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UNIVERSITY OF SAN DIEGO

Hahn School of Nursing and Health Science

DOCTOR OF PHILOSOPHY IN NURSING

SECOND-GENERATION THAI AMERICAN WOMEN'S PERCEPTIONS ON
CERVICAL CANCER SCREENING

By

Essie Asawapornmongkol

A dissertation presented to the

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DOCTOR OF PHILOSOPHY IN NURSING

April 2017

Dissertation Committee

Kathy James, DNSc., APRN, FAAN, Committee Chairperson

Jane M. Georges, PhD., RN, Committee Member

Bulaporn Natipagon-Shah, PhD., Committee Member

UNIVERSITY OF SAN DIEGO

Hahn School of Nursing and Health Science

DOCTOR OF PHILOSOPHY IN NURSING

CANDIDATE'S NAME: Essie Asawapornmongkol

TITLE OF DISSERTATION: Second-Generation Thai American Women's
Perceptions on Cervical Cancer Screening

DISSERTATION COMMITTEE:

Kathy James, DNSc., APRN, FAAN,
Chairperson

Jane Georges, PhD, RN,
Committee Member

Bulaporn Natipagon-Shah, PhD, RN,
Committee Member

Abstract

Background: Cervical cancer is one of the most preventable diseases in the United States (US)

(Center for Disease Control and Prevention, 2015a). Despite advances in early detection and a vaccine available, it continues to affect Southeast Asian American (SEAA) women in high numbers. Multiple barriers to cervical cancer screening are seen among SEAA women, which include acculturation, age, marital status, apprehension, financial burden, access to healthcare, and knowledge about cervical cancer, screening, and preventative health (Ho & Dinh, 2010). Studies on SEAA women and cervical cancer screening primarily involve women who were born in Southeast Asia. These studies have not considered SEAA women born in the US (second-generation) who have very different lived experiences and influences than those of their mothers. There is only one study published on Thai American women and cervical cancer, and all participants were born in Thailand.

Aim: The specific aims of this study are to explore the perceptions of second-generation Thai American women towards cervical cancer screening, explore how second-generation Thai American women make decisions about seeking cervical cancer screening services, and to initiate development of a theory, grounded in the data, regarding second-generation Thai American women and cervical cancer screening.

Methods: This is a qualitative study and inspired by the constructivist approach to grounded theory. The researcher's subjectivity and involvement with constructing and interpreting data are acknowledged in constructivist grounded theory. By using detailed

reflexive memoing and constant comparison, the researcher's stance and positionality is continuously integrated into the data (Charmaz, 2014).

Findings: Semi-structured interviews were conducted with 12 participants. Four themes emerged from the data: being proper, avoidance, realization, and feeling empowered.

Participants described experiencing these themes over a period of time with influencing factors in each stage whether it be family, cultural values, society, healthcare providers, friends, the internet, or outreach programs.

Implications: Cervical cancer focused educational outreach programs for second-generation Thai American women should occur in college or sooner. Healthcare providers need to be sensitive to the generational differences of immigrant groups, and to be aware that their needs may be different.

Copyright

Dedication

This dissertation is dedicated to my parents: Kanda and Rawat Asawapornmongkol. Thank you for always believing in me and teaching me the value of education. I could not have done this without your love, support, and guidance over the years.

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My sincere gratitude and love to my sister Lily, who has always believed in me, and my sweet niece Peyton; remember you can do anything you set your heart on. I thank you both for always brightening my days and making me smile! Mommy and Daddy, you inspire me to be the best that I can be, and I hope I made you proud!

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Chapter One

Introduction

Over 90% of cervical cancer can be prevented; it is one of the most preventable diseases in the United States (Centers for Disease Control and Prevention [CDC], 2015a). With early detection and a vaccine available, it is disturbing that cervical cancer is affecting Southeast Asian American (SEAA) women in high numbers. Unfortunately, the Papanicolaou (Pap) test, which has been shown to be effective in detecting cancerous and precancerous cells in the cervix, is severely underused among SEAA women. The trend over the last few decades in the US has been large declines in incidence rates, however that is not the case for SEAA women. The rate of cervical cancer in SEAA women is more than twice as high as non-Hispanic White women (American Cancer Society, 2015). Over the last 10 years, there has been an increase in research studies of migrant women's barriers to cervical cancer screening and breast mammography in the US. Many of these studies have focused specifically on SEAA women who have immigrated to the US from Thailand, Cambodia, Laos, Myanmar, and Vietnam. These studies have identified major barriers faced by SEAA women to cervical cancer screening, including acculturation, access to care, socioeconomic factors, and cultural influences (Natipagon-Shah & Clark, 2012; Jirojwong & MacLennan, 2003; Johnson, Mues, Mayne, & Kiblawi, 2008; Kagawa-Singer et al., 2007; Tanjasiri et al., 2004; Tsui & Tanjasiri, 2008).

Despite the increase in interest in SEAA women and cervical cancer screening, they continue to remain underrepresented in major cervical cancer screening studies, and are often grouped as one ethnicity/culture despite the heterogeneous nature of this population. Religious, cultural, and historical differences remain among the women who

originate from Southeast Asia, yet studies continue to group these women as one.

Furthermore, studies on SEAA women and cervical cancer screening primarily involve women who were born in Southeast Asia. These studies have not considered SEAA women born in the US (second-generation) who have very different lived experiences and influences than those of their mothers.

There are multiple studies on SEAA women as a group. However, when disaggregating the population, the studies primarily focus on Vietnamese, Cambodian, and Hmong (ethnic group from Laos and Thailand) women. There is only one published study focused solely on Thai American women and cervical cancer screening. This study was conducted on Thai American women living in Northern California. Results from the cross-sectional study indicated that Thai women had lower screening rates than the national average and for Asians in California (Tsui & Tanjasiri, 2008). Of the 322 identified as Thai women who participated, all were born in Southeast Asia (a majority in Thailand and a small amount in Laos). Again, none of the participants were born in the US.

Barriers to Cervical Cancer Screening Among SEAA Women

Since there is little known about the practices of second-generation Thai American women, a brief discussion of what is known in the broader SEAA population is warranted. Ho and Dinh (2010) published an article compiling results from multiple studies on SEAA women and cervical cancer screening. Multiple barriers were seen which included acculturation, age, marital status, apprehension, financial burden, access to healthcare, and knowledge about cervical cancer, screening, and preventative health. Ho and Dinh (2010) grouped the results from these studies within Bronfenbrenner's

Ecological Systems Theory, which attempts to understand an issue by considering the multiple levels of influence related to the problem. At the individual level of the ecological system, acculturation and demographic characteristics (age and marital status) associated with cervical cancer screening are the most proximal factors. In the microsystem level, interpersonal relationships and interactions are most likely seen as physician patient relationships. In the context of SEAA women and cervical cancer screening, physician gender and ethnicity play a major role. Many women indicated apprehension with having a male physician performing a Pap test. The macro system level comprises cultural and societal beliefs, which for SEAA women include the stigma associated with a Pap test.

Factors that contribute to poor screening practices are very complex and sometimes misunderstood. The factors can be broadly summarized into three different categories, including 1) lack of knowledge regarding cervical cancer and screening, 2) psychosocial beliefs about cervical cancer, and 3) structural barriers to healthcare access. The association between lack of knowledge and structural barriers with screening practices has been well explored and documented within the SEAA population. However, there is a growing interest to explore how psychosocial beliefs (which also include cultural and societal beliefs) are associated with screening practices. For SEAA women, fatalism and karma are major concepts that may have an impact on healthcare choices. For example, an early study on Cambodian-American women found that women who believed illness was a matter of karma were less likely to ever have a Pap test (Taylor et al., 1999).

While there is an increase in the number of studies that have documented factors associated with barriers and facilitators to cervical cancer screening among specific SEAA women, studies that focus on second-generation Thai American women in Southern California in regards to this topic are non-existent. Thus, no information exists on the perceptions of this group towards cervical cancer screening and preventive sexual health. Given the significant gap in the literature, this study will provide a beginning point in exploring the perceptions of this population.

Southeast Asian Immigration into the United States

When looking at Thailand and American history, it is evident Thai American women should be viewed through a different lens. Many studies regarding SEAA women and cervical cancer, group the viewpoints of SEAA women as one, but a closer look into Thai American history reveals that Thai people had a very different immigration background when compared to the rest of Southeast Asia. Although Asians have lived in the US for more than a century with the first Asian settlers coming from China in the 1850s, Southeast Asians did not begin migrating to the US until the 1960s. Specifically, the Vietnam War and the 1965 Immigration and Nationality Act greatly impacted the mass exodus of people from Southeast Asia into the US. Many people were escaping incredible hardships and terror in their homelands such as genocide and famine. In Cambodia, millions of people were murdered by the Khmer Rouge regime between 1975 and 1979 and thousands of refugees sought asylum in neighboring countries as well as in the US. With the fall of Saigon during the Vietnam War in 1975, more than 100,000 Vietnamese refugees entered the US, and many more continued to immigrate in the following decades. Laotian immigrants began to arrive as refugees escaping civil war

and a communist government post-Vietnam War (Gordon, 1987). However, this was not the case for Thai immigrants.

Despite Thailand being part of Southeast Asia, Thailand does not share the same tumultuous history as its neighboring countries. Historically, Thailand is the only country in Southeast Asia to resist European colonization during the nineteenth century (Central Intelligence Agency, 2016). Thailand also remained free from communist takeover in the 1970s. During the Cold and Vietnam Wars, Thailand remained a close ally to the US. The Thai government allowed the US military to station throughout the country during the Vietnam War. More than 80% of US military bombings to North Vietnam and Laos during the war were flown from Thai bases. The Thai economy saw a \$2 billion increase between 1950 and 1970 due to US involvement in the region (Randolph, 1986).

