Beliefs about treatment of mental health problems among Cambodian American children and parents

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Abstract

Beliefs about treatment of mental health problems are a critical area for examination among immigrant and refugee populations. Data on treatment of child problems have been conspicuously absent from the literature. This study examines explanatory models of treatment among 40 second-generation Cambodian children aged 8–18 and their parents in the US. Comparisons of perceptions of intervention for an externalizing problem (gang-related behavior) and an internalizing problem (depression) are made in a group of children who have received mental health services, their parents, and a matched community sample. A significant interaction between respondent and group membership was present in the perception that these problems could be helped, and contrary to past findings among Asian Americans, both children and parents generally endorsed the use of mental health services. Data about actual experiences with mental health services are used to help explain the findings and suggest implications for treatment of Cambodian-American youth.

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Introduction

Recent studies have documented that Latino, African American and Asian/Pacific Islander American children are largely underserved by the mental health system as compared to nonHispanic whites (e.g. Kataoka, Zhang, & Wells, 2002; Yeh, McCabe, Hough, Dupuis, & Hazen, 2003). Asian American children are particularly under-represented; Asian American youth constituted only 1.4% of the children enrolled in the California System of Care, in comparison to their population representation of 9.4% in these areas (Mak & Rosenblatt, 2002). Similarly, McCabe et al. (1999) noted significant under-representation of Asian American youth in both the

systems of child welfare services for seriously emotion-ally disturbed and in mental health services.

Formal mental health services undoubtedly have many limitations for minority populations. They are nevertheless likely to remain the cornerstone of treat-ment of psychological, behavioral and even social problems in urban areas of the US until the system of health care for lower income and underserved commu-nities broadens to include more diverse treatment options. However, the ubiquity of these services should not preclude investigations into other systems of care and treatment methods for all youth and families. This is especially true for Asian Americans, for whom standard mental health services may not be the first choice of treatment.

Contemporary research knowledge about treatment of Asian American children is mainly in the form of

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service utilization and prevalence studies. However, at least two studies have examined beliefs about treatment of child problems among Asian American or Asian populations. McKelvey, Baldassar, Sang, and Roberts (1999) found that Vietnamese parents in Australia actually endorsed a high preference for Western practitioners including mental health clinics, psychiatrists, hospitals, and psychologists. Religious practitioners, naturopaths/homeopaths and spiritual healers were the least likely to be sought. Awareness of child and adolescent mental health services was very low among parents. Also using a community sample, Lau and Takeuchi (2001) used vignettes to assess the relationship between values and help-seeking behavior among Chinese American parents. As with the findings of McKelvey et al., these authors did not find a relationship between a more traditional value orientation and less willingness to seek mental health services. Instead, perceived severity of the problem was the factor that best predicted help-seeking. In general, given the underutilization of services among Asian Americans, it is surprising that more studies have not sought to investigate beliefs about the usefulness of the mental health system for treatment of child mental health problems among Asian Americans.

Among Asian Americans in the United States, Cambodians have increasingly received attention as an especially high-need group (US DHHS, 2001). Economically, Cambodians on average fall well below the poverty line (Chan, 2003) and in Los Angeles county, rank lower than all other ethnic groups on almost every single indicator of economic and social adjustment (Louie, 1996). High levels of exposure to violence (Berthold, 1999) and significant rates of Post-Traumatic Stress Disorder (PTSD) and depression have been noted in nonclinical samples (Berthold, 1998). Cambodian youngsters are also exposed to varying levels of anxiety, depression and PTSD in their parents as a result of torture experienced during the "killing fields" of the 1970s (Kinzie, Boehnlein, & Sack, 1998). Gang activity has been identified as a particular concern by Cambodian parents (Chan, 2003). While many Cambodian children are referred for services, among children attending an Asian-specific clinic, Southeast Asian clients show less benefit from services than other Asian groups, suggesting that even specialized "parallel" services may not effectively serve the needs of Cambodian children and adolescents (Yeh, Takeuchi, & Sue, 1994).

While the economic, historic, and social realities of the Cambodian community point toward elevated levels of mental health problems in children, there are gaps in what is known about this issue. To date, the extensive research on Cambodian youth has focused on children and adolescents who themselves were refugees, rather than the generation of Cambodian youth born in the US. These youth may have different or additional issues with which they struggle than refugee populations. In addition, virtually no data are available on treatment of child problems among Cambodians settled in the US beyond what we know about the previous generation of adolescent refugees. It is unclear how parents believe most child problems should be handled: within the home, at school, in outpatient clinics, through parallel services, elsewhere, or not at all.

