et al. (2020) stated that health care systems must improve cultural sensitivity and incorporate cultural solutions in their mental health care services to provide culturally appropriate mental health services.

Backgrounds

To better assist the Lahu immigrants, in terms of their mental health needs and provide culturally appropriate mental health services, it is important to understand the background of the Lahu immigrants. Like other Southeast Asian populations, such as Mien (Fitzpatrick, 2008), the Vietnam War disrupted the traditional life of the Lahu immigrants and displaced them to neighboring countries, predominately in Thailand.

During the Vietnam War, most, if not all, Lahu immigrants joined the U.S. Army in the Special Guerrilla Units (SGU; Special Guerrilla Units Veterans and Family of USA, n.d.), which made them a prime target of the Communist Regime once the United States forces withdrew from the Country of Laos. During the war, the Lahu immigrants provided food and shelter for the U.S. forces. In addition, all males who were not in the military during the war delivered food, water, and ammunition from one military base to another.

After the war, the Communist Regime retaliated against the Lahu immigrants (Hays, n.d.). The Communist Regime raided from village to village looking to those who provided shelter for the U.S. forces. While many people escaped from the Communist

Regime by abandoning their homeland, some were captured and killed by the Communist soldiers. Those that escaped the Communist Regime, they were captured by the Thai government and imprisoned in the concentration camp for years prior to coming to the United States.

However, despite the Lahu immigrants' traumatic experiences prior to coming to the United States, there was no study conducted in terms of their attitudes, beliefs, or perceptions toward seeking mental health services. While there was one local study conducted by the Asian American Coalition (AAC), which included the Lahu people, the data was combined with other Asian groups. The report did acknowledge that 90% of the Lahu people relied on modern medicine with only 10% on folk remedies and other cultural practices. However, it was important to note that this study only included two Lahu people, not representative of the general Lahu population. In addition, the study did not indicate if these two participants had a similar experience as the Lahu immigrants who lived through the traumatic experiences of the Vietnam War and encampment. Nevertheless, this was the only study of the Lahu people at a local level in Tulare County.

Most recently, in 2014, there was one Ph.D. Dissertation on the Lahu people in Tulare County. However, the focus of the study was on health care access, not in the context of mental health. This demonstrated a gap in the literature and warranted the need for this study to provide a better understanding of the unique characteristics of the Lahu population. This information is paramount in enabling mental health professionals and practitioners to effectively work with this population. The Lahu population, in general, was not represented in local and national censuses.

Past studies of other Asian ethnic groups supported a population-based study to understand the unique characteristics of each population and provide culturally appropriate mental health services (Fu & VanLandingham, 2012; Weng & Spaulding-Givens, 2017). In particular, Fu and VanLandingham's (2012) study of Vietnamese Americans revealed that immigration affects a wide range of mental health issues directly and indirectly, including adverse social and economic conditions. According to Fu and VanLandinghan, culture plays a significant role in mental health issues among immigrant populations. Also, Lee et al.'s (2010) study of mental health literacy of Southeast Asian (SEA) elderly refugees residing in the United States revealed that mental health is understood, communicated, and responded to within their unique social and cultural contexts. In other words, the interpretation or perception of mental health may differ from culture to culture; therefore, research was paramount to understanding the unique social and cultural influences of each group, such as the Lahu immigrants to promote positive health outcomes. Sorkin et al. (2011), Yang et al. (2020), and Weng and Spaulding-Givens (2017) stated that there are disparities in mental health needs among older Asian Americans and emphasized the importance of incorporating cultural solutions and providing culturally appropriate mental health services.

This study provided a safe environment for the participants to express their attitudes, beliefs, and perceptions of mental health services, including their attitudes, beliefs, and perceptions about mental health care systems. An ethnographic, phenomenological study was appropriate to increase the reliability and validity of the data, as it explored the lived experiences of the Lahu immigrants. Findings from this

study may be paramount in terms of providing cultural knowledge to mental health professionals and practitioners to inform culturally appropriate mental health services. Additionally, this study findings may help to facilitate future research in the Lahu community.

Theoretical Framework

Health Belief Model

The health belief model (HBM) was developed in the 1950s to address the widespread failure of people refusing to participate in health prevention programs (Glanz et al., 2015; LaMorte, 2022). The HBM was later expanded to explore people's behavioral responses to illnesses, such as adherence to the medical regimen (Glanz et al., 2015; LaMorte, 2022). In other words, the HBM provides the foundation for understanding how external and internal influences affect people's behaviors. Additionally, the HBM assesses the degree to which people's assessment of a particular situation affects their actions or inactions (Glanz et al., 2015; LaMorte, 2022). According to Glanz et al. (2015) and LaMorte (2022), people's attitudes and beliefs about health and wellness collectively affect their behaviors.

Since the introduction of HBM, many researchers, such as See (2014) on health care access of Lahu people and Salihu et al. (2015) on barriers to colorectal cancer screening among the Chinese people, have used the model to explore the lived experiences of the participants. Also, other researchers such as Lee et al. (2010) and Yang et al. (2020) have used the model to investigate the disparities in mental health care utilization among Asian Americans and mental health literacy among SEA elderly

refugees in the United States Glanz et al. (2015) and Bishop (2010) stated that the HBM is one of the most widely applied theories of health behavior. Like the HBM, the social-ecological model (SEM) is another model that is widely used in exploring health behaviors.

Social-Ecological Model

The SEM, also known as the *Chicago School* or *Ecological School*, was developed by a group of sociologists at the University of Chicago in the 1950s (e.g., school of thought in sociology and criminology; Lutters & Ackerman, 1996). Lutters and Ackerman (1996) stated that the SEM is best suited for exploring lived experiences of people, such as observing human interaction in their natural environment. Bronfenbrenner later introduced the SEM as a framework for understanding human development in the 1970s (Kilanowski, 2017; Swick & Williams, 2006). The SEM recognized the complex social and environmental interactions that influence individuals' development and behavior (Kilanowski, 2017; Swick &Williams, 2006). Since the development of the SEM, many researchers have used the model in qualitative tradition. Most recently, researchers such as See (2014) and Salihu et al. (2015) have used the model to explore lived experiences of people.

Being an exploratory study, both HBM and SEM were used to inform the questions and the structure of this study. These models were appropriate, as I explored the Lahu immigrants' lived experiences through interviews. Jones et al. (2015) stated that optimal behavior change is achieved if perceived barriers, benefits, self-efficacy, and threats are addressed. Also, Salihu et al. (2015) posited that understanding the effects of

personal and environmental factors on behavior are critical to health promotion. The results of this study may provide valuable insights for mental health professionals and practitioners to work with this population more effectively.

Research Questions

RQ1: What are the attitudes of Lahu immigrants toward seeking mental health services?

RQ2: What are some beliefs and cultural practices of Lahu immigrants in terms of mental health?

RQ3: How do Lahu immigrants' attitudes toward mental health professionals contribute towards mental health access among the Lahu immigrants?

Nature of the Study

In this study, I used a qualitative methodology to explore the interplay of individual, interpersonal, and cultural factors in shaping the Lahu immigrants' attitudes toward seeking mental health services. An ethnographic and phenomenological approaches were used to answer my research questions. Using semistructured and open-ended questions, I conducted interviews to gain insights into the Lahu immigrants' attitudes, beliefs, and perceptions toward seeking mental health services.

According to Neubauer et al. (2019) and Jones and Smith (2017), qualitative research is an approach that offers a different lens through which to learn about the lived experiences of others—to explore and explain phenomena in their natural contexts. Jones and Smith (2017) stated that ethnography is one of the early approaches to studying people in their natural environment. That is, how social and cultural factors influence

how they assign meanings to their environment and construct their worldview (Jones & Smith, 2017). Similarly, phenomenology is a qualitative approach to studying people's lived experiences (Neubauer et al., 2019). Both ethnographic and phenomenological approaches were used to explore the lived experiences of the Lahu immigrants, including their attitudes, beliefs, and perceptions toward seeking mental health services.

Rationale for Selection of the Variables and Study Approach

The variables for this study were Lahu immigrants' attitudes and mental health care access. I selected these two variables since the conception and perception of mental health influence a person's health-seeking behavior. As ACC (2001), Jones et al. (2015), and Weng and Spaulding-Givens (2017) emphasized, one's belief about the etiology of mental health influences the person's attitudes toward seeking mental health services. Despite the Lahu immigrant's lived experiences of the Vietnam War and encampment, there was no scientific literature on the Lahu people in the context of mental health. This study is warranted to discover the unique characteristics of the Lahu immigrants and their attitudes toward seeking mental health services. Findings from this study may potentially assist mental health professionals and practitioners in providing culturally appropriate mental health services relevant to the social and cultural contexts of the Lahu immigrants.

Definitions

Christian: An individual who believe in Christianity and its teachings and follows and models behavior of Jesus (Compassion International, 2022).

Community: A community is defined as both a feeling and a set of common interests shared by people living in a particular area to form, maintain, and meet the

people's common needs (Chavis & Lee, 2015.

Culture: Culture is defined as a set of values, beliefs, and practices that distinguishes members of one group from another, such as ethnicity, race, gender, and religion (Gopalkrishnan, 2018; Hofstede, 1991; Patterson, 2014)

Health equity: Health equity means every individual has an equal opportunity to gain access to the full health potential without limitation of social position or other socially determined circumstances (Centers for Disease Control and Prevention [CDC], 2022).

Lahu: Lahu, also known as Muser, is an individual who is from Southeast Asia, particularly the Country of Laos, and is a part of the Lahu community (Deason, 2018; See, 2014).

Immigrant: Any individual who left one's country and is living in another country as a permanent resident (U.S. Immigration, 2022).

Minority: A minority is a population subgroup, such as Chinese, Hmong, Mien, Thai, Laos, Lahu, Vietnamese, and Cambodian, which differs from those of the majority of the population (APA, 2022).

Refugees: Refugees are individuals who flee war, violence, conflict or persecution across an international border to find safety in another county (United Nations High Commissioner for Refugees [UNHCR], 2021).

Religion: Religion is an individual's traditional values and practices related to a particular group, such as faith (Victor & Treschuk, 2019).

Spirituality: An individual's connection with quality and meaning of life, such as

the individual's connection with God, nature, and surrounding (Victor & Treschuk, 2019).

Underrepresented: A racial or ethnic group who are not represented or inadequately represented in healthcare profession or research, such as African American/Black, Asian, Hispanic, Native American/Alaskan Native, Native Hawaiian/Other Pacific Islander are among underrepresented minorities identified by the NIH (n.d.) and the University of California San Francisco (UCSF, 2022).

Possible Types and Sources of Data

The data for this study was obtained from interviews. Since there has not been a research study carried out on the Lahu immigrants in the context of mental health, a qualitative method through a convenience sampling was used to recruit participants to meet the targeted sample size of nine participants. Elfil and Negida (2017) stated that a convenience sampling is a nonprobability sampling method that is widely used in clinical research. In other words, a convenience sampling is a method that collects samples a pool of participants that are conveniently available (Edgar & Manz, 2017; & Galloway, 2005). Since this was a new study aimed to under the unique characteristics of the Lahu immigrants, a convenience sampling method was appropriate for this study.

Using a semistructured style interview, I conducted interviews with nine Lahu immigrants and explored their attitudes, beliefs, and perception toward seeking mental health services. DeJonckheere and Vaughn (2018) stated that semistructured-style interviews are commonly used in qualitative research and the most frequent sources of data in health research. In addition, semistructured style interviews allowed for an in-

depth and interactive dialogue between the researcher and the participant while providing the flexibility for follow-up questions, probes, and comments to explore the participant's attitudes, beliefs, and thoughts about a particular topic of discussion (DeJonckheere & Vaughn, 2018), which is essential to understanding the lived experiences of the Lahu immigrants in their natural contexts.

The interview was recorded on a digital recorder with consent from the participants. The information was protected with a password to safeguard the confidentiality and privacy of the participants. Since the Lahu immigrants speak limited English, the interview was conducted in Lahu's native language. However, since some words in Lahu cannot be translated word-for-word to English, the transcription were developed in English.

Possible Analytic Strategies

I analyzed the data using thematic analysis which is an approach to analyzing qualitative data. Nowell et al. (2017) stated that thematic analysis is widely used in qualitative traditions, which is a method for "identifying, analyzing, organizing, describing, and reporting themes found within a data set" (Nowell et al., 2017, p. 2). According to Nowell et al., thematic analysis has demonstrated meaningful and useful results and stated that it should be considered a foundational method for qualitative tradition. Taking raw data from interview transcripts, I looked for similarities and differences, finding themes, and developing categories.

Limitations, Challenges, and/or Barriers

One limitation of this study was the language barrier. Since the Lahu immigrants' primary language was other than English, translating this study into the Lahu's native language posed a challenge, as some words may not have word-for-word translation from English to Lahu or vice versa due to the language differences. Another limitation was the sampling method. Due to the nature of this study, only nine participants were recruited for this study using a convenience sampling. However, since the aim of this study was to explore the lived experiences of the Lahu immigrants and their attitudes, beliefs, and perceptions toward seeking mental health services, this study was not intended to generalize the study results across the population. Instead, I focused on the quality and trustworthiness of the information obtained from the participants in order to provide a better understanding about the unique characteristics of the Lahu immigrants related to seeking mental health services.

Summary

To improve the mental health services among the Lahu immigrants, there was a need to understand the unique characteristics of the Lahu immigrants, including their attitudes, beliefs, and perceptions toward seeking mental health services. By considering the factors faced by the Lahu immigrants, such as information from this study (individual and cultural factors related to mental health care access), service administration by health care providers and utilization by Lahu people may improve. Weng and Spauding-Givens (2017) stated that cultural knowledge is essential to work with diverse populations effectively. Additionally, Gopalkrishnan (2018) and Gopalkrishnan and Bacan (2015)

stated that cultural values and beliefs influence every aspect of people's lives, including the way in which how people assign meaning to their environment and the world.

This study was unprecedented in that there has not been a study carried out on the Lahu immigrants in the context of mental health. The results of this study may contribute new knowledge to the literature. In addition, the results of this study may have an immense impact on positive social change by providing cultural knowledge for mental health professionals and practitioners to work with this population more effectively.

In this chapter, I introduced a research topic that was understudied in the literature. I then developed a problem statement and discussed the significance and purpose of this study that focused on the lived experiences of the Lahu immigrants, the attitudes, beliefs, and perceptions toward seeking mental health services. In Chapter 2, I examine available literature focused on the Lahu immigrants in the context of mental health. Findings of past research were used as the foundation for this study and to assist this study in identifying the gap in the literature.

Chapter 2: Literature Review

The Lahu immigrants represent one of the largest Southeast Asian populations in Central Valley, California, behind Hmong and Mien. With the second and third generation Lahu people, the population is rapidly growing in the United States. Despite this demographic change and the first wave of Lahu immigrants arriving in the United States in the 1970s, information related to the Lahu people is not available in the scientific literature or the U.S. Census Bureau. Thus far, only two studies have been carried out on the Lahu people, both of which were not in the context of mental health (see AAC, 2001; See, 2014). As a result, the Lahu immigrants are underserved and miss-served by the mental health systems. While diversity is much emphasized in today's health care systems, to date, there is a lack of Lahu mental health professionals in the field.

As such, research concerning the Lahu immigrants' attitudes, beliefs, and perceptions toward seeking mental health services become paramount to understand the unique characteristics of this population and provide culturally appropriate mental health services (Weng & Spauding-Givens, 2017; & Yang et al., 2020). In terms of investigating the Lahu people's attitudes, beliefs, and perceptions in the context of mental health, the information does not exist in the scientific literature or in any national database. Gopalkrishnan (2018) and Gopalkrishnan and Babacan (2015) noted that culture is a multi-layered concept influenced by a variety of internal and external factors, such as gender, class, religion, language, nationality, social norms, and practices, all of which are critical not only to understand the unique characteristics of this population, but also for

mental health professionals and practitioners to engage them more effectively and promote positive social change.

Previous literature has yet to explore the Lahu immigrants' attitudes, beliefs, and perceptions in the context of mental health. With the Lahu population on the rise in the United States, understanding the unique characteristics of this population is paramount for mental health professionals and practitioners so they can engage with this population more effectively and promote positive social change. This literature review not only contributes to reduce the gap in the literature, but it also provides insight on the facilitating factors influencing the Lahu immigrants' attitudes, beliefs, and perceptions toward seeking mental health services.

The purpose of this study was to investigate the Lahu immigrants' attitudes, beliefs, and perceptions toward seeking mental health services and the facilitating factors that contributed to the underutilization of mental health services among this population. Findings from this study were essential to address the mental health care disparities among this population. Yang et al. (2020) emphasized the importance of incorporating cultural solutions in mental health care services to provide culturally appropriate mental health services and promote positive social change. According to Budiman and Ruiz (2021), Lee et al. (2010) and Sorkin et al. (2011), Asian population is one of the most diverse ethnic and racial groups in the United States with unique histories, cultures, languages and other characteristics. Understanding the unique characteristics of each population—their attitudes toward seeking mental health services—is essential to providing culturally appropriate mental health services.

In this chapter, I discuss the process and strategy of identifying relevant literature, including library databases, search engines, and key terms used in the literature search. In addition, I discuss the theoretical foundation and conceptual framework that informs the study. This includes but is not limited to the definition of the concept or phenomenon, the name of the theory or theories, the origin or source of theory, the rationale for the choice of the theory, and major theoretical propositions and/or major hypotheses, including delineation of any assumptions appropriate to the application of the theory. Finally, I include synthesis of key variables and concepts relevant to this study.

Literature Search Strategy

The literature was accessed through Walden Library from the following databases: PsychINFO, SAGE Journals, SocINDEX, ProQuest, ScienceDirect, and Academic Search Complete. Additionally, due to a lack of scientific literature on the Lahu immigrants in the United States, Google Scholar, and Google search engines were used to obtain other relevant sources pertinent to this study. Key search terms and combinations of search terms were used to obtain relevant literature pertinent to this study, such as *Attitudes or Perceptions or Opinions Towards Seeking Mental Health*, *Mental Health*, and *Mental Health Utilization*. Key phrases, such as *Lahu, Lahu Immigrant, Immigrant, Laotian, Asian Americans*, and *Southeast Asians*, were used in combination with the search terms to obtain relevant literature pertinent to this study.

Although this study was on Lahu immigrants, since there was no study carried out on Lahu immigrants in the context of mental health, relevant literature on other Southeast

Asian immigrants were used to support this study. As a result, the use of literature beyond the last 5 years was necessary to obtain relevant information for this study.

Theoretical Foundation

The theoretical frameworks, HBM and SEM, were used to inform the structure of this study. The HBM was built upon Bandura's social cognitive theory, which emphasized "the role of learning and human agency in behavior" (Glanz et al., 2015, p. 76). In other words, behavior was influenced by affective and cognitive factors (Glanz et al., 2015), such as social and cultural factors.

According to Gopalkrishnan (2018), culture is a set of values, beliefs, and practices shared by members of the group, which, in turn, influences the way in which individuals behave and interact with others in the environment. This includes how individuals and group members process information and make everyday decisions (Li et al., 2018). Culture shapes individuals' worldviews and influences every aspect of their lives, including their decisions to seek or not to seek help. Hinote and Wasserman (2017) stated:

> The etiology of illness is not biological but social, stemming from the current social conceptions of what disease is, limited perhaps by whatever few biological facts are universally recognized, and ordered by organizations and occupations devoted to defining, uncovering, and managing illness. (p. 178)

In other words, social influences (i.e., cultural or environmental influences) play a significant role in individuals' perceptions of illnesses, including the individuals' decisions to seek or not to seek help.

Also, Hills et al. (2013) and Let's Learn Public Health (2017) stated that cultural factors and social determinants of health (SDH), such as social, economic, and physical conditions in which people are born, grow, live, work, and age play a significant role in how people perceive health and illness, including their health behavior.

Since the development of the HBM in the 1950s by social psychologists, many researchers have used the model to investigate health behavior, such as people's responses to illnesses and medical regimens (Glanz et al., 2015). Shabibi et al. (2017) stated that people's attitudes and beliefs about health and wellness affect their health behavior. According to Glanz and Bishop (2010), the HBM is one of the most widely applied theories of health behavior. The HBM consists of six constructs that predict people's behavior: (a) perceived susceptibility, (b) perceived severity, (c) perceived benefits, (d) perceived barriers, (e) cues to action, and (f) self-efficacy (Glanz et al., 2015). These constructs are defined below:

- *Perceived susceptibility*: a person's beliefs about the likelihood of getting a disease or condition
- *Perceived severity*: a person's beliefs about the seriousness of contracting a disease or condition
- *Perceived benefits*: a person's beliefs about the positive aspects of adopting a health behavior
- *Perceived barriers*: a person's beliefs about the negative aspects of adopting a health behavior

- *Cues to action*: a person's internal or external factors that could trigger a health behavior
- *Self-efficacy*: a person's belief that one can perform the recommended health behavior (Glanz et al., 2015).