The immigration of Thais into the US was on very different circumstances compared to neighboring countries in Southeast Asia. Particularly in the 70s and 80s, the US saw a very large influx of Thai immigrants. There were no Thai *refugees*; rather, there were Thai professionals, such as medical doctors, nurses, and entrepreneurs. Many men from the US Air Force who were stationed in Thailand, brought their Thai wives to the US post war. At the time, more women were finding their way to the US with a ratio of three Thai women per one Thai man. Once the initial wave of Thai immigrants settled in the US, they began bringing other family members here as well (Randolph, 1986). There were approximately 200,000 Thai people living in the US according to the 2010 US Census, with almost 70,000 congregated in Los Angeles, California, making Los Angeles the largest population of Thais outside of Thailand (Thai Community

Development Center, 2015). Other major concentrated Thai communities are in New York and Texas.

The Second Generation: Being Bicultural

Thai women have been rarely studied separate from the SEAA community. Beyond that, there are no studies on the US-born children of Thai immigrants in regards to cervical cancer screening or preventive sexual health. This study aims to be one of the first to specifically explore the perceptions of the second-generation Thai American women towards these topics. The US Census Bureau (2013) and the Pew Research Center (2013) define “second-generation” as individuals born in the US who have at least one foreign-born parent, and for the purposes of this study, the foreign-born parent must have been born in Thailand. Health-related attitudes, beliefs, and perceptions can be shaped by culture and are passed on from one generation to another. The uniqueness that comes with being defined as second-generation has been explored before. The concept of the second-generation being bicultural is one that resonates and has major implications to this study.

Acculturation is the process of cultural and psychological change that results in the meeting between two cultures (Schwartz, S.J, Unger, J.B, Zamboanga, B.L, & Szapocznik, J., 2010). Acculturation does not stop with first-generation immigrants; rather it continues to affect the second-generation as well. The second-generation face the unique acculturative phenomenon of being bicultural, which involves managing the normative roles, beliefs, and values of the cultural heritage of their families along with those of the mainstream American cultural environment in which they live (Schwartz &

Unger, 2010). For second-generation Thai American women, being bicultural may play a role in their perceptions of cervical cancer screening practices.

Significance and Purpose

This dissertation addresses a major gap in SEAA cervical cancer literature, and therefore, will contribute to this lacking body of knowledge. This study is the first to explore perceptions of second-generation Thai American women towards cervical cancer screening. Findings from this study will help expand the body of knowledge regarding this population, and help shape future research on effective cancer prevention programs that can better address the specific needs of this population. Furthermore, this study will provide a voice to second-generation Thai American women, and acknowledge that this voice is different from the voices of their mothers. The overall purpose of this study is to explore the perceptions of second-generation Thai American women towards cervical cancer screening and the influence of these perceptions on the decision to seek preventive sexual health care services.

Specific Aims of the Study

The aims of this study are to:

- Explore the perceptions of second-generation Thai American women towards cervical cancer screening
- Explore how second-generation Thai American women make decisions about seeking cervical cancer screening services
- Initiate development of a theory, grounded in the data, regarding second-generation Thai American women and cervical cancer screening

Brief Overview of Study Design

The nature of this study is qualitative in design and inspired by Grounded Theory. Grounded Theory has its roots in symbolic interactionism. The term symbolic interactionism refers to how people react towards things based on what those things mean to them, and that those meanings are derived from social interactions. In other words, people respond to events based on the meanings the events have for them. Individuals derive these meanings based on their experiences (Blumer, 1969). Researchers using grounded theory examine the world from an individual's perspective and interpret this so others may understand it too. This approach is useful when investigating areas of interest that have not previously been explored, or where there is a lack of understanding. It is apparent after reviewing the literature regarding this topic that there are no studies involving second-generation Thai American women.

Grounded theory is a methodology for developing theory and was originally developed by Glaser and Strauss in the 1960s during their study of death and dying in the hospital. Grounded theory has evolved into different versions such as Glasserian grounded theory, Straussian grounded theory, dimensional analysis, situational analysis and the constructivist grounded theory (Richards & Morse, 2012). This study will use the constructivist grounded theory approach based on the work of Charmaz (2014). Research in the constructivist paradigm is based on the idea that reality is constructed by social, cultural, and historical interactions. Therefore, researchers attempt to look at a phenomenon through a contextual lens, meaning a context-specific perspective is imperative in this form of research. Since the researcher is the tool in grounded theory, the relativity of the researcher's background, perspectives, and positions need to be

examined (Bloomberg & Volpe, 2012). Charmaz points out that grounded theory techniques have uses beyond building theory, and can be used as helpful strategies for collecting, managing and analyzing data (Charmaz, 2008).

Theoretical sampling is a type of purposive sampling that is used in grounded theory. In theoretical sampling, the sample size is determined by the data and sampling is complete when theoretical saturation is reached. Theoretical sampling is a process of data collection where the researcher collects, codes, and analyzes simultaneously and makes decisions on what to do next based on the collected data (Breckenridge & Jones, 2009). For this study, the researcher conducted semi-structured interviews, took field notes, practiced reflexive memoing, and finally, coded the interviews. Reflexive memo writing allows the researcher to reflect on his or her views and feelings that will help in the analysis to give context and conceptualization to the data. Once initial coding is completed, the researcher may revise the semi-structure interview guide to illuminate or focus on categories that have emerged from coding. Theoretical sampling continued until all categories were saturated, and the researcher felt confident that all categories and concepts were fully understood.

Assumptions

Assumptions informing this constructivist grounded theory study are the following (Charmaz, 2014):

- 1) Reality is multiple and constructed
- 2) Interaction is the basis of the research process
- 3) The researcher and participants' positionality must be considered

4) Data are not simply observed, but are products of the research process that is co-constructed by the researcher and research participant.

Chapter Two

Literature Review

The purpose of this chapter is to review the relevant literature in this study area. Specifically, the incidence of cancer among Asian Americans, the influences on cervical cancer screening of SEAA women, an overview of the history and culture of Thai people, the incidence of cervical cancer and screening practices of women living in Thailand, the concept of being second-generation, and finally, the philosophical underpinnings of this study will be reviewed.

Incidence of Cancer among Asian Americans

Cancer remains the leading cause of death for Asian Americans (American Cancer Society, 2016). It is interesting to note that cancer patterns among Asian Americans are very like Hispanics, with high rates of cancer from an infectious origin such as the liver, stomach, and *cervix*, and low rates of common cancers. The lifetime probability of developing cancer is 33% in Asian American women (compared to 38% in non-Hispanic White women). Despite the heterogeneous nature of this population, disaggregate data is not always readily available for each subgroup of this population. The American Cancer Society (2016) states that demographic and health data are usually available only in aggregate form which makes finding specific data on Southeast Asian or Thai Americans difficult.

According to the American Cancer Society (2016), an estimated 12,990 new cases of invasive cervical cancer will be diagnosed, and 4,120 deaths will occur in the US due to the disease this year. Cervical cancer in Asian Americans remain low overall, but higher in several Asian American subgroups. Women from Southeast Asian countries

have higher incidence rates of cervical cancer as compared to the rest of this population. In contrast to non-Hispanic White women (6.8 per 100,000), women from Cambodia (12.7 per 100,000) have a cervical cancer incidence rate that is twice as high. Women from Vietnam (9.5 per 100,000) also have higher rates of cervical cancer (American Cancer Society, 2016). Analysis of the current literature reveals that SEAA women have a higher incidence of invasive cervical cancer primarily due to lack of screening.

Influences on Cervical Cancer Screening Among SEAA Women

Health-related attitudes, beliefs, and perceptions are often shaped by culture, then passed to the next generation. Cultural values and beliefs have been determined to be significant in determining the health behaviors of minority women (Xu, Ross, Ryan & Wand, 2005). In an early study in 1999, Asian American women were found to have cultural barriers to screening, such as communication barriers between themselves and their mothers in regards to sexual and gynecological issues, and less openness around sexuality (Tang, Solomon, Yeh, & Worden, 1999). The lack of communication and openness between mothers and their daughters can influence the willingness of young Asian American women to seek preventive sexual health care. Traditional mothers may not actively engage in discussions with their daughters regarding sexuality due to preconceived cultural beliefs. For example, in traditional Cambodian society, there is a belief that a lack of knowledge regarding sexuality prevents premarital sexual activity (which is regarded as dishonorable), and therefore discussions on sexuality including sexual intercourse, health, and prevention are kept to a minimum (Kulig, 1994). This lack of communication between mothers and daughters may play an intricate role in the

perceptions of second-generation SEAA women towards cervical cancer screening practices.

Currently, studies specific to second-generation SEAA women in regards to cervical cancer screening and prevention are non-existent. However, there has been a published dissertation on second-generation Chinese-American college students and their reasons for lack of cervical cancer screening (Bair, 2003). In this study, parental disapproval and taboo affected screening behaviors of these young women. The worldviews of the participants in this study were deeply tied to their parents, and thus the way these young women viewed the world reflected the way their parents did (Bair, Hutson, & Burnette, 2014). The results signify the importance of family, specifically parental beliefs, as influences of cervical cancer screening practices on second-generation daughters.

Since minimal research on second-generation SEAA women exists, related research on the immigrant, first generation, will be reviewed. The current research on first-generation SEAA women will provide context for understanding how the perceptions of the second-generation are formed. Ho and Dinh (2011) published an article reviewing the literature on factors associated with participation in cervical cancer screening among Vietnamese, Cambodian, and Hmong women. The factors included acculturation, age, marital status, knowledge about cervical cancer, access to health care, financial concerns, and apprehension about cervical cancer screening. Acculturation was explored in terms of how many years a woman was living in the US and their fluency in the English language. SEAA women who lived in the US longer were more likely to adopt mainstream practices such as the Pap test. The less fluent a woman was in the

English language, the more likely she as to encounter major barriers, not only due to lack of interpreters during the actual Pap test, but also to scheduling an appointment. Lack of knowledge about cervical cancer and cervical cancer screening, as well as apprehension about receiving a gynecological exam from a male physician, was also seen as a deterrent in screening practices.

