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Exploring Relationships Between Family Communication Patterns and Willingness to Communicate About Health Topics Among Vietnamese Americans

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Family communication patterns can affect health communication and ultimately health outcomes later in life. This study explored the effects of family communication patterns on health topics via an online survey of Vietnamese Americans (*N* = 850) aged 18 to 35 who have Vietnamese American immigrant parents. The study was guided by family communication patterns theory. Independent variables included conversation and conformity orientations; dependent variables included willingness to communicate about general, sexual, and mental health topics. Conversation orientation positively predicted willingness to communicate about general, sexual, and mental health topics. Conformity orientation positively predicted a willingness to communicate only about general health topics. The findings indicate a large need for education within families to increase the quality of family and health communication, particularly among first-generation immigrant families. Theoretical and practical implications are discussed.

Keywords: Vietnamese American, immigrant families, health communication, stigma, mental health, sexual health

The Vietnamese American experience is extremely complex, heavily shaped by United States (U.S.) foreign policy, the history of a decades-long war, remnants of French colonial rule, and the journey of cultural assimilation into U.S. culture (Ling & Austin, 2010). According to Pew Research's data in 2019, 62% of Vietnamese American adults were born outside of the U.S. (Budiman, 2021). Communication between immigrant parents and first-generation children (natural-born American citizens of immigrants) is often discordant because homeland cultures possess vastly different contexts and values than American culture. Because of these different cultures, it is worth investigating various factors that can drive these family

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dynamics. Research explores the individualist versus collectivist dimensions as Viet-Americans face daily decisions to preserve, adopt, and bury cultural factors from both Vietnamese and American values (Do, McCleary, Nguyen, & Winfrey, 2020). While cross-cultural differences provide extensive insight into some dynamics of the Viet-American family, we investigated differences in family communication styles in relation to health communication.

Scholars are interested in exploring the influence of cultural differences on communication patterns, and our work strives to contribute to this larger academic conversation. Dorrance Hall and colleagues (2021) were interested in the relationship between family communication environments and beliefs about diets. Their findings showed that family food beliefs, influenced by race/ethnicity, could lead to increased health issues or more meat consumption, with conversation orientation mediating these associations. This suggests that we can find similar processes within Viet-American populations, as families possess various levels of conversation orientation potentially affecting health decisions. This study examines the associations between family communication patterns and willingness to communicate (WTC) about health topics (e.g., overall health, sexual health, and mental health) among first-generation Vietnamese Americans through the lens of family communication patterns theory (FCPT). A survey of 850 Vietnamese Americans between 18 and 35 years old, whose parents immigrated to the United States, was conducted in the fall of 2021.

Literature Review

Cultural differences can impact health outcomes (Handtke, Schilgen, & Mösko, 2019). For example, a study exploring health disparities in emergency departments found that cultural and racial factors played a large role in the duration of hospital stays and health outcomes in the emergency department (Arora & Bahrini, 2024). Another study compared childrearing beliefs between European-American and Chinese mothers, focusing on making the child feel loved, building success skills, teaching values, fostering independence, and building group-related identity (Chao & Tseng, 2002). While Western mothers prioritized self-esteem and emotional processing, Eastern mothers valued education and adaptability with others (Chao & Tseng, 2002), demonstrating the nuanced differences in parenting values and potential mental health outcomes across cultures. One way that cultural differences impact health outcomes could be through different family communication patterns.

Vietnamese culture significantly shapes how Vietnamese Americans communicate. Factors such as family roles, political values, health perceptions, and communication patterns strongly influence parent-child interactions, particularly in immigrant families (Avdic & Büyükdurmus, 2015; Schrodt, Witt, & Messersmith, 2008; Scruggs & Schrodt, 2021). However, in being displaced from their country of origin, immigrants in the U.S. face compounding linguistic, sociocultural, political, economic, and structural barriers to health (Guan et al., 2021), particularly during their first ten years in the country or if they are under 17 at migration (Lee, Bhimla, & Ma, 2020). Because of this, we are interested in exploring family communication patterns in their relationships with different health dimensions, including general health, mental health, and sexual health. Investigating these health facets may offer insight into the nuanced cultural challenges these families may face.

The Role of Family Within Vietnamese Culture

Communication between immigrant Vietnamese Americans and first-generation Vietnamese Americans is complex, with intricate and oftentimes nuanced themes of filial piety and the importance of family within Vietnamese culture (Truitt, 2015). Compared with the general public (34%), 71% of Vietnamese American individuals consider being a good parent one of the most important things in their lives (Pew Research, 2012). The stark difference in the number of individuals who believe in the importance of good parenting shows how influential filial piety is for Vietnamese Americans. This difference underscores the unique experience of navigating cultural differences between Vietnamese and American culture while living in the United States. Furthermore, parent-child differences in cultural values can stress the family system, leading to conflict within the family (Nguyen & Cheung, 2009). Generational gaps between Viet parents and U.S.-born children have widened, as Viet-American children experience a heterogenous society with different cultural standards and values compared with their parents' homogenous culture (Cheung & Nguyen, 2001; Herz & Gullone, 1999; Nguyen & Cheung, 2009). Because of this difference in cultural standards, it is important to examine the communication styles of Vietnamese American families, which differ indisputably from the homogenous culture in their motherland. Specifically, we are interested in understanding how family communication patterns may be associated with willingness to discuss certain topics. Family communication patterns theory will be used as the theoretical lens.

Family communication patterns theory (FCPT) is well established. It originally demonstrated how family socialization affected children's information processing (McLeod & Chaffee, 1972); recently, family communication research uses FCPT to detail individual and relational outcomes in various contexts, including family cultural food beliefs (Dorrance Hall et al., 2021) and mental and physical health outcomes (Schrodt, Ledbetter, & Ohrt, 2007; Schrodt et al., 2008). Two dimensions constitute the FCPT framework: conversation orientation and conformity orientation (Koerner & Fitzpatrick, 2002, 2006). Conversation orientation is the degree to which families create a climate where all family members can discuss topics, whereas conformity orientation is the degree to which families stress a homogeneity of beliefs, values, and attitudes (Koerner & Fitzpatrick, 2006).

Conversation Orientation

Increased family communication can lead to more discussions about family health history (Watts & Hovick, 2023) and has been shown to hold across generations (Rauscher, Schrodt, Campbell-Salome, & Freytag, 2020). Families high in conversation orientation likely discuss health (and related issues) openly and often, as they have frequent and intimate interactions (Parks, 2015).

Parent-child communication is an understood method of protecting children from negative health outcomes resulting from high-risk behaviors (Askelson et al., 2011). Sharing a social reality within these families can allow children to actively participate in family dynamics, whereas parental avoidance of the topic in lower conversation orientation families shows an absence of social realities and can undermine parent-child relationships (Afifi, Caughlin, & Afifi, 2009; Caughlin & Afifi, 2004). Yet, little research examines how communication patterns among first-generation Vietnamese American families are related to their willingness to discuss health topics. It is important to further examine the Viet-American cultural context

and how differences in family communication styles about specific health issues could potentially affect individual health behaviors and outcomes. Therefore, we ask:

RQ1a: In what ways will conversation orientation be related to WTC about general health topics?