The underlying assumption of the HBM is that if people believe that they are at risk for a disease or condition, and such disease or condition could have potentially serious consequences, or if they believe that they could benefit from a health behavior and the perceived benefits outweighs the barriers, they are likely to engage in such health behavior (Glanz et al., 2015).

Similar to the HBM, the SEM, was developed in the 1950s to observe people's lived experiences in their natural environment (Lutters & Ackerman, 1996). It provides the foundation for understanding the complex social and environmental interactions of human development (Kilanowski, 2017; & Swick & Williams, 2006). The CDC (2022) and Frieden (2010) stated that the SEM is the model that recognizes the complex interplay between individual and their environment, that is, how external and internal influences affect people's lifestyle choices and, in turn, their health behavior (CDC, 2022; Frieden, 2010). The SEM consists of four levels: (a) individual, (b) relationship, (c) community, and (d) societal (CDC, 2022; Frieden, 2010).

The individual level is a person's internal determinants of behavior, such as knowledge, attitudes, beliefs, and skills. The relationship level is an individual's external influences, such as of family, friends, and others in the environment. This includes social norms and social identity, including institutional and organizational rules and policies

that influence and support the person's behavior. The community level involves an individual's physical and social environment, including the individual's relationship and association with the environment, such as institutions and organizations. The societal level is a person's environment which governs the societal norms, such as policies made by a local, state, or federal governing body that influence societal behavior (CDC, 2022; Frieden, 2010)

Both the HBM and SEM focus on the interrelationships between biological, psychological, and environmental factors and how these factors influence people's health behaviors (Glanz et al., 2015; Robinson, 2008), which is appropriate for an exploratory study (Glanz & Bishop, 2010). The applicability of the HBM and SEM among diverse cultures made these theoretical foundations appropriate for guide structure of my study (see Glanz et al., 2015; Glanz & Bishop, 2010).

The Lahu People

Lahu, also known as Muser, is one of the culturally diverse ethnic groups in the world (See, 2014). Within Lahu, there are many different tribes. In China, there are 56 officially recognized ethnic groups (Deason, 2018), such as Yellow Lahu (or Lahu Shi), Black Lahu (or Lahu Na), Sheleh Lahu, and Balah Lahu (Hilltribes, 2020; See, 2014). In 2018, there were over 700,000 Lahu in China and hundreds of thousands in Myanmar, Thailand, Laos, Vietnam, and the United States (Deason, 2018). Specifically, in the United States, the majority of Lahu population is made up of Yellow Lahu followed by Black Lahu. However, in terms of the current Lahu population in the United States, there is no formal census as the Lahu population is dispersed among other SEA ethnic groups.

Beason (2018) showed over 700,000 Lahu in China as of 2018 with hundreds of thousands in other countries.

The Lahu immigrants experienced both physical and psychological abuse. The Vietnam War displaced them from their homeland and forced them to relocate to America (Arax, 1999). Prior to coming to the United States, they spent most of their lives in rural areas of Laos, living a simple life, isolated from mainstream media. The Vietnam War disrupted their lives and forced them to escape their homeland. During the Vietnam War, the Lahu people served alongside the U.S. Army in the SGU (Special Guerrilla Units Veterans and Family of USA, n.d.). This led to retaliation by the Communist regime against the Lahu people. After the war, the Communist soldiers raided the villages of the Lahu people and forced them out of their homes. They left behind everything they owned and traveled hundreds of miles by foot to their neighboring country, Thailand. Along the way, the communist soldiers killed many Lahu people. Those that managed to escape the Communist regime crossed the Mekong River on a bamboo raft with water to their chest, while others crossed the river on a bamboo stick. For those that managed to escape the Communist regime and reached the Thailand border, they were captured by the Thai government and imprisoned in the concentration camp. They spent years in the concentration camp surrounded by barbed wires prior to resettling in the United States. As Ganesan et al. (2011) stated, these experiences may lead to South Asian or Southeast Asian patients (i.e., Lahu immigrants) experiencing physical and psychological stress.

The Lahu immigrants relocated to America in two waves: 1970s and 1990s (See, 2014). Due to the language barrier, the first wave faced many challenges adjusting to a

foreign land. In addition to the language barrier, differences in cultural practices and norms were obvious barriers. For example, coming from rural areas of Laos, they had not seen or heard of simple household equipment, such as a bathroom, microwave, stove, or sink. Even more challenging was seeking health services. Unlike before where they could walk into the woods and collect herbs for medicinal purposes when they were sick, in America, they had to rely on others, such as mental health professionals and practitioners in order for them to be able to obtain medication specific to illnesses (see See, 2014). The Lahu immigrants did not speak English, which added additional layers of trauma, in addition to the physical and psychological abuses suffered from the war and the concentration camp.

Current Studies on Lahu Immigrants

Currently, there is no scientific literature on the Lahu people in the context of mental health. To date, there were only two Ph.D. dissertations (See Fujimoto, 2010; See, 2014) conducted on the Lahu people. Despite these studies, however, they were not in the context of mental health. See (2014) explored the Lahu culture in the context of health care access, while Fujimoto (2010) only mentioned Lahu in the study, as it relates to organizing immigrant communities. In addition, there was one other study conducted by the Asian American Coalition (AAC) on the Southeast Asian population, which included the Lahu people. However, this study was limited to the health of Southeast Asian elders (e.g., health care access) (ACC, 2001). This study was original in exploring the Lahu immigrants in the context of mental health, including their attitudes, beliefs, and perceptions toward seeking mental health services.

Lahu Immigrants in the United States

According to the World Population Review (2022), California is home to one of the world's most diverse populations. In 2022, it estimated 39,664,128 Californians (World Population Review, 2022), of which the Asian population represented the third largest ethnic group with 15.5% behind 39.4% Hispanics and 36.5% Whites (United States Census Bureau, n.d.). In addition, Budiman and Ruiz (2021) predicted that the Asian population in the United States would reach 46 million by 2060. Despite this data, however, the Lahu population is not identified in the census data (United States Census Bureau, 2020). The national data recognized only the following Asian populations: Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, Pakistani, Thai, Hmong, Cambodian, Laotian, Taiwanese, Bangladeshi, Burmese, Nepalese, Indonesian, and Sri Lankan (United States Census Bureau, 2020).

Similarly, at the county level (e.g., Tulare County), there was no census data on the Lahu people. While Asian populations are considered the third largest population in Tulare County, it only represented 4% of the total population behind 65.6% Hispanics and 27.7% Whites, respectively. See's (2014) study also revealed a similar finding at local and national levels on the Lahu people. Unlike other SEA ethnic groups, such as Chinese, Hmong, Mien, Thai, Laos, Vietnamese, and Cambodian, the Lahus are often being identified in the census as "Asian," "Laotian," or "Asian American and Pacific Islander" (see See, 2014) because of their national origin. The Lahu population was not represented in the census (United States Census Bureau, 2020). Previous studies did not explore the unique characteristics of the Lahu people, specifically their attitudes, beliefs,

and perceptions toward seeking mental health services, which underscores the unique culture, language, and heterogeneity of the Lahu population.

Lahu Culture and Language

Gopalkrishnan (2018) and Patterson (2014) stated that culture is the conjugate product of individuals and groups with shared commonality and knowledge that give meaning to the environment and their actions and behaviors, such as shared values, beliefs, and practices held by members of a given group. In other words, culture plays a significant role in how individuals and group members behave and interact with the environment. Napier et al. (2014) pointed out that when it comes to culture, it would be premature to assume a universal behavior because culture varies from within and across sociodemographic groups. Also, Hofstede (1991) offered a similar definition of culture as a collective programming of the mind, that is, shared values, beliefs, and practices held by members of the group. In other words, culture (e.g., group membership) shapes individuals' and group members' attitudes and beliefs about their lifestyle choices, including their health behavior (Canadian Paediatric Society, 2021; Jia et al., 2017; Napier et al., 2014).

Within the SEA populations, Lahu is considered the most diverse sub-population group, which is further divided by different cultural and language differences, such as Yellow Lahu (or Lahu Shi), Black Lahu (or Lahu Na), Sheleh Lahu, and Balah Lahu (see Hilltribes, 2020; See, 2014). This study is focused on Yellow Lahu, also known as Lahu Shi, in Tulare County. While there was only one study in the United States on the Lahu people (see See, 2014), there were studies conducted by local and governmental

organizations outside of the United States, such as the Embassy of the People's Republic of China (2004) and Singkorn et al. (2019). Despite these studies, they were not focused on the unique characteristics of the Lahu people. Instead, these studies primarily focused on the Lahu people, in general, and their biochemistry.

Literature emphasizes the important role culture plays in people's everyday lives, including how people assign meaning to the environment and the world. Gopalkrishnan (2018) stated culture plays a significant role in all aspects of mental health, including people's attitudes towards mental health systems. Also, Gopalkrishnan and Babacan (2015) posited that culture is a multi-layered concept influenced by a variety of internal and external factors. This includes gender, class, religion, language, nationality, social norms, beliefs, and practices (Gopalkrishnan & Babacan, 2015).

Lahu Shi's culture and dialect are different from other SEA ethnic groups. These differences are significant—from cultural practices to spoken language. The Lahu people interact with other SEA ethnic groups using the general language, such as English, Thai, or Laos. However, due to the Lahu's upbringing, many Lahus speak multiple languages, which made them well versed in interacting with other SEA ethnic groups. The majority of the Lahu immigrants interact with other SEA ethnic groups using other SEA languages. A prime comparison of Lahu Shi is a comparison between Hispanics and Whites. They speak different languages with different cultural customs. Gopalkrishnan (2018) stated that culture influences "many aspects of mental health, ranging from how health and illness are perceived, health-seeking behavior, attitudes of the consumer as well as the practitioners and mental health systems" (p. 2). Also, Weng and Spauding-

Givens (2017) posited that a lack of culturally appropriate mental health services among minority groups, such as Lahu immigrants, creates disparities in health care services. Understanding the unique characteristics of the Lahu immigrants would be essential to mental health professionals and practitioners in terms of being able to incorporate cultural solutions in their mental health care services and to work with this population more effectively. Yang et al. (2020) also emphasized that health care systems must improve their cultural sensitivity and incorporate cultural solutions in their mental health care services in order to provide culturally appropriate mental health services and promote positive social change.

Spirituality of Lahu Immigrants

Spirituality is an individual's association with quality and meaning in life, such as the individual's connection with the higher power (e.g., God) and the environment (Victor & Treshuk, 2019). In the case of the Lahu immigrants, they may identify themselves as Christians and believe that their quality and meaning of life are orchestrated by a higher power (Facts and Detail, 2019). They maintain a very close-knit community and usually gather in large crowds for community events and worship. They celebrate religious holidays and believe in spirits and natural phenomena.

In Tulare County, in particular, the main religions of the Lahu immigrants include Lutheran, Baptist, and Catholic ideologies. They believe that God orchestrates and oversees everything around them, including illness as a part of life. For example, if a person becomes ill, instead of seeking medical treatment, they may rely on their faith and spirit for healing. Lee et al. (2010) emphasized the importance of mental health literacy

among Southeast Asian (SEA) elderly refugees residing in the United States., specifically in how mental health is understood, communicated, and responded to within their unique social and cultural contexts in order for them to become more educated on the importance of mental health and receptive to change.

Traditional Lahu Health System

Due to the lack of study on the Lahu people, information about Lahu's traditional health system is not available in the scientific literature. However, the Lahu's traditional health system was believed to be similar to those other ethnic groups originating from the Country of Laos, such as Laotian, Hmong, and Mien because of their similarities in religious beliefs and socioeconomic status. They lived in remote areas of Laos isolated from the mainstream media and society. As a result, they relied on natural herbs as a medicine to treat a physical wound and the spirits to heal illnesses (see Mary Jo, 1988).

However, there were articles about other Southeast Asian populations, such as the Hmong population, that discussed the traditional health system. The people of Hmong had a similar experience as the Lahu immigrants in that they both fought in the Vietnam War and escaped the persecution of the Communist regime after the war. In addition, they both were captured by the Thai government and spent years in the concentration camp prior to coming to the United States. In particular, the Hmong people believed that an illness is a supernatural event caused by spirits, called tlan, which emphasizes their perception of illness and validation to their cultural practices (Mary Jo, 1988). According to Mary Jo (1988), there are several tlan, such as the shaman spirit and the body spirit, all of which are believed to serve different purposes for different needs. For example, when

a person is severely ill, the shaman spirit is thought to give the person an opportunity to serve as an intermediary between the physical world and spiritual world during the healing process (Mary Jo, 1988). The body spirits consist of ancestors, dead friends, and animals (Mary Jo, 1988). The belief was that if spirits left the body and were not restored to the body in time, a person would die. Also, the body spirits at times cause illnesses because it wants an animal sacrifice in order for the ill person to recover. They also viewed a string of gold or silver charms tied to the baby's neck, hands, feet, or waist at birth as a sign of promoter of good health. To become a shaman, a person has to be trained by the spirit and a senior shaman before the person is allowed to treat any ill persons (Mary Jo, 1988).

Similar to Hmong, prior to becoming Christians, the Lahu was believed to worship spirits. They believed that illness is a supernatural event either caused by spirits or a higher power (e.g., the Creator of the Universe). Whenever a person is ill, they perform rituals by sacrificing livestock and asking the spirits for forgiveness and healing. These rituals were performed by the village elders, who usually spoke in a different tongue during the rituals (see Mary Jo, 1988). However, after the Vietnam War, the early 1970s, the Lahu became Christians. Since then, they have believed that life and death are pre-destined by the Creator of the Universe and rely on prayers for healing (see See, 2014).

Mental Health of Lahu Immigrants

According to Fu and VanLangingham (2012), immigration affects a wide range of mental health issues directly and indirectly, including adverse social and economic

conditions. This, in turn, affects individuals' attitudes toward mental health systems, including their health-seeking behaviors (Hall & Yee, 2012). Specifically, working with the SEA population, Hall and Yee (2012) emphasized the need to understand the unique characteristics of each ethnic group, such as Chinese, Cambodian, Vietnamese, Hmong, Mien, Laotian, Thai, and Lahu in order to provide culturally appropriate mental health services. In other words, mental health professionals and practitioners must have knowledge of the population being served in order for them to incorporate cultural solutions in their mental health care services to promote positive health outcomes. Hsu et al. (2004) stated:

> Many Southeast Asians endured government-sponsored intimidation and threats to their lives once the Communists gained control of their homelands in Vietnam, Cambodia, and Laos. Migration stressors include separating from or witnessing deaths of family and relatives while fleeing one's home country under life-threatening conditions. After SEAR escaped their native countries, they experienced additional stressors… While residing in refugee camps, encampment stressors included extended detainment in unsafe, overcrowded, and poorly sanitized environments... Research has shown that SEAR is at risk for developing a psychiatric illness due to their experience of leaving their native country and memories related to a brutal war, escape, or concentration camp experiences. (p. 195)

As Hsu et al. stated, the Lahu immigrants, having lived through the experiences of the Vietnam War and the concentration camp, suffered both physical and mental illnesses

resulting from migration. Psychiatric conditions, such as Major Depressive Disorder with or without psychotic features, Persistent Depressive Disorder, Posttraumatic Stress Disorder, and thoughts of suicide were common among the Lahu immigrants. Many Lahu immigrants reported reliving the traumatic experiences of the war and the brutal treatments in the concentration camp. Experiences such as nightmares, hallucinations, and delusions were common among Lahu immigrants, which led to psychotropic intervention to sustain a standard of living (see Ganesan et al., 2011; Hsu et al., 2004; Lee & Lu, 1988).

Lee and Lu (1988) discussed the relationship between traumatic events and PTSD. According to the authors, traumatic events, such as the experiences related to war and concentration camp, forced migration, and torture, negatively impacts a person's health and wellbeing, including the person's quality of life (Lee & Lu, 1988). Also, Ganesan et al. (2011) stated, "25% of South Asian or 24% of Southeast Asian patients had more diagnoses of anxiety disorder in comparison to other ethnic groups" (p. 1). In addition, Ganesan et al.'s study revealed that refugees are prone to physical and mental illnesses compared to non-refugees. However, despite this evidence, there was no scientific literature that explores the Lahu immigrants in the context of mental health. According to Nicholson (1997), only a few studies have investigated a nonclinical sample of SEA people. In spite of that, none of these studies were conducted on the Lahu people.

Additionally, due to the lack of knowledge about the Lahu people, current mental health systems and health policies do not include cultural-specific treatments for the Lahu immigrants. When it comes to health services among the Lahu immigrants, they are

underserved or mis-served in the community compared to other racial and ethnic groups. Uba (1982) emphasized the need for mental health policy decision makers to consider the dynamic approach to meet the mental health needs of Asian Americans. The author argued that adopting the mainstream approach to the mental health systems among diverse groups may alienate them from seeking such services (Uba, 1982). According to the author, the lack of knowledge would lead to reduced service utilization (Uba, 1982).

Past Studies Related to Mental Health of SEA

Fu and VanLandingham's (2012) study on the mental health consequences of Vietnamese Americans and the mediating effects of physical health and social networks revealed that migration directly and indirectly affects their mental health, including socioeconomic status (SES). When compared to "never-leavers" and "returnees" groups, those who resided in a foreign land reported poorer mental health (Fu & VanLandingham, 2012). According to Fu and VanLindingham (2012), migration links to a wide range of health outcomes. Despite this evidence, the authors argued that there was little literature focusing on the Vietnamese Americans (Fu & VanLindingham, 2012). In addition, their study found that Vietnamese Americans' mental health care access rate was lower than the general the U.S. population (Fu & VanLindingham, 2012). Hall and Yee's (2012) study also revealed that despite the mental needs of SEA, they were less likely to seek mental health services compared to other racial and ethnic groups. Also, Lee et al.'s (2010) study on the mental health literacy of Southeast Asian (SEA) elderly refugees revealed a similar result in that mental health was defined within the cultural context. This means that the interpretation of mental health may be different from the

U.S. mainstream media depending on the contexts. To address this gap, the authors emphasized the need for cultural knowledge in order to provide culturally appropriate mental health services among diverse populations. A lack of knowledge of the population being served could lead to misunderstanding and mistrust between mental health professionals and practitioners and patients. Lee et al.(2010) emphasized the importance of tailoring mental health services to each population's needs and providing culturally appropriate mental health services to promote positive health outcomes. The authors stated that mental health needs must be understood, communicated, and responded to within the unique social and cultural contexts (Lee et al., 2010). In other words, it is not about the program itself that influences health outcomes; rather, it is about understanding the unique characteristics of each population and their needs and tailoring the services to the population's needs to promote positive health outcomes.

The Department of Defense (2018) stated that mental health is a serious problem, specifically among service members, such as the Lahu immigrants. The traumatic experiences that service members face threaten their health and wellbeing, including their ability to sustain a standard of living (Department of Defense, 2018). As the Department of Defense stated, the Lahu immigrants served in the Special Guerrilla Units (SGU) during the Vietnam War, fled for their lives from the Communist regime to neighboring countries of Laos, and were imprisoned in the concentration camps for years before coming to the United States. This, in turn, poses serious physical, emotional, and psychological health risks. Kim et al. (2015) stated that Asian Americans have a high rate of depression. Also, a study by the Asian American Coalition (2001) stated that most

Asian Americans were diagnosed with PTSD and MDD.

At a local level, there was one study by the Asian American Coalition (ACC, 2001) on Asian Americans that included the Lahu people. However, despite mentioning the Lahu, the information about the Lahu people was provided by only two individuals in the study from the Lahu Baptist Church in Visalia, California, which calls into question the reliability and validity of the study results. It stated that 90% of the Lahus relied on modern medicine compared to 10% using folk remedies and other cultural practices. In addition, the study noted that 100% of the Lahu group reported a Medi-Cal as their only payment method for health care (ACC, 2001), which may be true to the two participants, but it may not be representative of the general Lahu population. The study findings contradict the Lahu's 100% reliance on folk remedies prior to the Vietnam War, such as natural herbs for physical injuries and spiritual rituals for illnesses (see Mary Jo, 1988). From 1994 to 1995, Medi-Cal insured 51% of Asian Americans in California; however, from 1996 to 1997, the percentage dropped to 34% (see ACC, 2001). This supports Meyer et al. (2009) and Yang et al. (2020) studies in which the authors stated that when it comes to mental health care service utilization, there are disparities among Asian Americans.

Potential Ways to Improve Mental Health of Lahu Immigrants

The Lahu immigrants lived through the experiences of the Vietnam War and encampment, which contributed to their physical and mental illnesses, such as depressive symptoms and PTSD (see ACC, 2004; Ganesan et al., 2011). However, Meyer et al. (2009) and Weng and Spaulding-Givens (2017) stated that Asian Americans, such as

Lahu immigrants, are less likely to seek mental health services. Weng and Spaulding-Givens (2017) stated that cultural barriers and cultural beliefs about the etiology of mental illness are believed to be a factor in the underutilization of services among Asian Americans. This, in turn, influences their health behaviors. Another cultural barrier identified by Weng and Spaulding-Givens (2017) was the language barrier. They believed that individuals who have limited English, such as Lahu immigrants, are less likely to seek mental health services. In addition, Weng and Spaulding-Givens (2017) study found that while Asian Americans speak over 100 languages, they are underrepresented in the mental health workforce.