Nguyen, McPhee, Nguyen, Lam, & Mock (2002) studied 1,566 Vietnamese-American women via phone interview and found that respondents were more likely to have a Pap test if their physician was female (Nguyen et al., 2002). Women who never had a Pap test before were more likely to have the test with a male physician if a female standby were also in the room. The women may have wanted the Pap test, however, when faced with a male physician performing the Pap test, the women were unwilling to challenge the physician to ask for a female standby or a new female physician. This stems from the complex traditional Vietnamese values of modesty, respect for authority, and conflict avoidance

A study by Taylor et al. (1999) specific to Cambodian women, surveyed 413 Cambodian women living in the Seattle, Washington area. The surveys were conducted face-to-face, and questions were developed based on the PRECEDE model that assessed predisposing, reinforcing, and enabling factors associated with cervical cancer screening participation. Results noted that women who believed illness was a matter of karma were significantly less likely to have a pap test than other women (Taylor et al., 1999). Karma, in laymen's terms, can be described as the saying "what goes around, comes around". Within the Buddhist and Hindu religions, karma is a force that is created by a person's actions and determines what that person's next life will be like. In a different qualitative

study, women who were Buddhist believed that cancer was inevitable and completely dependent on one's karma (Wong, Wong, Low, Khoo, & Shuib, 2008). These misconceptions regarding cancer as a matter of karma leads to the perception that early detection of cancer is unnecessary since the cancer cannot be prevented (due to karma) and all it would bring is more emotional turmoil knowing that one has a terminal illness.

A qualitative study on Hmong women conducted in California revealed that embarrassment and stigma were major barriers to cervical cancer screening. Women discussed their fears that once cervical cancer is diagnosed, stigma attaches; the community may assume the diagnosis is the result of inappropriate behavior on the part of the sufferer, such as premarital intercourse. One of the women interviewed described cervical cancer as not being talked about at all within the Hmong community. She described her knowledge of cervical cancer and screening coming from health professionals and media, but never from her parents or other Hmong women in general (Fang & Baker, 2013). This study reiterates the notion that lack of communication and openness regarding sexuality may influence the willingness of young women to seek preventive sexual healthcare services.

A study specific to Thai women in Northern California conducted 322 face-to-face interviews. This cross-sectional study revealed that Thai women living in the US had lower Pap test screening compared to the national average. Women who spoke only Thai were found to be less likely to have had a Pap test. There was a strong belief among Thai women that only those who are sexually active needed to be screened for cervical cancer. There was also a cultural norm that the physician has authority, therefore, if the physician recommends a Pap test, then the women would comply. Interestingly, results from this

study indicated that Thai women reported higher rates for screening compared to other Southeast Asian groups (Tsui & Tanjasiri, 2008). This finding indicates the potential cultural and/or immigration differences between Thai women and other Southeast Asian groups that may affect use of preventive services.

The current literature on barriers to cervical cancer screening among SEAA women can be categorized into three categories: 1) lack of knowledge, 2) psychosocial beliefs, and 3) structural barriers to healthcare. Regardless of the country of origin in Southeast Asia, SEAA women were found to have poor knowledge of cervical cancer (Gor, Chilton, Camingue, & Hajek, 2011; Ho & Dinh, 2011; Robinson et al., 2013; Tsui & Tanjasiri, 2008). Psychosocial beliefs such as karma, fatalism, modesty, and taboo were found to be common among SEAA women (Bair et al., 2014; Tang et al., 1999; Taylor et al., 1999; Wong et al., 2008; Xu et al., 2005). Structural barriers, such as lack of healthcare insurance and language barriers, also contributed fewer cervical cancer screenings in this population (Tanjasiri et al., 2004).

Cervical Cancer and Screening Practices of Women in Thailand

Thailand, like most of the developing world, has alarmingly high cervical cancer rates. It has been shown that 85% of all cervical cancer cases can be accounted to developing countries, and unfortunately, many of those women lack the resources to treat or prevent their illnesses from occurring, which is why many women are diagnosed in the late stages of cancer. Almost 90% of women who die from cervical cancer live in developing countries. Most of Southeast Asian countries, including Thailand, are considered “developing.” In Thailand, cervical cancer is the second most frequent cancer among women, occurring at an alarming rate of 29.2 per 100,000 women. This is a

relatively high rate compared to other developing countries in Southeast Asia, as well as the rest of the world (Parkin, Bray, Ferlay, & Pisani, 2005). Recent study reports from the World Health Organization estimates that almost 10,000 Thai women are diagnosed with cervical cancer annually, approximately 4,500 of which will die from the disease, making cervical cancer one of the leading causes of cancer deaths in women living in Thailand (International Agency for Research on Cancer, 2012).

It is interesting to note that the Pap test has been available in Thailand since 1952, however, the test is used mainly for diagnostic purposes rather than for regular cervical cancer screening (Kietpeerakool, 2006). Besides the Pap test, using visual inspection with acetic acid (VIA) was launched for women ages 30-45 in 2000. This preventive test combines VIA with cryotherapy as a single-visit approach to help minimize patients being lost to follow up. Studies in Thailand have demonstrated that these methods are feasible and sustainable. However, even though these two screening measures were added to Thailand's new public health policy under the Universal Coverage Scheme in 2004, the incidence and mortality rate of cervical cancer continues to remain high (Tangcharoensathien et al., 2008).

Although there is universal healthcare in Thailand, cervical cancer screening is only available in certain healthcare centers throughout the country. Much of Thailand is rural, making travel to these specific health centers not feasible for many women. Furthermore, many women remain uneducated, and may not understand the importance of these tests (Sriamporn, Khuhaprema, & Parkin, 2006). Women's preventive health behaviors are one of the main reasons for low rates of cervical cancer screening utilization. Knowledge, attitudes, beliefs, and sociocultural factors play a crucial role in

Thai women accepting cervical cancer screening. Studies have shown that perceived low susceptibility and seriousness of cervical cancer play a part in low screening rates. Thai cultural values, such as modesty, are also considered barriers. The literature also reports that embarrassment regarding exposing the genital area for examination is a major factor (Juntasopeepun et al., 2012).

History and Culture of Thai People

To assist in understanding the sociocultural influences affecting the perceptions and practices regarding cervical cancer and screening among second-generation Thai American women, a brief overview of the Thai people will be discussed. Historically, Thailand is the only country in Southeast Asia to remain free from European colonization (Central Intelligence Agency, 2016). Also, during the Vietnam War, Thailand remained a strong ally to the US, and profited from the relationship (Randolph, 1986). When most Southeast Asian immigrants were refugees escaping incredible adversities such as genocide, Thai immigrants did not come as refugees fleeing their homeland. Rather, Thai immigrants were professionals and were welcomed into the US as medical doctors, entrepreneurs, and specialist such as goldsmiths.

Buddhism and Gender Roles

In terms of religious affiliation, Thailand is 95% Buddhist (Central Intelligence Agency, 2016). The Thai culture and traditional way of living has been deeply influenced by Buddhism. Buddhism permeates all aspects of daily cultural activities in Thailand, and has influenced the notion that women are inferior to men. Ideological Buddhism views women negatively and “less than” men. This is very evident during Buddhist ceremonies where only men can perform any religious activities. Women are

not allowed to be ordained as monks, they are not allowed to lead any chanting prayers, and they are not even allowed to touch a monk (Klunkin & Greenwood, 2005). For example, if a woman would like to give something to a monk, or vice versa, the item must be passed through a man first.

Karma is another influence of Buddhism on Thai culture. Karma is the law of cause and effect. Thai people believe very deeply in the laws of karma, and believe that their present lives are a direct reflection of the deeds performed in their past lives. Thai people have a strong belief in reincarnation; they believe that their lives are a chain of birth, death, and rebirth, and depend greatly on their good deeds (Klunkin & Greenwood, 2005). Ideological Buddhists do not believe that karma is only based on the past life, but it can continue to be changed in current life as well. Thus, karma should not mean passive defeat when it comes to cancer, yet many Buddhists believe there is nothing they can do. The cultural norms of women being inferior to men and karma as a way of life continue to affect women's beliefs and perceptions towards cervical cancer and screening in Thai women living in Thailand and those who have immigrated abroad.

A significant predictor of cervical cancer screening behavior in Thailand is the influence of significant others. For example, many Thai women will seek screening tests only after being prompted to do so by someone they know. Like many Asian countries, Thailand is viewed as a collectivist society; therefore, Thais see themselves as interdependent with their groups and may behave primarily based on group norms. Another cultural norm for Thai women is that society still assumes women should take a traditional subordinate role. Thai women often sacrifice themselves for their families. As a result, this may prohibit them from seeking screening services, which are not always

located nearby (Sriamporn et al., 2006). Thai social and cultural norms discourage open discussions of sexuality, especially among women, which also prevents open discussion of preventive sexual health care (Liu et al., 2006; Thato, Jenkins, & Dusitsin, 2008).

The Second-Generation Experience: Being Bicultural

Growing up in bicultural environments shape how second-generation Americans view the world and themselves. The Asian American population is the fastest growing population in the US with about 18 million Asian Americans in the US (Pew Research Center, 2013). The number of Asian American children of immigrants is on the rise, and of interest is the growing number of them who have attained adulthood. The experience of second-generation SEAA women is significantly different than that of their mothers. Second-generation SEAA women have not one, but two sets of cultural identities to manage. They need to negotiate roles, beliefs, and values of their cultural heritage with the roles, beliefs, and values of mainstream American society. For second-generation SEAA women, the act of balancing two cultures may be difficult due to Southeast Asian values not always being in alignment with American values.