One avenue through which to explore beliefs about mental health stems from the *explanatory model* framework (Kleinman, 1980). An explanatory model is a way to characterize a personal belief system about an illness or illnesses, and traditionally refers to five areas: etiology, time and mode of symptom onset, pathophysiology, course of sickness and treatment. With roots in medical anthropology and health psychology, the framework has also been incorporated into the most recent edition of the Diagnostic and Statistical Manual as part of the recommended practice for establishing cultural factors that may be associated with a psychiatric diagnosis. Research has previously examined parental beliefs about childhood mental illness and behavior, including ADHD (Bussing, Schoenberg, Rogers, Zima, & Angus, 1998), generally "deviant" behavior (Hackett & Hackett, 1993), mental illness (McKelvey et al., 1999), as well as a range of physical problems in children.

A major impetus for the focus on explanatory models in both the original conceptualization (Kleinman, 1980) and in the current study is that this framework holds potential for improved service delivery and clinical outcome for clients. In particular, the Explanatory Model component of beliefs about treatment may have the most immediate relevance for addressing challenges such as those faced by Cambodian youth because the specific questions probe for ideas about how to alleviate distress. Past research on Cambodian populations have incorporated different aspects of the explanatory model paradigm to understand adult treatment beliefs. For example, Eisenbruch (1992) used multidimensional scaling to classify 45 perceived causes of illness into four categories: Western physiological, nonWestern physiological, stress, and supernatural. Cheung and Spears (1995) subsequently found that 78% of Cambodian adults had beliefs that could be classified in all four categories. This finding helps explain earlier results by Kinzie (1985) in which there were significant discrepancies in concepts of mental health between mental health professionals and Khmer refugees.

Despite the utility of explanatory models with Cambodian populations, no studies have focused on Cambodian beliefs about child problems or Cambodian children's own beliefs. The aim of the current study is to use a mixture of rating scales with analyses of qualitative data to examine beliefs about treatment of mental health problems among refugee Cambodian parents and their

American-born children. The focus of comparison in this study is twofold: first, we compare parents and children, given that differences in beliefs about treatment could impact the effectiveness of certain strategies (Lau & Takeuchi, 2001). Understanding these differences may be the first step to reconciling them. Second, we compare children and parents who have direct experience with mental health services with a carefully matched control group. By tapping into the beliefs of those with direct experience, we can asses which aspects of mental health services are viewed positively and which are viewed negatively, and may also find that Cambodian children and parents see value in other sources of help that can operate in tandem to or in lieu of formal mental health services. The inclusion of a control group also allows for greater generalizability. Through the use of vignettes, we explore the extent to which two common problems are perceived as "helpable," that is, how they are thought to be remedied through different treatment options. Then, through the analysis of both qualitative and quantitative data, we examine which strategies or services Cambodian children and parents perceive as the most useful for addressing these problems.

Method

Participants

Forty parent–child dyads were recruited to participate in the study. Twenty children of Cambodian origin were recruited from two community-based, Asian-specific mental health agencies. One was a Department of Mental Health (DMH) agency, and the other was a nonprofit agency with a DMH contract. Children were considered eligible for participation if they were between the ages of 8–18, lived with at least one biological parent, and did not have a primary diagnosis of a cognitive impairment or thought disorder. The parents of eligible children were contacted either in person or by phone by the clinic case manager. Consent to release clients' phone numbers to the project staff was obtained, and a research assistant from the project contacted parents to further explain the study and ascertain interest in participating. An estimate provided by the caseworker suggests that approximately 75% of clinic families agreed to be contacted and 100% of the families contacted by the research team chose to participate.

Clinic children were primarily referred from their schools (N = 8). Five entered services through a legal avenue such as Department of Children and Family Services or probation, and five had services initiated by their parents. The referral source for two cases was either unclear or conflicting between reports. Of the diagnosis provided at intake, 70% of the clinic sample evidenced an externalizing problem, and 25% an internalizing problem as their primary diagnosis, a distribution which is typical for outpatient child mental health clinics (Manteuffel, Stevens, & Santiago, 2002). Table 1 presents diagnostic information from chart records at intake.

Twenty community participants were recruited to serve as a matched control group and were recruited through strategies such as distribution and posting of flyers at temples, churches, apartment complexes, community centers and businesses in the main Cambodian community, recruitment at school and community events, and snowball sampling with multiple originating points selected to maximize the likelihood of obtaining a heterogeneous sample that met the criteria needed for matching purposes. Groups were matched on child gender (3 girls, 17 boys) and matched within 6 months of

Table 1
Sample characteristics (N = 40)

	Clinic *M* (SD) N = 20	Community *M* (SD) N = 20
Child age	13.69 (2.26)	13.71 (2.33)
Age of parent respondent	46.23 (7.99)	43.19 (7.85)
Parent respondent years of education	4.25 (3.81)	5.15 (3.38)
Parent respondent number of years in US	18.62 (2.87)	18.48 (2.59)
Number of living children of mother	4.35 (1.87)	5.10 (1.68)
Number of household members	5.03 (1.95)	5.91 (1.77)
Annual income	$20,444 ($6640)	$20,853 ($6345)
Percent of single parent homes (N = 40)	55%	55%
Percent of homes with no parent employed (N = 40)	85%	60%
Percent of homes with Khmer reported spoken by both parents and children (N = 40)	65%[a]	60%[a]
	55%[b]	60%[b]
Primary DSM-IV classification of child clinical sample at intake		
Oppositional defiant disorder (N = 8)	40%	
ADHD (N = 5)	25%	
Depressive disorder NOS (N = 3)	15%	
Dysthymic disorder (N = 2)	10%	
Conduct disorder (N = 1)	5%	
Adjustment disorder (N = 1)	5%	