Currently, in Tulare County, there is a lack of Lahu mental health professionals or practitioners in the field. The County's mental health department uses a third-party organization to serve as a liaison to provide interpreting services due to a lack of Lahu professionals in this field. Consistent with Weng and Spaulding-Givens (2017) findings, Kim et al. (2015) stated that language and health literacy barriers are major factors to underutilization of services and misdiagnosis. Kim et al. (2015) argued that many depressive symptoms among Asian Americans might go unnoticed as a result of the language barrier. Hence, Kim et al.(2015) pointed out that some researchers combined data on Asian Americans with other ethnic groups, such as under "other," which made the data on Asian Americans unclear. Also, the ACC (2001) stated that the language barrier is a major barrier to help-seeking behavior. They need to be able to communicate with mental health professionals and practitioners in order for them to receive services. Additionally, a lack of knowledge about the mental health services, a lack of

transportation to get to and from the services, and stigma are other barriers that contribute to the underutilization of services among Asian Americans (Corrigan et al., 2018; Weng & Spaulding-Givens, 2017). According to Abdullah and Brown (2011) and Knaak et al. (2017), stigma poses severe mental health consequences, which diminishes a person's sense of worth and self-esteem and negatively affects the person's attitude or perception towards seeking mental health services, including mental health care systems. According to the authors, culture plays a significant role in mental illness stigma (Abdullah & Brown, 2011; Knaak et al., 2017). This may include, but not limited, to organizational or workplace culture, such as attitudes toward seeking mental health services (e.g., feeling devalued, dismissed, and dehumanized by healthcare professionals), which, in turn, affects patient-provider interactions and, in turn, the person's decision to seek or not to seek help.

According to the health belief model (HBM), if people's perceived barriers, benefits, self-efficacy, and threats are successfully addressed, they are likely to seek the services (Jones et al., 2015). To achieve this, Kim et al. (2015) stated that there is a need to better understand the unique characteristics of each population, such as the Lahu immigrant populations. In other words, there is a need to incorporate cultural solutions in mental health services, including making sure that mental health is understood, communicated, and responded to within the unique social and cultural contexts of the Lahu immigrants (Lee et al., 2010; Weng and Spaulding-Givens (2017). This includes cultural competency training for the mental health professionals and practitioners (Park et al., 2011) and health care systems improving cultural sensitivity and incorporating

cultural solutions in their mental health care services (Yang et al., 2020). As the Department of Defense (2018) stated, effective screening processes are essential to provide adequate physical and mental health services to communities like the Lahu immigrants.

Summary

Culture is unique and not a system of values, beliefs, and practices that can be transferred across different cultures (Napier et al., 2014). It is a complex system consisting of personal and interpersonal levels that govern an individual's action and behavior (Gopalkrishnan, 2018; Patterson, 2014). There is not a universal behavior, as culture varies from within and across sociodemographic groups (Napier et al., 2014). However, despite past studies revealing the need to study unique cultures through a population-based study (Fu & VanLandingham, 2012), there has not been a study carried out on the Lahu immigrants in the context of mental health, which would be paramount for mental health professionals and practitioners to better understand the unique characteristics of this population, such as their attitudes, beliefs, and perceptions about health and illness in order to work with this population more effectively.

With a lack of study on the Lahu immigrants, there is a paucity of knowledge about the Lahu people, which is particularly important when attempting to incorporate cultural solutions into mental health care services in order to provide culturally appropriate mental health services (Yang et al., 2020). Lee et al. (2010) and Sorkin et al. (2011) stated that to address health disparities in the health care systems, it is important to understand the unique characteristics of the target population.

This study was original in that there has not been a study carried out on the Lahu immigrants in the context of mental health. However, with the Lahu population on the rise in the United States, this study was essential not only to contribute to the literature gap but it also to learn about the unique characteristics of this population, including their attitudes, beliefs, and perceptions toward seeking mental health services. The results of this study may provide cultural knowledge to mental health professionals and practitioners to better assist the Lahu community.

An ethnographic, phenomenological approach is used to explore the lived experiences of the Lahu immigrants. This approach allows in-depth discussions between the interviewer and the participants and encourages them to express their experiences. Information obtained from this study would be essential for mental health professionals and practitioners to work with this population more effectively to promote positive social change. In Chapter 3, I provide information about the methodology of this study to address the research questions.

Chapter 3: Research Method

The purpose of this study was to explore how the Lahu immigrants' attitudes, beliefs, and cultural practices influence their health-seeking behavior to provide a better understanding of the unique characteristics of this population to assist mental health professionals and practitioners to work with this population more effectively. In addition, this study contributed to the literature gap related to the Lahu immigrants. While there were literatures on other SEA populations such as Cambodian, Laotian, Hmong, Mien, Korean, Chinese, Laos, and Vietnamese (ACC, 2001; Fu & VanLandingham, 2012; Lee et al., 2010; Lo, 2019), there was not a study on the Lahu immigrants in the context of mental health.

This study provides valuable insights into the unique characteristics of the Lahu immigrants and their attitudes toward seeking mental health services, which could be paramount for mental health professionals and practitioners in providing culturally appropriate mental health services. Yang et al. (2020) stated that to provide culturally appropriate mental health services, healthcare systems must incorporate cultural sensitivity in their mental health services. In fact, Lee et al. (2010) and Sorkin et al. (2011) stated when given cultural diversity of SEA populations, understanding the unique characteristics of each population is paramount to health promotion and addressing disparities in mental health care services.

With a lack of literature on the Lahu immigrants in the context of mental health, existing literature on other SEA populations was used as justifications for this study, particularly individuals having lived through the experiences of migration, war or

encampment, and their attitudes toward seeking mental health services. In this chapter, I describe the methodology and specific actions to be taken to investigate the research problem and the rationale for the application of specific procedures to identify, select, process, and analyze the study results, including the reliability of the study (see University of California [USC] Libraries, 2018). Findings from this study may enable mental health professionals and practitioners to effectively work with the Lahu immigrants and provide culturally appropriate mental health services.

In this chapter, I explore their attitudes, beliefs, and cultural practices that may influence their health-seeking behavior, including their attitudes towards mental health care systems. The following topics are discussed in detail: (a) the research design and rationale, (b) the researcher's role, (c) the methodology of the study, (d) instrumentation, (e) trustworthiness of the study, and (f) ethical considerations of the study.

Research Design and Rationale

In this qualitative study, I explored the Lahu immigrants' attitudes, beliefs, and perceptions toward seeking mental health services. A qualitative study design was appropriate for this study, as I explored the interplay of individual, interpersonal, and cultural factors in shaping the Lahu immigrants' attitudes toward seeking mental health services, including their attitudes towards the mental health care systems. In other words, I sought to understand the unique characteristics of the Lahu immigrants and their lived experiences in their natural contexts. Burkholder et al. (2016) stated that a qualitative study is "an exploratory investigation of a complex social phenomenon conducted in a natural setting through observation, description, and thematic analysis of participants'

behaviors and perspectives for the purpose of explaining and/or understanding the phenomenon" (p. 68). In other words, a qualitative study describes the phenomena experienced by individuals or groups, such as through observation or individual and focus group interviews (Burkholder et al., 2016).

A qualitative research design was appropriate, as I explored the Lahu immigrants' attitudes, beliefs, and perceptions toward seeking mental health services using overarching semistructured and open-ended questions through interviews. This study addressed the following three research questions:

RQ1: What are the attitudes of Lahu immigrants toward seeking mental health services?

RQ2: What are some beliefs and cultural practices of Lahu immigrants in terms of mental health?

RQ3: How do Lahu immigrants' attitudes toward mental health professionals contribute towards mental health access among the Lahu immigrants?

I used an ethnographic and phenomenological approaches to address my research questions, which were one of the early approaches to studying people in their natural environment, such as how social and cultural factors influence the way in which people perceive and assign meanings to their environment and worldview (Jones & Smith, 2017). Similarly, Neubauer et al. (2019) explained that phenomenology is a qualitative approach to studying people's lived experiences and exploring phenomena in their natural contexts.

Research Tradition

Since the development of qualitative research methods, qualitative studies are widely conducted by researchers from various fields, such as psychology, anthropology, sociology, and program evaluators (California State University of California Long Beach, n.d.). In particular, the method has been used when exploring lived experiences on people in their natural setting (Burkholder et al., 2016; Nebauer et al., 2019; Salihu et al., 2015; See, 2014). Recent studies by See (2014) and Salihu et al. (2015) have used a qualitative approach to explore lived experiences of people in their natural setting. Burkholder et al. (2016) and Nebauer et al. (2019) stated that qualitative research is an exploratory investigation into lived experiences of people in their natural setting observation, such as exploring the Lahu immigrants' attitudes toward seeking mental health services.

Given this interpretation of qualitative research approach, this method was appropriate for this study to investigate the Lahu immigrants' attitudes toward seeking mental health services. I investigated external and internal factors affecting mental health care services for the Lahu immigrants. This included the Lahu immigrants' beliefs and cultural practices as it relates to mental health care services, including their attitudes toward mental health professionals and mental health care systems. Therefore, an ethnographic and phenomenological approach were used to inform the structure of this study and address the research questions. Using semistructured and open-ended questions, I explored the Lahu immigrants' attitudes towards seeking mental health services through interviews.

Role of the Researcher

As the researcher, my role in the qualitative study was to design the study process, conduct interviews, collect data, analyze data, and interpret data to address the research questions. This included coding data and finding themes to present the research findings in a coherent and meaningful way. Additionally, I ensured that the handling of data was appropriate and in alignment with the research design. Sutton and Austin (2015) stated that the role of the qualitative researcher is to gain insights into a participant's thought and feeling to understand the way in which the participant assigns meanings and values to the environment and the world. Through interviews and observations, this study aimed to provide an insight into the Lahu immigrants' attitudes toward seeking mental health services.

The Lahu community relies on trust and relationship in social and community functions, and they do not engage with individuals outside of their community (see See, 2014), particularly when it comes to exchanging personal information, such as an individual's attitude and belief about seeking mental health services. As such, collaboration with entrusted Lahu community leaders (e.g., community elders, pastors) was important to establish my relationship with my study participants and to gain their trust, which, in turn, was critical to the quality of the research data and the study process. Burkholder et al. (2016) stated that the researcher should negotiate and adopt a level of participation in ways that will produce meaningful data.

Also, important to note is that the Lahu culture expects respect for community elders, or older individuals, in general (see See, 2014). The belief is that older individuals

have more life experiences and contribution to the community and society; therefore, they should be respected by younger generations. This means that older individuals do not expect to answer questions for someone younger than them. As such, it was important for me to work collaboratively with community leaders, as some of my study participants may be older than me and may not provide meaningful data without the influence of the community leaders.

While I led this study, I collaboratively worked with the community leaders (e.g., community elders, pastors) to recruit the participants. The support of community leaders helped me develop my identity as the researcher among the community members and enhanced the level of comfort, trust, communication, and respect among the community members (see Lo, 2019). In turn, participants may have been more open and forthcoming to share their life experiences and produce meaningful data (see Lo, 2019).

I partnered with community leaders and a local church to recruit the participants, such as through an announcement during a church service, posting of recruitment flyers in the church lobby, and by word-of-mouth regarding the participant requirement. In addition, I developed an interview guide and consent form with the collaboration of the community leaders in both Lahu and English. See (2014) stated that community often perceives researchers as an outsider; therefore, having the support of the community leaders to address the language barrier is vital to the success of this study.

Methodology

Participant Selection

The population of interest was first generation Lahu immigrants living in the Tulare County—individuals who migrated to the United States. Through a collaboration with the community leaders and partnering church board members, I recruited nine participants for this study. Unlike in quantitative study, an ethnographic, phenomenological study is used to contribute to understanding (Sergeant, 2012); therefore, the number of participants depends on the number required to fully address the research questions and achieve data saturation (Dworkins, 2012). In other words, the quality of the data is more important than the quantity of participants (Dworkins, 2012; Sergeant, 2012).

The participant selection was purposeful, and the participants selected for this study were best to address the research questions and provide better understanding of this population's attitudes, beliefs, and perceptions toward seeking mental health services. The USC Libraries (2018) emphasized the importance of reliability and quality of the research data in a qualitative study. Burkholder et al. (2016) and Creswell and Creswell (2018) also stated that in a qualitative study, the quality of each participant's experience is more important than a mere number of the participants. In other words, a qualitative study focuses on the meaningfulness of the data through in-depth interaction with the participants, as opposed to the number of the participants.

The participants were given both verbal and written information about the proposed research and its intended outcomes and benefits. The participants were educated

on their rights to ensure their understanding of voluntary participation, meaning they could withdraw at any time. The participants who were interested in participating in the study were required to acknowledge the study by signing a consent form.

Inclusion Criteria

There were several criteria that participants had to meet to be included in this study. First, the participants had to be Lahus. Second, the participants had to be immigrants who went through the immigrant process to come to the United States; therefore, the participants were expected to be over the age of 18. Third, the participants had to live in Tulare County. With the collaboration with the community leaders and a partnering church, the participants were recruited by word-of-mouth and through flyers.

Justification of Sampling Strategy

Since there has not been a research study carried out on the Lahu immigrants in the context of mental health, coupled with the inclusion criteria, a convenience sampling (see Edgar & Manz, 2017; Elfil & Negida, 2017; Galloway, 2005) was used to recruit participants. A convenience sampling method was appropriate as this study seeks to provide an understanding about the Lahu immigrants' attitudes, beliefs, and perceptions toward seeking mental health services. Elfil and Negida (2017) stated that a convenience sampling is widely used in clinical research. Using a convenience sampling method, it allowed me to ensure not only that I meet the targeted sample size but as well as the participants' relevant experiences to address the research questions. In this case, a Lahu who went through the migration process to come to the United States and living in Tulare

County. In a convenience sampling, I selected participants who were conveniently available that met the inclusion criteria.

Participant Number

Unlike in quantitative study where there are established statistics-driven rules on determining sample size, in a qualitative study the sample size is the subject of ongoing discussions (Vasileiou et al., 2018). Vasileiou et al. (2018) stated that the adequacy of sample size in qualitative study is dependent on the appropriate of the sample composition and size. Also, Moser (2018) posited that sample size is dependent on the characteristics of the context, such as participants' vulnerability. In other words, it is not about just the mere number of participants; rather, it is about the quality of the research data (e.g., participants' experiences such as the participants' perceptions, thoughts, and feelings; Burkholder et al, 2016; Creswell & Creswell, 2018; Vasileiou et al., 2018).

As such, I recruited nine participants for this study. This sample size was appropriate, as this study was an exploratory study where I engaged in in-depth discussions with the participants to contribute to understanding (see Sergeant, 2012). In a qualitative study, the number of participants depends on the number required to fully address the research questions (Burkholder et al., 2016; Creswell & Creswell, 2018; Dworkins, 2012; Moser, 2018; Sergeant, 2012; USC Libraries, 2018; Vasileiou et al., 2018).

To fully address the research questions, the interviews were focused on the participants' lived experiences (e.g., quality of the data) by using semistructured research questions and follow-up questions as necessary to address the research questions. The

interviews were conducted face-to-face with each participant for about 1 to 1.50 hours. Each participant was provided ample time to respond to each question and, if necessary, follow-up questions to address each research question.

With the collaboration of the community leaders and a partnering church, I did not experience any difficulty in recruiting the participants. To the contrary, I turned away some participants due to the time constraint of this study. Therefore, a follow-up recruitment plan was not applicable for this study.

Recruitment Process

The participants were recruited on first come first basis and had to be a Lahu who went through the immigration process to come to the United States. In collaboration with community leaders and a partnering church, the announcement for recruitment was made during the Lahu church service to inform the Lahu community of the proposed research, intended outcomes and benefits. In addition, flyers were posted at the church lobby, including a sign-up sheet for anyone who meets the research criteria and is interested in participating in the study. The recruitment process was closed once nine participants were reached.

Data Saturation and Sample Size

Since this was new research, the focus of this study was to elicit the participants' attitudes, beliefs, and perceptions toward seeking mental health services through in-depth discussions. Burkholder et al (2016), Creswell and Creswell (2018), and Vasileiou et al. (2018) stated that in a qualitative study, the focus is about the quality of the data, not a mere number of the participants.

To ensure data saturation, I used semistructured questions for the interview. In addition, where appropriate, I asked follow-up questions to obtain maximum information to address the research questions. Moser (2018) and Moser and Korstjens (2018) stated that data saturation is reached when there is enough information about the phenomenon of the study. Similarly, Fusch and Ness (2015) stated that data saturation is reached when there is enough information to replicate the study. In other words, data saturation is reached when researchers feel a sense of closure with the information obtained and no longer yields new information (see Moser, 2018; Moser & Korstjens, 2018). The participants were given ample time to respond to each question, along with follow-up questions where appropriate.

Instrumentation

The data was collected from the participants through interviews. During the interview, I asked semistructured questions to the participants. The participants were given ample time to respond to each research question to contribute to the study. Where appropriate, I asked follow-up questions to ensure maximum information was obtained from the interview to address the research questions.

The interviews were recorded on a digital recorder. The information was protected with a passcode and will be destroyed in accordance with the Walden University's retention policy. I also took notes of the interviews to reference during the transcription process to help improve the validity of the information obtained from the interviews. See (2014) stated that in an ethnographic, phonological study, interview data is sufficient for qualitative studies. Additionally, See (2014) stated that in qualitative

studies, semistructured questions are commonly used. Since this study collected data through interviews, using a digital recorder and as well as interview notes are sufficient to gather the information to address the research questions.

Frequency and Duration of Data Collection

The interview was planned for 1 to 1.50 hours for each participant. I met with each participant for the interview. The participants were provided with my contact information if they wish to change their responses after the interview. Immediately, after the interview, I transcribed each participant's responses onto a Word document. I notified each participant once his or her responses were transcribed. The participants were provided with an opportunity to review their responses and make any changes they feel appropriate, as long as the responses were not uploaded to transcription software and have not been finalized to be submitted to Walden University.

Recording

With the consent of the participants, the interview was recorded on a digital recorder and on paper. The information was protected with a passcode to protect the confidentiality and privacy of the participants. The interview notes recorded nonverbal cues such as the participants' behaviors. Due to the language barrier, the interviews were conducted in Lahu; however, since there was no word-for-word translation from Lahu to English, transcription was developed in English.

The data was analyzed using a thematic analysis, which is an approach that is widely used in qualitative tradition and has demonstrated reliability (see Nowell et al., 2017). I examined raw data (e.g., interview data) and looked for similarities and

differences to identify themes and develop categories. I used a qualitative data analysis tool, Quirkos, to help with coding and data analysis.

Participant Exit Procedures

At the conclusion of each interview, an exit interview was conducted with each participant where I acknowledged each participant's contribution to the study. I reiterated the proposed research study and its intended outcomes and benefits. This was also an opportunity to address each participant's questions or concerns regarding the study. I shared with each participant how the data will be used, stored, protected, and destroyed at an appropriate time. In addition, each participant was provided with my contact information to contact me regarding any questions with the study, or if the participant wishes to change their responses to any research questions. The participants were provided an opportunity to change their responses by contacting me directly or upon their review of the transcript before the data analysis and submission to Walden University. For any participants wishing to obtain their transcription, prior arrangement will be made to go over their responses, as the responses will need to be translated into the Lahu language. Unless a request is received from the participants, information obtained will be considered true and accurate and representative of the participants' experiences.

Issues of Trustworthiness

The validity and reliability of this study was paramount, as the study seek to provide an understanding regarding the unique characteristics of the Lahu immigrants in the context of mental health, including their attitudes, beliefs, and perceptions toward seeking mental health services. The common issues of trustworthiness in a qualitative

study are: (a) credibility, (b) transferability, (c) dependability, and (d) confirmability (see Burkholder et al., 2019). These issues are addressed through the use of semistructured questions to engage in in-depth discussions with the participants and follow-up questions where appropriate to ensure the quality of the data. In addition, each step of this study process was documented to ensure the reliability of the study. Hence, this study used scientific models such as HBM and SEM to inform the research questions and the structure of this study. Further, conducting the interviews in the Lahu native language helped to ensure that data obtained from the interviews are representative of the participants' experiences. A detailed discussion of trustworthiness of the collected data is discussed in Chapter 4.

Ethical Procedures

The community leaders and a partnering church contacted for permission to recruit participants and conduct interviews at the church. I sent a formal letter to the Lahu church board members outlining my recruitment and participant selection process to fulfill this research requirement. Upon approval, I retained the letter as an official document granting permission to recruit participants and conduct interviews using a church space. With cultural differences of the Lahu immigrants, collaborating with the community leaders were critical to the study outcomes, as the Lahu people engage with the community members through trust and relationships (see See, 2014).

The recruitment flyer, interview guide, and consent forms were developed in the Lahu language to ensure that participants were informed about the goal of this study and

as well as their roles in the study. In addition, since this study was conducted in the native Lahu language, it helped me to better prepare for the interview process.