Defining Bicultural

Researchers have looked at different ways of integrating two cultures and two major patterns have emerged: alternating bicultural pattern and blended bicultural pattern. The concept of the alternating bicultural pattern of biculturalism has been identified by LaFramboise, Coleman, and Gerton (1993). Specific to this pattern, bicultural individuals can move between their culture groups. This definition suggests that a bicultural second-generation SEAA woman can maintain a sense of being in both her heritage and mainstream American cultures. LaFramboise et al. (1993) state that both

cultures can continue to be distinguished from each other, and that bicultural individuals switch back and forth, adopting certain behaviors per context. Within the blended bicultural pattern, Birman (1994) proposes that bicultural individuals adopt a new identity that is a combination of both heritage culture and mainstream culture. In this view, heritage and mainstream cultures interlay with each other.

Second-Generation Thai American Women

Specific to second-generation Thai American women, traditional Thai values are based on collectivist society values which include family, uniformity, and belonging to a group; whereas American values are based on individualism which include assertiveness, individuality, and openness of expression. The health beliefs and practices (including cervical cancer screening) of second-generation Thai American women are very much influenced and shaped by the values and morals of the two worlds in which they are situated. These women are unique, having to confront and negotiate their own position in relation to often opposing views on preventive healthcare from their heritage and mainstream cultures.

As to preventive sexual healthcare, the two cultural identities are sometimes in conflict with each other. Asian Americans do not tend openly to discuss sexuality with their children. This could reflect their own experiences with sexuality education. For example, children in Thailand receive minimal sexuality education in schools and many teachers continue to be reluctant to teach sexuality education in class. Moreover, the focus of sexuality education in Thailand is almost exclusively regarding controlling adolescent sexual behavior (Boonmongkon & Thaweesit, 2009). In contrast, historically, the primary goal of sexuality education in the US is the promotion of sexual health

(Planned Parenthood, 2012), and many states, such as California, prohibit abstinence-only education in public schools (California Department of Education, 2016).

The medical community in California has advocated preventive sexual health practices and cervical cancer screening prevention with such programs as Every Woman Counts, which provides free clinical breast exams, mammograms, pelvic exams and Pap tests to underserved women (California Department of Health Care Services, 2016). Therefore, second-generation Thai American women may be exposed to American perspectives in regards to cervical cancer screening through school, peers, and media. However, these perspectives are not always congruent with the traditional perspectives held by their parents, who likely play a role in influencing their children. Therefore, it is this group of women who must decide what aspects of each perspective to retain in respect to this behavior. This is where understanding the influences on second-generation Thai American women to seek cervical cancer screening services can be significant.

Philosophical Underpinnings

The philosophical underpinnings framing this study are from the constructivist perspective in grounded theory and the Health Belief Model (HBM). Grounded theory (GT) provides the researcher with clear direction in collecting, managing, coding, and analyzing data. The HBM provides the researcher with theoretical insight into developing research questions, as well as providing a theoretical lens to describe the health beliefs, behaviors, and attitudes of second-generation Thai American women towards preventive healthcare and cervical cancer screening.

Constructivist Grounded Theory

The grounded theory approach has its origin from symbolic interactionism, and can be used to study processes and change over time (Richards & Morse 2013). The constructivist grounded theory approach seems most apt in this study and focuses on Charmaz's (2008) stance that individuals construct reality as they assign meaning to the world around them. Traditional GT focuses on conceptualizing understanding of social behavior, whereas Charmaz's 2008 Constructivist GT focuses on the interpretive understanding of participant's meanings. Charmaz (2008) makes the following assumptions:

- (1) Reality is multiple, processual, and constructed-but constructed under particular conditions;
 - (2) The research process emerges from interaction;
 - (3) It takes into account the researcher's positionality, as well as that of the research participants;
 - (4) The researcher and researched co-construct the data – data are a product of the research process, not simply observed objects of it. Researchers are part of the research situation, and their positions, privileges, perspectives, and interactions.
- (Charmaz, 2008, p. 402).

The Health Belief Model

The HMB is one of the most commonly used theories in health education and health promotion research. This model was developed in the 1950s in response to the failure of a free tuberculosis health program offered by the US Public Health Services. The HBM maintains that personal beliefs or perceptions about a disease and the belief

that certain actions may prevent the illness determine preventive health behavior. The six main constructs of the HBM include perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and perceived self-efficacy (Rosenstock, 1974). The following sections will describe each construct and its application to cervical cancer screening.

Perceived Susceptibility. The perceived susceptibility refers to an individual's belief about how susceptible one is to getting the disease or condition (Rosenstock, 1974). This is one of the most powerful constructs of the HBM because it can drive the individual to change his or her behavior or adopt a new healthier behavior (Tavafian, 2012). For example, a woman must believe there is a possibility she may get cervical cancer before she would be willing to have a Pap test. Another example is if an individual's sister had cervical cancer, the individual may have a personal perception that she is susceptible to cervical cancer and thus, seek preventive services. On the other hand, an individual may perceive little or no susceptibility to the disease and therefore not seek services at all. This can be influenced by knowledge about the disease.

Perceived severity. This construct speaks to the individual's belief of how serious the disease may be. Perceived severity varies between individuals (Rosenstock, 1974). For example, the flu is typically viewed as a relatively minor condition and most people will stay home from work and rest. But for a single mother of 3, staying home from work may not be an option, and therefore the perception of the flu becomes more serious for this individual. In terms of cervical cancer, if an individual understands the severity of the disease (potential to cause pain, disability, and death), they may be more likely to seek preventive action.

Perceived Benefits. This construct refers to an individual's opinion of the value of a new behavior in reducing the risk or preventing the development of a disease (Rosenstock, 1974). Perceived benefits play a major role in the adoption of behaviors such as preventive health screenings. For example, women must believe that preventive behaviors, such as the Pap test, would be beneficial in preventing cervical cancer.

Perceived Barriers. This construct refers to an individual's own evaluation of the obstacles preventing them from adopting a new behavior. For a new behavior to stay, a person needs to believe that the new behavior outweighs the consequences of continuing the old behavior (Rosenstock, 1974). For example, women who believe that a Pap screening is painful or embarrassing must believe that the benefit of the Pap test outweighs these consequences.

Cues to Action. The HBM refers to cues to actions as events, people, or things that move people to change their behavior (Rosenstock, 1974). An example of this is women being reminded by family members or physicians to have a Pap test. Another example can be the media, such as television commercials or magazine advertisements, regarding cervical cancer screening.

Perceived Self-Efficacy. Self-efficacy is the belief or confidence that one is capable of performing a given action. This is one's perception of being capable of engaging in preventative health behavior (Rosenstock, 1974). For example, if a woman does not believe she will be able to schedule an appointment on her own due to language barriers, she will probably not to schedule the appointment at all.

Summary

This chapter provides an insight into the uniqueness of second-generation Thai American women. In Southern California, where there is the highest number of Thai Americans, healthcare providers need a deeper understanding of the cultural practices and health beliefs of their patients. Even though second-generation Thai American women may speak English fluently and have attended American schools, they have a unique bicultural upbringing. This chapter provides a brief overview of Thai culture and its influence on Thai women's health beliefs and practices regarding cervical cancer screening, which in turn, influences the beliefs and practices of Thai American daughters. Since there is no specific research on cervical cancer screening in second-generation Thai American women and very little research on first-generation Thai American women, a review of the broader SEAA population was examined. Finally, since constructivist grounded theory and the HBM were the basis of the philosophical underpinnings of this study, this chapter also provided a brief overview of both.

Chapter Three

Methodology

The purpose of this chapter is to describe the methods used for this study and their justification, while also describing data collection, management, and analysis. Ethical issues are also discussed.

Description and Justification of Methods

This is a grounded theory study of second-generation Thai American women and their perceptions towards cervical cancer screening. This study is centered philosophically in the constructivist perspective of grounded theory as developed by Charmaz (2008). The selection of a constructivist grounded theory methodology for this study was guided by constructivist epistemology. The constructivist approach to grounded theory views grounded theory methods as a set of principles and practices that can be flexible instead of prescriptive and mechanical. Rather than the assumption that the researcher is an objective, passive, and neutral observer of reality; the constructivist view is that reality is co-constructed and that the researcher's position, perspectives, and interactions account for part of that reality. The researcher's subjectivity and involvement with constructing and interpreting data are acknowledged in constructivist grounded theory. By using detailed reflexive memoing and constant comparison, the researcher's stance and positionality is continuously integrated into the data (Charmaz, 2014).

The researcher for this study is second-generation Thai American, and therefore the researcher acknowledges her own subjectivity and the fact that it cannot be distanced from the research. Thus, using a constructivist approach, which cultivates reflexivity, the

co-construction of reality is formed by a combination of the researcher and the participants' views. Because the phenomenon of interest is well aligned with the intentions of constructivist grounded theory, this methodology was most suited in guiding this research.

Setting

For this study of second-generation Thai American women, the main setting was in Southern California where the largest population of Thais reside in the United States. The study sites included Los Angeles, Orange, and San Diego counties. The interviews were conducted in locations convenient for the participants. The interview sites were somewhat quiet and private which facilitated dialogue and maintained a sense of privacy. Interview sites included participant homes, local coffee shops, available classroom/office space at local Thai temples or other buildings, and recreational parks.

Sample

Purposeful, theoretical, and snowball samplings were used as frameworks for identification and selection of participants in this study. The two principals that guide qualitative sampling, appropriateness and adequacy, served as a guide in selection and sample size. *Appropriateness* refers to selecting study participants who can best inform the research, that is, those who can communicate experiences in an expressive and reflective manner. *Adequacy* refers to having enough data to develop a rich and full description of the phenomena of interest (Morse & Field, 1996). Using the two main principals of appropriateness and adequacy, the main goal of purposeful sampling was to obtain *rich data* for the purposes of this study (Sandelowski, 2000). Sampling continued

until all categories were saturated, and the researcher felt confident that all categories and concepts were fully understood.

