# Mapping out the Vietnamese American experience: Parenting styles and communication satisfaction among Vietnamese American generations

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## Abstract

Communication is vital for all communities and is particularly relevant for families. This study explored intergenerational communication on health and political topics within Vietnamese American communities. While a large body of research explores family communication themes in Asian American (especially Chinese American) communities, little exists about Vietnamese American communities, especially on family, health, and political communication. The study surveyed 869 Vietnamese Americans aged 18 to 35 who have Vietnamese American immigrant parents, asking them questions pertaining to their family's parenting styles, family communication styles, and willingness to communicate health and political topics. Results found that authoritative, authoritarian, and permissive parenting styles were significantly related to communication satisfaction. Further research showed that authoritative, authoritarian, and permissive parenting styles were also significantly related to the willingness to communicate various health topics, including mental and sexual health. When looking at political communication within the family, results found that there were significant differences between concordant and discordant political affiliations within the family and communication satisfaction. Authoritative, authoritarian, and permissive parenting styles were also significantly related to willingness to communicate about politics. The findings indicate that there is a large need for education within families to increase the quality of family, health, and political communication. Findings can inform campaigns to improve communication within this community and provide better health outcomes and constructive political dialogue.


*Keywords:* Vietnamese American, immigrant families, health communication, political communication, Vietnamese American politics, stigma, mental health, sexual health, family communication, eastern family parenting styles

## Introduction

The Vietnamese American experience is extremely robust, heavily shaped by U.S. foreign policy, history of a decades-long war, remnants of French colonial rule, and the journey of cultural assimilation into U.S' culture v. With this rich and complex context, future generations will eternally be affected in countless ways, including their communication patterns. Communication between immigrant parents and 1st generation children (natural-born American-citizens of immigrants) is oftentimes different because of homeland cultures possessing vastly different contexts and values than American culture, resulting in varying levels of acculturation. One stark example of this phenomenon is the traditional Vietnamese expectation to obey parents "unquestioningly, while the U.S.-born children, raised in a culture that values individualism, often chafe at such restrictions" (Ling & Austin, 2010, p. 575). The difference between individualism in American culture and collectivism in Vietnamese culture is one of many key cultural differences that Viet-Americans must face on a daily basis as they're met with the dilemma of picking and choosing which aspects of which cultures to preserve or bury away.

### Significance of the Study

The purpose of this study is to explore communication between two Vietnamese Americans generations: immigrant parents and their U.S-born (or 1st-generation) children. Health and political communication will be explored while applying cultural contexts to draw inferences from themes found in the study. Findings within the realm of health communication will allow health officials, practitioners, and patients to find better ways to effectively communicate health information to ensure increased positive health outcomes. Answers uncovered in political communication contexts can allow politicians and constituents alike to synthesize better ways to convey political information, process politics differently, and improve political involvement in

one's community. Being able to understand parenting styles and communication can also allow different interventions to increase the quality of communication within the family, which in return can boost the quality of the family life.

## Literature Review

Vietnamese culture inevitably plays a large part in how Vietnamese Americans communicate; being conscious about these cultural pillars can help one explain why these phenomena happen and draw future interventions for improved communication. Factors such as the role of family, political values, perception of health, and family communication styles are strong driving forces that shape a large part of communication between parent and child, especially in the context of immigrant families. Utilizing existing literature will prove useful to draw future interventions for families who struggle with communication and possibly improve quality of life.

### The Role of Family within Vietnamese Culture

Before diving into the complex world of communication between immigrant Vietnamese Americans and first-generation Vietnamese Americans, one must first understand the intricate and oftentimes nuanced themes of filial piety and importance of family within Vietnamese culture. Most Vietnamese families' households are nuclear, and the importance of family is emphasized through holding closer ties to family than U.S families do, accentuating elders' opinions in decision-making processes, and settling near other family members within easy visiting distance (Ling & Austin, 2010). These obvious differences of a Vietnamese collectivist culture compared to an American individualistic create a challenging for Vietnamese refugees and their children to navigate through.

The complexities of navigating through various cultural differences between Vietnamese and American culture constitutes a unique experience living in the United States. Weaving around these differences is not only unique in immigrant families, but differences in "cultural values between the parents and children also play a crucial role in fueling the overall stress of the family system, thus, creating friction and conflicts in the family" (Nguyen & Cheung, 2009). This can range anywhere from conflicting familial expectations to radically different communication styles. Several sociologists have made note that authoritative parenting styles tend to be more emphasized in Western societies than Asian cultures. However, because authoritarian and authoritative parenting styles exist in all cultures, one can suggest that Vietnamese children can experience a negative effect from this phenomenon due to a heterogeneous society with different cultural standards and values, unlike their parents' homogenous culture (Cheung & Nguyen, 2001; Hertz & Gullone, 1999; Papps et al., 1995; Nguyen & Cheung, 2009).