To protect the confidentiality of the participants, the interviews were conducted at a church in an enclosed room. During the interviews, the participants were reminded that their participation was voluntarily, and they may choose to decline to answer to any questions or terminate their participation altogether if they wish, which was also outlined in the consent form in both Lahu land English. The American Psychological Association (APA, 2017) stated that it is the psychologists (e.g., researchers) obligation to protect and safeguard the welfare and rights of those with whom they interact or work with, such as research participants.

The interview was recorded using a digital recorder and protected using a unique passcode. Upon transcription, the recording information will be destroyed in accordance with the Walden University's retention policy. As described in the data collection section, I took notes during the interview to be referenced during the transcription process to ensure the validity of the data. The interview notes will also be destroyed in accordance with the Walden University's retention policy.

Prior to engaging in this study, such as collaborating with the community leaders and a partnering church board member, I obtained an approval from the Walden University's Institutional Review Board (IRB). Walden University (2022) stated that before participant recruitment or data collection, IRB approval is required for all Walden-affiliated studies. Upon approval, I began the study by collaborating with the community

leaders and a partnering church board members and started the participant recruitment, interview, and data collection process to fulfill this study's requirement.

Summary

Since there has not been a study on the Lahu people in the context of mental health, this study was paramount to providing valuable insights into the unique characteristics of this population. This information may not only assist mental health professionals and practitioners to work with this population more effectively, but it will also contribute to the literature gap.

As such, this study was conducted using a qualitative design. Using semistructured questions, I conducted an in-depth interview with nine participants. To ensure the validity and reliability of the data, interviews were conducted in the Lahu native language. In addition, follow-up questions were used where appropriate to ensure the quality of the data. Hence, to gain the participants' trust, I collaborated with the community leaders and a partnering church board members in recruiting participants, which was critical to the outcome of this study, as the Lahu people interact with others through trust and relationships (see See, 2014).

In Chapter 4, I discuss the research findings in detail. The findings may provide valuable insights into the unique characteristics of the Lahu immigrants in the context of health, which may be critical to enabling mental health professionals and practitioners to provide culturally appropriate mental health services. Furthermore, the findings may inform the cultural dynamic of the Lahu people and future studies with the Lahu community.

Chapter 4: Results

The purpose of this study was to explore the lived experiences of the Lahu immigrants residing in Tulare County, California, in terms of their attitudes, beliefs, and perceptions toward seeking mental health services. The sample for this study was Lahu immigrants (e.g., Lahu refugees) from the Country of Laos and Thailand. I employed a qualitative design to engage in in-depth interactions with the participants to gain a better understanding of their lived experiences in terms of their attitudes, beliefs, and perceptions toward seeking mental health services.

This study was original, as there has not been a found study carried out on the Lahu immigrants in the context of mental health. With the Lahu immigrant populations on the rise in the United States, there was a need to develop cultural knowledge of this population for mental health professionals and practitioners to effectively engage this population. Findings from this study should provide valuable insights for mental health professionals and practitioners to incorporate cultural solutions in their mental health services and provide culturally appropriate mental health services among this population.

The HBM and SEM were used to inform the structure of this study. The HBM was developed in the 1950s to explore people's behavioral responses to illnesses, which seek to understand how external and internal influences affect people's health behaviors (see Glanz et al., 2015; LaMorte, 2022; University of Pennsylvania, n.d.). Similarly, the SEM was developed to explore the lived experiences of people, such as observing human interaction in their natural environment (see Lutters & Ackerman, 1996). These models were appropriate for this study, as this study focused on exploring the lived experiences

of the Lahu immigrants in the context of mental health. These models allowed me to engage in in-depth discussions with the participants in their natural setting to better understand the unique characteristics of the population in terms of their attitudes, beliefs, and perceptions toward seeking mental health services. The following research questions were developed to guide the interview questions in exploring the participants' attitudes, beliefs, and perceptions related to mental health-seeking behaviors:

RQ1: What are the attitudes of Lahu immigrants toward seeking mental health services?

RQ2: What are some beliefs and cultural practices of Lahu immigrants in terms of mental health?

RQ3: How do Lahu immigrants' attitudes toward mental health professionals contribute towards mental health access among the Lahu immigrants?

The results of the study regarding the Lahu immigrants' attitudes, beliefs, and perceptions toward seeking mental health services are presented in this chapter in chronological order of the research questions. In addition, this chapter includes detailed discussions of the setting, demographics, data collection, data analysis, and evidence of trustworthiness. Finally, I conclude this chapter with the interview analysis and results.

Setting

The interview was conducted at a church in Visalia, California in an enclosed office. The office has no exterior window with beige color walls on four sides. The room has one computer desk and one rectangle table with chairs on the opposite end of the room. Both the interview guide in English and Lahu were placed on the interview table,

along with snacks and water. Since the office was connected to the hallway and it was at a church, some external noises were expected due to church activities. However, formal conversations inside the room cannot be heard on the outside of the room. Also, since the participants attend the church regularly and are familiar with the environment, this was an ideal setting for the interview.

Demographics

The population for this study was the Lahu immigrants living in Tulare County, California. As communicated in the recruitment flyer, all the participants had to meet the inclusion criteria; that is, the participants must be Lahu immigrants (i.e., refugees) living in Tulare County, California and be at least 18 years of age.

Only limited demographic information was gathered to ensure participants met the inclusion criteria after the participants expressed interest in participating in the study. I asked the participants for their names (i.e., “who am I speaking with?”), their genders (i.e., “What is your gender?”), their ages (i.e., “What is your age?”), and whether they were born outside of the United States (i.e., migrated to the country).

A total of nine participants volunteered for this study with five men and four women. The age of the participants ranged from 34 years of age to 71 years. Table 1 describes the participants’ demographics.

Table 1

Participant Demographics

ID	Gender	Age	Live in Tulare County	Migrated to the United States
P1	Male	51	Yes	Yes
P2	Female	48	Yes	Yes
P3	Female	52	Yes	Yes
P4	Male	55	Yes	Yes
P5	Female	46	Yes	Yes
P6	Male	50	Yes	Yes
P7	Female	34	Yes	Yes
P8	Male	36	Yes	Yes
P9	Male	71	Yes	Yes

Data Collection

The data for this study was collected through face-to-face interviews using a convenience sampling. A total of nine participants volunteered for this study and agreed to share their experiences regarding their attitudes, beliefs, and perceptions toward seeking mental health services. Using semistructured questions, I asked open-ended questions and as well as follow-up questions where appropriate to engage in in-depth discussions with the participants and to explore their lived experiences toward seeking mental health services.

The participants contacted me via the phone number provided in the recruitment flyer to express their interest in participating in the study. During the call, I confirmed the participants' gender, age, county of residence, and whether if the participants were refugees to ensure they met the inclusion criteria. Once they met the inclusion criteria, I scheduled a date and time for a meeting with each participant at a church. Once the nine

participants confirmed to participant in the study, the flyers were taken down at the church.

Prior to the interview, each participant was provided the consent form in both English and Lahu for review. Once the participant reviewed and agreed to participate in the study, the participant was required to sign the consent form to indicate their understanding of the study.

The interview was conducted in the Lahu language at a church in Visalia, California in an enclosed office. The length of the interviews varied from participant to participant, ranging from 20 to 45 minutes, which is shorter than anticipated. This may be due to fact that Lahu language does not have many descriptive word choices like English and information being shared was in short sentences. The interviews were audio-recorded and saved on a personal computer with a password-protected method and accessible only by me. In addition, all interview notes, including any changes made to the transcripts by the participants were also maintained in a secured safe only accessible by me.

Since this interview was conducted in the participants' native language, Lahu, I read each question in English and Lahu, and I provided further clarifications in Lahu if necessary. Due to the differences in the language, the participants' responses may be brief but the translation itself into English may include more words to capture the real meaning of the response. For example, there is not a word-per-word translation between English and Lahu; one word in Lahu may have to be translated through a couple words in English. In addition, the participants' brief responses to the interview questions may be

due to the participants' first time engaging in interviews. This was evident when participants reviewed the transcript and wanted to revise or add additional information.

Immediately after the interview, I reviewed my notes for each participant and reviewed each participant's recording and developed a transcript in Microsoft Word. I read each transcript once for accuracy. Once the transcript was reviewed, I scheduled a date and time with each participant to review the transcript. Any transcript with changes made by the participants because they changed their response or simply corrected their responses were updated and kept in a secured and safe file only accessible by me.

Data Analysis

After interviewing the participants, I transcribed each interview verbatim in Microsoft Word. The interview transcripts were organized in the order of the interview (i.e., P1, P2, P3, etc.). Once all the transcripts were transcribed, I read each interview once along with the recorded audio to ensure the accuracy of the transcripts and that they were reflective of the participants' experiences. After that, I scheduled a date and time with each participant and reviewed the interview transcripts. Any changes made to the transcript were maintained in a secured space only accessible to me. Once all the transcripts were updated, I re-read each transcript once and made preliminary notes of key words, such as recurring words or phrases within and across the interviews. After that, using the interview guide, I reviewed all the questions and their topics and grouped them into six categories: (a) health/mental health definitions, (b) attitude/perception of mental health, (c) preventative services, (d) cultural beliefs and practices, (e) barrier to

mental health, and (f) need to improve mental health (see categories in Table 2 below). I labeled these categories as Level 1 codes.

Once the categories were identified, I uploaded each transcription into Quirkos (a qualitative data analysis software) in the chronological order of the interviews (i.e., P1 for Participant 1, P2 for Participant 2, P3 for Participant 3, etc.) and reviewed the recurring words and phrases through queries. I created the same list of six categories (Level 1 codes) in the queries on Quirkos. Then I reviewed all the recurring words and phrases, and I moved them under the appropriate categories. After that, I compiled a list of recurring words and phrases for each category and transferred the results of queries (list) onto Microsoft Excel for review.

I began the coding process by reviewing the recurring words and phrases from Quirkos. Using the hierarchical coding method, I developed priori codes. I identified six categories (Level 1 codes) based on the interview question guide. Next, I developed the subcodes: Level 2 codes which include a more specific groupings of the recurring words and phrases; and Level 3 codes, which were the actual themes.

Overall, the themes were developed for each Level 2 codes which fall under each question category (Level 1 codes), which is a tree coding style format, one of the most popular approaches to analyzing complex data (see Rokach & Maimon, 2023). The following steps highlights the data analysis process:

1. Reviewed the interview notes, listened to audio, and developed transcripts in Microsoft Word.
2. Read each transcript once with the audio to ensure accuracy.

3. Identified six categories (level 1 codes) using the interview guide questions.
4. Conduct preliminary review of recurring words and phrases.
5. Upload all the transcripts into Quirkos.
6. Created six categories (level 1 codes) in queries (Quirkos) using the interview guide question topics.
7. Looked for recuring words and phrases through queries and moved them under the appropriate categories (Level 1 codes).
8. Transferred a list of recuring words and phrases for each category identified through queries to Microsoft Excel.
9. Developed priori codes through the tree coding style format using the six interview question categories (e.g., Level 1 for the six interview question categories, Level 2 codes for more specific groupings, and Level 3 for actual themes).
10. Developed subcode list with definitions.
11. Reviewed for duplicate subcodes.

After all the subcodes were identified, the data were further reviewed to determine whether the codes would be included in the presentation as themes. Based on the results, any codes that were mentioned four or more times in the nine interviews were considered themes and included in the presentation. The codes were then organized and classified in the chronological order of research questions. A total of 22 themes were derived from the data, which are discussed in detail in this chapter. Additionally, discrepant cases were also reported in this chapter under the section, discrepant finding.

Table 2 illustrates the themes emerged from the research questions. The themes such as not sick/good health, exercise, and energy were defined as the health definitions (i.e., “health and wellness are someone who is healthy…has good appetite for food, maintains a healthy diet and eats healthy food,” “someone who is in good health and does not get sick often,” and “someone who is strong… and healthy”). In contrast, themes such as crazy, brain problem, medication, treatment, depression, and difficulty sleeping were identified as mental health definitions (i.e., “a place for crazy people to go and get mediation and treatment” and “people with brain problem, brain immaturity, a place for them to go and get a diagnosis and medication and treatment”). In addition, the participants identified the theme, “only when sick,” with mental health services, while at the same time, they acknowledged the importance and benefits of mental health services provided by the mental health systems, specifically among individuals with mental health illnesses (i.e., “I only go to the doctor when I’m ill or sick”). Further, themes such as God, prayer, herbs, and faith healer were identified as the participants’ cultural beliefs and practices (i.e., “life and death is a way of life, orchestrated by God,” “if it’s your time, then even doctors would not be able to help,” and “as a Christian, I think life and death is a gift from God, orchestrated by God, cannot be fixed by a human”). Lastly, themes such as don’t speak English and don’t drive were identified as a barrier to seeking mental health services (i.e., “a lack of interpreter preventing me and others like me from seeking services at times” and “older Lahu immigrants do not drive or speak English”).

Table 2

Themes from the Research Questions

Research Question 1: Categories and Themes	Research Question 2: Categories and Themes	Research Question 3: Categories and Themes
Categories: Health/Mental health definitions Attitude/Perception of mental health Preventative services Themes: Not sick Exercise Energy Eat healthy food Crazy people Brain problem Medication Treatment Depression Difficulty sleeping Service is important Service is helping people Reserved only for ill people Only when sick	Categories: Cultural beliefs Cultural practices Themes: God Prayer Herbs Faith healer	Categories: Barrier to mental health Need to improve mental health Themes: Don’t speak English Don’t drive Provide transportation Provide interpreter

Evidence of Trustworthiness

In a qualitative study, evidence of trustworthiness is paramount to demonstrate the reliability and internal and external validity of the study (Burkholder et al., 2019). The four concepts used to evaluate a qualitative study are credibility, transferability, dependability, and confirmability. In this chapter, I used the following strategies related to evidencing trustworthiness of this study.

Credibility

Credibility concerns the internal validity (Burkholder et al., 2019), which is one of the most important concepts in validating qualitative research. In other words, credibility concerns the quality of the data and whether the data collected is representative of the study participants' experiences. Candela (2019) stated that confirming the accuracy of the data collected increases the credibility of a qualitative study.

To ensure the credibility for this study, I employed member checking technique to validate the quality of the study results, which is one of the strategies widely used in a qualitative study (see Burkholder al., 2019; Candela, 2019). During the interview, I read each question in both English and Lahu at least once and provided further clarification in the Lahu language where appropriate. I actively engaged with the study participants by validating and confirming their responses where appropriate. In addition, once the interviews were transcribed, I scheduled a date and time with the participants to review the transcripts. This provided an opportunity for the participants to make corrections or add on to their responses to make sure the data were representative of their experiences; this process ensures data validity of the study. Any corrections made to the transcripts were kept in a secured space only accessible by me. Candela (2019) stated that member checking is an integral part of validating a qualitative study.

Transferability

Transferability concerns the external validity, that is, whether if the study results are generalizable to the population of interest for the study (Burkholder et al., 2019). One

of the strategies widely used in a qualitative study is called thick description (Burkholder et al., 2019). For example, the researcher provides sufficient descriptions of the study setting, participants, and detailed descriptions of the study findings, including sufficient direct quotes from the participant interviews.

To meet the standard of transferability, I employed the thick description technique. I provided a detailed description of the study setting, which included the location and description of the location. In addition, I included information of the participants' demographics, including the inclusion criteria (i.e., the participant must be a Lahu immigrant living in Tulare County, and at least 18 years of age and older). Furthermore, I included sufficient direct quotes from the participant interviews to support the study findings.

Since this study is one the first studies among the Lahu immigrants in the context of mental health, the information presented in this study could be crucial to future researchers to replicate a similar study in another context. However, the intent of this qualitative study (i.e., phenomenological study) was not to generalize the study results beyond the Lahu immigrants' experience in Tulare County; rather, to understand the study participants' experiences related to a particular phenomenon (i.e., the participants' attitudes, beliefs, and perceptions toward seeking mental health services).

Dependability

Dependability is one of the important concepts in a qualitative study. It concerns with the evidence of consistency related to the data collection, analysis, and reporting (Burkholder et al., 2019). In other words, is the data reliable and produces consistent

results (Burkholder et al., 2019). To ensure evidence of dependability, I employed an inquiry audit (e.g., audit trial) technique, which is one of the techniques used in evaluating a qualitative study, which included "reviewing how the data were collected, how the categories were derived, and how decisions were made throughout the inquiry" (Burkholder et al., 2019, p. 77). I documented each step of the research process, including the methodology, sampling method, and interview setting. In addition, due to the language barrier, cultural competence was taken into consideration, which led to the decision to conduct this study in the native Lahu language paired with English. Additionally, the demographic information about the participants and inclusion criteria were documented to ensure accuracy and to allow future researchers to replicate a similar study in another context.

Confirmability

Confirmability focuses on objectivity (Burkholder et al., 2019). That is, if another researcher examining the same data used in this study would arrive at the same conclusion. Ravitch (2016) stated that confirmability is "the concept that the data can be confirmed by someone other than the researcher" (p. 209).

To ensure confirmability, the health belief model (HBM) and socio-ecological model (SEM) were used to inform the structure of this study and the development of the research questions, which were widely used models in qualitative studies (Bishop, 2010; CSULB, n.d.; Glanz et al., 2015). In addition, interview notes, audio recordings, and transcripts used in this study were saved in a secured location only accessible by me. Furthermore, I used the qualitative data analysis software Quirkos to analyze the

interview data, which is one of the qualitative data analysis tools used in qualitative studies. This systematic method minimizes internal biases in analyzing the data and, in turn, contributes to the objectivity of the study results. Moreover, each step of the research process was documented, which allows other researchers to verify the study findings.

Results

The purpose of this study was to explore the Lahu immigrants' attitudes, beliefs, and perceptions toward seeking mental health services. Using HBM and SEM frameworks, the research questions sought to explore the lived experiences of the Lahu immigrants in the context of mental health. These models guided the research questions and the structure of this study.

The findings for each research question are presented in the chronological order of the research questions. Since this study was to explore the Lahu immigrants as a group, the findings are summarized and presented for each theme, as opposed to each individual participant's responses. In addition, for each theme, discrepant cases are presented in the paragraph heading, discrepant finding.

Research Question 1: Attitude Towards Mental Health

The first research question for this study was *What are the attitudes of Lahu immigrants toward seeking mental health services?* This research question was focused in two areas: 1) the participants' knowledge about health and wellness, and 2) the participants' attitudes toward seeking mental health services. In terms of the participants' knowledge about health and wellness, the following themes emerged from the data:

eating healthy food, not sick/good health, exercise, and energy. As for the participants' attitudes toward seeking mental services, the following themes emerged from the data: crazy people, brain problem, medication, treatment, depression, difficulty sleeping, only when sick, important, and helping people.

The following interview questions were asked for this research question:

1. How do you define health and wellness?
    a. When you hear the words mental health, what comes to mind?
    b. Can you explain some of the terms associated with mental health?
2. How important or unimportant are mental health services to you and why?
3. Do you seek mental health services as a preventative measure?
4. In your opinion, do you believe that mental health services are only reserved for those with disabling illnesses, such as individuals with psychotic disorders, and why?
5. What are some things that discourage you from seeking mental health services?

Interview Question 1

The first interview question for this research was *How do you define health and wellness?* The following themes emerged from the data: eating healthy food, not being sick, exercise, and having a high level of energy as a sign of good health. Each theme is described below.

Eat Healthy Food

The words *eat healthy food* were mentioned four times by the interview participants. The participants mentioned that eating healthy food is the definition of good health. They believed that not eating healthy food leads to health complications, which, in turn, leads to the needs of mental health interventions. P1 stated that the definition of health and wellness are "someone who engages in healthy living and maintains a healthy diet and watches what he or she eat. Often, unhealthy lifestyle that leads to health problems." Also, P8 provided a similar definition that health and wellness mean "someone who is healthy, exercise, has good appetite for food, maintains a healthy diet and eats healthy food." The participants defined "eating healthy food" as a sign of good health. No other responses were provided by the participants. Not being sick was another theme that emerged from the data as the definition of good health.

Not Sick/Good Health

The words *not sick/good health* was mentioned seven times by the interview participants. Out of the nine participants, seven participants (i.e., P1, P2, P3, P4, P5, P7, P9) mentioned that the absence of any illness (i.e., not being sick) as a sign of good health. P1 stated, "Health and wellness mean someone without any illness or sock." Most of the participants associated physical health as an important aspect of being in good health. Exercise was another theme that emerged from the data as the definition of good health.

Exercise

The word *exercise* was mentioned four times by the interview participants. The participants (i.e., P3, P6, P8, & P9) mentioned that exercise promotes good health. P1 stated, “I think health and wellness is someone who has full of energy, healthy, exercise, and without any illness.” Similarly, P6 stated, “Someone who exercises and takes care of oneself.” The participants mentioned that if a person exercises regularly, the person is likely to be healthy. No other responses were provided by the participants. Having a high level of energy was another theme that emerged from the data as the definition of good health.