Inclusion Criteria

The inclusion criteria for this sample included the participant 1) self-identifying as Thai or Thai-American; 2) having been born in the US; 3) having at least one parent born in Thailand; 4) being 21-45 years of age; 5) having never had a hysterectomy in which the cervix was removed; 6) being able to understand and speak English fluently; and 7) being able to sign an informed consent prior to data collection. The lower end of the age range was selected based on the screening guidelines that recommend a Pap smear for all those at least 21 years old (Centers for Disease Control and Prevention, 2015b), and the upper age range captures daughters of early Thai immigrants.

Recruitment

Recruitment of potential participants for this study was primarily from posting a flyer (Appendix A) through social media and word of mouth among the Thai community. Prospective participants were referred to contact the researcher via phone call, text, or email. During initial contact (if via email, the researcher would text the potential participant), the researcher would explain the purpose of the study and requirements of the study participants. The researcher would also conduct an eligibility screening based on the inclusion criteria for the study. Once the participant was deemed eligible and interested, a verbal consent from the participant was obtained, and a 1.5-hour appointment was scheduled for the face-to-face interview. A \$20 gift card was provided to participants of the study at the time of the interview regardless if the participant completed the interview or not.

Human Subjects Consideration

Prior to any data collection, this study proposal was submitted for review to the Institutional Review Board (IRB) of the University of San Diego. Each study participant was asked to review the consent form (Appendix B) and ask any questions for further clarification prior to signing it. The consent process explained the purpose of the research study, the estimated time for the interview process, any foreseeable risks/discomforts and benefits, measures to assure confidentiality of participants, compensation, the voluntary nature of the research, contact information for the investigator, and the right of the participant to withdraw at any time without penalty. No major risks were anticipated from this qualitative study. However, due to the nature of the topic (preventive sexual healthcare and cervical cancer screening), if some participants felt uncomfortable during the interview and potentially chose not to answer certain questions, the researcher was prepared to be sensitive and respectful, as well as provide information to local, free or low cost resources (such as counseling centers and women's health clinics). Throughout the interviews, there was only one incident where the researcher provided information to local low cost resources.

Confidentiality and Anonymity

To protect the participant identities, real names were replaced with subject numbers. Pseudonyms were used for any individuals mentioned during interviews. No identifying information was disclosed in any presentations or publications. To ensure confidentiality for the participants, all names, contact information, interview recordings, or transcriptions were kept in a secure location that could only be accessed by the investigator. Any computerized documents such as audio recordings, email

correspondence, and transcriptions were located only on the researcher's computer and kept in a secure location.

Data Collection and Management

Data collection was facilitated by obtaining demographic data (Appendix C) and conducting face-to-face interviews using a semi-structured interview guide with open-ended questions (Appendix D). Gentle probes were used to elicit clarification or further experiences from participants. Prior to starting the interview, permission to record and transcribe the interview was obtained from the participant. Immediately after the interview, field notes were taken by the investigator to record observations such as facial cues, setting, and any other thoughts. These field notes helped to facilitate a better understanding of the context of the interview when it came to analysis. Furthermore, reflexive memoing was an important aspect of data collection. Reflexive memoing enabled the investigator to develop a strong awareness of any subjectivity that may have shaped the inquiry and analysis. The transcribed interview, along with field notes and memos, were all analyzed as part of the data.

All data including audio recordings, transcriptions, demographic data, and field notes were identified only by subject number. Any data with identifying information such as participant contact information or name were kept in a locked file cabinet in a secured area only accessible to the investigator.

Data Analysis

Constant comparison was used to analyze data generated from this study. All interviews were recorded, professionally transcribed, and reviewed for accuracy. Charmaz (2014) outlines the approach to data analysis using initial coding, focused

coding, and theoretical coding. Due to the iterative nature of grounded theory, data collection and analysis are interwoven and occur simultaneously. Using the constant comparison method, data were continuously reviewed for emerging themes and additional participants were recruited until theoretical saturation occurred.

Coding

By coding, researchers can define what is happening in the data and begin to make meaning from the data. Coding is the link between data and an emerging theory explaining the data. *Initial* coding is used early on to sift through data for initial ideas, which can direct further data collection. Initial coding remains open and sticks closely to the data. The researcher looks for action in each transcription segment, and can use gerunds with line-by-line coding as a heuristic approach. After initial coding, *focused* coding occurs seamlessly. Focused coding starts with studying, assessing, and comparing initial codes to find the codes that appear more frequently and have a higher significance. Focused coding is more conceptual than initial coding and helps the researcher organize how to treat and manage the data. Finally, *theoretical* coding occurs later in the analysis process and can help the researcher tell the analytic story. In theoretical coding, the researcher makes possible connections and relationships between categories developed in focus coding (Charmaz, 2014).

Scientific Adequacy

The standard approach to validity and reliability in quantitative research is not appropriate to the qualitative setting. Specific to qualitative research is a model developed by Guba (1981) for assessing scientific rigor, or the trustworthiness, of

qualitative data. Guba's model is based on four aspects of trustworthiness: 1) credibility; 2) transferability; 3) dependability; and 4) confirmability.

Credibility

Credibility can be also described as establishing truth value. The researcher must establish confidence in the truth of the findings for the subjects and the context (Guba, 1981). For this study, credibility was maximized through the process of writing field notes, memoing, and peer debriefing. Since qualitative approaches are reflexive in that the researcher is part of the research, field notes and memoing will be important for the researcher to become aware of any biases and preconceived assumptions. Peer debriefing is another technique that can enhance the credibility of a study. Peer debriefing was achieved by periodically consulting with doctoral committee members, professional colleagues, and doctoral student peers who are familiar with the study topic and methodology.

Transferability

In qualitative research, generalizability or external validity is known as *transferability* and depends on the degree of similarity (or fittingness) between two contexts (Guba, 1981). To enhance transferability, this study presents thick, detailed descriptions from interviews and field notes. Presenting sufficient detailed descriptions allows other researchers to apply this study to another context with essential similarities (Krefting, 1990).

Dependability

Guba (1981) proposes that *dependability* is related to the *consistency* of findings. Maintaining an audit trail and having an external peer review performed by a member of

the committee who is an expert in managing qualitative data can enhance the dependability of this study. Guba (1981) describes the term auditable as a state where another researcher can clearly follow the investigator's thinking process and decision trail used by the investigator.

Confirmability

Practicing reflexivity in the form of writing field notes and detailed memoing enhances *confirmability* or neutrality. Neutrality refers to freedom from bias, which is an inherent part of qualitative research, and therefore will need to be managed (Guba, 1981). The investigator kept regular notes about field experiences, which included thoughts, feelings, and potential biases including strategies to manage them. And finally, like dependability, confirmability can also be evaluated through an external review process of the audit trail.

Chapter Four

Findings

The following chapter details the findings of this study. Based on the qualitative methodology described in Chapter Three, the data were derived from 12 interviews. Findings include a description of the participants and emergent themes that evolved through the analysis process.

Participants

There were 12 participants in this study, aged 22-35 years (average age of 30 years), who met eligibility requirements. All participants were born in the US, and for all 12, both parents were born in Thailand. Four of the participants hold an advanced degree, six completed a four-year college, and two participants completed some college. Three participants work in the medical field with two of them working as registered nurses and one as a pharmacist. All women in this study had some type of insurance whether it was private or through Medicaid/Medi-Cal. One participant in this study had a history of cervical cancer within her family. Though not derived directly from the demographic questionnaire given to each participant, other demographic data was discovered through the interview and noted in memos. Many of the participants had family members who worked in the healthcare field. One participant had a mother and sister who were both registered nurses. Three participants had mothers who were registered nurses and two participants had boyfriends who were registered nurses as well.

Out of the 12 participants, five received a Pap test in their late 20s on recommendation from their healthcare providers and another five received their first Pap when they became sexually active, wanted to take birth control, and therefore, sought

services. Only one received a Pap test because her mother suggested it, and one participant had never had a Pap test at the time of the interview.

Table 1

Participants' Demographic Information

Participant	Age (Yrs)	Parents born in Thailand	Education	Occupation	Insurance	Hx of Cerv. Ca. in Family
1	31	Both	College	Student	Private	No
2	32	Both	Adv. College	RN	Private	No
3	31	Both	College	RN	Private	No
4	29	Both	Adv. College	Analyst	Private	No
5	30	Both	Some College	Retail	Medicaid	No
6	35	Both	College	Manager	Private	No
7	22	Both	College	Student	School	No
8	30	Both	Adv. College	Manager	Private	No
9	24	Both	Some College	Supervisor	Private	No
10	33	Both	Adv. College	Pharmacist	Private	No
11	28	Both	College	Student	Medicaid	No
12	32	Both	College	Pharm Tech	Private	No

Data Gathering

The 12 interviews were conducted over a 7-week period. Interview length ranged from 20 minutes to 1.5 hours. Interview locations were variable and depended on the preference of the participant. Interviews were conducted at coffee shops, restaurants,

and participant homes in San Diego and Los Angeles counties. All 12 interviews were completed, transcribed, and utilized for the analysis of this study. Any comments or observations made after the recording was stopped were noted in field notes.

Identified Themes

In reviewing the data, four themes were identified: being *reīybŕxy* (proper), avoidance, realization, and feeling empowered. These themes evolved throughout analyzation, and have emerged as the main process in which the cultural upbringing of these women merged with their social worlds to influence their perceptions on cervical cancer and screening practices. The next section will discuss each theme in detail.

Being Proper (Reīybŕxy): เรียบร้อย

The theme of being “reīybŕxy”, which is the Thai adjective meaning proper, is the first major theme to emerge from the data. The definition of “reīybŕxy” is to be proper, polite, and presentable. For many women in this study, the concept of being proper was instilled in them since childhood with direct instruction from their parents on how to act and behave, especially when it came to the opposite sex.