Researchers have been particularly interested in parenting styles and how they affect the Vietnamese family, particularly the children, who experience both the parents' culture and culture in the U.S. According to Wong and colleagues (2011), a mixed-methods study was conducted to examine the effectiveness of a tailored, community-based parenting education intervention for Vietnamese American immigrant parents; themes that emerged from the focus groups included need for improvement in communication skills, parent-child cultural gaps, trust issues, and perceived benefits from participating within the parenting workshop. In quantitative research findings, parents had more interest in being more expressive with their love after the workshop, which spoke volumes about the effectiveness on parenting interventions such as this one. It was suggested that future researchers must take these themes, such as the need for

improved communication skills and bridged cultural gaps, and apply them to shaping new methods of interventions to advocate for improved communication between parent and child. Failure to do so can negatively impact "adolescents' mental health, lowering self-esteem and increasing the level of depression" (Nguyen & Cheung, 2009).

When diving into more research about the cultural differences between American parenting styles and Asian parenting styles, it was found that differences lie beyond just the nature of individualistic Western culture and collectivist Eastern cultures (contrary to previous beliefs). Research has suggested that "many of the European American views of childrearing may also be tied to the larger influence of North American psychology in the United States" (Chao, 1995). To be more specific, the European Americans studied tended to take more of a developmental approach to parenting, where independence and the concept of child developmental stages were considered. Chao continues to note that another major influence involves psychotherapy, where Western mothers approached parenting by playing the role of psychotherapist to intercede during the child's conflicts (Chao, 1995). This would involve parents helping their children "get in touch with" their feelings, identifying or labeling these feelings, and articulating those feelings to others. What's different about Eastern culture, especially in Chinese culture, is the philosophy is geared more towards the individual's relation to others, which calls for concern for harmonious relationship within the community (especially the family unit). This becomes the backbone of problem-solving for many Eastern cultures: to work things out to benefit the familial unit or community, as opposed to Westerners' relationship within their kin group dependent on personal preference (Hsu, 1981). Chao also compared childrearing beliefs between these two groups, making note of the fact that both mothers' goals included making the child feel loved, building skills for success, teaching a value for others,

teaching skills relating to others, fostering independence, and building some group-related identity or roots. Examples included European-American mothers focusing on processing feelings with the child whereas Chinese mothers seek to foster good personality and adaptability with others, along with good moral character. Western mothers look to build the child's self-esteem while Eastern mothers value education for the child more.

Studies exploring the ways of seeking balance within Vietnamese refugee parenting practices and adolescent well-being have found that Vietnamese-refugee parents utilize strong transmission of Vietnamese cultural values (such as Vietnamese language training, emphasis on family, and faith beliefs) as a means of survival (Tingvold et al., 2012). This, in turn, fosters a culture of interdependence within the community in order to bridge the gap between the culture of their home country and the culture of their host country. With this culture of interdependence, first-generation children may feel the pressure to continue fostering familial interdependence while living in the United States, which prides itself on individualism.

**Communication Satisfaction**

Downs and Hazen's (1977) communication satisfaction explored communication satisfaction, taking note that there was a growing interest in developing comprehensive procedures to audit communication within organizations. In this study, they concluded that communication satisfaction is a multidimensional construct, including dimensions such as "general organizational perspective, organizational integration, personal feedback, relation with supervisor, horizontal-informal communication, relation with subordinates, media quality, and communication climate" (Downs & Hazen, 1977). These dimensions were found indicative of the climate of organizational functioning, which can provide a barometer to organizational communication satisfaction.

Extraordinarily little research contributes to communication satisfaction within Vietnamese American communities, but studies conducted within other Asian communities may provide a bit of insight into communication satisfaction potentially in Vietnamese American communities. Mansson and Lee (2014) examined American and South Korean engineering students' communication motives and their student-instructor communication satisfaction, keeping a note of how strong American and South Korean students' motivations are, along with the extent they take their motivations. The study reveals the robust cultural differences regarding what each group perceives as satisfactory communication with their instructors. This includes not only the individualistic American culture and collectivistic Asian cultures, but also the dimension of femininity and masculinity, theorized by Hofstede (2001) and conceptualized by the degree of competitiveness, assertiveness, and dominance expected by members of the group and how well-defined or blurred their gender roles are. American culture takes on more masculine qualities such as toughness, competition, and winning, whereas South Korean culture takes on more feminine qualities such as valuing relationships, nurturing one another, and practicing modesty (Mansson & Lee, 2014; Hofstede, 2001). Due to these differences in cultures, American students engaged in more participatory communication while South Korean students made more efforts to form relationships with their professors. This could predict the nature of Vietnamese American U.S born children's (who grow up in a more individualistic and masculine society) communication satisfaction compared to their immigrant parents, who previously grew up in a collectivistic and feminine society. Both parties may possess different criteria as to what constitutes as satisfactory communication, which is only one of many factors that contribute to the differences in communication within this community.