Energy

The word *energy* was mentioned four times by the interview participants. The participants (i.e., P3, P4, P7, & P9) mentioned that having a “high level of energy” means an individual is likely to be in good health. P2 stated, “I think health and wellness is someone who is strong, full of mental and physical energy and healthy.” Similarly, P7 stated, “The absence of any illness, healthy appetite, and full of mental and physical energy.” The participants mentioned that a lack of energy was a sign of health decline. No other responses were provided by the participants.

Discrepant Finding

By and large, the interview participants associated “eating healthy food,” “not being sick,” “exercise,” and having a “high level of energy” as the definitions of good health. However, P8 offered a contrasting response to the interview question. When asked *How do you define health and wellness?* P8 responded that drinking lots of water

being as associated with good health. It stated that health and wellness mean "someone who…drink plenty of water." P8 mentioned that insufficient consumption of water leads to health complications.

Question 1 Follow-Up Questions Findings

The two follow-up questions for the first interview question was 1) *When you hear the word mental health, what comes to mind?* and 2) *Can you explain some of terms associated with mental health*? The following themes emerged from the data: crazy people, brain problem, medication/treatment, depression, and difficulty sleeping. The participants associated mental health with individuals with psychotic disorders or disabling mental health illnesses. Most of the participants provided a similar response.

Crazy People

The words *crazy people* were mentioned 15 times by the interview participants. Each participant mentioned the words *crazy people* at least once when referring to mental health services. All the participants mentioned that mental health services are reserved only for people with disabling mental health illnesses and psychotic disorders. P1 stated, "a place for the crazy people, people with psychotic illnesses, a place that provides medications for crazy people and people with disabling illnesses." All the participants provided a similar response. Brain problem was another theme that emerged from the data.

Brain Problem

The words *brain problem* were mentioned six times by the interview participants. The participants (i.e., P2, P5, P8, & P9) identified a "brain problem" as one of the terms

associated with the mental health services. P9 stated, “people with brain problems, brain immaturity, a place for them to go and get a diagnosis and medication and treatment.” Similarly, P2 stated, “Psychotic people, people that can’t get along with other people and people with brin immaturity, a place for these people” to go and get help.” The participants associated the term “mental health services” with individuals experiencing disabling mental health illnesses and psychotic illnesses. Most of the participants provided a similar response for this question. Medication was another theme that emerged from the data.

Medication

The word *medication* was mentioned 10 times by the interview participants. Out of nine participants, eight participants associated the term, medication, with mental health services. The participants (i.e., P1 through P7, & P9) mentioned medication when referring to mental health definition. They mentioned that people who usually seek mental health services are those that need medication to manage their mental health symptoms. P9 stated that mental health is “a place for people to go and get diagnosis and medication….” Similarly, P4 stated that mental health is “a place for someone with mental health illnesses, a place to go and get medication.” Most of the participants provided a similar response. Treatment was another theme that emerged from the data.

Treatment

The word *treatment* was mentioned eight times by the interview participants. Out of nine participants, seven participants (i.e., P1, P2, P5, P6, P7, P8, & P9) mentioned the word *treatment* when referring to mental health. They stated that mental health exists to

provide treatment for people with psychotic disorders or disabling mental health illnesses. P2 stated that mental health is “a place for psychotic people to get medication and treatment.” Similarly, P7 stated that mental health is “a place for crazy people and people with difficulty sleeping or eating disorders to go and get a diagnosis to get medication and treatment.” Most of the participants provided a similar response. Depression was another theme that emerged from the data.

Depression

The word *depression* was mentioned five times by the interview participants. Out of nine participants, four (i.e., P3, P4, P5, P8) mentioned depression in relation to mental health. They stated that mental health systems exist to help people with depressive episodes that have difficulty sustaining their standard of living. For example, P3 stated that mental health is “a place for people who have a psychological and emotional distress to get help and get medication, such as people with… depression.” Similarly, P3 stated that mental health is “a place for people who are depressed” to go and get diagnosis and treatment. No other responses were provided by other participants. Difficulty sleeping was another theme that emerged from the data.

Difficulty Sleeping

The words *difficulty sleeping* were mentioned four times by the interview participants. The participants (i.e., P3, P7, & P8) mentioned that mental health systems exist for people with mental health illnesses, such as people with difficulty sleeping in order to help them control and maintain their symptoms. P7 stated, “A place exists for

people with sleep disorders, people who cannot sleep, or experience nightmares to go and get medication and treatment." No other responses were provided by other participants.

Discrepant Finding

Most of the interview participants provided a similar response, with the exception of one participant (i.e., P4). P4 mentioned the word *fatigue* as one of the words associated with mental health stating that if a person was fatigued, the person should seek the services. According to the participant, fatigue was a sign of illness.

Question 2 Findings

The second interview question for this research was *How important or unimportant is mental health services to you and why?* The following theme emerged from the data: important.

Important

The word *important* was mentioned nine times by the interview participants as it relates to mental health services. All the participants mentioned that mental health services are very important to maintain or address mental health illnesses. P9 stated, "I think it is very important. Without it, in the world, many people with brain problems, uh, sleep problems, associated with mental health illnesses would not be able to manage and cope with their symptoms." Similarly, P5 stated, "I think it's important. The services are helping people, people with depression, anxiety, and people with problems related to brain function." All the participants emphasized the importance of mental health services in sustaining health and wellbeing and provided a similar response. The benefits of

mental health services were acknowledged by all the participants, no other responses were provided by the participants

Discrepant Finding

All the interview participants emphasized the importance and benefits of mental health services and provided a similar response. No other responses were provided by the participants.

Question 3 Findings

The third interview question for this research was *Do you seek mental health services as a preventative measure?* The following themes emerged from the data: only when sick.

Only When Sick

The words *only when sick* were mentioned 26 times by the interview participants. While all the interview participants mentioned that preventative services are vital for people with mental health illnesses to sustain a standard of living, none of the participants seek mental health services as a preventative measure. They only seek the services when ill or sick. P4 stated, “I only go to the doctor when I’m ill or sick or only when I have appointments.” Similarly, P8 stated, “I don’t go to the doctor if I’m not ill or sick.” All the participants provided a similar response.

Discrepant Finding

While all the interview participants mentioned that preventative services are vital to sustaining health and wellbeing, they only seek the services when they are ill or sick. P5 stated that preventative services are “very important. Since we don’t know what is

going with our body, we must go to the doctor for a diagnosis and treatment before it becomes a serious health problem." Similarly, P1 stated, "since we cannot see the inside of us or know what is happening, it is critical that we go to doctors and get a diagnosis to see what is happening inside of us to maintain our health and wellbeing." While all the participants emphasized the importance of preventative services, none of the participants seek mental health services as a preventative measure. The participants provided contradictory responses; however, this may be due to their cultural differences in health practices.

Question 4 Findings

The fourth interview question for this research was *In your opinion, do you believe that mental health services are only reversed for those with disabling illnesses, such as individuals with psychotic disorders, and why?* The following themes emerged from the data: reserved only for ill people.

Reserved Only for Ill People

The words *reserved only for ill people* were mentioned five times by the interview participants. The participants (i.e., P1, P2, P3, P4, & P8) mentioned that mental health services are reserved only for people disabling mental health illnesses or psychotic disorders. P1 stated, "I think mental health systems exist for people with illnesses or psychotic disorders because people that go there are usually people with illnesses like they cannot sleep, nightmares, or people who considers to be somewhat crazy or different from the society." Similarly, P8 stated, "I think mostly only ill people that seek mental health services, like people with psychotic disorders to get medication, assistance, and the

help they need to manage and cope with their symptoms." All five participants provided a similar response.

Discrepant Finding

Out of nine participants, four participants provided contrasting responses. They mentioned that if a person was not feeling well, the person should seek services and that it does not have to be disabling mental health illnesses or psychotic disorders. P9 stated, "Speaking of mental health, it's not only for those with disabling illnesses, if you don't feel right, you must go and get a diagnosis to get the appropriate treatment in a timely manner." All four participants provided a similar response.

Question 5 Findings

The fifth interview question for this research was *What are some things that discourage you from seeking mental health services?* The responses for this interview question were included under the Interview Questions 2 and 3, as the responses produced duplicate codes and they were more appropriate to report under these interview questions. However, seven out of the nine participants mentioned that they were not discouraged from seeking mental health services, and that they would seek the services if they are ill or sick; otherwise, they do not seek the services. P4 stated, "I don't feel like there's anything that made me not wanting to seek services; however, I don't go unless I'm ill or sick." All seven interview participants provided a similar response.

However, two out of the nine participants provided contrasting responses. P8 mentioned that she would seek mental health services because the mental health systems offer rental assistance programs for people with no income. Whereas P9 mentioned that

he could not seek the services because of the language barrier. Even if he wanted to go to the doctor, they would not be able to assist him because of the language barrier. He did mention, however, that when it comes to disabling illnesses, he would seek the services despite the language barrier. No other responses were provided by the participants.

Research Question 2: Cultural Beliefs/Practices of Mental Health

The second research question for this study was *What are some beliefs and cultural practices of Lahu immigrants in terms of mental health?* The following themes emerged from the data: God, only when sick, prayer, herbs, and faith healer.

The following interview questions were asked for this research question:

6. In your culture, what is the belief about life and death?
7. Some cultures may have different health practices in terms of treating illnesses, do your health practices encouraging you or discouraging you from seeking mental health services?
8. How different or similar is your traditional health practice compared to the Western medicine?
9. Based on your experience, do you believe that the Western medicine is helping individuals with mental health illnesses?

Question 6 Findings

The sixth interview question for this research was *In your culture, what is the belief about life and death?* The following theme emerged from the data: God. Seven out of nine participants mentioned “God” when it comes to their beliefs about life and death.

God

The word *God* was mentioned seven times by the interview participants. The participants (i.e., P1, P2, P3, P6, P7, P8 & P9) mentioned that life and death are predestined and orchestrated by God and that it could not be changed by human beings. P8 stated, “Life and death is orchestrated by God, cannot be fixed by human. Even if I go to the doctor, if it’s time, there’s nothing they can do.” Similarly, P9 stated, “My belief is that since there is a birth, there will always a death. This is the law of the land. This is the law that God give each and every one of us. In the Bible, God also talks about this being the laws of the land.” The participants believed that their actions or inactions would not change the outcome when it comes to life and death. All seven participants provided a similar response.

Discrepant Finding

While most of the participants provided a similar response when it comes their beliefs about life and death, one interview participant (i.e., P4) provided a contrasting response. P4 stated “I think the mental health systems exist for to help people and doctors want us to improve doesn’t really matter what the belief is or if I’m a Christian. The services are helping people with mental health illnesses.” According to P4, mental health systems exist for the purpose of assisting people with mental health illnesses regardless of cultural beliefs or practices. He noted that the services are helping people who are struggling with mental health illnesses; therefore, a person should seek the services when ill or sick regardless of the religious beliefs or practices. No other responses were provided by other interview participants.

Question 7 Findings

The seventh interview question for this research was *Some cultures may have different health practices in terms of treating illnesses, does your health practices encouraging you or discouraging you from seeking mental health services?* This interview question produced a similar code as the Interview Question 2 (i.e., only when sick); therefore, the data was combined and reported under Category 3 – Presentative Services. While all the participants mentioned that their health practices did not deter them from seeking the services, all the participants mentioned that they would only seek the services when they are ill or sick. P6 stated, "My health practices do not affect my decision to seek or not to seek help. If I'm ill or sick, I would seek the services. The services help. I would not let my belief prevent me from seeking the services when I'm ill or sick." All the participants provided a similar response.

Discrepant Finding

No discrepant findings to report under this section.

Question 8 Findings

The eighth interview question for this research was asked *How different or similar is your traditional health practice compared to the Western medicine?* The following themes emerged from the data: Prayer, herbs, and faith healer. All the interview participants provided a similar response.

Prayer

The word *prayer* was mentioned seven times by the interview participants. They mentioned that their traditional health practice was significantly different from the

Western medicine. In their native Country, access to medicine or medical services were reserved only for rich people that could afford to pay for the medical services. In addition, there was no government provided medical services like in the United States. When ill or sick, the participants' initial response is to pray. P8 stated, "The health practice back then was much different. We rely on natural herbs, prayers, and Shaman for healing. Sometimes it works and sometimes it doesn't. Here, they have medicine and doctors and nurses." Similarly, P5 stated, "Our traditional health practice is much different compared to the Western medicine. Back in our home country, if you don't have the money, you cannot get medical services. We rely on natural herbs and prayer. Sometimes, faith healers would perform healing rituals and they help at the time." Most of the participants provided a similar response to this interview question. Herb was another theme that emerged from the data as their initial response to health practice.

Herb

The word *herb* was mentioned eight times by the interview participants. All the participants (i.e., P1, P2, P3, P4, P6, P7, & P8) provided a similar response stating that they relied on natural herbs (i.e., folk medicines) as one of their initial responses when ill or sick. P6 stated, "Our traditional practice mainly relies on natural herbs, prayers, and Shaman for healing." Similarly, P8 stated, "Before no medication, only relied on herbs. Now, they have a variety of medications and technology. Today's medicine is more advanced and better." Most of the participants provided a similar response. Faith healer (i.e., Shaman) was another theme that emerged from the data as their traditional health practice.

Faith Healer

The words *faith healer* were mentioned six times by the interview participants. The participants (i.e., P1, P2, P3, P4, P8, & P9) mentioned the use of a faith healer (i.e., Shaman) to perform a healing ritual was common practice in their culture. P6 stated, "Back in our home country, if we don't have the money, you can't get the medical services. You have to rely on natural herbs, prayers, and faith healers to heal you." Similarly, P7 stated, "Our traditional practice mainly relies on natural herbs, prayers, and Shaman for healing." According to the participants, medicine was only available to rich people, people that could afford pay for the services. All six participants provided a similar response.

Discrepant Finding

By and large, the interview participants mentioned a significant difference between their traditional health practice compared to the Western medicine. The use of prayer, natural herbs, and faith healer were common practices in response to treating illnesses. However, one interview participant (i.e., P5) provided a contrasting response from the rest of the participants. P5 mentioned that health practices were similar, while she did not provide an elaborative response. It stated, "I think many ways it's the same in terms of treating illnesses." This may be due to the participant's lack of experience in traditional health practice or may have misinterpreted the intent of the interview question. No other responses were provided by the participants.

Question 9 Findings

The nineth interview question for this research was *Based on your experience, do you believe that the Western medicine is helping individuals with mental health illnesses?* The following theme emerged from the data: helpful. All the interview participants provided a similar response.

Helpful

The word *helpful* was mentioned 26 by the interview participants when referring to the benefits of mental health services. All the mentioned that mental health services are helpful and helping to those suffering psychotic disorders or disabling mental health illnesses. P4 stated, "When someone is ill and they go to the doctor, it helps." Similarly, P7 stated, "People with mental health illnesses are able to cope with their symptoms with the services they received from the mental health systems. The services help and heals people." All the participants provided a similar response.

Discrepant Finding

No discrepant findings to report under this section.

Research Question 3: Viewpoints on Mental Health Professionals /Systems

The third research question for this study was *How do Lahu immigrants' attitudes toward mental health professionals contribute towards mental health access among the Lahu immigrants?* This research question was focused in two areas: 1) the participant's perception of mental health, 2) the participant's opinion to improve mental health services among the Lahu immigrants. For the perception of mental health, the following themes emerged from the data: don't speak English and don't drive (i.e., no

transportation). As for the participant's opinion to improve mental health services, the following themes emerged from the data: provide a transportation and provide interpreting services.

The following interview questions were asked for this research question:

10. When you hear the word mental health professionals or mental health systems, what comes to mind?
11. What are some things that may influence your decision to seek or not to seek help?
12. Do you believe that the traditional mental health systems addressing the needs of the Lahu immigrants, and why?
13. What, if any, are some of the changes that you feel would motivate the Lahu immigrants to seek mental health services?

Question 11 Findings

The tenth interview question for this research was *When you hear the word mental health professionals or mental health systems, what comes to mind*? The responses from this interview question produced a duplicate code as the Interview Question 1a, which most of the interview participants mentioned, "A place for crazy people to go and get a diagnosis and medication." Therefore, the data was combined and reported under the Category 1 - Mental Health Definitions. All the interview participants provided a similar response.

Discrepant Finding

No discrepant findings to report under this section.

Question 11 Findings

The eleventh interview question for this research was *What are some things that may influence your decision to seek or not to seek help?* Similar to the Interview Question 10, the responses to this interview question produced a similar code as the Interview Question 3; therefore, the data was combined and reported under the Category 3 - Preventative Services. All the participants provided a similar response. For example, P3 stated, "None, actually. If I'm ill, or I have an appointment, I would seek the services. But I don't go if I'm not sick or ill." No other responses were provided by the participants.

Discrepant Finding

No discrepant findings to report under this section.

Question 12 Findings

The twelfth interview question for this research was *Do you believe that the traditional mental health systems addressing the needs of the Lahu immigrants, and why?* Similar to Interview Questions 10 and 11, the responses to this interview question produced a duplicate code as the Interview Question 9; therefore, the data was combined and reported under the Category 2 – Attitudes/Perception of Mental Health. For example, when asked, P4 stated, "Yes, I think it's helping. Even if receiving medications and taking medications alone is helping people to cope with mental illnesses." All the participants provided a similar response, which was narrowly focused on an illness, as opposed to the needs of the Lahu immigrants. This may be due to the interview participants' inexperience with the interview and as well as the lines of questions they

were being asked, which they may be understood or misinterpreted the intent of the interview questions. Eight out of nine participants responded that the services are helpful and addressing the needs of the Lahu immigrants. No other responses were provided by other participants.

Discrepant Finding

While most of the participants provided a similar response, one interview participant (i.e., P8) mentioned that not having a transportation (i.e., don't drive) and don't speak English were barriers to accessing mental health services. P8 added that the mental health systems are only helping those that have full access to the services, not for people that don't drive or don't speak English. P8 stated, "For those that can go, that have their own transportation, it helps. But for those that don't drive or speak English, it does not appear to be helping." No other responses were provided by other participants.

Interestingly, the words *don't drink* and *don't speak English* were mentioned four and nine times respectively by the participants on the previous questions, which they identified as barriers to accessing mental health services among the Lahu immigrants. However, when asked directly whether if the mental health systems are addressing the needs of the Lahu immigrants, they provided a different response. As mentioned above, this may be due to their lack of experience with interviews and perhaps due to the types and format of the interview questions, which they may have understood or misinterpreted the intent of the interview questions. No other responses were provided by the participants.

Question 13 Findings

The thirteen interview question for this was *What, if any, are some of the changes that you feel would motivate the Lahu immigrants from seeking the services*? The following themes emerged from the data: provide transportation and provide interpreting service.

Provide Transportation

The words *provide transportation* were mentioned six times by the interview participants. The participants (i.e., P1, P3, P5, P7, P8, & P9) mentioned that a lack of transportation contributed to the low mental health services utilization rate among the Lahu immigrants. They stated that for the Lahu immigrants that "don't drive," they had to rely on others to go with them to and from the doctor's office. If they could not find someone to drive them or to translate for them, they could not seek the services. P3 stated, "Some people don't drive, so having a transportation would help…." Similarly, P8 stated, "Providing a transportation and interpreting services will motivate the Lahu immigrants that "don't speak English" or "don't drive" to seek the services." All six participants provided a similar response. In addition to provide transportation, a lack of interpreting service was another theme that emerged from the data as a barrier to accessing mental health services among the Lahu immigrants.

Provide Interpreting Service

The words *provide interpreting service* were mentioned seven times by the interview participants. The participants (i.e., P1, P2, P4, P5, P7, P8, & P9) mentioned that the language barrier was one of major barriers in accessing mental health services among

the Lahu immigrants. They stated that providing an "interpreting service" would increase the service utilization among the Lahu immigrants. P2 stated, "If there's an interpreter that speaks the Lahu language, I feel that people that don't speak English would be motivated to want to go to the doctor." Similarly, P9 stated, "If they provide a transportation and an interpreter, more people are likely to seek the services." All seven participants provided a similar response.

Discrepant Finding

While most of the interview participants provided a similar response, one participant (i.e., P6) mentioned provided a contrasting response. In particular, the participant mentioned that a lack of relationship with the doctor and the long wait time as factors for not seeking the mental health services. P6 mentioned that at times, the doctor did not show any interest in his health and wellbeing, which played an important role in his decision to seek or not to seek help. P6 stated, "Sometimes, I feel like the doctors or nurses do not show their best interest in my health and wellbeing. I think developing relationships with clients would increase the Lahu immigrants from the seeking the services." No other responses were provided by other participants.

Summary

In this chapter, I discussed the study results of the study. I presented the participants' demographics, of which, five were males and four were females. All the participants were refugees from Thailand. The participants' ages ranged from 34 to 71 years old. In addition, I presented the data coding process and the main themes derived from the data. The study results were presented in the chronological order of the research

questions. A total of 22 themes were identified from the data. The responses from all the participants were included in each theme.