*“Ever since I can remember, my mom always reminded me to be ‘reīybŕxy’. I always had to wear certain clothes, and be a proper Asian kid who got good grades and never got in any trouble. I was never supposed to interact with any boys and it was pretty clear in my household that I was not supposed to date at all. They made it clear I was not to be one on one with a boy **ever** ... and they really did not want me to date till after I got a college degree.” [Participant 2]*

The concept of being proper can mean many different things. However, it was consistently described by the participants in terms of relationships, sexuality, and sex. It was often linked to feelings of guilt and shame. The next excerpt discusses bringing shame to the family by not acting proper. These feelings of guilt and shame were linked to the act of getting a Pap test.

“Growing up in the Thai culture, it was always that you need to be ... I don’t know ... ‘reīybr̂xy’. You had to be proper. You had to be good. You weren’t supposed to have sex before marriage. So the thought of getting a pap smear before getting married makes you admit to having had sex. Almost like I’m doing something wrong. If I’m not ‘reīybr̂xy’, I’d be considered a slut, and if that went around the Thai community, my parents would kill me. It’s one of those things ... I represent my family, so if I wasn’t proper ... it could potentially affect my parents too! To put it in Disney Mulan terms ... I’d bring shame to my family”. [Participant 2]

The consistent message from parents, whether it was implicit or explicit, was that premarital sex was not what proper girls should be involved in and it was unacceptable in Thai society, no matter how old they were. Many of the women interviewed were well into their 30s, but still felt the need to be their parents’ definition of proper. Two participants in their 30s described how they could not tell their parents that they were living with their significant other because it was considered an act of disrespect. In one account, the participant described being able to confide in her mother that she was living with her boyfriend, but her mother very clearly stated to keep this secret and to not let

anyone else in the family know that they were living together. This was to “save face” so that no one would talk about her.

The concept of being proper is also portrayed in Thai soap operas or lakhons (as it is known in Thai). In Thailand, lakhons are shown on primetime, and in the US, many Thai households rent lakhons on DVDs from their local Thai video store. Thai soap operas have been criticized for glorifying rape and portraying the heinous act as a vehicle to true love. Many second-generation Thai American women grow up watching these lakhons with their mothers. One participant described what she saw:

“I grew up watching lakhons with my mom all the time! What I find to be the stupidest thing is that in lakhons the love scenes are always rape scenes. When I was little girl, and I would watch theses Thai soaps with my mom, it was always like the main guy would rape the girl, but the rape scene wasn’t violent, and somehow it’s the guy winning over the girl. Then the girl eventually gets married to the guy, and they live happily ever after. So basically, they had sex right? ... but the Thai soaps don’t want to portray that they had consensual sex... they still want the girl to be proper and ‘reīybr̂xy’ ... to the point where they would rather portray her being raped than to portray her as someone who just wants to have sex!” [Participant 12]

Thai soap operas are a basic staple in most Thai households, thus, many Thai American daughters learn and observe behaviors by watching these shows at home. The description from Participant 12 was very telling of the situation in many Thai soap operas. The main male character will initiate sex, and the woman will try to reject it and

say no to show she is sexually naive, and the man will then initiate sex anyway. This is the constant storyline in most Thai soap operas, which is very different from American shows such as *Sex in the City* where women are shown to embrace their sexuality.

Avoidance

In almost all interviews, the theme of avoidance emerged. The topics of sex, sexual health, Pap smears, gynecology, and boyfriends were all topics perceived to be sexual and therefore completely avoided by most families. Participants described not ever talking to their mothers about these topics and noted them as being *taboo*.

“People from Thailand ... it’s just not something they talk about that much; it is just awkward. It never comes up. I guess it is embarrassing for my mom and embarrassing for me too. I do not know what to talk to her about. I do not think cervical cancer is ever in her mind. I do not think my mom connects a pap smear with cervical cancer, but she connects it with sex. So they avoid the topic all together. Maybe I have never tried talking to her about it because she does not bring it up, so I don’t either.” [Participant 4]

By not talking about something, it was inferred that it was not happening. Thus, not talking about sex meant that sex was not happening, even though it typically was occurring.

One participant’s mother was a practicing nurse in an OB/GYN clinic, and she expressed her frustration that her mother still did not talk with her about sexual health. She did not know her mother specialized in women’s health until after she graduated college.

“My mom just kind of told me she went into women’s health as a specialization after I was finished with college, so I was much older. Up until then, we’ve never discussed anything like that. After that, she started sort of opening the communication a little bit but even then, I don’t think we nearly talked about it that much. I feel like even things like the HPV vaccine, I don’t know much about it and she’s never encouraged me to get it either. It’s one of those things where I feel like she should tell me more about it since that’s her job. By the time I learned about it, it was too late for me to get the vaccine. I guess for my mom it wasn’t important or I would hope she would have told me about it. She didn’t stress the need for it.” [Participant 8]

Another participant whose mother was a nurse also echoed her frustrations:

“She just never really brought it up (safe sex practices and preventive care). I feel like her not bringing it up really hurt me more than anything. Maybe I would have waited a little bit longer till I engaged in sexual activity, and I probably would have practiced safer sex. I probably would have gotten a pap test sooner if my mom suggested it”. [Participant 4]

A third participant illustrated the taboo and stigma that comes with talking about sex:

“I think it’s a stigma that’s created in the Asian culture that it’s frowned upon to talk about it or to discuss about it. It’s almost like a weakness in terms of depression and sex ... it’s just like a taboo in general to bring it up whether in

terms of health or just talking about it, bringing it up, watching it ... anything related to it, it's just not talked about ... it's just bad. So ... it's kind of sad too because it creates a barrier that if anything should go wrong, it's really hard to discuss it with them. And if they were to have it, I don't know if they would be comfortable talking about. Like, I don't know if my mom would ever be comfortable telling me if she ever had it. She definitely didn't recommend me to get a pap test, but she didn't actively say not to ... she just never brought it up, so I never received it until my late 20s!" [Participant 12]

In the three excerpts, the young women garnered from their mothers that the HPV vaccine and the Pap test were not important. Their mothers did not stress the need for either, therefore, the young women did not perceive the need for them. What was important was always emphasized by their parents, such as being proper. Thus, the lack of emphasis and the avoidance of discussing the HPV vaccine or the Pap test inferred that it was not important.

Out of the 12 participants, 11 of them discussed receiving their first Pap test. The one participant who did not receive the Pap test was the youngest participant aged 22. She did not know anything about the Pap test or the HPV vaccine. During her interview, she echoed other participants' stories in that sexual health, and anything related to sex, was constantly avoided in her family. She openly revealed that she had been sexually active and had no idea that she should be receiving a Pap test. She also had no idea that the Pap test was used to detect abnormal cells that can lead to cervical cancer, despite having an aunt who was diagnosed with cervical cancer.

“My aunt was diagnosed with cervical cancer, but she lives in Thailand. My mom told me about it, but she didn’t go into detail about it. Honestly, I don’t even know where the cervix is exactly. I had no idea that a pap smear was used for cervical cancer, I just thought it was what you did once you started having sex. No one ever told me about this.” [Participant 7]

Despite having a relative with cervical cancer, there was still an avoidance of talking about this subject within her family.

Besides avoiding discussing sexual topics, in many cases medical checkups were also avoided in childhood whenever possible. Many women expressed that their parents only took them to the doctor when it was necessary, such as for immunizations needed for school. One participant described her parents trying to make ends meet, eluding to health not being a priority for them:

“Doctor visits... when we had insurance she would try to. Honestly, like I said, I think a lot of parents from their generation were really focused, especially if they were immigrants, really focused on getting themselves and their families on their feet. Making sure there was food on the table. Health, unfortunately, was on the back burner.” [Participant 12]

Almost every participant described her childhood medical checks ups as sparse and only when the school deemed it necessary. One woman echoed the sentiments of others when she talked about her parents not having “normal healthcare”, and even sometimes seeking services in Thailand when the family was on vacation.

*“My parents didn’t work for big companies that had health insurance for their employees. My parents barely spoke English, and I just remember it was hard for them to find a Thai doctor. We didn’t have health insurance like Kaiser or whatever, so we’d only go to the doctor ... and even the dentist, if I had a **real** problem. Even for dental, sometimes we’d go years before we’d go see a dentist on our visits to Thailand. I just remember when I got sick, my mom would always have some type of antibiotic that she bought over the counter in Thailand ... I think Augmentin or something, and I’d take a round of antibiotics prescribed by my mom!” [Participant 5]*

Certain antibiotics are sold over the counter in Thailand at local pharmacies. Many Thai parents would buy Amoxicillin, Augmentin, and Cipro over the counter in Thailand, and keep them in their medicine cabinets in the US. One of the nurses described this practice:

“Every sore throat, every ear infection ... every little thing ... my mom would bust out the Amoxicillin. As a little girl, I would take it without hesitation and I do remember in a few days my sore throat would be gone so we would never need the doctor. Then I became a nurse and realized this is how people get MRSA. I explained it to my mom, but still ... when I complain of a sore throat, I’d notice a pack of Amoxicillin on my desk! I think it’s just part of the Thai culture ... we avoid the doctor and we treat everything with Amoxicillin!” [Participant 3]

Realization

Many of the women who received the Pap test did not quite understand the connection of the Pap test to cervical cancer until it was explained to them by their practitioners. Prior to this realization, they continued to seek screening services because it was necessary if they wanted to continue with birth control or because their health care providers suggested it.

It was more for birth control and I think just health. I don't think cervical cancer was ever in my mind. Planned Parenthood would not give NuvaRing or any kind of contraceptive without a screening, but I didn't think it was for cervical cancer screening cause they always checked for STDs and stuff, so I always thought the Pap test was for general health down there.” [Participant 4]

Once the participants realized the Pap test was used to prevent cervical cancer, many viewed the test differently. One participant received her first Pap at a young age because she wanted access to birth control. She continued to receive the Pap test so she could renew her birth control and check for STDs. It was not until her recent Pap test came back positive for HPV that her provider explained to her the cells could become cancerous. She expressed her shock at receiving this information.