[a]Parent report.
[b]Child report.

child chronological age; the average age difference between groups was less than 1 month. Community children could *not* have received any services from either a community or school-based program for behavioral, emotional or mental problems at any time in their life. The samples were comparable on reported income per person, parent years of education, age of parent at arrival in the US, language spoken in the home, and religion. In addition, the families were well matched for the number of years of residence in the US, the household size, and number of children in the family; there were no significant differences among any of these variables.

The mean age of children in the study was 13.71 (SD = 2.27). Mothers were always the respondent chosen for interviewing in two-parent homes given that they were self-identified or identified by the clinic as being the primary caregiver and responsible for the child's clinic treatment. Half of both groups were single-parent homes which included single fathers. Parents have lived in the US an average of 18.55 years (SD = 2.69); all children in the sample were either born in the US or in two cases, arrived before the age of 6 months and in one case, arrived at the age of 3 years. Families reported a mean combined household income (including sources such as cash assistance, SSI, and food stamps) of $20,648 for a family of 5.4. Seventy-three percent of the sample was families in which both parents or the only caregiver was unemployed. There was no difference in the distribution of working and unemployed single and two-parent homes between the groups (see Table 1).

Procedure and measures

Parents and children were interviewed separately in their homes. A research assistant who fluently spoke Khmer (the Cambodian language) was present for all parent interviews. Parents were encouraged to speak in whatever language they preferred, or a combination of both languages. Seventy-one percent of the interviews were conducted exclusively in Khmer, 29% of the interviews involved a mixture of English and Khmer. All child procedures were conducted in English by the primary investigator and were not attended by any other individuals. Parents reported on basic demographic information such as the child's date and place of birth, school, grade, mother's and father's date and place of birth, occupation, total years of schooling, ethnic group identification of the parents, religious affiliation of parents, approximate household income, number of household members and number of children.

Measurement of beliefs about treatment

The research tool for obtaining information about explanatory models of treatment was a modified version of the Explanatory Model Interview Catalogue, a semi-structured interview that has been developed to elicit illness-related perceptions, beliefs and practices (Weiss et al., 1992). Two vignettes were used. By basing the vignettes on data collected through a chart review of all the current clients at one of the clinics, it was possible to make these vignettes reflective of actual and significant problems of Khmer children. Descriptive clinical information from the presenting problem reported at the first session was used as the basis of the vignette to approximate the most common problems seen.

The vignettes represent a general externalizing (''Sombo'') and internalizing child (''Jauna''). Ages used in the vignettes are averages of the actual ages of children at time of presentation. As a result, the age of the children in the two vignettes differs, but provides a more realistic reflection of actual Cambodian children than would be achieved by using identical ages. The vignettes were discussed with three Khmer child mental health professionals to ensure accuracy, and modifications were made. The order of presentation of the two vignettes was counterbalanced within the two samples, and parents and children received the vignettes in the same order. They appear in Appendix A.

Both parents and children were asked, ''What kind of help or treatment do you think would be best for ⟨ VIGNETTE NAME's ⟩ behavior?'' Following their response to this open-ended question, respondents were provided a list of different treatment options and were asked to rate from 0 to 4 how helpful they thought each would be for the child in the vignette. For the options receiving the highest endorsement, respondents were asked *how* they thought that could help the child in the story. Respondents were also asked to rank and explain any items they volunteered that were not already on the list. Items chosen for the list included the most common options for children experiencing a behavioral or emotional problem, and also included any sources of previous help obtained from a chart review conducted before the study.

Responses to the open-ended question were coded into one of seven categories using a bottom-up procedure (see Appendix B). Coding was completed by two Cambodian-American assistants, who were blind to group membership of the respondents. Interrater reliability for the coding scheme was high; $k = .91$ for parent and $k = .86$ for child coding. Respondents were offered 13 treatment options; following data collection, these were collapsed into seven categories. Where more than one item is present, the items were averaged: (1) religious (priest or monk); (2) school (child or parent approaching teachers and school personnel); (3) friends (child or parent approaching child's friends); (4) doctors (taking medicine or going to a pediatrician); (5) traditional Cambodian options (a *kruu khmer*, Cambodian medicine, cupping/pinching/coining); (6) mental health ser-

vices, and (7) parents in general. These categories are not absolute or devoid of overlap, of course; for example, it is also possible that one way a parent could be helpful is by talking to teachers. They are used as a convenient framework for comparison.