This project also adapted the existing WTC about health topics (Wright, Frey, & Sopory, 2007), as there were no existing measures that addressed WTC about sexual or mental health. Specifically, we sought to explore offspring's WTC about different topics with their parents. An open family environment (high in conversation orientation) was shown to correlate with more conversations about overall health (Rauscher et al., 2020). Parent-child sexual communication, where caregivers discuss sexual topics with their children, is shown to be associated with lower sexual risk-taking behaviors, more positive condom attitudes, and improved self-concept (Astle & Anders, 2022; Malcolm et al., 2013; Widman, Choukas-Bradley, Noar, Nesi, & Garrett, 2016). Many studies explore stigma in Asian countries as a contributing factor to untreated health issues, including sexual health and mental health complications. From leaving sexually transmitted illnesses untreated to perceiving mental illnesses as pathological to "save face," stigma seems to impede conversations about these health topics (Huber et al., 2019; Kaljee et al., 2007; Kramer, Kwong, Lee, & Chung, 2002). Conversation orientation, or the openness/willingness to communicate, could serve as a preventive mechanism to reduce stigma within families. Stigma is a powerful mechanism that serves to identify perceived dangers, but family closeness in Vietnamese American families could reduce the risk of being stigmatized (López-Ibor, 2002). Therefore, we ask:

RQ2a: In what ways will conversation orientation be related to WTC about sexual health topics?

RQ3a: In what ways will conversation orientation be related to WTC about mental health topics?

Conformity Orientation

Conformity orientation is quite complex and multidimensional (Horstman et al., 2018; Watts & Hovick, 2023). Specifically, conformity orientation encompasses the idea that the homogeneity of ideas and beliefs can be inherently negative. Yet, this same homogeneity can potentially bring a family together and, in this case, offer a means of survival for Vietnamese American families. Tingvold, Hauff, Allen, and Middelthon (2012) studied Vietnamese refugee parenting and adolescent well-being and found that parents emphasized Vietnamese cultural values, like language training, family, and faith, as a means of survival. While native Vietnamese parents often prefer that their children obediently adopt their cultural norms without thinking of their constraints as oppressive, identity acculturation has clear impacts on the family system (Ho & Birman, 2010). As first-generation Vietnamese American families are tasked with acculturation, the varying levels of conformity orientation are important to examine as families adopt a culture of interdependence within the community to bridge the gap between the culture of their home country and the culture of their host country. With this culture of interdependence, first-generation children may feel the pressure to continue fostering familial interdependence while living in the United States, which prides itself on individualism.

One stark example of this phenomenon is the traditional Vietnamese expectation to obey parents "unquestioningly, while the U.S.-born children, raised in a culture that values individualism, often chafe at such restrictions" (Ling & Austin, 2010, p. 575). Most Vietnamese families' households are nuclear, placing a strong emphasis on family. They maintain closer ties than typical U.S. families, value elders' opinions in decision making, and settle near other family members within easy visiting distance (Ling & Austin, 2010). These differences between Vietnamese collectivist culture and American individualistic culture create a challenge for Vietnamese refugees and their children to navigate as they acclimate to the host culture (Parks & Vu, 1994).

Horstman and colleagues (2018) expanded the theoretical and conceptual scope of conformity orientation, highlighting four primary factors. This nuanced perspective challenges the earlier view that conformity orientation is the opposite of conversation orientation. The first factor, respecting parental authority, describes how parents expect their children to respect various forms of authority (e.g., respecting elders). The second, experiencing parental control, describes how controlling parents may be in their interactions with their children. The third, adopting parents' values and beliefs, describes the expectations or pressures the children feel to adopt their parents' values and beliefs. The fourth factor, questioning parents' beliefs and authority, describes the lack of encouragement children experience to challenge their parents' beliefs and authority.

While the lack of previous research on more diverse families is a limitation of many studies examining FCPT constructs, this more nuanced development and application of conformity orientation may be relevant for families ascribing to non-U.S. centered backgrounds. In particular, Asian cultures often emphasize familial values and strong parental influence and authority. For example, Cooper, Baker, Polichar, and Welsh's (1993) found that Mexican, Chinese, Vietnamese, and Filipino adolescents tended to endorse strong parental influence whenever making decisions, along with strong hierarchical patterns of communication. Yet, few of these studies examine the implications of these decisions made based on family communication patterns about one's own health, particularly in first-generation immigrant/assimilating families. Furthermore, due to the Vietnam War between 1950 and 1960, Vietnamese American children and their parents are a particularly unique collectivistic population to study as their children are oftentimes made aware of their parents' privileges and opportunities—due to their sacrifices during the war—which can affect parent-child relationships (Nguyen & Chung, 2009; Nguyen, Leung, & Cheung, 2011).

Research on reconceptualized conformity orientation measures is limited and mixed (e.g., Hesse, Rauscher, Goodman, & Couvrette, 2017; Wu & Pask, 2023). Wu and Pask (2023) found that daughters' sexual health protective behavior intentions were associated with two dimensions of the extended conformity orientation scale: higher parental control and less adoption of parental values. Watts and Hovick (2023) found that conformity orientation (specifically the dimension of respecting parental authority) was positively associated with perceived collective psychological ownership of health information. Yet, little research examines discussions about sexual or mental health topics in relation to family communication patterns, specifically among Vietnamese American families who have family dynamics. The following research questions are presented:

RQ1b: In what ways will conformity orientation be related to WTC about general health topics?

RQ2b: In what ways will conformity orientation be related to WTC about sexual health topics?

RQ3b: In what ways will conformity orientation be related to WTC about mental health topics?

Conformity orientation is more complex than originally proposed (Horstman et al., 2018; Watts & Hovick, 2023). Specifically, conformity orientation encompasses the idea that the homogeneity of ideas and beliefs can be inherently negative. As referenced previously, the same homogeneity can potentially bring a family together and could offer a means of survival for Vietnamese American families; this concept mirrors Horstman and colleagues' sense of "togetherness" within a family. Other studies have explored age in relation to health communication and found significant conditional indirect effects on the collection of family health history (Campbell-Salome, Rauscher, & Freytag, 2019). Curiously, they also noted that families that strongly emphasized family hierarchies and homogenic beliefs inhibited open communication about family health history. With this existing scholarship, we are eager to see if these factors also shape communication within the Viet-American family. Examining the individual dimensions of conformity orientations as the reconceptualized construct may provide a more nuanced understanding of the utility of the measures, particularly in understudied populations such as first-generation Vietnamese Americans. Therefore, we ask:

RQ4: How are the dimension components of conformity orientation related to WTC about health topics in Vietnamese American families?