## Theoretical Framework

To accompany the literature surrounding the Vietnamese American contexts, theoretical frameworks can serve as useful tools to draw inferences. The theories explored in this thesis include Baumrind's (1967) Parenting Styles Theory and Family Communications Patterns Theory (Koener & Fitzpatrick, 2006).

The theory of parenting styles provides insight into how Vietnamese immigrant parents can raise their children and provide an opportunity to draw implications from different styles. The theory itself is robust, pioneered by Baumrind (1967) and enriched by Maccoby & Martin (1983). Parenting styles operate on a spectrum and can be categorized by 4 different categories: 1. *Authoritative parenting*: nurturing, affectionate, open communication, and discipline through guidance, 2. *Authoritarian*: strict, inflexible, obedience, and high expectations, 3. *Permissive*: nurturing, affectionate, and few/inconsistent boundaries, 4. *Uninvolved*: emotionally detached, inconsistent/no boundaries, and slight interactions. As stated before, Asian families tend to gravitate more towards authoritarian parenting styles, which includes the parents exercising more strictness towards their children, unyielding to their children's opinions, and hold high expectations for the family (Cheung & Nguyen, 2001). Because Baumrind's parenting styles offer a Western-centric lens to viewing parenting styles, however, their archetypes may not fully encompass the cultural nuances and social expectations embedded in Asian parenting. For example, other studies have identified four common subtypes of parenting styles, including authoritarian, authoritative, average-level undifferentiated, and strict-affectionate (Zhang et al., 2017). Results from this study may show where Baumrind's parenting styles lack in attempting to explain parenting styles within Asian families.

Understanding different communication patterns in different family types can offer many answers to questions raised about health communication within Vietnamese families. Do these families tend to have high levels of conversation orientation, where they have open communication about a wide variety of topics? Do these families tend to have high levels of conformity orientation, where family members are encouraged to think alike and behave similarly? Some families avoid discussing health topics, where communication between family members is far and few, and where families may be bound to an emphasis on obedience to "parental authority and by little concern for conceptual matters or for open communication within the family" (Koerner & Fitzpatrick, 2006). As familial values and a strong emphasis towards parental influence and authority corresponds to the protective style of communication, it is interesting to note that Cooper et al.'s study (1993) found striking results, finding that Mexican, Chinese, Vietnamese, and Filipino adolescents tended to endorse strong parental influence whenever making decisions, along with strong hierarchical patterns of communications (Cooper et al., 1993).

Patterns of acculturation may also heavily contribute to communications, as Vietnamese immigrants in the United States face language and cultural barriers as they assimilate into U.S culture. Researchers have acknowledged the potential of immigrant families acculturating at different rates, finding that "family cohesion and satisfaction were predicted by gaps in Vietnamese identity acculturation" (Ho & Birman, 2010). Certain Vietnamese parents acculturate quickly, being able to pick up English quickly and immerse themselves with U.S culture and norms, whereas other Vietnamese parents struggle with the language barrier and cultural differences. The varying levels of acculturation can function as a gage to predict how each family communicates in the U.S. and finding ways to facilitate communication can be

useful for future immigrant families. Therefore, I present the following research question and hypotheses.

*RQ1: How do family parenting styles affect communication satisfaction within the Vietnamese American family?*

H1: *Authoritative* parenting style will be positively related with communication satisfaction within the Vietnamese American family

H2: *Authoritarian* parenting style will be negatively related with communication satisfaction within the Vietnamese American family

H3: *Permissive* parenting style will be negatively related with communication satisfaction within the Vietnamese American family

H4: Conversation orientation will be positively correlated with communication satisfaction within the Vietnamese American family

H5: Conformity orientation will be negatively correlated with communication satisfaction within the Vietnamese American family

**Health Communication**

Health communication is vital for maintaining one's health, including patient-provider, interpersonal, and family health communication (which can encompass moral support, discussion of symptoms, and decision-making) (Thompson et al., 2011). This can also involve short-term communication such as patient satisfaction, acquisition of health information, and confirmation of recommended treatments, to long-term communication, which can include symptom reduction and improved quality of life, cure, or survival rates (Beckman et al., 1989). The study of health communication, for many, is considered one of the most important contexts of communication because the outcomes of communication are viewed with such significance and relevance in

daily life. Politi and Street (2011) bring light to the importance of health communication, highlighting aspects such as collaborative decision-making and arguing that quality medical decision-making involves clinicians and patients working together to gather the best clinical evidence and respect to the patient's values and preferences. Building a mutually agreed upon treatment plan is complex but attainable when clear expectations are proposed, values and concerns are respected, and a mutually acceptable follow-up plan is created during the health journey. This may be one small portion of the vast world of health communication, but issues can arise when seemingly small aspects of health communication go awry.