The SPSS 11.5 statistical program was used for analysis of quantitative data, and the EthnoNotes (Lieber, Weisner, & Presley, 2003) was used for analysis of the open-ended questions.

Results

Extent that problem can be helped

One question of this study asks to what degree each of the two children presented in the vignettes is viewed as being able to be helped. To determine this, an average score was derived from the list of possible sources of help, plus any others mentioned. The design is a 2×2 (respondent $\times$ clinical status) multivariate analysis of variance (2-way MANOVA) to determine the effect of the respondent (parent/child) and clinical status (clinic/community) on the two dependent variables, the degree that the children portrayed in each of the externalizing and internalizing vignettes can be helped. A multivariate test for respondent was not significant (Wilks' Lambda = .973, $F = 1.021$, df = 2.75, $p = .36$). There was also no main effect for clinical status (Wilks' Lambda = .970, $F = 1.151$, df = 2.75, $p = .32$). However, a significant respondent by clinical status interaction was present for the perception that the child in both vignettes could be helped (Wilks' Lambda = .864, $F = 5.922$, df = 2.75, $p < .005$). For both the internalizing and externalizing vignette, the pattern of response was the same: parents in the clinic sample reported the highest score, followed by community children, clinic children, and lastly, community parents. Among the four groups, mean scores ranged from 1.63 to 2.17 for the externalizing child and 1.66 to 2.33 for the internalizing child, where "0" signifies "not at all" and "4" signifies "very much". Table 2 contains the means and the standard deviations of the DV's for the four groups and Fig. 1 depicts the interaction.

Helpfulness of different treatment choices

The second question of this study examines parent and child beliefs about what specific interventions and strategies are perceived as *most* useful for the problems presented in the vignettes, and why. To address this question, two types of data are presented: a descriptive comparison of the strategies suggested from open-ended responses and endorsement of a list of treatment options.

Table 2
Means and standard deviations of perceived potential of vignette children to be helped

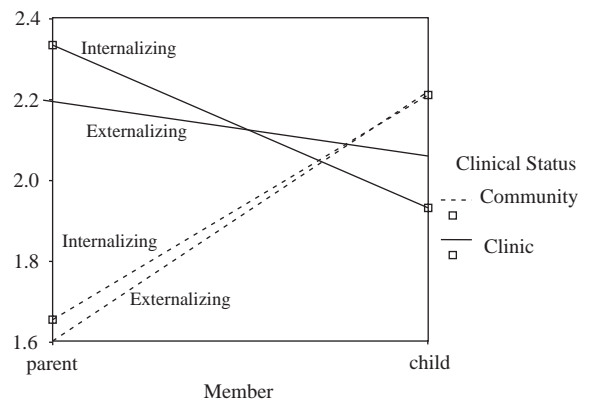|	M	SD
Externalizing vignette		
Clinic parent	2.17	.85
Community parent	1.63	.56
Clinic child	2.06	.66
Community child	2.17	.71
Internalizing vignette		
Clinic parent	2.34	.55
Community parent	1.66	.52
Clinic child	1.93	.69
Community child	2.21	.71

Fig. 1. Average ability to be helped for children depicted in externalizing and internalizing vignettes.

Strategies from open-ended responses

The open-ended responses were coded for the primary approach to treatment that participants felt would be helpful. In general, the pattern of responses was similar between groups, and for clarity of presentation, the main comparison will be between parents and children. The use of formal services and informal guidance emerged as the two most common suggestions, except for children's response to the externalizing vignette. For this vignette, children most frequently recommended restriction and punishment. As will be discussed below, mental health providers were often seen as a useful strategy; more than a third of the parent responses and about a quarter of the child responses for both reflected a formal treatment, such as an agency or facility whose purpose was to provide services (see Fig. 2). A small number of these responses included churches or temples, but the overwhelming majority of formal services mentioned were in the mental health profession.
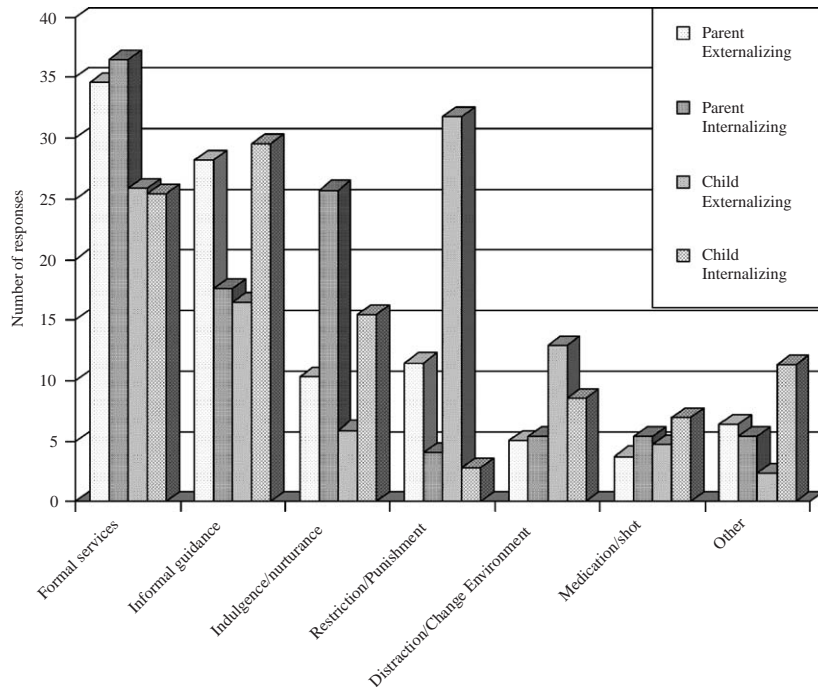
Fig. 2. Primary strategy for intervention from open-ended responses.