Method

Participants

The final sample consisted of 850 Vietnamese Americans between 18 and 35 years from across the United States. The 850 participants each reported their age range, and 842 reported their exact age (M = 24.46, SD = 4.98). All eligible participants had Vietnamese American immigrant parents, were fluent in English, and lived in the United States. Participants had to be either U.S.-born or had immigrated there when they were below the age of 10, which is about the age children become acculturated to U.S. culture—based on research examining integration strategies among Vietnamese immigrants (Pham & Harris, 2001). Participants' parents were not U.S.-born and had immigrated to the United States. Participants predominantly self-identified as female (80%), male (17%), genderqueer/gender nonbinary (3%), transgender females (<1%), and transgender males (<.01%). The largest group of participants held a Bachelor's degree (38%), followed by those who attended some college (27%), obtained a Master's degree or higher (17%), earned a high school diploma or GED equivalent (12%), received Associate's degrees (5%), completed some high school (1%), and attended trade school (<1%). With regard to participants' health insurance, most were insured through their parents (47%), had their own insurance (43%), were insured under another individual's policy (3%), were uninsured (5%), or selected "other" (1%). See Table 1.

Table 1. Demographics.

Variable	Levels	#of Participants	% of Participants
Gender	Female	676	79.5
	Male	147	17.3
	Gender queer / Gender Nonbinary	24	2.8
	Transgender female	1	0.1
	Transgender male	2	0.2
Education	Some high school	8	0.9
	High school diploma/GED equivalent	100	11.8
	Some college	232	27.3
	Trade/vocational/technical	6	0.7
	Associate degree	40	4.7
	Bachelor's degree	321	37.8
	Master's degree or higher	143	16.8
Age	18–24	457	53.8
	25–35	393	46.2
Health Insurance	Insured (through parents)	401	47.2
	Insured (on own insurance)	369	43.4
	Insured (on someone else's insurance, not parents' or own)	27	3.2
	Not insured	41	4.8
	Other	12	1.4

Procedures

Institutional ethics approval (#2021-0662) was obtained before recruiting participants. Vietnamese Americans who had Vietnamese immigrant parents were invited to participate using a convenience sampling frame. The study was advertised via e-mails to administrators of Vietnamese American Facebook groups, direct messages to Vietnamese Student Association Instagram accounts and various prominent Vietnamese American figures, and social media posts. Participants were self-selected and could enter a drawing for one of five $10 Starbucks gift cards. Participants remained anonymous. The survey was administered using QuestionPro (https://www.questionpro.com/). To begin, all participants were informed about the study and given the opportunity to voluntarily agree to participate.

Measures

Participants completed several measures on the following constructs: family communication patterns (conversation and conformity orientations), WTC about health (including sexual and mental health), and demographic information.

Independent Variables

Conversation orientation was assessed on a 15-item scale (Ritchie & Fitzpatrick, 1990). The participants indicated their level of agreement with statements on a 5-point scale ranging from 1 (strongly

disagree) to 5 (strongly agree). Higher scores indicated greater perceptions of openness in their family's communication. Example items included: "My parents often asked my opinion when the family talked about something" and "I could tell my parents almost anything." Scale reliability (α = .92) was acceptable.

The expanded conformity orientation scale (ECOS) (Horstman et al., 2018) measured conformity orientation. ECOS is a 24-item scale that assesses four latent factors shown as valid and reliable (Watts & Hovick, 2023): respect for parental authority, experience of parental control, adoption of parents' values/beliefs, and questioning of parents' beliefs/authority. Example items include "My parents emphasize certain attitudes that they want the children in our family to adopt" (respect for parental authority, α = .87), "My parents try to persuade me to views things the way they see them" (experiencing parental control, α = .84), and "I am expected to adopt my parents' views" (adopting parents' values/beliefs, α = .85). The fourth dimension, labeled as questioning parents' beliefs/authority, was reverse coded so that all dimensions of the conformity orientation were measured in the same direction. A sample item included, "My parents encourage open disagreement" (α = .85). The full conformity scale reliability (α = .93) was acceptable.

Dependent Variables

The 10-item willingness to communicate measure (WTC) (Wright et al., 2007) was used to measure subjects' WTC about health information to family members, healthcare providers, and individuals outside the family and to participate in health maintenance. A sample item was: "I am comfortable talking about my health with my family members." The same questions were adapted to focus on sexual health (10 items) and mental health (10 items), with all being measured on a 5-point Likert scale. An example item is, "I am comfortable talking about my sexual health with my family members." Higher scores indicated greater WTC about (general/sexual/mental) health information. Three items were reverse-coded. Reliability for the general WTC about health scale (α = .70) was acceptable after one item was dropped due to the factor not loading. Reliability for the WTC about sexual health scale (α = .68) was borderline fair after one item was dropped due to the factor not loading. Reliability for the WTC about mental health scale (α = .70) was fair after one item was dropped due to the factor not loading.

Results

Descriptive Statistics

SPSS version 29.0 was used for statistical analyses. Before running the statistical models to answer the research questions, the relationships between potential control variables and the dependent variables were tested. Descriptive statistics and correlations for variables appear in Table 2. Insurance was coded as having insurance (1) or not having insurance (0).

About willingness to participate in health maintenance, participants had higher means on items related to proactiveness in seeking out health information for themselves (M = 3.86, SD = 1.02) than on their promptness to schedule health appointments (M = 2.90, SD = 1.24). This held across both the sexual (M = 3.95, SD = .98; M = 3.19, SD = 1.23) and mental health contexts (M = 3.85, SD = 1.03; M = 2.89, SD = 1.27).

Table 2. Descriptive Statistics and Intercorrelations.

Var	*M*	*SD*	Age	Edu	Gen	HI	Cv	Cf	Val	Auth	Cont	Bel	Gen	Sex	Men
1. Age	24.5	4.98	–	–	–	–	–	–	–	–	–	–	–	–	–
2. Edu	4.77	1.82	0.65***	–	–	–	–	–	–	–	–	–	–	–	–
3. Gen	1.24	0.53	−0.01	−0.03	–	–	–	–	–	–	–	–	–	–	–
4. HI	0.94	0.24	−0.10**	0.01	−0.04	–	–	–	–	–	–	–	–	–	–
5. Cv	2.25	0.79	−0.11**	−0.05	−0.04	−0.08*	–	–	–	–	–	–	–	–	–
6. Cf	4.10	0.58	0.03	0.01	−0.03	−0.05	−0.55***	–	–	–	–	–	–	–	–
7. Val	3.67	0.84	−0.01	−0.05	−0.01	−0.03	−0.36***	0.82***	–	–	–	–	–	–	–
8. Auth	4.44	0.55	−0.05	0.04	−0.03	−0.03	−0.25***	0.77***	0.52***	–	–	–	–	–	–
9. Cont	4.04	0.78	0.00	−0.02	−0.04	−0.07*	−0.46***	0.87***	0.63***	0.61***	–	–	–	–	–
10. Bel	4.25	0.74	0.04	0.07*	−0.01	−0.02	−0.65***	0.74***	0.41***	0.47***	0.51***	–	–	–	–
11. Gen	3.32	0.60	0.15***	0.18***	−0.07*	0.10**	0.29***	−0.11***	−0.13***	0.02	−0.09**	−0.13***	–	–	–
12. Sex	2.74	0.56	0.17***	0.17***	−0.06	0.07*	0.14***	−0.11***	−0.12***	−0.01	−0.05	−0.14***	0.56***		
13. Men	3.01	0.60	0.15***	0.16***	−0.03	0.08*	0.23***	0.14***	0.14***	0.05	0.11***	0.14***	0.55***	0.51***	–