The following themes were emerged from the first research question: eat healthy food, not sick/good health, exercise, energy, crazy people, brain problem, medication, treatment, depression, difficulty sleeping, important, helpful, reserved only for ill people, and only when sick. For the second research question, the following themes emerged from the data: God, prayer, herbs, and faith healer. Finally, for the third research question, the following themes emerged from that data: don't speak English, don't drive, provide transportation, and provide interpreting service.

Most of the participants provided a similar response to the interview questions, with the exception of a few responses that deviated from the interview questions, which were discussed in the discrepant finding sections. By and large, the participants responded positively in terms of the benefits of mental health services. However, most of the participants mentioned the language barrier and a lack of transportation as major barriers in their inability to gain access to mental health systems.

The study findings revealed that the Lahu immigrants' perception of health and wellness, specifically mental health services, were significantly different from the mainstream media. Based on the study findings, the Lahu immigrants retained their cultural practice when it comes to treating illnesses (i.e., health practice), which may be attributed to them identifying health and wellness only in terms of physical health, such as eating healthy food, taking vitamins, exercising, strong, and not being sick. In addition, all the participants had preconceived idea about the mental health services or

systems in that people who were receiving services from the mental health systems were viewed as “less than” among the community, specifically as “crazy people.” As a result, seeking mental health services were their last resort—only when they have exhausted their traditional practices of treating illnesses.

Given there was not a study conducted on the Lahu immigrants in the context of mental health, this study was warranted and much needed to understand the unique characteristics of this population. Findings from this study provided new health information about this population. This included their understanding of the mental health services or systems, and the effects of their cultural beliefs and practices affected their identification and interpretation of health and wellness. This information may assist mental health professionals and practitioners to effectively work with this population and provide culturally appropriate services. In the next chapter, I discuss the interpretation of the study findings, limitations of the study, recommendations, and positive social change implications.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to explore the attitudes of the Lahu immigrants living in Tulare County, California, in relation to their attitudes, beliefs, and perceptions toward seeking mental health services. While the Lahu population in the Tulare County, California, represents one of the largest SEA population groups in the nation, there is no known study on the Lahu immigrants in the context of mental health. This leads to a lack of cultural knowledge about the Lahu immigrants, specifically in the context of mental health. Yang et al. (2020) stated that incorporating cultural solutions in the mental health care services was vital to meet the needs of today's diverse populations. Also, Lee et al. (2010) and Sorkin et al. (2011) echoed a similar argument by acknowledging health disparities among the minority ethnic groups, such as the Lahu immigrant populations, and emphasized the importance of understanding the unique characteristics of each population to provide culturally appropriate services. Further, Gopalkrishnan (2018) stated that culture is dynamic, and it affects many aspects of life, including how individuals define health and wellness, including their health-seeking behavior.

While literatures exist for other SEA population groups, such as Cambodian, Chinese, Hmong, Japanese, Laos, and Vietnamese, there was no study conducted on the Lahu people in the context of mental health. Thus, there is a lack of scientific knowledge regarding health disparities, need, and opportunities among the Lahu immigrants in the mental health systems. With the Lahu population on the rise in the United States, there is a need to develop cultural knowledge in order to assist mental health professionals and

practitioners to work with the Lahu population more effectively and provide culturally appropriate services.

The Lahu immigrants face many challenges in accessing mental health services due to cultural and social influences, including the language barrier. This qualitative study was conducted to provide cultural knowledge for mental health professionals and practitioners on how to work with the Lahu population more effectively and provide culturally appropriate services. Findings from this study may enable mental health professionals and practitioners to incorporate cultural solutions in their mental health care services to effectively engage this population in health provision and achieve a positive social change.

This qualitative study was guided by the theoretical frameworks of HBM and SEM. The HBM was developed to investigate people's responses to illnesses and medical regimens (i.e., health behavior) (Glanz et al., 2015). Similarly, the SEM was developed to explore people's lived experiences in their natural environment (Lutters & Ackerman, 1996) and how their social and environmental interactions affect development (Kilanowski, 2017; Swick & Williams, 2006). Since this study was an ethnographic, phenomenological study, these models were appropriate to inform the structure of this study. This study was guided by the following three research questions:

RQ1: What are the attitudes of Lahu immigrants toward seeking mental health services?

RQ2: What are some beliefs and cultural practices of Lahu immigrants in terms of mental health?

RQ3: How do Lahu immigrants' attitudes toward mental health professionals contribute towards mental health access among the Lahu immigrants?

Guided by the research questions, semistructured and open-ended interview questions were developed (Appendix C). Using a convenience sampling through promotion of flyers, nine participants volunteered and participated in the study.. There were five men and four women with the participants age ranging from 34 years of age to 71 years . Using the interview questions based on the research questions, each participant was asked to share their lived experiences related to accessing mental health services, specifically their attitudes, beliefs, and perceptions toward seeking mental health services, including their attitudes, beliefs, and perceptions toward mental health professionals/systems. The following categories and themes emerged from the study.

Table 3

Categories and Main Themes

Research Question 1: Categories and Themes	Research Question 2: Categories and Themes	Research Question 3: Categories and Themes
Categories: 1. Health/Mental health definitions 2. Attitude/Perception of mental health 3. Preventative services	Categories: 1. Cultural beliefs 2. Cultural practices	Categories: 1. Barrier to mental health 2. Need to improve mental health
Themes: 1. Not sick 2. Exercise 3. Energy 4. Eat healthy food 5. Crazy people 6. Brain problem 7. Medication	Themes: 1. God 2. Prayer 3. Herbs 4. Faith healer	Themes: 1. Don't speak English 2. Don't drive 3. Provide transportation 4. Provide interpreter

8. Treatment
9. Depression
10. Difficulty sleeping
11. Service is important
12. Service is helping people
13. Reserved only for ill people
14. Only when sick

A total of 22 themes emerged from the data. In this chapter, I discuss the themes relative to the literature review findings in Chapter 2 and whether they support or contradict previous literature findings. In addition, I discuss the interpretation of the findings, recommendations, limitations, and implications of this study. Finally, this chapter concludes with the key essence of this study.

Interpretation of the Findings

Nine participants volunteered for this study. They were actively engaged with me and provided their lived experiences related to seeking mental health services, including their attitudes, beliefs, and perceptions toward mental health professionals/systems.

The first research question explored the Lahu immigrants' attitudes, beliefs, and perceptions toward seeking mental health services, including their knowledge about mental health, in general. The second research question explored the Lahu immigrants' cultural beliefs and practices of mental health. The third research question explored the Lahu immigrants' attitudes toward mental health professionals/systems and its impact towards mental health care access among the Lahu immigrants. Based on the participants' responses, 22 themes emerged from data. Most of the participants provided a similar response to the interview questions, which indicated that many of the Lahu

immigrants were experiencing similar challenges or had similar viewpoints in relation to seeking mental health services. As previous literature findings noted, this was anticipated as culture is a collective values, beliefs, and practices shared by members of the group (see Gopalkrishnan, 2018; Hofstede, 1991; & Patterson, 2014). The key findings are presented in the chronological order of the research questions.

Research Question 1

The first research question was *What are the attitudes of Lahu immigrants toward seeking mental health services?* To address this research question, the following interview questions were used to engage in in-depth discussions with the interview participants:

1. How do you define health and wellness?
    a. When you hear the word mental health, what comes to mind?
    b. Can you explain some of the terms associated with mental health?
2. How important or unimportant is mental health services to you and why?
3. Do you seek mental health services as a preventative measure?
4. In your opinion, do you believe that mental health services are only reversed for those with disabling illnesses, such as individuals with psychotic disorders, and why?
5. What are some things that discourage you from seeking mental health services?

The themes from the first research question are described below.

Not Being Sick as a Sign of Being Healthy

Most of the participants defined "not being sick" as a sign of being healthy—a definition of health and wellness. The participants narrowly focused their definition of health and wellness on physical health, which is contradictory to the modern definition of health and wellness as defined by the World Health Organization (WHO) as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Stoewen, 2015, p. 983). The participants only considered a person without any illness or physically in good health as being healthy. For example, P2 stated, "Health and wellness to me is the absence of illness, someone who is healthy, not sick." The participants' interpretation and identification of health and wellness may be due to the participants' cultural point of view. This was consistent with previous literature finding in that culture played a significant role in many aspects of people's lives, including how they interpret the environment and the world (i.e., gender, class, religion, language, nationality, social norms, beliefs, and practices; Gopalkrishnan & Babacan, 2015). Napier et al. (2014) stated that culture varied from within and across sociodemographic groups. An individual's association or membership in a particular group influences how the individuals behave, interact, and assign meaning to the environment and the world. Similarly, Gopalkrishnan (2018) stated that culture had a significant influence on individuals' perceptions of health and illness, including their health-seeking behaviors. To this respect, it was not surprising that the Lahu immigrants only defined health and wellness within the context of physical health. Lee et al.'s (2010) explained that health and wellness are defined within the cultural context.

Engaging in Exercise as a Sign of Being Healthy

Similar to “not being sick”, the participants defined engaging in “exercise” as a sign of being healthy. While the act of exercising itself does not determine the health of a person, participants explained that healthy people usually engage in some sort of physical activities, such as exercise. Out of nine participants, four mentioned that engaging in regular exercise promotes good health. For example, P8 stated, “Health and wellness to me is someone who is healthy, exercise, has good appetite for food, maintain a healthy diet and eats healthy food, takes vitamins and drinks plenty of water.” This definition is not inclusive of the definition of health and wellness as defined by the WHO, which defined health and wellness as a complete physical, mental, and social well-being (Stoewen, 2015). The participants focused the definition of health and wellness only on physical health, which may be due to the participants’ cultural differences in the interpretation and identification of health and wellness. Napier et al. (2014) stated that culture is unique in that values, beliefs, and practices belonging to a particular group may not be transferable to other cultures. While there were no prior studies on the Lahu immigrant to compare the results of this study, from the theoretical perspective, the findings were consistent with prior literatures for other SEA populations. Past study findings showed that the differences in culture and lived experiences led to the different interpretation and identification of health and wellness. Previous literature findings also noted that individuals belonging to, or membership of a particular group, shaped the individuals' attitudes and belief systems, including their health behavior (Canadian

Paediatric Society, 2021; Jia et al., 2017; Napier et al., 2014). According to the participants, engaging in exercise is being healthy.

Having Energy as a Sign of Being Healthy

About half of the participants identified having "energy" as a sign of being healthy. The participants mentioned that a lack of energy was a sign of illness. As mentioned earlier, the participants defined health and wellness narrowly focused on physical health. For example, P7 stated, "Health and wellness to me is the absence of any illness, healthy appetite, and full of mental and physical energy." The participants believed that if a person has energy, the person is healthy. While there was no prior literature on the Lahu immigrant to compare the findings, based on prior literature of other SEA populations, differences in the interpretation and identification of health and wellness were expected due to differences in culture.

Eating Healthy Food as a Sign of Being Healthy

Eating healthy food was another theme the participants identified as one of the definitions of being healthy. The participants focused on the health and wellness with tangible items (i.e., food items). The participants believed that eating healthy food leads to healthier life. Whereas eating unhealthy food leads to various health complications. For example, P6 and P7 stated that health and wellness is someone who engages in healthy eating, eats well, and full of energy. Similarly, P9 stated that health and wellness is "a person who eats healthy food, exercise, and so no, to increase energy. A person who does not get sick often." The participants' responses support the literature findings in that belief systems, values, and practices are different from culture-to-culture, and that it may

not be transferable from one culture to the next (Gopalkrishnan, 2018; Napier et al., 2014; Patterson, 2014). According to the participants, being healthy is eating healthy food.

Crazy as a Definition of Mental Health

All the participants mentioned the word *crazy* when referring to mental health or mental health services. When the participants heard the word "mental health" or "mental health professionals/systems", the initial thought was a place for crazy people to go to get help. The participants stated that when a person receives services from the mental health systems, the person is considered "less than" or "different" by the community. The participants supported their response by stating that only people with disabling illnesses or psychotic disorders were accepted or admitted into the mental health clinic in Tulare County. For example, when asked about mental health, P6 stated, "A place for crazy people to go and seek help, like someone who is hallucinating and yelling at other people for no reason." Similarly, P7 stated, "Crazy people, people with psychotic episodes who yells at people and hits people for no reason. A place for these people to go and get medication." They believed that mental health services were reserved only for people with disabling illnesses and psychotic disorders; therefore, seeking mental health services was not their priority to treating mild to moderate illnesses. Instead, they relied on their traditional health practice (i.e., folk medicine). Once they have exhausted their traditional health practice and their symptoms did not improve, they would then seek mental health services. In other words, they would only seek mental health services if it was emergency or urgent. As previous literature findings, this was not a surprise given the cultural

differences. Lee et al.'s (2010) study on other SEA revealed that the identification and interpretation of mental health were understood within their social and cultural contexts.

Brain Problem as a Definition of Mental Health

About half of the participants mentioned a *brain problem* as one of the definitions of mental health. When the participants heard the word "mental health" people with a brain problem or brain immaturity came to mind. They stated that most of the people that received services from the mental health services were those with cognitive and psychological problems, such as people with psychotic disorders or people that could not get along with other people. For example, when asked, P1 stated, "I often hear terms like crazy people or people with brain problems associated with mental health." Similarly, P2 stated, "I often hear terms like crazy people or people with brain problems associated with mental health. Likewise, P7 stated, "Crazy people, people with psychotic episodes who yells at people and hits people for no reason. A place for these people to get and get medication." The participants believed that mental health services are reserved only for people with disabling illnesses or psychotic disorders. They stated that receiving services from the mental health systems would be labeled as being crazy or different from the society. As a result, the participants only seek mental health services when all traditional practices were exhausted and only in urgent and emergency situations to avoid being labeled as "less than" or "different" from the community.

Medication as a Term of Mental Health

Medication was another theme that the participants identified with mental health. They stated that people who receive mental health services from the mental health

systems needed medication (i.e., medication for psychotic disorders). Eight out of nine participants believed that the mental health systems exist to provide medication to people with disabling illnesses or psychotic disorders. When asked, P1 stated, “A place for crazy people to go and get help or get medication.” Similarly, P9 stated, “A place for crazy people to stay. If there, doctors provide diagnosis and treatment to help the people improve their health and wellbeing.” According to the participants’, taking medication was a sign to become healthy. It is possible that the participants’ health practices played a role in how they perceive health and wellness.

Treatment as a Term of Mental Health

Most of the participants mentioned the word *treatment* when referring to mental health or mental health services. They stated that people who receive mental health services from the mental health systems require some sort of treatment. When asked, P5 stated, “When I received treatment or take medication it helps with coping with mental health illnesses.” Similarly, P9 stated, “Speaking of mental health services, first, we must go and get preventative diagnosis to get the appropriate treatment to help us prevent and improve our health and wellbeing.” According to the participants, receiving treatment is a way to help improve health.

Depression as a Term of Mental Health

About half of the participants associated the word *depression* as sign to seek mental health services. They mentioned that when they hear the word *mental health* or *mental health services*, depressive episodes come to the forefront of their mind. When a person is depressed, the person needs to seek services to improve their symptoms. When

asked, P1 stated, “Mental health services are very important. The institution itself exists for that purpose. People who are not able to sleep, have difficulty sleeping, or with depression and anxiety, they are able to get help to help them sustain a standard of living. These people may not be able to do so without the services provided by mental health systems.” Similarly, P3 stated, “I think the mental health services is for people with depression, anxiety, or sleep problems, people with health problems.” According to the participants, mental health services are to help improve depressive symptoms.

Difficulty Sleeping as a Term of Mental Health

Difficulty sleeping was another theme that the participants identified in the context of mental health or mental health services. The participants believed that mental health services help to improve symptoms related to sleep disorders (i.e., difficulty sleeping). For example, when asked, P1 stated, “When I hear the word mental health, the first thing that comes to mind is a place for people with illnesses or psychological problems. People who have difficulty sleeping, cannot sleep, or disease.” Four participants mentioned difficult sleeping as one of the terms associated with mental health. It is possible that the participants’ identification of mental health was influenced by the participants’ traditional health practice.

Attitudes Toward Mental Health

While the participants may have different identification and interpretation of mental health or mental health services, all the participants agreed that mental services are important to promote health and wellness (i.e., service is important was identified as one of the themes), specifically for people with mental health illnesses as a mean to

manage mental health symptoms. For example, P2 stated, “I think it’s important. It’s helpful and good. It helps people experiencing mental illnesses able to sustain their standard of living, if they are taking medications.” Similarly, P3 stated, “Mental health services is important. People with psychotic episodes or sleep problems are able to sustain their standard of living because of the services they received from the mental health systems.” All the participants acknowledged the importance of mental health services in promoting health and wellness, which Lor et al. (2017) also emphasized as an important factor to improving the mental health services. They stated that understanding the link between the cause of illnesses (i.e., perceived severity) and treatment (i.e., perceived benefits) are vital to promoting a desired health behavior (Lor et al., 2017; Shabibi et al., 2017).

Perception of Mental Health

Despite the participants’ acknowledgement of the importance and benefits of mental health services, most of the participants believed that mental health services are reserved only for people who are ill. For example, when asked P7 stated, “It’s very important. People with mental illness are able to cope with their symptoms with the services they received from the mental health systems. The services help and heals people.” Similarly, P9 stated, “I think it is very important. Without it, in the world, many people with brain problems, uh, sleep problems, associated with mental health to heal them and to help them improve so it is very important.”

While most participants provided a similar response when it comes to the importance and benefits of mental health services, they do not believe that mental health

services are for everyone. Weng and Spaulding-Givens (2017) emphasized how differences in culture and health practice may influence how individuals perceive and interpret the environment and the world. Specifically, Weng and Spaulding-Givens's study revealed that Asian Americans are less likely to seek mental health services because of their cultural barriers (i.e., language barrier) and cultural beliefs about health and wellness (i.e., how health and wellness are interpreted in their cultural context). Similarly, Abdullah and Brown (2011) and Knaak et al. (2017) posited that stigma, such as being labeled as "less than" or "different" by the society played a significant factor in a person's decision to seek or not to seek help. Most of the study participants believed that mental health services are only reserved for people with disabling mental health illnesses or psychotic disorders.

Access to Mental Health as a Preventative Measure

All the participants emphasized the importance and benefits of mental health services, but none of the participants sought mental health services as a preventative measure. All nine participants mentioned "only when sick" 26 times when discussing seeking the mental health services. For example, when asked, P2 stated, "I do not seek mental health services as a preventative measure, I only seek mental health services when I'm ill." Similarly, P3 stated, "I do not seek mental health services as a preventative measure. If I'm ill or difficulty sleeping or depressed, then I would seek the services. I only seek the services when I'm ill or not feeling well." As Weng and Spaulding-Givens (2017) stated, this may be due to the cultural differences of health practices of the Lahu immigrants, which all of the participants believed that mental services are reserved only

for people with disabling mental health illness or psychotic disorders. Similar to Weng and Spaulding-Givens 's study, Hall and Yee's (2012) study revealed that despite the mental health needs of the SEA populations, they are less likely to seek mental health services due to the differences in their culture. This was consistent with the local data reported by the Kaweah Delta Healthcare District (KDHCD), the largest hospital in Tulare County (United States Census Bureau, n.d.). KDHCD stated that only 2.2% of Asian Americans utilized mental health services compared to other ethnic groups, while at the same time, Asian Americans represent the third largest population in California (15.5%) only behind Hispanics (39.4%) and Whites (36.4%) (United States Census Bureau, n.d.). All the participants believed that only ill people should seek mental health services.

Research Question 1 Summary

The differences in the identification, interpretation, and knowledge about health and wellness were evident by the participants' responses. This may be due to the Lahu immigrants' culture and religion. The responses were ambiguous when it comes to the identification and interpretation of health and wellness. They narrowly defined health and wellness only in terms of physical health, such as not being sick, engaging in physical activity, having energy, and eating healthy food.

In addition, all the participants associated mental health services or mental health systems with individuals who are identified as "less than" or "different" by the society, which resulted in the participants seeking mental health services as a last resort. They associated terms such as crazy, brain problem, medication, treatment, depression, and

difficulty sleeping with mental health services and mental health systems. All the participants do not seek mental health services as a preventative measure. They retained cultural beliefs and health practices when it comes to treating illnesses.

These findings were consistent with the HBM and SEM models. From the HBM perspective, cultural barrier (i.e., perceived barrier/benefit) may be preventing the Lahu immigrants from seeking mental health services. From the SEM perspective, the participants relied on other people (i.e., family members and friends) to gain access to the mental health systems. In addition, the interplay between personal and societal levels played a significant role in the decision to seek or not to seek help, such as being labeled as "less than" or "different" by the society. This may contribute to the participants' attitudes toward seeking mental health services as a last resort and not viewing mental health services as a preventative measure.

Research Question 2

The second research question was *What are some beliefs and cultural practices of Lahu immigrants in terms of mental health?* To address this research question, the following interview questions were used to engage in in-depth discussions with the interview participants:

6. In your culture, what is the belief about life and death?
7. Some cultures may have different health practices in terms of treating illnesses, does your health practices encouraging you or discouraging you from seeking mental health services?