Almost as consistently, parents and children recommended the strategy of providing informal guidance ("talking it over"), with a family member, friend, or another adult, such as a parent who recommended, "talking to him and guiding him, the parents need to guide and advise the child…then you're gonna have to ask him and take time to ask him what's going on, and say 'Son talk to me what did you do wrong, tell us and we'll help you' then the child will be more relaxed, in case if he did do something wrong he can go back and depend on his parents to support him and help him." Another parent echoed this idea by noting that "the child doesn't want to talk to the parents so if there isn't another person like an uncle who he may talk to, you have to ask the other people like neighbors or friends to help you by asking the child and talking to the child." Children similarly suggested "family talk" or friends to steer him out of trouble.

Restricting behavior and punishment was brought up as an effective strategy, but this was more so for the child in the externalizing vignette and particularly among children, nearly a third who suggested it. Thirteen children responded that "boot camp" was a way to help the child in the externalizing vignette; an additional three responded "jail," and various other types of punishment or discipline were noted, such as putting the child in a special class with a mean teacher, solitary confinement, giving him a "whopping," and taking him to police officers, an option mentioned by

five kids. One parent explained that "if the child doesn't listen to the parent, send her to boot camp for a few months, and then she comes back, she's okay." One youngster described the mechanism of effectiveness of boot camp as "they discipline kids who are aggressive and hard-headed…[it would help because] the kids just get a lot of discipline, exercising, and being respectful to people. If they don't be respectful, the soldiers or whatever, the sergeants, they're loud." Children frequently mentioned not allowing the child in the externalizing vignette to go outside, and while less frequent, some parents expressed the idea, "that child needs someone to teach him a lesson."

At the other end of the spectrum from restriction and punishment, indulgence and nurturance was suggested, particularly for the child portrayed in the internalizing vignette. Parents and children both recommended "give(ing) the children money, food, or whatever they want," "just do what makes him more happy," and "let him stay home and have games and food in the house, let him eat well and if he needs or want something, give it to him… care about him and give him attention and ask him questions on what he wants so he won't be sad or upset and take him to the park to play around and stuff," as described by parents. Emotional nurturance was suggested for "Sombo" as well, such as a parent noting that "since he's already like this, you will just need to sweet talk him." One youngster replied that "he'll probably need his parents to tell him that they

love him and stuff like that, and like let him kick it with the right crowd" another noting the importance of "someone just going out to him and talking to him, asking about how he feels. Why he feels that way, just asking why he doesn't associate with so many kids, why he's so emotional; a person who actually cares and is sincere in his questions or his or her questions. Not just someone who says, 'why are you acting this way, I want you to be better.' Someone who actually cares about how he feels."

While not as commonly mentioned, the strategy of distracting the child, either through getting him or her interested in something else or changing the environment (for example, relocating the child to live with another family member or changing neighborhoods) was suggested as a way to help, especially by children who viewed bad neighborhoods as the cause of the problem and felt that "it's best if they move out of whatever neighborhood they're in and go to another peaceful neighborhood. And let him kick it with a good surrounding and um, just give it like a month and he'll start changing the way he behaves." Distracting also included ideas such as "hav(ing) fun, go to places, pools," and getting "a lot of clowns and all this stuff that makes him really happy and everything else...like some funny jokes, some funny movies and also get some excitement. Make some funny faces so he'll make some friends; that might make him really happy." In sum, the open-ended responses were dominated by reliance on formal services and informal guidance, although both extremes of punishment and indulgence were also invoked.