Note: Age = age; Edu = education; Gen = gender; HI = health insurance status; Cv = conversation orientation; Cf = conformity orientation; Val = conformity adopting values; Auth = conformity respecting parental authority; Cont = conformity experiencing parental control; Bel = conformity questioning beliefs and authority; WCHG = willingness to communicate general health; WCSH = willingness to communicate sexual health; WCMH = willingness to communicate mental health

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

Regression Analyses

RQ1 examined the relationship between (a) conversation orientation (b) conformity orientation and WTC about general health topics in Vietnamese American families. RQ2 examined the relationship between (a) conversation orientation (b) conformity orientation and WTC about sexual health topics in Vietnamese American families. RQ3 examined the relationship between (a) conversation orientation (b) conformity orientation and WTC about mental health topics in Vietnamese American families. To answer each RQ, a multivariate regression model was run. Due to significant relationships with the other variables, age, education, and health insurance status were added to the models as controls.

RQ1a found a positive relationship between conversation orientation (β = .34, $p < .001$) and WTC about general health topics, while RQ1b did not find a relationship between conformity orientation and WTC about general health topics. The model was significant (adjR^2 = .13, F(6,835) = 22.15, $p < .001$). Age (β = .13, $p = .004$), and education (β = .10, $p = .016$) and health insurance status (β =.09, $p = .007$) were also significant positive predictors. See Table 3 for predictor statistics for RQs 1–3.

Table 3. The Effects of Conversation and Conformity Orientations on Willingness to Communicate about Health Topics.

Variable	SE	β	t	*p*-value	*F* value	Adj. R^2	*p*-value
General Health Topics					**22.15**	**.13**	**<.001**
Age	0.01	0.13**	2.91	0.004			
Education	0.01	0.10*	2.41	0.016			
Gender	0.04	−0.05	−1.41	0.158			
Health Insurance Status	0.08	0.09**	2.69	0.007			
Conversation Orientation	0.03	0.34***	8.80	<0.001			
Conformity Orientation	0.04	0.07	1.91	0.056			
Sexual Health Topics					**10.01**	**.06**	**<.001**
Age	0.01	0.14**	3.16	0.002			
Education	0.01	0.08	1.79	0.074			
Gender	0.04	−0.05	−1.45	0.147			
Health Insurance Status	0.08	0.07*	2.00	0.046			
Conversation Orientation	0.03	0.13**	3.28	0.001			
Conformity Orientation	0.04	−0.04	−0.04	0.334			
Mental Health Topics					**13.87**	**.08**	**<.001**
Age	0.01	0.12**	2.76	0.006			
Education	0.01	0.09*	2.10	0.036			
Gender	0.04	−0.01	−0.32	0.747			
Health Insurance Status	0.08	0.06	1.93	0.055			
Conversation Orientation	0.03	0.23***	5.73	<0.001			
Conformity Orientation	0.04	−0.02	−0.44	0.664			

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

RQ2a found a positive relationship between conversation orientation (β =.13, p = .001) and WTC about sexual health topics. RQ2b did not find any relationship between conformity orientation and WTC about sexual health topics. The model was significant, (adjR^2 = .06, F(6, 835) = 10.06, p < .001). Age (β = .14, p = .002) and health insurance status (β = .07, p = .046) were also significant positive predictors.

RQ3a found a positive relationship between conversation orientation (β = .23, p < .001) and WTC about mental health topics, while RQ3b did not find a relationship between conformity orientation and WTC about mental health topics. The model was significant, (adjR^2 = .08, F(6, 835) = 13.87, p < .001). Age (β.12, p = .006) and education (β = .09, p = .036) were also significant positive predictors.

RQ4 examined how the dimension components of conformity orientation were related to WTC about general (model 1), sexual (model 2), and mental (model 3) health topics in Vietnamese American families. The first model was significant, (adjR^2 = .08, F(8, 833) = 10.04, p < .001). Education (β = .11, p = .012) and health insurance status (β = .10, p = .003) were significant positive predictors, while values/beliefs (β = −.13, p = .004) and questioning parents' beliefs/authority (β = −.16, p < .001) were significant negative predictors. The second model was significant, (adjR^2 = .07, F(8, 833) = 8.97, p < .001). Respect for parental authority (β = .09, p = .006) was a significant positive predictor along with age (β = .12, p = .006), education (β = .09, p = .047), and health insurance status (β = .09, p = .04), while adopting parents' values/beliefs (β = −.14, p = .002), and questioning parents' beliefs/authority (β = −.17, p < .001) were significant negative predictors. The third model was significant, (adjR^2 = .06, F(8, 833) = 7.38, p < .001). Age (β = .09, p = .036), education (β = .10, p = .025), and health insurance status (β = .07, p = .03) were significant positive predictors. Adopting parents' values/beliefs (β = −.11, p = .016) and questioning parents' beliefs/authority (β = −.14, p < .001) were significant negative predictors. Experiencing parental control was not a significant predictor in any model. See Table 4 for predictor statistics.

Table 4. The Effects of Individual Conformity Orientation Dimensions on Willingness to Communicate About Health Topics.

Variable	SE	β	t	*p*-value	*F* value	Adj. R^2	*p*-value
General Health Topics					**10.04**	**.08**	**<.001**
Age	0.01	0.08	1.85	0.065			
Education	0.01	0.11*	2.52	0.012			
Gender	0.04	−0.06	−1.73	0.085			
Health Insurance	0.08	0.10**	2.95	0.003			
Respect Authority	0.05	0.17	3.96	<0.001			
Experience Control	0.04	−0.03	−0.52	0.606			
Adopt Values/Beliefs	0.03	−0.13**	−2.92	0.004			
Question Beliefs	0.03	−0.16***	−3.99	<0.001			
Sexual Health Topics					**8.97**	**.07**	**<.001**
Age	0.01	0.12**	2.75	0.006			
Education	0.01	0.09*	1.96	0.047			
Gender	0.04	−0.05	−1.46	0.146			
Health Insurance	0.08	0.08*	−0.14	0.025			
Respect Authority	0.05	0.09*	2.05	0.040			
Experience Control	0.04	0.07	1.39	0.164			
Adopt Values/Beliefs	0.03	−0.14**	−3.09	0.002			
Question Beliefs	0.03	−0.17***	−4.29	<0.001			
Mental Health Topics					**7.38**	**.06**	**<.001**
Age	0.01	0.09*	2.10	0.036			
Education	0.02	0.10*	2.25	0.025			
Gender	0.04	−0.02	0.53	0.594			
Health Insurance	0.09	0.07*	2.17	0.030			
Respect Authority	0.05	0.06*	1.29	0.196			
Experience Control	0.04	0.01	0.16	0.876			
Adopt Values/Beliefs	0.03	−0.11*	−2.42	0.016			
Question Beliefs	0.03	−0.14***	−3.46	<0.001			