8. How different or similar is your traditional health practice compared to the Western medicine?
9. Based on your experience, do you believe that the Western medicine is helping individuals with mental health illnesses?

The themes from the second research question are described below.

Relying on God for Healing

Relying on God for healing was a common practice for the Lahu immigrants. Many of the Lahu immigrants identified themselves as Christians and believed that life and death are orchestrated by God, something that cannot be changed or altered by human beings. This finding was consistent with previous literature of Southeast Asian populations. In particular, the Hmong people believed that illnesses are supernatural events caused by spirits (Mary Jo, 1988). A similar finding was revealed by Facts and Detail (2019) in that people who identified as Christians may believe that the quality and meaning of life are orchestrated by a higher power. When asked, P1 stated:

> Life and death are a way of life, orchestrated by God. Some people may be reluctant to seek services or refuse to take medication based on their cultural belief, but I believe the institution exists for a reason. It's there to help people. Since we cannot see the inside of us or know what is going on, it is critical that we go to doctors and get a diagnosis of what's happening inside of us to maintain our health and wellbeing.

Similarly, P8 stated, “Life and death is orchestrated by God, cannot be fixed by human. Even if I go to the doctor, if it’s time, there’s nothing we can do.” This shows the extent to which cultural differences in treating illnesses among the Lahu immigrants.

Using Prayer for Healing

In addition to God, payer was another method many Lahu immigrants resorted to for treating illnesses. The Lahu community believed that everything was orchestrated and controlled by God, and one of the ways to communicate with God was through prayer. Out of the nine participants, eight mentioned relying on prayer for healing before they would go to the hospital. For example, P7 stated, “Our traditional practice mainly relies on natural herbs, prayers, and Shaman for healing.” Similarly, P3 stated, “We rely on natural herbs and prayer. Sometimes, faith healer to perform healing rituals and it helps at the time.”

This finding was similar to Hmong people’s use of Shaman for healing, as an intermediary person to communicate with the spirits (Mary Jo, 1988). However, as Christians, the Lahu community would perform the act of praying by themselves or ask the community leaders or pastors to pray for them. Similar to Hmong, prior to becoming Christians, the Lahu community uses faith healers (i.e., Shamans) to perform healing rituals by offering meals and livestock to the spirits. The Lahu community retained much of their cultural practice after they relocated to the United States.

Using Natural Herbs to Health Illnesses

The use of natural herbs was another method used by the Lahu immigrants to treat illnesses. While this practice was limited due to the availability of the natural herbs

compared to their homelands in Southeast Asian countries, the Lahus still practice this cultural method today. P3 stated, “Our traditional health practice is much different compared to the Western medicine. Back in our home country, if you don’t have the money, you cannot get medical services. We rely on natural herbs and prayer.” Similarly, P1 stated:

> We only rely on herbs and folk medicine. Doctors are not available to everyone. If you don’t have money, you cannot get services. Here, they provide assistance to low-income families and provide a variety of health services. They have vaccines, oral medications, creams, and even major procedures covered by the government if you don’t have the financial means to do so. I believe this difference is for the better compared to traditional health practice.

This finding was similar to other Southeast Asian populations living in rural areas. Due to the lack of resources, they relied on natural herbs as a medicine to treat illnesses. After the migration to the United States, much of the Lahu immigrants continued this health practice.

Using Faith Healer to Heal Illnesses

While using a faith healer was mentioned in the interview responses, the Lahu immigrants rarely use this practice anymore. According to the participants, this ritual must be performed by individuals who do not believe in Christianity and chosen by the spirits. Since all the Lahu immigrants are Christians, they abandoned this practice completely. Due to the reporting criteria, this code was included in the report.

It is also noteworthy that other SEA groups such as Hmong still use a similar health practice for illnesses. They believe the human body consists of several spirits such as the body spirit and the shaman spirit, which they interact with one another through the healing process (Mary Jo, 1988). For the Lahu immigrants, when all the medical remedies are exhausted, including prayer, they may seek this practice as a last resort.

Research Question 2 Summary

While there are differences in how the Lahu immigrants perceive and respond to health and wellness, the practices are similar to other SEA cultural groups. Using natural herbs, prayer, and relying on God for healing are common among rural SEA cultural groups. This may be due to the availability of resources in rural areas such as socioeconomic status (SES), a lack of health education, or simply due to their religions. The Lahu immigrants identified life and death as a way of life orchestrated and controlled by God.

These findings were consistent with the HBM and SEM models. From the HBM perspective, the Lahu immigrants' beliefs may serve as barriers in preventing them from seeking the mental health services, which, in turn, resorted them to utilizing their cultural practices to treat illnesses. The HBM model emphasizes that if people believed that adopting a healthy behavior provides a positive aspect, they are likely to adopt such a behavior. Similarly, from the SEM perspective, cultural barriers (i.e., individual level and relationship level) may prevent them from seeking current mental health services. They relied on other people (i.e., relationship level) to gain access to the mental health systems, which may explain the use of mental health services as their last resort.

Research Question 3

The third research question was *How do Lahu immigrants' attitudes toward mental health professionals contribute towards mental health access among the Lahu immigrants?* To address this research question, the following interview questions were used to engage in in-depth discussions with the interview participants:

10. When you hear the word mental health professionals or mental health systems, what comes to mind?
11. What are some things that may influence your decision to seek or not to seek help?
12. Do you believe that the traditional mental health systems addressing the needs of the Lahu immigrants, and why?
13. What, if any, are some of the changes that you feel would motivate the Lahu immigrants to seek mental health services?

The themes from the third research question are described below.

Don't Speak English as a Barrier to Mental Health

Not speaking English is a barrier to accessing mental health services among the Lahu immigrants. Most of the Lahu immigrants do not speak English. For some people that do speak English, they do not speak the language fluently. This poses a challenge for the Lahu immigrants in accessing mental health services. This finding was consistent with previous findings on SEA cultural groups. Weng and Spaulding-Givens (2017) stated that cultural barrier, such as the language barrier, was a major factor in seeking the

services. Similarly, Asian American Coalition's (ACC, 2001) study stated that the language barrier is a major barrier to health-seeking behavior. For example, P2 stated:

> For me, a lack of interpreters prevented me from seeking services at times. I have to rely on other people to go with me and translate for me. If there's an interpreter that speaks my language, I feel that people that don't speak English would be motivated to want to go. Right now, they only go to the clinic when someone who speaks English is available to go with them. If you don't speak English, there no point of going because we won't be able to communicate with the nurses or doctors.

The ACC's study revealed that not being able to communicate with provider was a major barrier for the Lahu immigrants.

Don't Drive as a Barrier to Mental Health

Not driving was another barrier that the Lahu immigrants face in accessing mental health services. Most of the Lahu immigrants do not speak English; therefore, they were never able to obtain a driver license to drive. P1 stated:

> I think the overall, the services provided are sufficient to address the needs of the Lahu immigrants. However, there are some challenges that sometimes may prevent people from seeking the services. For example, some people do not speak English or lack transportation and not able to seek the services, especially for the Lahu immigrants. If they provide interpreting service and able to communicate or have the means to get to the doctor's office, I think more people will seek the services, especially for the Lahu elders who don't drive or speak English.

As a result, they relied on other people to provide transportation to and from the doctor's office. This finding is consistent with other Asian cultural groups who faced similar challenges in accessing the mental health services. Weng & Spaulding-Givens (2017 and Corrigan et al.'s (2018) studies revealed that a lack of transportation attributed to the underutilization of services among Asian Americans.

Provide Transportation to Improve Access to Mental Health

Most of the participant mentioned that not having a reliable transportation was one of the barriers among the Lahu immigrants. They mentioned that having a reliable transportation to and from the doctor's office would likely increase the service utilization among the Lahu immigrants. Weng and Spaulding-Givens (2017) stated that a lack of transportation attributed to the underutilization of services among Asian Americans. Similar to other Asian cultural groups that do not drive, they rely on other people (i.e., family members and friends) to drive them to and from the doctor's office in order for them to gain access to the services. P3 stated:

> I think for people that don't drive and don't speak English, if they provide transportation to and from the clinic and have an interpreter, more people will be able to seek the services routinely. Right now, these people are relying on others to seek services.

As previously mentioned, due to the language barrier, most of the Lahu immigrants do not drive.

Provide Interpreting Service to Improve Access to Mental Health

Not being able to speak English was a major barrier among the Lahu immigrants, which affected many aspects of their lives. The Lahu immigrants do not speak English; therefore, they relied on interpreters who speak their language in health care settings to translate for them. For some people that do speak English, they do not speak the language fluently which requires someone to provide interpretation. This poses a communication barrier and limits their ability to not only receive the services, but also to gain access to the mental health systems. P9 stated, “I think the most important is that some people don’t want to go because of the language barrier and a lack of transportation. If they provide transportation and an interpreter, more people are likely to seek the services.”

However, this challenge is not limited to the Lahu immigrants. Other studies on SEA cultural groups also revealed a similar finding (see ACC, 2020; Corrigan et al., 2018; Weng & Spaulding-Givens, 2017). Weng and Spaulding-Givens (2017) stated that the language barrier is a major barrier among Asian Americans. Similar to other SEA cultural groups, the Lahu immigrants rely on other people to gain access to the services.

This finding correlates with the HBM and SEM models. From the HBM perspective, cultural barrier (i.e., perceived barrier) of not speaking English prevented the Lahu immigrants from seeking the services. Similarly, from the SEM perspective, the Lahu immigrants relied on other people (i.e., personal and relationship levels) to gain access to services.

Research Question 3 Summary

The Lahu immigrants faced similar challenges as other Asian cultural groups when it comes to accessing mental health services. Most of the Lahu immigrants do not speak English, nor drive (i.e., perceived barriers of HBM model); therefore, they are not able to communicate with the provider, nor have a reliable transportation get to and from the doctor's office. They relied on other people (i.e., personal and relationship levels of SEM) to drive them to the doctor's office and to translate for them.

These findings are consistent with the HBM and SEM models. From the HBM perspective, cultural barrier, such as the language barrier (i.e., perceived barrier) limited the Lahu immigrants from engaging with individuals and health care providers who do not speak Lahu, and thus prevented them from seeking the services. Similarly, from the SEM perspective, the Lahu immigrants relied on other people (i.e., personal and relationship levels) to transport them to and from the doctor's office and to translate for them in order for them to gain access to the services.

Limitation of the Study

Several limitations are present in this study. The first limitation is the size of the sample for this study, which included only nine participants. While the aim of this study was not to generalize the study results, this is a fairly small population compared to the Lahu immigrants living in Tulare County; therefore, it may not be a large enough sample to represent all Lahu immigrants' lived experiences related to seeking mental health services.

The second limitation is the sampling technique. The participants were recruited on a first come first basis; therefore, the participants recruited for this study may have different experiences compared to the general Lahu immigrant population. In addition, given this study's criteria, many Lahu immigrants who qualified for this study may be excluded from this study. Some of these individuals may have had different lived experiences and may have provided a different story. For example, the Lahu immigrants who are fluent in English may be able to provide more elaborate responses to the interview questions than those who do not speak English.

The third limitation is that none of the participants had any experience in participating in a study. This was the participants' first-time volunteering for a study. As a result, many of the participants' responses were brief. This may be due to the participants' lack of experience in interviewing or due to the language barrier. However, most, if not all, of the participants provided a similar response to the interview questions, which, in turn, supported the credibility of the findings.

The last and final limitation is the language barrier. Since the participants' English literacy ranged from poor to no English, the study was conducted in the native Lahu language. As such, the interview guide was developed in English and translated to Lahu. This poses a challenge, as there may not be a word-for-word translation from English to Lahu or vice versa due to the language differences. I translated the interview data from Lahu to English to the best of my ability and were reviewed by the participants. It was assumed that the participants were honest and provided accurate information that

represented their lived experiences regarding their attitudes, beliefs, and perceptions toward seeking mental health services.

Recommendations for Further Research

With the Lahu population on the rise in the United States, there is a need to develop cultural acknowledge about this population. With this study being the first study on the Lahu immigrants in the context of mental health, this study could serve as a foundation for future studies to expand on specific to the Lahu population. This study only included nine volunteered participants; therefore, the findings may not be representative of all Lahu immigrants. The participants were recruited on a first come first basis. Future research should consider a larger sample size using different sampling methods, such as a random sampling method to ensure that all participants are given an equal opportunity to participate in the study.

In addition, this study was conducted in the native Lahu language due to the participants' language barrier, which poses a limitation because of the language differences between English and Lahu. Future research should include Lahu immigrants who are fluent in English, as they may have different lived experiences. Future research should also consider a comparative study of the Lahu immigrants based on their years living in the United States, such as 10 years, 20 years, and 30 years living in the United States. This type of study may be useful in understanding how differences in years living in the United States may influence their decision-making process in terms of seeking mental health services.

Also, this study revealed that not speaking English and not driving to be major barriers to accessing mental health services. The participants mentioned that they had to rely on other people (i.e., family members and friends) to get to and from the hospital and to provide translation for them. To address this gap, future research should consider the availability of the resources of the mental health care systems to effectively engage and provide effective services to the Lahu population.

Further, this study revealed differences in the identification and interpretation of health and wellness among the Lahu community, which was consistent with challenges faced by other SEA cultural groups. In the Lahu community, health and wellness are defined narrowly in the context of physical health terms, such as being healthy and not being sick. Similarly, the community associated the term *mental health* with individuals who are "less than" or "different" from the society, such as individuals with disabling mental health illnesses or psychotic disorders. As a result, the community's perception plays a significant role in the context of mental health. For example, people may be discouraged from seeking mental health services to avoid being labeled as "less than" or "different" by the society. As a result, many of the Lahu community members rely on traditional health practice before seeking mental health services. Further research should consider the role of culture and the decision-making process.

Implications

Positive Social Change

The Lahu immigrants have been living in the United States since the early 1970s. However, there has not been a study conducted on the Lahu immigrants in the context of

mental health. As a result, the mainstream media does not acknowledge the Lahu people, specifically their lived experiences when it comes to mental health care services. The Lahu is often misidentified as other SEA ethnic groups such as Chinese, Hmong, or Laotian by the mainstream media.

This study provided valuable insights into the importance of cultural distinction and its impact on the decision-making process in terms of seeking mental health services. Understanding the Lahu immigrants' challenges and barriers to accessing mental health services is the first step towards a positive social change. The result of this study may be vital to assist mental health professionals and practitioners to incorporate cultural solutions in their mental health care services and provide culturally appropriate services among this population.

In addition, this study results indicated the need for more health education among the Lahu population to increase awareness and improve mental health services among the Lahu community. The Lahu community defines health and wellness narrowly in relation to physical health, such as being healthy and not being sick. In contrast, the Lahu community associates the term *mental health* with stigma, such as to avoid being labeled as "less than" or "different" by the society. This resorted them to rely on traditional health practice, as opposed to mental health services. Currently, there are no health educational programs in the Lahu language. Acknowledging this fact is an important step towards a positive social change. Gopalkrishnan (2018) stated that understanding the unique characteristics of each population, such as the Lahu immigrants, is a crucial step to engage this population and provide culturally appropriate services. To address this gap,

mental health professionals and practitioners need to understand the challenges faced by the Lahu immigrants and incorporate cultural solutions in their mental health care services to the Lahu people to achieve a positive social change.

Conclusion

This study is significant in that there has not been a study conducted on the Lahu immigrants in the context of mental health. Not only may this study contribute to the literature gap, but it may also serve as a foundation for future studies to expand on specific Lahu immigrant populations. In addition, insights from this study may provide cultural knowledge to mental health professionals and practitioners working with this population to determine ways to better assist the Lahu community and achieve a positive social change.

The results of this study revealed significant cultural and community influences on the Lahu community's decision-making process, in terms of seeking mental health services. In the Lahu community, maintaining a positive image among the community members is important. For example, the Lahu community are less likely to seek mental health services to avoid the stigma of being labeled as "less than" or "different" from society. As a result, most of the Lahu members resort to traditional health practice (i.e., folk medicine) as their initial response to treating illnesses.

The Lahu community is facing many challenges when it comes to accessing the mental health services. In addition to cultural and community influences, the lack of health educational programs in the Lahu language and the mainstream media's lack of knowledge about the Lahu's presence is problematic, especially given the Lahu has been

living in the United States since the 1970s. This suggests the need for further research in the Lahu community to better understand the unique characteristics of this population and address their health needs.

With the public's lack of knowledge about the Lahu people, it may require a collective effort from local community, partnered organization, and state and federal levels to address the needs of the Lahu community. This may include but not limited to systematics changes, such as providing culturally appropriate health educational programs and mental health services to the Lahu community but as well as education about the Lahu community to mental health professional and practitioners. In turn, it will provide cultural knowledge among the mental health professionals and practitioners to incorporate cultural solutions in their services to achieve a positive social change among the Lahu community.

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Appendix A: Recruitment Flyer in English

Interview study seeks Lahu immigrants living in Tulare County

You are invited to participate in a research study called, "An Exploratory Study of the Lahu Immigrants' Attitudes Toward Seeking Mental Health Services." This study is part of the doctoral study for Nulek Singkeovilay, a Ph.D. student at Walden University. The purpose of this study is to explore the lived experiences of the Lahu immigrants. If you choose to participate in this study, you will be invited to describe your attitudes, beliefs, and perceptions toward seeking mental health services, including mental health care systems.

About the study:

- One 30-90 minutes interview that will be audio-recorded.
- Participation is voluntary, there will be no compensation for participation.
- To protect your privacy, the published study would use fake names.

Volunteers must meet these requirements:

- A Lahu immigrant
- 18 years old or older
- Live in Tulare County

This interview is part of the doctoral study for Nulek Singkeovilay, a Ph.D. student at Walden University.

To confidentially volunteer in the study, contact the researcher

Nulek Singkeovilay

Appendix B: Recruitment Flyer in Lahu

Kanˉ te pa_ hta_ g'a_ ca ve li_

Awˬ baˬ mvuhˇ miˬ lo hpaw loˆ la leh Tulare County venˇ hk'aw chehˇ taˍ ve Laˇhuˍyaˇhui ve a shaˆ teˆ hk'aˇ htaˆ henˇ shiˍ tuˬ ve na nyi (interview) liˆ (study)

"Aw_ ba_ mvuhˉ mi_ lo hpaw lo_ la ta_ ve Laˉhu_ yaˉ hui, nyi ma chehˉ sha caw_ sha hpawˉ ve services hk'aw lo_-e ga_ tu_ aw_ pon, yawˉ hni hk'a_ hk'e_ te nyi maw_ chehˉ ve " hta_ teˉ geh chan_ nyi k'ai tu_, ku_ laˉ ve yo_. Li_ chi teˉ k'oˆ leh_ Nulek Singkeovilay, Walden University aw_ hk'aw lo Doctor ve li_ tanˉ hta_ henˉ leh te tawˆ tu_ ve li_ (study) teˉ ma_ hpeh_ ve yo_. Dawˉ law kui_ leh_ aw_ ba_ mvuhˉ mi_ lo hpaw lo_ la ta_ ve Laˉhu_ yaˉ hui ve a sha_ te_ hk'aˉ hta_ henˉ shi_ gaˉ ve yo_. Li_ (study) chi teˉ ma_ te tawˉ kui_ lo naw_ ka_ lo_ la leh teˉ geh te k'ai gaˉ ve law k'o, naw_ ve dawˉ hk'aˉ, yon_ hk'aˉ, leh nyi ma chehˉ sha caw_ sha hpawˉ ve services hk'aw lo_-e ga_ tu_ ve maˉ k'oˆ, kanˉ hk'aˉ hta_ maˉ k'oˆ, naw_ hk'a_ hk'e te nyi maw_ chehˉ ve hta_ g'a hto ma_ laˉ ve yo_.

Li_ (study) chi teˉ k'oˆ ve aw_ lawn

- Na nyi hkawˉ teˉ pawˆ ve 30-90 minutes hk'e yehˉ leh aw_ hkawˉ hpaˉ keu (record) tu_ yo_.
- Volunteer ve g'aˉ hpfuhˉ maˉ caw_
- Naw_ aw_ to hta_ shu maˉ g'a shi_ tu_, aw_ meh aw_ teh_ ve maˉ yehˉ, aw_ meh jaw-eh_ hta_ yehˉ tu_ yo_.

Volunteer te pa_ caw_ cawˉ ve aw_ ceu_

- Aw_ ba_ mavhˉ mi_ lo hpaw lo_ la ta_ ve Laˉhu_ yaˉ g'a hpeh_ ve
- A sha_ 18 hk'aw_ aw_ hk'oˆ
- Tulare County venˉ hk'aw chehˉ ve

Li_ chi leh_, Nulek Singkeovilay, Walden University aw_ hk'aw lo Doctor ve li_ tanˉ hta_ henˉ chehˉ ve li_ (study) teˉ k'oˆ hpeh_ ve yo_.