Endorsement of list items

Across the groups and across the vignettes, mental health services, which were described as "a counselor, psychologist or mental health center" were chosen as among the most helpful. For parents, this option was ranked most popular in both the community and clinic samples; parents in the clinic sample expressed the most faith in mental health services with a mean of 3.48 out of a possible 4 (differences between the clinic and community sample will be discussed below). Among children, mental health was selected either first of second highest for the internalizing child. The explanations of how mental health services would help centered on the idea that they were trained to help "this kind of kid" and would be able to "guide and help and talk good to lead the child to a good path for him to calm down." For example, parents suggested that for externalizing problems, "they can guide the child to do good, and they can give examples to the child, helping the child distinguish from good to bad, and when the child sees that, it'll work." Similarly, for internalizing problems, parents noted, "from what I hear about it, they help with not letting the child think too much, and think

positive" and that "the counselor will already know what's going on with the child's problem so they can talk to the child and guide him a lot, they can talk good to him."

Children's responses tended to be less elaborate as to the mechanism by which mental health services could help, although some youth were able to articulate reasons such as "they're trained to deal with this kind of situation or similar situations to him, so they would know if he really needed help, or if he could just handle it himself" and "if the social worker or psychologist is sincere, I think that would be beneficial and also because it's a new face he might open up to."

For parents, following the first choice of mental health services, subsequent choices are less consistent between vignettes, although the overall order does not markedly differ between the clinic and community samples (see Table 3). Most dramatically, parents are viewed as the second most helpful option for the internalizing vignette, but the second *least* helpful for the externalizing vignette. This sense of helplessness experienced by parents in the face of their "out of control" children was expressed repeatedly, with explanations such as

> You know how the child doesn't listen to the parents, if the child goes to the clinic, then he can listen to the people at the clinic. Like my own child, he doesn't listen to me but he listens to other people.
> The parents can help, but if he doesn't listen? Normally parents want their child to do good, but what can you do if the child doesn't listen?
> [Parents] can help Sombo a little because he thinks that 'it's just my mother and I'm too lazy to listen to her and I rather listen to other people than my mother.'
> The parents can help only up to "2" because for some kids they don't listen to the parents because they are not scared of the parents.

For children, talking to teachers at school followed parents and mental health professionals for the community sample and for the internalizing vignette of the clinic sample. School was fourth (behind religion) for the externalizing vignette for the clinic sample. Children made remarks that it would help for reasons such as

> 'Cause her teacher will say do you want to go to the principal office or you want to stay here. If you don't want to stay here, you'll get sent to principal's office since you been stealing from other people and not listening to me and keep talking to your friend the whole time.
> Well, teachers see those kinds of students all the time and they really know what's going on and I think if he finds comfort in the fact that, that he knows his teachers knows what's best and if he trusts his

Table 3
Choice of helpfulness of different treatment sources based on mean responses

Externalizing vignette

| | Clinic sample | | | | Community sample | | | |
| | Parents | | Children | | Parents | | Children | |
Order	Source	Mean	Source	Mean	Source	Mean	Source	Mean
1	MH	3.43	Parents	3.00	MH	3.05	Parents	3.13
2	Medical	2.5	MH	2.75	Teachers	1.73	MH	2.97
3	Friends	2.39	Religion	2.13	Medical	1.70	Teachers	2.73
4	Teachers	2.36	Teachers	2.00	Religion	1.70	Religion	2.10
5	Religion	2.32	Medical	1.99	Parents	1.67	Medical	1.89
6	Parents	2.19	Friends	1.94	Friends	1.59	Friends	1.88
7	Traditional	1.08	Traditional	1.11	Traditional	.57	Traditional	1.06

Internalizing vignette

1	MH	3.53	MH	3.03	MH	3.08	Parents	3.19
2	Parents	2.88	Parents	2.65	Parents	2.21	MH	2.97
3	Teachers	2.78	Teachers	2.00	Teachers	2.05	Teachers	2.80
4	Religion	2.51	Friends	1.95	Religion	1.73	Religion	2.19
5	Medical	2.34	Medical	1.84	Friends	1.70	Friends	2.13
6	Friends	2.31	Religion	1.84	Medical	1.46	Medical	1.94
7	Traditional	1.34	Traditional	1.04	Traditional	.65	Traditional	.95

teacher, it would really help him a lot because he would follow the guidance of the teacher, someone who has experience in situation. So I think that it's like most important.

The teacher might give a conference with his parents. [That would help because] the parent tell him to listen more or he'll be punished.

Because, personally I kinda think they really couldn't express a lot to their own parents, I mean, they feel like their parents don't understand them, where a teacher could understand him better. So, it's like that bridge between him and his parents…

I think it's very important because I think a lot of Khmer people, they think teachers are more understanding because they're, think they can relate better, so, yeah, I think it's "4."

Least helpful for all groups and both vignettes were the Cambodian methods of intervention. Both parents and children explained that cupping, pinching and coining could be helpful only if Sombo or Jauna were "sick," but not for their behavior, suggesting that these problems were indeed perceived as behavioral or emotional rather than physical in nature. Parents also noted that there are no or few "real" *kruu khmer* that live here in the US.