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

Discussion

Little research explores the family communication patterns in Vietnamese American communities, especially between immigrant parents and their U.S.-born (or 1st generation) children. This study contributes to this gap in the literature, showing that a family communicative environment higher in openness was associated with increased WTC about overall sexual and mental health among Vietnamese American first-generation individuals. Conformity orientation as a whole was not significant in any model. Our findings also provide insight into how FCPT performs in relation to Asian cultures and their family communication styles, as it tends to be Western-centric. FCPT offers a Westernized approach to viewing

communication styles and does not examine cultural nuances that remain rich in Vietnamese American culture (including themes of Confucianism, the Vietnamese diaspora experience, and the prominent collectivist values that weave through Vietnamese culture).

First, we found a positive relationship between conversation orientation (RQ1a) and WTC about general health topics. This finding suggests that conversation orientation (reciprocity, mutual understanding, and flexibility) is positively related to willingness to communicate about health topics. This WTC about health topics could stem from the mutual trust shared between parent and child, nurtured by an open communication style. Sorkhabi (2005) explains that supporting autonomy (defined as opportunities that foster children's abilities to meet their obligations without parental control or assistance) creates an environment where the child can set their own goals coupled with a space to reciprocate with parental needs. The child may then exercise proactivity in communicating many topics, including potential health topics.

Second, we found a positive relationship between conversation orientation (RQ2a) and WTC about sexual health topics. Chen, Rueter, Anderson, & Connor's (2020) findings mentioned previously are worth noting here, as their study focused on sexual health communication; high conversation orientation can open a space for well-adjusted children to discuss medically assisted reproduction information sharing. As perceptions of stigma may be enhanced for Vietnamese American children (who may be used to not having any conversations about sexual health), having open conversations about various sexual health topics may, in a way, buffer stigma's effect on willingness to communicate. Having these conversations can meet expert recommendations for age-appropriate parent-child sexual communication (Astle, Rivas-Koehl, Rivas-Koehl, & Mendez, 2024). The strength of communication patterns developed by one's family is stronger than externally perceived stigma; thus, family closeness in Vietnamese families may reduce the risk of being stigmatized. Openly communicating about these topics could, in turn, help children feel open toward communicating about future health topics, potentially affecting their interactions with healthcare providers later in life.

We also found that higher levels of conversation orientation predicted increased WTC about mental health topics. Research assessing the beliefs of Vietnamese individuals living in Central Vietnam indicates a need for educational and awareness programs about mental illnesses. Examining mental health with Hoskin's findings on authoritarian parenting predicts that authoritarian parents discourage open communication about their children's mental health. This is quite indicative of the child's WTC about their own mental health, given the unwelcome environment that their parents have created for them. Improved access to mental health resources can allow children to be more open to discussing their personal struggles and possibly increase the WTC about mental health. For example, Shea and Yeh (2008) found that "lower adherence to Asian values, lower levels of stigma, and higher relational-interdependent self-construal were associated with more positive help-seeking attitudes," which is promising for future applications of Asian health communication education (p. 157). With these findings, health professionals can aid in alleviating pressures that come with adherence to Asian values and stigma and foster self-interdependence to promote more help-seeking attitudes. Understanding potential implications is crucial to promoting good health practices because ineffective health communication can

lead to low health literacy, increased risk of injuries, and decreased use of health resources that are readily made available to the public (Vahabi, 2007).

Importantly, conformity as a whole did not significantly predict WTC regardless of the context. This is one of the first studies to break apart the dimensions of the expanded conformity orientation scale (Horstman et al., 2018), demonstrating the complexity of conformity as a construct and reaffirming the decision to test alternative ways of measuring conformity within the family. Individuals who reported higher levels of respecting authority were more likely to discuss sexual health and mental health topics, with adopting parents' values/beliefs and questioning parents' beliefs/authority negative significant predictors of WTC about general, sexual, and mental health topics. According to Hoskins (2014), some parents do not exhibit high levels of trust or engagement with their children, choosing instead to focus on controlling and discouraging open communication. When viewing this with a sexual health lens, for example, this may mean that parents focusing on homogeneity in beliefs and values in family conversations can exhibit low levels of trust in their children's romantic relationships, discourage open communication about sexual health, and engage in strict control of curfew, friend groups, and other various hallmarks of being an adolescent. Lectures align closely with conformity as originally conceptualized; lectures are also used often in authoritarian parenting styles, which emphasize orderliness and structure, obedience without discussion or reason, and close surveillance of a child's behavior, commonly used in highly restrictive parents (Givertz & Segrin, 2014). Because of this, children may not be able to establish bonds of trust with their parents and can hide their different health issues or concerns in fear of potential repercussions from their restrictive parents. This could further stem into health issues such as sexual health (discussing reproductive health, risk for STIs, unwanted pregnancies, etc.) or even mental health (struggles with depression, schoolwork, family history of mental illnesses, etc.). Our findings therefore extend this research by testing the same concepts in a unique population with varied experiences. Keeping an open line of communication about sexual health topics between parent and child and engaging in age-appropriate conversations have continually shown to help maintain sexual health for the child.

Adopting parents' values/beliefs and questioning parents' beliefs/authority negatively and significantly predicted WTC about mental health issues (e.g., RQ4). Hoskins (2014) explored the implications of families that could be considered low conformity and found that adolescents from these families report a higher frequency of substance use, less engagement in school, and school misconduct due to low self-esteem and a lack of behavioral control. Using these findings and viewing them with the interest of sexual health in mind, our findings contribute to a larger body of work that may ultimately inform health communication interventions to discourage adolescents from partaking in risky sexual behavior due to a lack of sexual health communication.

Finally, participants also showed an interest in various types of health information, but there are gaps between seeking this information and acting to get an appointment. Some culprits that might explain the gap between the two involve perceptions of necessity, availability, and desirability of seeking out medical care (Taber, Leyva, & Persoskie, 2014). Traditional barriers in Taber and colleagues' study also included a lack of health insurance and time constraints, along with fear of unfavorable evaluations from healthcare practitioners. Nearly 95% of this study's population had health insurance, however, which may mean that there are other factors beyond simply health insurance at play.