“... they told me I was HPV positive, I had the cancer cells and I didn't even know what that was! They told me that this could lead to cervical cancer, and I was like “WHAT!?”. The only reason I've heard of it was because when they told me I had it. I mean, I didn't know that the pap test was looking for HPV! I thought it

was looking at STDs. I thought it was just a checkup, like a physical, I didn't know ... but now I do, and I am so much more diligent at going to get screened."

[Participant 4]

The act of seeking services to receive a Pap test came before even knowing what the Pap test was for. Once the realization that the Pap test was for more than just STDs and birth control, the women expressed this was an important piece of knowledge that helped them decide to continue receiving the pap test. The women who received the test when they were younger, typically in high school, may have been told the test was for detecting cancerous cells, but at the young age of 15, the comprehension of the meaning of cancerous cells may not have been completely understood. The women who received the test when they were older understood the meaning of the Pap once it was explained, but were not exposed to the Pap test earlier. The theme of realization refers to when the participant described her understanding of the importance of receiving the Pap test as it relates to her health and prevention of cervical cancer.

Feeling Empowered

Many of the women in this study came from an upbringing where anything sexual was deemed as inappropriate. A stigma was placed on these topics and the avoidance was very apparent in the home environment. However, these women were encouraged to get the Pap test and once they realized the importance of the Pap test, these women felt empowered to continue. One participant discussed learning about the Pap test in a college health class. This was the first time she ever heard of the Pap test, and that it

tested for HPV. The class also reviewed HPV and its links to cervical cancer. She discussed how learning about this made her feel empowered to take care of herself.

“It still feels awkward but not as bad as before [the pap test]. I sort of think it’s unpleasant for a few minutes, but that it’s okay. It helps me to think about it as something for my health, my own health, and I want to be sure that I’m okay.”

[Participant 1]

She continued to talk about how her life would have been different if it she was not in the health education class in college.

“My life would be so different. I would have probably had the same idea of “Why would I need a pap test?” or maybe I’d just continue to be embarrassed and not willing to go. It is because I had that class and that nurse urged us, and so I went. Physically, it was uncomfortable but at the same time I felt empowered and a sense that I was doing this for myself, and I should do this annually and take care of my own health.” [Participant 1]

This sentiment of empowerment was felt by many of the women who were continuing their "well woman checkup".

"As a nurse, I know how important getting checkups are, especially for women. With my health insurance, they call it the well woman checkup... and I think it’s recommended to get the Pap every five years. But I feel like ... um, five years is a long time to see if there’s a cancer cell growing in me. I push to get mine done every year if possible, even if my doctor thinks it’s unnecessary. Once I learned that the Pap test could help prevent cervical cancer by detecting it sooner, I was

like I'm all in... this is on me. It's a cancer that I can help prevent. Sure, the speculum is uncomfortable and whatever but the feeling I get after knowing that I did something good for me... it's a good feeling." [Participant 2]

One participant described receiving her first Pap test like going through a rite of passage into adulthood. She was in college and had access to healthcare on campus (her family did not have health insurance). After a discussion with her roommates, she realized that out of all her friends, she had never had a pap test before.

"I think it was the first time I probably had health insurance through the school. After having this interesting talk with my roommates, I thought to myself ... I'm an adult now, I'm already sexually active ... I need to get a pap test. This is what adults do! If I'm going to have sex, I better keep myself safe!" [Participant 6]

The notion of doing it for yourself was something resonated with many women. With Participant 6, she felt that having a Pap test was part of being an adult and in a sense protecting herself.

Summary

The themes that emerged from the data can be looked at as a process in which second-generation Thai American women decide to receive a Pap test or continue with screening practices. Figure 1 shows the four themes over time and the influences on those themes. Women in this study described being proper, avoidance, realization, and feeling empowered over a period of time with influencing factors in each stage whether it

be family, cultural values, society, healthcare providers, friends, the internet, or outreach programs.

Figure 1. Themes and Influences.

Chapter Five

Discussion

The purpose of this study was to explore the perceptions of second-generation Thai American women towards cervical cancer screening and the influences on the decision to seek cervical cancer screening services. In listening to and understanding their views on the Pap test and the influences of their parents and culture in shaping their perceptions, the voice of this generation of women emerged as unique and different from the voices of their mothers. In this chapter, significant findings, limitations, and implications for education, practice, and research will be discussed.

Findings

Taboo Topics

The meaning of *taboo* is described in the works of anthropologist and cultural theorist Mary Douglas (1966) in her work analyzing the concepts of pollution and taboo. Taboo derives from a Polynesian word that means a religious restriction that can result in punishment if not performed. In the evolution of the word, taboo is not only restricted to religious purposes; it now underpins social structure in terms of learned behaviors that are absorbed by each generation. Taboos are rules of behaviors, but must be looked at within the social context in which they are found (Douglas, 1966). For the outsider, certain taboos may be irrational, yet for the believer, no explanation is needed as to the righteousness of the taboo. In this inquiry into second-generation Thai American women, the taboos that were imposed onto these women were perpetuated and defended by their parents.

For the women in this study, the word taboo was used to describe topics relating to sexuality such as boyfriends, the Pap test, and anything generally related to sex. Topics that were considered taboo were off limits to discussion. These topics were deemed taboo by learned behaviors, which were exhibited by parents throughout each woman's childhood. By default, not talking about these topics affected perceptions of cervical cancer and screening practices. Things that were considered important to parents were discussed openly and instilled in their children at young ages, such as cultural values of being proper and polite. What was important to parents became important to their children, and thus, the world view of these women is deeply rooted with the world view of their parents.

In Asian cultures, there is a strong collectivist, hierarchical social structure that guides behavior. In this social structure, individuals represent the family and thus, the behavior of one individual reflects the rest of the family. The hierarchical structure puts parents and their opinions in a place of authority. Parents affected screening behaviors both indirectly and directly, and for both good and bad. For example, when the mother of a participant (also an active working registered nurse) did not openly talk to her daughter about the importance of the Pap test, her daughter did not deem it important to get one. The logic here is that if it was something of importance, which was how these women were raised to think, then their parents would not just talk to them about it, they would insist that their daughters were compliant. Mothers did not broach these topics with their daughters because it was considered a taboo subject in their views; which is in line with what researchers have found as barriers to cervical cancer screening in women from Southeast Asia (Ho & Dinh, 2011; Johnson et al., 2008; Tsui, & Tanjasiri, 2008).

Lack of Knowledge, Socioeconomic and Demographic Factors and Screening Practices

Earlier studies on first-generation Thai American women have largely focused on socioeconomic factors such as language proficiency, low income, access to healthcare, and education level as barriers to screening (Tsui, & Tanjasiri, 2008). For the purposes of this study, socioeconomic factors were not looked in detail and were not part of the aims; however, there were some significant findings that should be discussed.

In terms of language proficiency, all the women in this study spoke and wrote English. This did not present itself as a problem for seeking services. All the women in this study had some college experience, with most them having college and secondary college degrees. Despite the high education levels among these women, the lack of knowledge regarding the Pap test and cervical cancer was still prevalent. Knowing to get the test and knowing what the test is for are two very different concepts. About half of the women in this study received the Pap test in their teens and early 20s because they were seeking birth control. Many of these women confided that they were unaware that the test was to detect precancerous and cancerous cells on the cervix. They thought the test was specifically to make sure they were healthy enough to take birth control or to rule out any STDs. For the other group of women, the lack of knowledge was in knowing when it was time to receive the Pap test. These women generally received their first Pap test in their late 20s on the recommendation of their healthcare providers. The women who received the Pap test in their later 20s discussed understanding what the test was for, but did not realize they needed one.

Access to healthcare was only a problem for one participant who recently graduated from college. She also happened to be the only participant to have never had Pap test. Most of the women sought their first Pap test after receiving a recommendation from their healthcare providers. Some received information on the Pap test in health education classes in college. What was prevalent in all interviews is that once the women realized it was important for them to receive a Pap test, they sought services. These results are similar to a study on Thai American women in Northern California who sought services if recommended by their healthcare providers. For first generation Thai American women, physicians were viewed as people with authority and complying with their recommendations was culturally appropriate. For the second-generation Thai American women, it was more about gaining the knowledge about the Pap test and understanding its importance; it was their realization and feeling empowered to stay healthy and do what was best for themselves.

Study Limitations

There were some limitations to this study. First, the results of this study do not represent all second-generation Thai American women living in the US. The women in this study were all from Southern California where the largest population of Thai Americans in the US reside. Thus, these women grew up in a tight knit Thai community that supported each other and was well established. Their upbringing may be very different from Thai Americans who have settled in the Midwest or other parts of the US. The degree of transferability of these study results may be limited to other areas of the US where Thai Americans have established themselves such as areas in Texas and Nevada. This study specifically explored the perceptions of second-generation Thai

American women; however, many young Thai American women immigrated to the US as infants and were raised the same way as their counterparts who were born in the US. It would be interesting to study the perceptions of young immigrant Thai Americans who were born in Thailand but immigrated to the US as young children.

Finally, the confirmability of this study is another potential study limitation. Confirmability refers to neutrality or freedom from bias (Guba, 1981). There was a potential for researcher bias in this study since the researcher is personally connected to the population as a second-generation Thai American woman herself. This bias was minimized by reflexive memoing, field note taking, and peer debriefing. Confirmability was also minimized with the methodological approach used for this study. By using constructivist grounded theory, the researcher is acknowledged throughout the research process as co-constructing the reality. However, it is possible that the closeness of the researcher to the population could have affected the way in which the researcher approached the participants and conducted the interviews.

Implications

Education

This study suggests that second-generation Thai American women do not have the same barriers to cervical cancer screening as their first-generation mothers. The barriers to cervical cancer screening for this generation of women stem from deep rooted taboos related to sexuality and what is deemed appropriate or not. These taboos have caused a delay in the understanding of cervical cancer and the screening process. Once understanding occurs, these women went through a process of realization and empowerment that either stimulated them to seek or continue with services. To bridge

the gap from avoidance to realization, educational outreach programs should be targeted for this population.