Comparisons were made in the perceived degree of helpfulness between parents and children and between the clinic and community samples, based on the ratings from zero to four. A series of two-way ANOVA's

(respondent by clinical status) were run for each of the seven treatment options. Generally speaking, there were more similarities between parents and children and between clinic and community participants than there were differences. The only main effects for respondent occurred in perceived usefulness of mental health services, which parents endorsed as significantly more useful $F(1, 75) = 4.178$, $p < .05$, and parents, which children endorsed as significantly more useful, $F(1, 57) = 9.128$, $p < .005$.

While the main effects for respondent and group were generally unremarkable, there was a significant interaction for the remaining four dependent variables (religion, school, friends, and doctors). In each case, the pattern was quite similar, with clinic parents generally providing the highest ratings, and in all but one case (mental health), the community parents providing the lowest ratings (see Table 3 for means).

Discussion

This study examined beliefs about treatment of two common emotional and behavioral problems within the Cambodian-American community: depression and gang involvement. Parents and children with and without direct mental health experience were asked about their perception of how much various treatments could help these problems. Examining the degree to which each problem was viewed as remediable revealed that among

these four groups (clinic and community parents and children), parents in the clinic group saw both problems as more able to be helped than did parents from the community sample, and for specific interventions, clinic parents consistently saw most forms of help as more useful than community parents. Community parents were, in fact, the least optimistic that either of these problems could be helped. No significant differences were observed between children in the two groups; however, in comparing parents with children, differences were again observed. Within the community sample, children saw both types of problems as more readily helped than their parents. On the other hand, when clinic children were compared to their parents, they perceived the internalizing problems as significantly *less* able to be helped than did their parents.

This interaction raises several possible interpretations. Perhaps clinic parents have the most optimism because they have the most experience with formal services and have seen formal services work for their own children, and in some cases, even sought services for their child because they have more conviction that problems can be helped. However, parents of children with identified mental health problems could maintain a positive view because they need to have faith that there is hope for these hypothetical children if they are going to maintain hope for their own children.

Along the same line of reasoning, what might explain the relative lack of optimism among community parents and clinic children? Perhaps the views of these community parents reflect a sense of frustration among many members in the community about the trajectory that many Cambodian children have taken by becoming involved with gangs (Chan, 2003), or their lack of optimism is a representation of empathy for their neighbors and friends whom they have seen try to handle such problems. For children, their beliefs could be a reflection of their need for services, for example, that depressed children may be less optimistic globally. Alternatively, it could it be interpreted as children with the most direct experience are in the best position to realistically determine what is possible for other similar children.

The comparison of specific forms of help demonstrated interesting patterns. Contrary to what might be expected from this population given the general conclusion in the research literature about the reluctance of Asians to seek mental health services (e.g. Bui & Takeuchi, 1992; Yeh et al., 2002; Zhang, Snowden, & Sue, 1998), but consistent with McKelvey et al. (1999), both parents and children in this study endorsed the potential helpfulness of mental health services for the problems presented in the vignettes. This was true in the community sample as well as the clinic sample, and even before being asked directly, parents and children spontaneously mentioned counselors and clinics as a good option. This readiness to endorse mental health could potentially reflect a selection bias, such that only the most satisfied clinic clients chose to participate in this study. For the community sample, this can be at least somewhat ruled out, since the description used to recruit participants did not explicitly talk about "mental health" or a related phrase.

One explanation for the discrepancy between this apparent endorsement of mental health services and clear underutilization of services by Asian children (e.g. Mak & Rosenblatt, 2002; McCabe et al., 1999) is that mental health services may be viewed as a good idea in a hypothetical situation or for "other people," but not actually used. It is also possible that the past decade of effort to destigmatize mental health services in this particular community by providing culturally competent parallel centers of care may be paying off. Another possibility is that the Cambodian community could be different from other Asian groups in their positive regard for mental health services as a result of their particular use of services; this community tends to be more familiar with mental health services because of the high number of adults who receive Supplemental Security Income for trauma-related disability (Chan, 2003). Parents often replied "so many people!" or "everyone here (at the apartment complex)!" when asked if they knew anyone who received services at a mental health clinic. In this case, receiving services from a clinic may be just part of the process of receiving something more significant, an income, and in itself, is not viewed with any particular valence. Yet an additional alternative hypothesis could be that respondents continue to feel the stigmatizing effect of mental health problems, and by having them treated in stand-alone, separate facilities they are able to keep the discussion of problems out of the community, and would therefore endorse mental health services as a good option.

One of the differences observed between parents and children in this study was the amount that they perceived parents to be a help; children rated parents as more helpful than parents rated themselves. When presented with the kind of challenging behaviors of an externalizing child, parents particularly expressed frustration and hopelessness about their own ability (as parents) to help such a child. This lack of faith in their abilities may come from real experiences, their own, or those of their neighbors and relatives, in successfully handling such children. Cambodian parents of this generation may also lack effective parenting skills partially as a result of their pre-immigration experience during the Khmer Rouge (Kinzie et al., 1998). Since many parents in this sample were children and adolescents during the Pol Pot regime, they may have experienced a traumatic loss of their parents at an early age and may not have had models of parent–child

relationships for a period of their own development, leading them to find the challenges of parenting particularly overwhelming.