Understanding FCPs in culturally specific contexts can also allow different interventions to increase the quality of communication within the family, which can in turn boost the quality of family life. Findings can offer insight into where the Vietnamese American population is lacking in terms of health and familial communication for improving parent-child communication about health topics. Researchers must take these themes, such as the need for improved communication skills and bridged cultural gaps and apply them to shaping new methods of interventions to advocate for improved communication between parent and child. Failure to do so can negatively impact teenager and adolescent mental health, contributing to decreased self-esteem and increased depression levels (Nguyen & Cheung, 2009). Public health officials should use these findings to gauge how this community communicates about their health. Creating concrete health initiatives in both Vietnamese and English while targeting Vietnamese American-dense areas can foster improved health communication. Implementing innovative ways to educate this community about important health topics, such as sexual and mental health, can reduce stigma and improve knowledge about these health issues. As we had a large sample size, our data give representative data for closer insights into the population of Vietnamese Americans; previous studies largely focused on examining East Asian American communities (e.g., Chinese Americans).

Limitations and Future Directions

One limitation of the items assessing FCPT constructs is that the many nuances of strict "tiger parenting" as mentioned in the discussion are limited. On the surface, Vietnamese American children may answer questions about their FCPs with the perception of restrictiveness and control, which may appear to be consistent with an authoritarian parenting style. Nguyen, Chang, and Loh (2014) explored the nuances of Vietnamese parenting and found that the motivations behind strictness and rule establishment came from concern for personal development within education and training. This can be explained through Confucian-collectivistic values of honor, the reality of adjusting to a new host country, and the idea that higher education is a means of financial security and social mobility. Researchers' findings support the growing concern that existing measures "are inaccurate for cross-cultural populations" (Nguyen et al., 2014). Therefore, while we acknowledge the limitations within our study, we also must acknowledge the theoretical implications our study provides, particularly for a global audience. Future research must consider creating new measures to effectively assess Asian parenting styles, respecting cultural nuances commonly found in Eastern cultures.

The reflective accounts of some of the survey questions are retrospective, which could open grounds for skewed recounts by memory bias. Introducing a longitudinal study with young children of Vietnamese American immigrant parents and following them throughout adulthood while administering surveys every few years would partially eliminate flawed accounts. It is also important for future research to ascertain how long ago the parents may have immigrated. Within the survey instrument, some items of WTC were problematic, necessitating them being dropped for poor loading scores. The internal consistency for the WTC about sexual health was 0.68, which is borderline fair. We did not provide examples of what the types of communication might look like so as not to limit participants to our line of thinking; this may have limited some participants' concept of sexual health in particular. While some previous research indicates that items have had to be dropped in the past (Brannon & Rauscher, 2019), it is unknown which

items are problematic throughout the literature. This phenomenon should continue to be examined, and future research should also investigate other potential measures.

Across the board for all hypotheses' analyses, the amount of variance within the models as evidenced by the adjusted R^2 values was small. This is likely because other variables are at play (e.g., political communication) and may also be related to the lack of measures designed for people from non-Western-centric cultures (Landrine & Corral, 2014; Ramírez, Ford, Stewart, & Teresi, 2005). Future research should examine how measures designed for, tested, and validated within non-White populations may better encompass the constructs they are designed to measure. Of note is that experiencing control was not found to be significant in the three dependent variables. Future research should continue to examine this sub-construct to determine why it does not demonstrate the same patterns of significance as its co-constructs.

In future studies, we would like to explore stigma as an additional dimension in the Vietnamese American health communication experience. The Vietnamese word equivalent to "stigma" has two terms with two different levels of meaning: "dấu sỉ nhục," which means "mark of dishonor" in a physical sense, and "kỳ thị xã hội," which means "social stigma" (kỳ thị, translates to "stigma" as an unnatural thing). Asian cultures often face stigmatization when it comes to health issues, especially sexual and mental health, which can lead to unchecked underlying health issues and pose serious consequences if left untreated (Huang, Wen, Li, Chen, & Weng, 2020; Iwamoto & Liu, 2010). Examining stigma's role in influencing health communication more closely can provide interesting insights into this population's willingness to communicate.

Finally, as this study focused on children's perspectives, the voices and stories of immigrant Vietnamese American parents were not examined. Specifically, we did not collect data on the parental reason(s) for immigrating to the U.S. This is partly because the adult child may not be aware of the specific reasons. However, it is reasonable to assume that parents directly involved in or displaced by the fall of Saigon, or those who were indigenous to the Central Highlands, may be qualitatively different than those who were not involved in the war. Future studies should continue exploring health communication among Vietnamese American immigrants, focusing on communication satisfaction and challenges they experience, and offering interventions that officials can use for this oft-ignored community.

Conclusion

This study examined first-generation Vietnamese Americans' perceptions of FCPs and associations of WTC about health topics, extending what is known by testing previously validated measures in an understudied population. Findings allow for opportunities to continue expanding family and health communication research among Vietnamese American generations. Practically, our findings, when applied within the realm of health communication, can allow health officials, practitioners, and patients to find better ways to effectively communicate health information to ensure increased positive health outcomes for minority populations, particularly for immigrant and assimilating families across generations. Understanding more about FCPs in a health context through this study can provide a baseline toward exploring how other immigrant families negotiate similar issues.

References

Afifi, T. D., Caughlin, J. P., & Afifi, W. (2009). The dark side (and light side) of avoidance and secrets. In B. H. Spitzberg & W. R. Cupach (Eds.), *The dark side of interpersonal communication* (pp. 32–61). Mahwah, NJ: Lawrence Erlbaum Associates.

Arora, N., & Bahrini, A. (2024, May). *Equity in emergency care: A predictive analysis of cultural and racial impacts on health outcomes.* Paper presented at the meeting of the 2024 Systems and Information Engineering Design Symposium (SIEDS). IEEE. Charlottesville, VA.

Askelson, N. M., Campo, S., Smith, S., Lowe, J. B., Dennis, L. K., & Andsager, J. (2011). The birds, the bees, and the HPVs: What drives mothers' intentions to use the HPV vaccination as a chance to talk about sex? *Journal of Pediatric Health Care, 25*(3), 162–170. doi:10.1016/j.pedhc/2010.01.001

Astle, S., & Anders, K. (2022). The relationship between topic-specific quality of parent–child sexual communication and measures of sexual self-concept and sexual subjectivity. *The Journal of Sex Research, 60*(7), 1055–1067. doi:10.1080/00224499.2022.2081312

Astle, S., Rivas-Koehl, D., Rivas-Koehl, M., & Mendez, S. (2024). Timing the talks: Exploring children's ages at parent-child conversations about gender, sexual orientation, and various sexual behaviors. *Sexuality Research and Social Policy, 21*, 738–758. doi:10.1007/s13178-023-00894-0

Avdic, D., & Büyükdurmus, T. (2015). Communication problems? The role of parent-child communication for the subsequent health behavior of adolescents. *Ruhr Economic Paper, 547*, 1–36. doi:10.2139/ssrn/2618395

Budiman, A. (2021, April 29). *Vietnamese in the U.S. fact sheet*. Pew Research Center's Social & Demographic Trends Project. Retrieved from https://www.pewresearch.org/social-trends/fact-sheet/asian-americans-vietnamese-in-the-u-s-fact-sheet/