Volunteer te gaˉ ve, ya_ hk'aˉ shu hta_ maˉ shi_ tcuh g'aˉ law k'o,
li_ chi te tawˆ pa_ Nulek Singkeovilay hta_ caˉ da_ hpeh_ ve yo_.

Appendix C: Interview Guide in English

A Study of Lahu immigrants' Attitudes Toward Seeking Mental Health Services

Participant attitudes toward seeking mental health services:

1. How do you define health and wellness?
    a. When you hear the word mental health, what comes to mind?
    b. Can you explain some of the terms associated with mental health?
2. How important or unimportant is mental health services to you and why?
3. Do you seek mental health services as a preventative measure?
4. In your opinion, do you believe that mental health services are only reversed for those with disabling illnesses, such as individuals with psychotic disorders, and why?
5. What are some things that discourage you from seeking mental health services?

Participant cultural beliefs/practices of mental health:

6. In your culture, what is the belief about life and death?
7. Some cultures may have different health practices in terms of treating illnesses, does your health practices encouraging you or discouraging you from seeking mental health services?
8. How different or similar is your traditional health practice compared to the Western medicine?
9. Based on your experience, do you believe that the Western medicine is helping individuals with mental health illnesses?

Participant viewpoints on mental health professionals/systems:

10. When you hear the word mental health professionals or mental health systems, what comes to mind?
11. What are some things that may influence your decision to seek or not to seek help?
12. Do you believe that the traditional mental health systems addressing the needs of the Lahu immigrants, and why?
13. What, if any, are some of the changes that you feel would motivate the Lahu immigrants to seek mental health services?

Appendix D: Interview Guide in Lahu

Na nyi tu˗ aw˗ hk'a˅

Nyi ma cheh˅ sha caw˗ sha hpaw˅ ve services hta˫ La˅hu˗ ya˅ hui ve nyi maw˗ hk'a˅

Nyi ma cheh˅ sha caw˗ sha hpaw˅ ve services hta˫ La˅hu˗ ya˅ ve nyi maw˗ hk'a˅

1. Cheh˅ sha caw˗ sha ve, leh hpeh˫ sha ve teh˫ k'o^ ve taw˅ chi 2 hkaw˅ hta˫ naw˗ hk'a˗ hk'e te na g'a ve le?
    a. Nyi ma cheh˅ sha caw˗ sha hpaw˅ teh˫ k'o^ ve taw˅ hkaw˅ hta˫ naw˗ g'a ka˅ hta˅ a hto˫ ma hta˫ daw˅ naw˅ ve le?
    b. Nyi ma cheh˅ sha caw˗ sha hpaw˅ teh˫ k'o^ ve taw˅ chi hta˫ ca¯ da˫ ve aw˗ ka˗ aw˗ nu ve taw˅ hkaw˅ ka˫ a ci¯ hto ma˗ la˅ hpeh˫ aw la˅ ?
2. Nyi ma cheh˅ sha caw˗ sha hpaw˅ ve services hta˫ naw˗ aw˗ pon a ye˅ ui˗ ve la˅, ma˅ ui˗ la? Hk'a˗ hk'e le?
3. Naw˗ ve nyi ma cheh˅ sha caw˗ sha pui¯ tu˗ fa˗ ta˗ ga˅ ve pa taw services hta˫ yeh˅ tu˗ yo˗ la˅?
4. Naw˗ daw˅ k'o, chaw na˗ ceh ti¯ services chi hta˫ lo˗ ve heh¯ la˅ ? A hto˫ pa aw chi hk'e daw˅ ve le?
5. What are some things that discourage you from seeking mental health services?
   Nyi ma cheh˅ sha caw˗ sha hpaw˅ ve services chi hta˫ naw˗ ca yeh˅-e hta˅ ha˗ kui˗ a hto˫ ma caw˗ law le?

Chaw li˅ va˅ li˅ hta˫ ca¯ da˫ ve yon˗ hk'a˅ / te hk'a˅

6. Naw˗ ve aw˗ li˅ aw˗ hk'a˅ law k'o, chaw ya˅ a sha˫ te˫ ve, leh chaw suh ve hta˫ hk'a˗ hk'e to yon˗ ve le?
7. Chaw te˅ hpa˗ hpa˗ ve aw˗ li˅ aw˗ hk'a˅ law k'o, chaw na˗ ha˫ sha¯ ve aw˗ hk'a˅ peun da˫ kui˗ caw˗ ve yo˗. Naw˗ ve aw˗ li˅ aw˗ hk'a˅ law k'o, nyi ma cheh˅ sha caw˗ sha hpaw˅ ha˫ sha¯ ve hta˫ te caw˅ la˅, ma˅ te caw˅ la˅ ?
8. Cheh˅ sha caw˗ sha hpaw˅ nyi ha˫ sha¯ ve aw˗ hk'a˅ hta˫ ca¯ da˫ leh mvuh˅ nyi k'eh˗ hpaw˅ ve na^ tsuh^ sa˗ la˫ go˗ hui ve aw˗ hk'a˅ leh naw˗ hui te cheh˅ ve aw˗ hk'a˅, hk'a˗ hk'e te peun da˫ ve law le?
9. Naw˗ g'a hpu˅ g'a maw˗ ta¯ ve aw˗ ceu˗ hta˫ nyi k'o, mvuh˅ nyi k'eh˗ hpaw˅ ve na^ tsuh˅ leh˗ chaw ya˅ nyi ma hpaw˅ ve a na˗ hta˫ ha˫ sha¯ g'a ve teh˫ naw˗ yon˗ aw˗ la˅ ?

Volunteer hui, nyi ma cheh˅ sha caw˗ sha hpaw˅ cu˅ yi˗ caw˗ ve chaw hui hta˫ hk'a˗ hk'e te nyi maw˗ cheh˅ ve aw˗ aw˗ lawn.

10. Nyi ma cheh˅ sha caw˗ sha hpaw˅ ve cu˅ yi˗ caw˗ ve chaw hui aw˗ lawn g'a ka˅ hta˅, naw˗ hk'a˗ hk'e daw˅ ve le?
11. Nyi ma cheh˅ sha caw˗ sha hpaw˅ ve services hta˫ naw˗ ca yeh˅ tu˗ la˅, ma˅ yeh˅ tu˗ la˅ ve hta˫ daw˅ che^ g'a ve a hto˫ ma caw˗ le?
12. Pon˗ ta¯ hta˅ ve, nyi ma cheh˅ sha caw˗ sha hpaw˅ ha˫ sha ve aw˗ hk'a˅, naw˗ hui La˅hu˗ ya˅ hui hta˫ aw˗ teh˗ aw˗ na ga la˅ g'a ve yo˗ la˅, ma˅ he^ la˅? Hk'a˗ hk'e le ?
13. Nyi ma cheh˅ sha caw˗ sha hpaw˅ ve services hta˫ ca¯ da˫ leh te˅ ceu˗ ceu˗ pe˗ pa tu˗ caw ve law k'o, a hto˫ ma hta˫ pe˗ pa tcuh ga˅ ve le?

Appendix E: Priori Codes

Level 1	Level 2	Level 3	Sources/ Interviews	References
Category 1	Health Definition	Not sick	7	7
		Exercise	4	4
		Energy	4	4
		Eat healthy food	3	4
		Take vitamins	1	1
	Mental Health Definitions	Crazy people	8	15
		Brain problem	4	6
		Medication	8	10
		Treatment	7	8
		Depression	4	5
		Anxiety	3	3
		Difficulty sleeping	3	4
		Fatigue	1	1
Category 2	Attitudes/Perception of Mental Health			
		Service is important	9	9
		Service helping people	9	20
		Reserved only for ill people	5	5
Category 3	Presentative Services	Only when sick	9	26
Category 4	Cultural Belief	God	6	7
	Cultural Practice	Prayer	8	8

		Herb	7	8
		Faith healer	6	6
Category 5	Barrier to Mental Health	Don't speak English	7	8
		Don't drive	6	6
Category 6	Need to Improve Mental Health	Provide transportation	6	6
		Provide interpreter	7	7
		No relationship with Provider	1	1

Appendix F: Hierarchical Coding by Priori Codes

Research Question #	Level 1 Codes: Question Category	Level 2 Codes	Main Themes	Mentioned Frequency (4+)	Quotes
1	1	Health definitions			
1		0	Eat healthy food	4	"Someone who is healthy food…" "Someone who is healthy... has good appetite for food, maintain a healthy diet and eats healthy food." "Healthy appetite." "Someone who engages in healthy lifestyle and maintains a healthy diet and watches what he or she eat."
1			Not sick/Good health	7	"Someone who is healthy…" "Some who is in good health and does not get sick often." "Someone who is without any illness or sock." "The absence of illness, someone who is healthy, not sick." "Someone who is healthy…free of any illnesses." The absence of any illness" The absence of any illness, someone who is strong…and healthy."
1			Exercise	4	"Someone who…exercise."

					"Someone who is healthy, exercise and takes care of themselves." "Some who exercise and without any health problem." "Someone who exercise…maintains a healthy diet…takes vitamins and drink plenty of water."
1			Energy	4	"Someone who has full of mental and physical energy." "Someone who is healthy…full of mental and physical energy." "The absence of any illness, healthy appetite and full of mental and physical energy." "Someone who is strong, full of mental and physical energy…."
Research Question #	**Level 1 Codes: Question Category**	**Level 2 Codes**	**Main Themes**	**Mentioned Frequency (4+)**	**Quotes**
1	1	Mental Health Definitions			
			Crazy people	12	"A place for cray people to go and get medication and treatment." (2) "Crazy people or people who are different from others are what come to mind."

					"A place for the crazy people, people with psychotic illnesses a place that provides medications for crazy people and people with disabling illnesses." "A place for crazy people." (3) "A place for crazy people to go and get diagnosis, medication, and treatment." "Someone who is having brain problems, or crazy people." "A place for crazy people; people that talk to themselves without anyone being around them." "A place for crazy people to go and get help." (2) "A place for crazy people and people with difficulty sleeping or eating disorders to go and get a diagnosis to get medication and treatment."
1			Brain problem	5	"People with brain problems, depression, and anxiety." "Someone who is having brain problems, or crazy people." "People with brain problems, brain immaturity, a place for them to go and get a diagnosis and medication and treatment." "Depression, anxiety, and people with problems related to brain functions."

					"Psychotic people, people that can't get along with other people and people with brain immaturity."
1			Medication	10	"A place for crazy people to and get medication and treatment." (2) "A place for people with mental health illnesses to go and get medication and treatment." "A place for these people to go and get medication." "A place for crazy people to go and get diagnosis, medication, and treatment." "People with brain problems, brain immaturity, a place for them to go and get a diagnosis and medication and treatment." "People with sleep disorders, people who cannot sleep, or experience nightmares to go and get medication and treatment." "A place for someone with mental health illnesses, a place to go and get medication." "Crazy people, people with psychotic episodes who yells at people and hits people for no reason." "A place for crazy people and people with difficulty sleeping or eating disorders to go and get a diagnosis to get medication and treatment."

1			Treatment	8	"A place for cray people to and get medication and treatment." (2) "A place that provides diagnosis and treatment for mental health illnesses." "A place for people with mental health illnesses to go and get medication and treatment." "A place for crazy people to go and get diagnosis, medication, and treatment." "People with brain problems, brain immaturity, a place for them to go and get a diagnosis and medication and treatment." "People with sleep disorders, people who cannot sleep, or experience nightmares to go and get medication and treatment." "A place for crazy people and people with difficulty sleeping or eating disorders to go and get a diagnosis to get medication and treatment."
1			Depression	4	"People with brain problems, depression, and anxiety." "A place for people who are depressed, anxious, or difficulty sleeping."

					"Sleep disorders, depression, anxiety, and fatigue." "Depression, anxiety, and people with problems related to brain functions."
1			Difficulty sleeping	4	"A place for people who are depressed, anxious, or difficulty sleeping." "Sleep disorders, depression, anxiety, and fatigue." "People with sleep disorders, people who cannot sleep, or experience nightmares to go and get medication and treatment." "A place for crazy people and people with difficulty sleeping or eating disorders to go and get a diagnosis to get medication and treatment."
Research Question #	**Level 1 Codes: Question Category**	**Level 2 Codes**	**Main Themes**	**Mentioned Frequency (4+)**	**Quotes**
1	2	Attitude/Perception of Mental Health			
			Service is Important	9	"I think it's important. The services are helping people, people with depression, anxiety, and people with problems related to brain function." (5)

					"I think it is very important. Without it, in the world, many people with brain problems, uh, sleep problems, associated with mental health illnesses would not be able to manage and cope with their symptom." "Mental health services is vital to our health and wellbeing." "Mental health services is very important." "I think the services is much needed, especially medications. Some people with psychotic or disabling illnesses may not be able to function or sustain a standard of living without the services or medications provided the mental health system."
			Service is helping people	20	"The services are helping people, people with depression, anxiety, and people with problems related to brain function." "I think the Western medicine is certainly helping people with mental health illnesses. People with difficulty sleeping, cannot sleep, depressed, or anxious may not be able to sustain their standard of living without the services provided by the mental health systems." (4)

						"I think the current mental health systems are addressing the needs of the Lahu immigrants. People with psychotic or disabling illnesses are able to get the services from the mental health systems to help them maintain their standard of living." "I think they are helping the Lahu immigrants to deal with their mental health illnesses." "The services provided are sufficient to address the needs of the Lahu immigrant." "The medication helps with people struggling with mental health illnesses." (2) "Mental health services, they provide medication and education which they help to cope with mental health illnesses." "I think they are addressing the needs of the Lahu immigrants." (3) "The service is very helpful and helps people with mental health illnesses." (2) "Taking a medication alone is helping people to sustain their normal lives."

					"I think the mental health services are helping a lot of the Lahu immigrants because of the advanced medicine we have today. They are able to manage their mental health symptoms and able to live their normal life." "People experiencing psychotic episodes or difficulty sleeping are able to sleep or sustain their standard of living if they take medication." "It helps tremendously. If it's not time for people to go, the doctors are able to help patients. Some people who are severely ill and not able to talk are able to recover fully with today's medicine."
			Reserved only for ill people	5	"I think the mental health services is reversed only for ill people and people with psychotic disorders." "I think the mental health services is for people with depression, anxiety, or sleep problems, people with health problems." "I think it's reserved only for people with illnesses like people how have nightmares and not able to sleep."

					"I think mental health systems exist for people with illnesses or psychotic disorders because people that go there are usually people with illnesses like they cannot sleep, nightmares, or people who considers to be somewhat crazy or different from the society," ": I think mostly only ill people that seeks mental health services, like people with psychotic disorders to get medication, assistance, and the help they need to manage and cope with their symptoms."
Research Question #	**Level 1 Codes: Question Category**	**Level 2 Codes**	**Main Themes**	**Mentioned Frequency (4+)**	**Quotes**
1	3	Preventative Services			
			Only when sick	26	"I don't go to a doctor, if I'm not ill or sick." "I don't seek mental health services as a preventative measure. I only go to the doctor when I'm ill or sick..." (4) "I don't go to a doctor if I'm not ill or sick." "If I'm ill or sick, I will always seek the services." "I would seek the services when I'm not feeling well or sick."

					"I only seek the services when I'm sick or not feeling well." "When I'm ill or sick, I will seek the services." (3) "If you are sick, you have to go to the doctor and get help, get medication." "I don't go the mental health unless I'm sick or ill…." "If I'm sick and my body is telling it cannot take it any longer, then I will seek the services." "If I'm sick or I'm not feeling well, I have to go to the doctor." (2) "If I'm sick or ill, I would seek the services." (4) "If I don't feel well or sick, I will seek the services." "If I'm sick or ill, I have to go. I have to go and get a diagnosis. I don't go if I'm not sick or ill." "The services help. If I'm ill or sick, I would seek the services." "When we are ill or sick, we always have to go to a doctor." "If I'm not ill or sick, I would not go."
Research Question #	**Level 1 Codes: Question Category**	**Level 2 Codes**	**Main Themes**	**Mentioned Frequency (4+)**	**Quotes**

2	4	Cultural Belief			
			God	7	"If there's a birth, there will always a death. This is the law of the land that God has given us." "I think it's orchestrated by God. He put us on earth live and bless us many things." "Life and death are a way of life, orchestrated by God." "Life and death are orchestrated by God." "If it's your time, then even doctors would not be able to help. I think life and death are orchestrated by God." "Everything is created and orchestrated by God so if it's time to die then we will have to go." "As a Christian, I think life and death is a gift from God, orchestrated by God, cannot be fixed by a human."
Research Question #	**Level 1 Codes: Level 1 Codes: Question Category**	**Level 2 Codes**	**Main Themes**	**Mentioned Frequency (4+)**	**Quotes**
2		Cultural Practice			
			Prayer	7	You have to rely on natural herbs, prayers, and faith healers to heal you.

					"We don’t have medications. We only rely on herbs, prayers, and Shaman for healing." "If you don’t have the money, you cannot get medical services. We only rely on natural herbs and prayers. Sometimes, faith healers to perform healing rituals. It helps at the time." "We rely on natural herbs, prayers, and Shaman for healing. There’s no medication back in our home country." "Our traditional practice mainly relies on natural herbs, prayers, and Shaman for healing." "We rely on natural herbs and prayer for healing." "As a Christian, my first response would be to pray."
			Herbs	8	"Use natural herbs to treat it first." You have to rely on natural herbs, prayers, and faith healers to heal you. "We don’t have medications. We only rely on herbs, prayers, and Shaman for healing." "We only rely on herbs and folk medicines. Doctors are not available to everyone. If you don’t have money, you cannot get the services."

					"If you don't have the money, you cannot get medical services. We only rely on natural herbs and prayers. Sometimes, faith healers to perform healing rituals. It helps at the time." "We rely on natural herbs, prayers, and Shaman for healing. There's no medication back in our home country." "Our traditional practice mainly relies on natural herbs, prayers, and Shaman for healing." "We rely on natural herbs and prayer for healing."
			Faith healer	6	"You have to rely on natural herbs, prayers, and faith healers to heal you." "We don't have medications. We only rely on herbs, prayers, and Shaman for healing." "If you don't have the money, you cannot get medical services. We only rely on natural herbs and prayers. Sometimes, faith healers to perform healing rituals. It helps at the time." "We rely on natural herbs, prayers, and Shaman for healing. There's no medication back in our home country." "Our traditional practice mainly relies on natural herbs, prayers, and Shaman for healing."

					"People rely on folk medicine and faith healer for healing. Sometimes it works and sometimes it doesn't work."
Research Question #	**Level 1 Codes: Question Category**	**Level 2 Codes**	**Main Themes**	**Mentioned Frequency (4+)**	**Quotes**
3	5	Barrier to Mental Health			
			Don't speak English	8	"Someone may not have access to the services because of their language barrier." "I cannot go to the doctor because I don't have a transportation or speak English." "Some people did not go to the doctor because they don't speak English." "People do not speak English or lack transportation to get to and from the service." "A lack of interpreter preventing me and others like me from seeking services at times. I have to rely on other people to go with me and translate for me." "Older Lahu immigrants that do not drive or speak English." "The majority of the older people don't speak English and don't drive, so they rely on other people to seek the services."

					"Some people that do not have access to the mental health services because they do not have transportation or speak English."
3			Don’t drive	6	"I cannot go to the doctor because I don’t have a transportation or speak English." "People do not speak English or lack transportation to get to and from the service." "Older Lahu immigrants that do not drive or speak English." "The majority of the older people don’t speak English and don’t drive, so they rely on other people to seek the services." "Some people don’t drive so a lack of transportation is a problem for these people to gain access to the service." "Some people that do not have access to the mental health services because they do not have transportation or speak English."
Research Question #	**Level 1 Codes: Question Category**	**Level 2 Codes**	**Main Themes**	**Mentioned Frequency (4+)**	**Quotes**
3	6	Needs to Improve Mental Health Access			

			Provide transportation	7	"Providing transportation or interpreting services would allow them to gain access to the mental health services." "People that don't speak English or drive, having an interpreter or transportation would help these people to gain access to the services." "Provide a transportation and an interpreter." "Providing transportation and interpreter services will motivate the Lahu immigrants that don't speak English or have transportation to seek the services." "Provide an interpreter and able to communicate with the doctors and nurses or have transportation, I think more people will seek the services." "Some people don't drive, so having a transportation would help…." "The language barrier and a lack of transportation are a barrier for some people."
3			Provide interpreter	7	"Providing transportation or interpreting services would allow them to gain access to the mental health services." "People that don't speak English or drive, having an interpreter or transportation would help these people to gain access to the services."

					"If there's an interpreter that would translate for people that don't speak English, I think more people will go." "Providing transportation and interpreter services will motivate the Lahu immigrants that don't speak English or have transportation to seek the services." "Provide an interpreter and able to communicate with the doctors and nurses or have transportation, I think more people will seek the services." "If there's an interpreter that speaks Lahu language, I feel that people that don't speak English would be motivated to want to go to the doctors." "The language barrier and a lack of transportation are a barrier for some people."