Educational outreach for this population should occur in college and if possible, sooner. For these women, the embarrassment was not the act of going to the gynecologist, it was the act of talking about these topics with their mothers. Therefore, openly discussing gynecological issues and procedures would be valuable to these women. The perceived risk and susceptibility to the disease is low among this population since it is rarely talked about, even when family members actively have the disease. Educational outreach programs should emphasize the specifics about the Pap test, especially more information about abnormal, precancerous, and cancerous cells on the cervix which were misunderstood by many participants when they were initially exposed to the Pap test.

Besides education among second-generation Thai American women, educational outreach programs should also target first-generation Thai American mothers. Even though many of the participants knew their mothers went to the gynecologist, it was never talked about. Outreach programs should focus on important topics to talk to daughters about, including cervical and breast cancer screenings. If mothers are having these screening tests done, ideally they should feel comfortable telling their daughters the process and the importance of these practices. If Thai American mothers were more comfortable bringing up gynecological issues with their daughters, the step from avoidance to realization would be bridged sooner, and second-generation Thai American women would feel empowered to care for themselves.

Practice

For healthcare providers, it is important not to treat all Thai American women the same. Providers need to be sensitive to the generational differences of immigrant groups, and to be aware that their needs may be different. Young second-generation Thai American women may be more open to visiting their healthcare providers as compared to their mothers; however, they may lack understanding of the Pap test. Providers should be more open and direct in explaining the purpose of the Pap test, and continue to help these young women learn and understand their role in preventing cervical cancer.

Research

This is the first study to identify perceptions from this population. Future studies, such as a cross sectional study focusing on acculturation and cervical cancer knowledge, could be of benefit. Besides the first and second-generations, there is also a generation that is in between which is known as the “1.5 generation”. The women who fall into this generation are those who were born in Thailand, but immigrated as children and raised in the US. This group of women will also have different lived experiences that would be worth looking at on a deeper level.

Conclusion

This study identified four major themes (being proper, avoidance, realization, and feeling empowered) as it pertains to the perceptions of second-generation Thai American women living in Southern California. The process for this population to reach feeling empowered starts with learned behaviors. Initially the learned behaviors towards anything gynecological are taboo, and then somewhere on the path to feeling empowered there is a realization that occurs. This realization occurs when the previous taboo topics

are openly discussed as it pertains to cervical cancer and one's own health. It is imperative that healthcare professionals and educators bridge the gap of time it takes to reach realization to ensure second-generation Thai American women feel empowered to make informed health decisions.

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Appendix A

CERVICAL CANCER SCREENING STUDY

I am a doctoral student at the University of San Diego conducting a study to explore the perceptions of second-generation Thai American women towards cervical cancer screening.

Who is eligible?

- Women born in the United States
- Women who self-identify as Thai or Thai American
- 21-45 years of age
- Have at least one parent born in Thailand

What is involved?

- A casual one to one interview about your experiences
- The whole process will last about 60 minutes.

CONTACT INFO: [REDACTED]
[REDACTED]

\$20 gift card
will be provided
to qualifying
participants!

ESSIE ASAWAPORN MONGKOL, RN, MSN
DOCTORAL STUDENT
UNIVERSITY OF SAN DIEGO
HAHN SCHOOL OF NURSING AND HEALTH SCIENCES

Appendix B

University of San Diego
Institutional Review Board

Research Participant Consent Form

For the research study entitled:

Second-Generation Thai American Women's Perceptions on Preventive Sexual
Healthcare

I. Purpose of the research study

Essie Asawapornmongkol is a student in the Hahn School of Nursing at the University of San Diego. You are invited to participate in a research study he/she is conducting. The purpose of this research study is: to explore perceptions of second-generation Thai American women towards cervical cancer screening

II. What you will be asked to do

If you decide to be in this study, you will be asked to:

Participate in a private interview about your experiences with cervical cancer screening.

You will be audiotaped during the interview.

Your participation in this study will take a total of 60 minutes.

III. Foreseeable risks or discomforts

Sometimes when people are asked to think about their feelings, they feel sad or anxious. If you would like to talk to someone about your feelings at any time, you can call toll-free, 24 hours a day:

San Diego Mental Health Hotline at 1-800-479-3339

Los Angeles Crisis Hotline at 1-800-854-7771

Riverside HELP Line at 1-951-686-4357

Orange County Crisis Prevention Hotline at 1-877-4747

IV. Benefits

While there may be no direct benefit to you from participating in this study, the indirect benefit of participating will be knowing that you helped researchers better understand the perceptions of second generation Thai American women towards cervical cancer screening.

V. Confidentiality

Any information provided and/or identifying records will remain confidential and kept in a locked file and/or password-protected computer file in the researcher's office for a minimum of five years. All data collected from you will be coded with a number or pseudonym (fake name). Your real name will not be used. The results of this research project may be made public and information quoted in professional journals and meetings, but information from this study will only be reported as a group, and not individually.

VI. Compensation

If you participate in the study, the researcher will give you \$20 Target gift card the following way: personally

You will receive this compensation even if you decide not to complete the entire interview

VII. Voluntary Nature of this Research

Participation in this study is entirely voluntary. You do not have to do this, and you can refuse to answer any question or quit at any time. Deciding not to participate or not answering any of the questions will have no effect on any benefits you're entitled to, like your health care, or your employment or grades. **You can withdraw from this study at any time without penalty.**

VIII. Contact Information

If you have any questions about this research, you may contact either:

1) Essie Asawapornmongkol

Email: [REDACTED]

Phone: [REDACTED]

2) Kathy James

Email: [REDACTED]

Phone: [REDACTED]

I have read and understand this form, and consent to the research it describes to me. I have received a copy of this consent form for my records.

Signature of Participant

Date

Name of Participant (Printed)

Signature of Investigator

Date

Appendix C

Demographic Questionnaire

Subject ID#: _____ (to be filled out by investigator) Date: _____

Please fill in the blank or check the correct response.

1. What is your age? _____
2. Which of your parents were born in Thailand?
 - ☐ Mother
 - ☐ Father
 - ☐ Both
3. What level of education have you completed?
 - ☐ Less than high school graduate
 - ☐ High school graduate
 - ☐ Some college or technical school
 - ☐ College graduate
 - ☐ Advanced college degree
 - ☐ Other – Specify: _____
4. What is your occupation? _____
5. What is your healthcare insurance coverage? (Check all that apply)
 - ☐ Private insurance
 - ☐ Medicaid
 - ☐ None
 - ☐ Other – Specify: _____
6. Does anyone in your family have a history of cervical cancer?
 - ☐ Yes
 - ☐ No

Appendix D

Interview Guide

General Statement: Thank you for participating in this study. I'm a doctoral student who is interested in women's health and culture. The reason I'm doing this study is to better understand perceptions of second-generation Thai American women towards cervical cancer screening or the Pap smear.

I'd like to start with some general questions about you.

Family

- Can you describe to me your family that you grew up with?
 - Siblings?
- How are your relationships with your:
 - Siblings?
 - Mother?
 - Father?
 - Have these relationships changed over the years?

Culture and Ethnicity

- What ethnicity do you identify with?
 - Why?
 - What values do you hold close?
 - Examples
- Can you share with me any times that you have felt conflicted with your ethnicity or cultural values?

General Health

- What does "being healthy" mean to you?
- What do you do to stay healthy?
- What is your regular source of healthcare? Provider?

Experience with healthcare

- Can you tell me about what happened if you ever got sick growing up?
- Do you remember if you had regular checkups growing up?
- Do you think your caregiver (when you were a child) felt that health was a priority?
- How do you view the healthcare system?

Health Seeking Patterns

- Who do you talk to about health? (Family, friends, etc)
- Where do you get your information about health from?

- How do you think your upbringing influences your health choices?

Women's Health Care

- What kinds of discussions have you had about women's health issues with your family, friends, or anyone else?
- Would you feel comfortable talking with your mom about women's health issues?
- Who would you talk to if you had questions about women's health issues?
- Has anyone in your family had any women's health issue (cervical cancer, uterine cancer, breast cancer, etc)?
- Do you remember what you learned about women's health or sex education in school?
 - Grade School
 - High School
 - College

Pap Smear

- What comes to mind when I say Pap smear?
 - Where do you think these thoughts or opinions on the Pap test come from?
- Have you ever had a pap smear?
 - What do you think encouraged you to get a Pap smear?
 - What do you think prevents you from getting a Pap smear?

Appendix E

Institutional Review Board Project Action Summary

Action Date: October 10, 2016 *Note: Approval expires one year after this date.*

Type: ☐ New Full Review ☒ New Expedited Review ☐ Continuation Review ☐ New Exempt Review
☐ Modification

Action: ☒ Approved ☐ Approved Pending Modification ☐ Not Approved

Project Number: 2016-10-035

Researcher(s): Essie Asawapornmongkoi Doc SON

Dr. Kathy James Fac SON

Project Title: Second-Generation Thai American Women's Perceptions on Cervical Cancer Screening

Note: We send IRB correspondence regarding student research to the faculty advisor, who bears the ultimate responsibility for the conduct of the research. We request that the faculty advisor share this correspondence with the student researcher.

Modifications Required or Reasons for Non-Approval

None

The next deadline for submitting project proposals to the Provost's Office for full review is N/A. You may submit a project proposal for expedited review at any time.

Dr. Thomas R. Herrinton
Administrator, Institutional Review Board
University of San Diego
herrinton@sandiego.edu
5998 Alcalá Park
San Diego, California 92110-2492

Office of the Executive Vice President and Provost
Hughes Administration Center, Room 214
5998 Alcalá Park, San Diego, CA 92110-2492
Phone (619) 260-4553 • Fax (619) 260-2210 • www.sandiego.edu