Brannon, G. E., & Rauscher, E. A. (2019). Managing face while managing privacy: Factors that predict young adults' communication about sexually transmitted infections with romantic partners. *Health Communication, 34*(14), 1833–1844. doi:10.1080/10410236.2018.1536951

Campbell-Salome, G., Rauscher, E. A., & Freytag, J. (2019). Patterns of communicating about family health history: Exploring differences in family types, age, and sex. *Health Education & Behavior, 46*(5), 809–817. doi:10.1177/1090198119853002

Caughlin, J. P., & Afifi, T. D. (2004). When is topic avoidance unsatisfying? Examining moderators of the association between avoidance and dissatisfaction. *Human Communication Research, 30*(4), 479–513. doi:10.1093/hcr/30.4.479

Chao, R., & Tseng, V. (2002). Parenting of Asians. In M. H. Bornstein (Ed.), *Handbook of parenting: Social conditions and applied parenting* (pp. 59–93). Mahwah, NJ: Lawrence Erlbaum Associates Publishers.

Chen, M., Rueter, M. A., Anderson, K. N., & Connor, J. J. (2020). Conversation orientation moderates the relationship between information sharing of medically assisted reproduction and child adjustment. *Family Process, 59*(1), 229–243. doi:10.1111/famp.12415

Cheung, M., & Nguyen, S. M. (2001). Parent–child relationship in Vietnamese American families. In N. B. Webb (Ed.), *Culturally diverse parent–child and family relationships* (pp. 261–282). New York, NY: Columbia University Press.

Cooper, C. R., Baker, H., Polichar, D., & Welsh, M. (1993). Values and communication of Chinese, Filipino, European, Mexican, and Vietnamese American adolescents with their families and friends. *New Directions for Child and Adolescent Development, 62,* 73–89. doi:10.1002/cd.23219936207

Do, M., McCleary, J., Nguyen, D., & Winfrey, K. (2020). Mental illness public stigma and generational differences among Vietnamese Americans. C*ommunity Mental Health Journal, 56*(5)*,* 839–853. doi:10.1007/s10597-019-00545-y

Dorrance Hall, E., Ma, M., Azimova, D., Campbell, N., Ellithorpe, M., Plasencia, J., . . . Hennessy, M. (2021). The mediating role of family and cultural food beliefs on the relationship between family communication patterns and diet and health issues across racial/ethnic groups. *Health Communication, 36*(5), 593–605. doi:10.1080/10410236.2020.1733213

Givertz, M., & Segrin, C. (2014). The association between overinvolved parenting and young adults' self-efficacy, psychological entitlement, and family communication. *Communication Research, 41*(8), 1111–1136. doi:10.1177/0093650212456392

Guan, A., Kim-Mozeleski, J. E., Vyas, P., Stewart, S. L., Gildengorin, G., Burke, N. J., . . . Tsoh, J. Y. (2021). Neighborhood ethnic composition and self-rated health among Chinese and Vietnamese American immigrants. *Journal of Immigrant and Minority Health, 23*(3), 574–582. doi:10.1007/s10903-020-01041-2

Handtke, O., Schilgen, B., & Mösko, M. (2019). Culturally competent healthcare - A scoping review of strategies implemented in healthcare organizations and a model of culturally competent healthcare provision. *PLoS One, 14*(7), e0219971. doi:10.1371/journal.pone.0219971

Herz, L., & Gullone, E. (1999). The relationship between self-esteem and parenting style: A cross-cultural comparison of Australian and Vietnamese Australian adolescents. *Journal of Cross-Cultural Psychology, 30,* 742–761. doi:10.1177/0022022199030006005

Hesse, C., Rauscher, E. A., Goodman, R. B., & Couvrette, M. A. (2017). Reconceptualizing the role of conformity behaviors in family communication patterns theory. *Journal of Family Communication, 17*(4), 319–337. doi:10.1080/15267431.2017.1347568

Ho, J., & Birman, D. (2010). Acculturation gaps in Vietnamese immigrant families: Impact on family relationships. *International Journal of Intercultural Relations, 34*(1), 22–23. doi:10.1016/j.ijintrel.2009.10.002

Horstman, H. K., Schrodt, P., Warner, B., Koerner, A., Maliski, R., Hays, A., & Colaner, C. W. (2018). Expanding the conceptual and empirical boundaries of family communication patterns: The development and validation of an Expanded Conformity Orientation Scale. *Communication Monographs, 85*(2), 157–180. doi:10.1080/03637751.2018.1428354

Hoskins, D. (2014). Consequences of parenting on adolescent outcomes. *Societies, 4*(3), 506–531. doi:10.3390/soc4030506

Huang, F. F., Wen, Z. P., Li, Q., Chen, B., & Weng, W. J. (2020). Factors influencing cognitive reactivity among young adults at high risk for depression in China: A cross-sectional study. *BMC Public Health, 20*(1), 703. doi:10.1186/s12889-020-08845-9

Huber, J., Ferris France, N., Nguyen, V. A., Nguyen, H. H., Thi Hai Oanh, K., & Byrne, E. (2019). Exploring beliefs and experiences underlying self-stigma among sex workers in Hanoi, Vietnam. *Culture, Health & Sexuality, 21*(12), 1425–1438. doi:10.1080/13691058.2019.1566572

Iwamoto, D. K., & Liu, W. M. (2010). The impact of racial identity, ethnic identity, Asian values and race-related stress on Asian Americans and Asian international college students' psychological well-being. *Journal of Counseling Psychology, 57*(1), 79–91. doi:10.1037/a0017393

Kaljee, L. M., Green, M., Riel, R., Lerdboon, P., Tho, L. H., Thoa, L. T., & Minh, T. T. (2007). Sexual stigma, sexual behaviors, and abstinence among Vietnamese adolescents: Implications for risk and protective behaviors for HIV, sexually transmitted infections, and unwanted pregnancy. *Journal of the Association of Nurses in AIDS Care, 18*(2), 48–59. doi:10.1016/j.jana.2007.01.003

Koerner, F. A., & Fitzpatrick, M. A. (2002). Understanding family communication patterns and family functioning: The roles of conversation orientation and conformity orientation. *Annals of the International Communication Association, 26*(1), 36–65. doi:10.1080/23808985.2002.11679010

Koerner, F. A., & Fitzpatrick, M. A. (2006). Family communication patterns theory: A social cognitive approach. In D. Braithwaite & L. A. Baxter (Eds.), *Engaging theories in family communication: Multiple perspectives* (pp. 50–65). Thousand Oaks, CA: SAGE Publications.

Kramer, E. J., Kwong, K., Lee, E., & Chung, H. (2002). Cultural factors influencing the mental health of Asian Americans. *The Western Journal of Medicine, 176*(4), 227–231.