Lack of effective parenting skills for challenging children may be reflected in the type of strategies respondents suggested. Both parents and children suggested formal services (such as taking the child to a place that was designed to provide help), or informal guidance from a family member, friend of the child, or another community member. However, two other common strategies included both harsh punishment and overindulgence. If a parent truly swings between these extremes, the result could actually be an exacerbation of problems, and at the very least, the child could be confused about limits and consequences. In some respects, this confusion may be observed in the divergence between parents and children in their approach to help when discussing the vignette representing the externalizing child. Perhaps contrary to what might be expected, children frequently mentioned punishment and restriction as effective strategies. In conjunction with children's endorsement of parents as helpful (and more helpful than parents perceived themselves), this finding suggests that children are asking for more involvement and attention from their parents, rather than less.

Certain important limitations should be noted about these findings. First, as is evident from the composition of the sample, these findings primarily reflect the beliefs of mothers and boys, and are not necessarily generalizeable to fathers and girls. Future research with larger sample sizes is needed to determine how beliefs about the usefulness of different treatment options may differ as a function of sex differences among both parent and child respondents. Secondly, this study cannot address whether beliefs about treatment are actually linked to behavior—this is an important factor in the potential applicability of the findings. One possibility is that this study highlights a belief, that there is some usefulness of mental health services, that has not yet been enacted through behavior, but increased use of services may still be seen in the future. Further investigations are crucial to examine the use of and adherence to the different interventions suggested by parents and children.

Understanding beliefs about treatment in this population and specifically among children highlights a perspective that is often underrepresented, or misrepresented, in the clinical context. As such, the findings from this study suggest that parents and children are open to the possibility of mental health services as a source of help, while also endorsing the usefulness of other sources of help, and that the helpfulness of parents and others may depend on whether the problem is an internalizing or externalizing one. Despite this apparent willingness among parents and youth to consider utilizing mental health services, no less effort should be made to ensure that these services remain culturally relevant and are provided in a sensitive manner. Indeed, it may be precisely because more attention has been paid to this in recent years that Cambodians are willing to consider using these services. The provision of mental health services should clearly continue, but with ongoing, thoughtful evaluation of the congruence of these services with other beliefs about treatment that are held by Cambodian children and parents. In particular, the reliance on informal guidance is likely to remain an important source of help whether or not formal services are sought.

Acknowledgments

Appendix A

Vignette 1: Externalizing

Sombo[1] is a 14-year-old boy who attends high school. His mom found out that Sombo has been drinking on the weekends. Also, Sombo got caught stealing something from another child at school. Sombo has a really short temper and gets angry a lot. He sometimes lies and blames other people for his mistakes. Sombo has not been doing well in school. He cannot sit still on his chair, he always talks a lot in class and does not listen to his teacher. Sombo is talking with his friends and not doing his work. At home, Sombo likes to argue and not listen to advice from his mother, and he screams at his family members and always is fighting with his siblings.

Vignette 2: Internalizing

Jauna is an 11-year-old boy who attends middle school. Recently, Jauna has seemed worried, sad and

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[1]Female names were Sokha and Phalla.

down. He keeps to himself, seems to be thinking a lot, and stares at the floor. Jauna's mother says that she has noticed Jauna is not sleeping well. Jauna has not been able to complete his tasks at home and he is often very forgetful. Jauna has said that he can not concentrate or stay focused at school. He seems sad and like he is going to cry a lot of the time. Jauna is also moody and sometimes gets upset very easily. He seems very sensitive to things that other people say. Recently, Jauna has not spending much time with his friends.

Appendix B

Codes for treatment strategy and examples of representative items

1. *Formal service for consultation*: e.g. mental health, counselor, psychologist, psychiatrist, doctor (if not specific to medication), social worker, government worker, community agency, church, temple.
2. *Informal guidance*: e.g. talk to him, "talking it over" advise him, lecturing, explain, show him role models, "tell him to___" [emphasis on guidance].
3. *Change of environment/distraction*: e.g. move to a new neighborhood, hang around with new friends, separate from parents, make him laugh, keep him entertained, think about something else, "take him places to clear his head," help her not think a lot.
4. *Indulgence/nurturance*: e.g. give whatever he wants, buy him things, "talk nicely," "talk sweet," nurturance, console him, spend time with him, take him places, make him feel better.
5. *Restriction/punishment*: e.g. don't let him outside, don't let him drink, make him stop; police to threaten, give to police, boot camp, jail, teach a lesson, call police, probation, house arrest, punish.
6. *Medication, shot*.
7. *Other*: e.g. exercise, go someplace to chill, "I won't be his friend," "I don't want friends," don't do anything.

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