Landrine, H., & Corral, I. (2014). Advancing research on racial-ethnic health disparities: Improving measurement equivalence in studies with diverse samples. *Frontiers in Public Health, 2*(282), 1–22. doi:10.3389/fpubh.2014.00282

Lee, M., Bhimla, A., & Ma, G. X. (2020). Depressive symptom severity and immigration-related characteristics in Asian American immigrants. *Journal of Immigrant and Minority Health, 22*(5), 935–945. doi:10.1007/s10903-020-01004-7

Ling, H., & Austin, A. W. (2010). Asian American history and culture: An encyclopedia. New York, NY: Routledge.

López-Ibor, J. J. (2002). The power of stigma. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA), 1*(1), 23–24.

Malcolm, S., Huang, S., Cordova, D., Freitas, D., Arzon, M., Jimenez, G. L., . . . Prado, G. (2013). Predicting condom use attitudes, norms, and control beliefs in Hispanic problem behavior youth: The effects of family functioning and parent–adolescent communication about sex on condom use. *Health Education & Behavior, 40*(4), 384–391. doi:10.1177/1090198112440010

McLeod, J. M., & Chaffee, S. R. (1972). The social construction of reality. In J. Tedeschi (Ed.), *The social influence processes* (pp. 50–99). Chicago, IL: Aldine-Atherton.

Nguyen, P. V., & Cheung, M. (2009). Parenting styles as perceived by Vietnamese American adolescents: C & A. *Child & Adolescent Social Work Journal, 26*(6), 505–518. doi:10.1007/s10560-009-0182-0

Nguyen, P. V., Leung, P., & Cheung, M. (2011). Bridging help-seeking options to Vietnamese Americans with parent–child conflict and depressive symptoms. *Children and Youth Services Review, 33*(10), 1842–1846. doi:10.1016/j.childyouth.2011.05.009

Nguyen, T., Chang, P. P., & Loh, J. M. (2014). The psychology of Vietnamese tiger mothers: Qualitative insights into the parenting beliefs and practices of Vietnamese-Australian mothers. *Journal of Family Studies, 20*(1), 48–65. doi:10.5172/jfs.2014.20.1.48

Parks, C. D., & Vu, A. D. (1994). Social dilemma behavior of individuals from highly individualist and collectivist cultures. *Journal of Conflict Resolution, 38*(4), 708–718. doi:10.1177/0022002794038004006

Parks, M. R. (2015). Weak and strong tie relationships. In C. R. Berger & M. E. Roloff (Eds.), *The international encyclopedia of interpersonal communication.* Hoboken, NJ: Wiley.

Pew Research. (2012). *Vietnamese*. Retrieved from https://www.pewresearch.org/social-trends/rise-of-asian-americans-2012-analysis/vietnamese/

Pham, T. B., & Harris, R. J. (2001). Acculturation strategies among Vietnamese-Americans. *International Journal of Intercultural Relations, 25*(3), 279–300. doi:10.1016/S0147-1767(01)00004-9

Ramírez, M., Ford, M. E., Stewart, A. L., & Teresi, J. A. (2005). Measurement issues in health disparities research. *Health Services Research, 40*(5 Pt 2), 1640–1657. doi:10.1111/j.1475-6773.2005.00450.x

Rauscher, E. A., Schrodt, P., Campbell-Salome, G., & Freytag, J. (2020). The intergenerational transmission of family communication patterns: (In) consistencies in conversation and conformity orientations across two generations of family. *Journal of Family Communication, 20*(2), 97–113. doi:10.1080/15267431.2019.1683563

Ritchie, L. D., & Fitzpatrick, M. A. (1990). Family communication patterns: Measuring intrapersonal perceptions of interpersonal relationships. *Communication Research, 17*(4), 523–544. doi:10.1177/009365090017004007

Schrodt, P., Ledbetter, A. M., & Ohrt, J. K. (2007). Parental confirmation and affection as mediators of family communication patterns and children's mental well-being. *Journal of Family Communication, 7*, 23–46. doi:10.1080/15267430709336667

Schrodt, P., Witt, P. L., & Messersmith, A. S. (2008). A meta-analytical review of family communication patterns and their associations with information processing, behavioral, and psychosocial outcomes. *Communication Monographs, 75*(3), 248–269. doi:10.1080/03637750802256318

Scruggs, X., & Schrodt, P. (2021). The frequency and comfort of political conversations with parents as mediators of family communication patterns and relational quality in parent–child relationships. *Journal of Family Communication, 21*(1), 17–33. doi:10.1080/15267431.2020.1860053

Shea, M., & Yeh, C. (2008). Asian American students' cultural values, stigma, and relational self-construal: Correlates of attitudes toward professional help seeking. *Journal of Mental Health Counseling, 30*(2), 157–172. doi:10.17744/mehc.30.2.g662g5l2r1352198

Sorkhabi, N. (2005). Applicability of Baumrind's parent typology to collective cultures: Analysis of cultural explanations of parent socialization effects. *International Journal of Behavioral Development, 29*(6), 552–563. doi:10.1177/01650250500172640

Taber, J. M., Leyva, B., & Persoskie, A. (2014). Why do people avoid medical care? A qualitative study using national data. *Journal of General Internal Medicine, 30*(3), 290–297. doi:10.1007/s11606-014-3089-1

Tingvold, L., Hauff, E., Allen, J., & Middelthon, A. (2012). Seeking balance between the past and the present: Vietnamese refugee parenting practices and adolescent well-being. *International Journal of Intercultural Relations, 36*(4), 563–574. doi:10.1016/j.ijintrel.2012.03.004

Truitt, A. (2015). Not a day but a Vu Lan season: Celebrating filial piety in the Vietnamese diaspora. *Journal of Asian American Studies, 18*(3), 289–311. doi:10.1353/jaas.2015.0025

Vahabi, M. (2007). The impact of health communication on health-related decision making. *Health Education, 107*(1), 27–41. doi:10.1108/09654280710716860

Watts, J., & Hovick, S. R. (2023). The influence of family communication patterns and identity frames on perceived collective psychological ownership and intentions to share health information. *Health Communication, 38*(6), 1246–1254. doi:10.1080/10410236.2021.1999573

Widman, L., Choukas-Bradley, S., Noar, S. M., Nesi, J., & Garrett, K. (2016). Parent-adolescent sexual communication and adolescent safer sex behavior: A meta-analysis. *JAMA Pediatrics, 170*(1), 52–61. doi:10.1001/jamapediatrics.2015.2731

Wright, K. B., Frey, L., & Sopory, P. (2007). Willingness to communicate about health as an underlying trait of patient self-advocacy: The development of the willingness to communicate about health (WTCH) measure. *Communication Studies, 58*(1), 35–51. doi:10.1080/10510970601168673

Wu, Q. L., & Pask, E. (2023). How family sex talks can increase daughters' intentions to engage in sexual health protective behavior: Mediating roles of parents' direct and indirect sexual communication. *Health Communication*, 1–10. Advance online publication. doi:10.1080/10410236.2023.2291268