Poor health communication can negatively affect outcomes, leading to increased health care costs, negative relational outcomes, and even death. For example, Tiwary and colleagues (2019) explored two case studies examining the implications of poor health communication. One case showed a 50-year-old woman being admitted into the emergency room due to joint pains and was prescribed 15 mg methotrexate weekly and 5 mg folic acid twice weekly. The rheumatologist and pharmacist handling this woman's medication, however, failed to stress the importance of taking the methotrexate weekly and not daily, resulting in the woman consuming 15 mg methotrexate daily for 11 days, causing multiple episodes of vomiting and oral ulcers. Another case study presented a 40-year-old man that was prescribed anti-tubercular-therapy (ATT) and prednisolone for his ileo-cacal tuberculosis. The patient failed to take the ATT due to poor communication and was presented to the hospital with symptoms of disseminated tuberculosis, a more severe condition in which a tuberculosis infection has spread from the lungs to other parts of the body. Because of these individuals' worsened conditions, the number of physicians' visits, medication, and tests ran contributed to increased medical bills and lack of trust in healthcare providers. These case studies show how paramount improvement of

communication between practitioner and patient is so that life-threatening complications like these can be avoided in the future.

Studies that explore health literacy within Asian American populations are scarce, especially for Vietnamese Americans. Existing literature, however, shows that low health literacy was significantly associated with poor self-reported health in Asian American/Pacific Islander communities (Sentell et al., 2011). This may be due to the obvious language barriers, lack of health education opportunities, and cultural differences that may impair health communication, such as stigma.

*Stigma*

The word ‘stigma’ originated from the Greeks, who utilized the term to refer to “bodily signs designed to expose something unusual and bad about the moral status of the signifier” (Goffman, 1986). These signs were marked upon the body to show that the bearer of the mark was a slave, traitor, or criminal, largely shamed in society. The inclination to judge and discriminate has long been discussed by evolutionists, with findings showing that humans possess a “need of evaluation of other creatures around us” (Jacobsson, 2002). Plenty of research sought out to identify different factors that evoke negative emotions and reactions towards those who are socially deviant, exploring the implications on those outcast and the society responsible.

The Vietnamese word equivalent to ‘stigma’ has two terms with two different levels of meaning: ‘dấu sỉ nhục’, which means ‘mark of dishonor’ in a physical sense and ‘kỳ thị xã hội’, which means ‘social stigma’. Kỳ thị, specifically, translates to ‘stigma’ in a sense that it’s a strange and unnatural thing. Many Asian cultures struggle with the stigma of disclosing certain aspects of health as they value avoiding deviation from the norm, emotional self-control, and familial recognition through achievement (www.uniteforsight.org, 2019), opening grounds for unchecked underlying health issues that cause serious health implications in the future. many

cultures. Because of this, conditions such as mental illnesses are often "stigmatized and seen as a source of shame" (www.uniteforsight.org, 2019). The inclination to keep one's health conflicts to oneself due to stigma poses potentially grave consequences if the illness isn't treated.

Similarly, saving face, and fearing shame have prevented Asian Americans from seeking mental healthcare (Kramer et al., 2002). Many researchers have dived into exploring this finding, utilizing discussions with specifically Vietnamese immigrants in the United States and health care practitioners; signs also point to stigma as a culprit of impeding on seeking care (Do et al., 2014). In this study, Vietnamese participants agreed that mental illness was a departure from the norm, utilizing words such as "crazy" and "weird" to describe individuals with mental illness and applied a "normal people like us VS. them" attitude. Because very little has been researched on other issues surrounding mental illness stigma, researchers suggested opportunities for future research, including diving deeper into understanding the cultural significance stigma has on Vietnamese populations, how they may vary between generations, and short and long-term impacts (Do et al., 2014).

Along with mental health stigma, sexual health is also heavily stigmatized within Asian cultures, bearing a vast number of consequences, including the lack of seeking female reproductive health, STIs as a result of little to no sexual education, and life-threatening diseases. For example, the stigmatization of sexual health has been attributed to the lack of HIV education in Vietnam with scientists speculating this as a factor of the rising HIV cases in the country (Kaljee et al., 2007). Although it has been found that sexual health is a source of stigma in these communities, more research is needed to gain more insight into this phenomenon.

As mentioned before, challenges in health communication can pose a myriad of consequences in the healthcare industry. There are many studies that explore the consequences to

make educated suggestions for future healthcare practices. For example, Shea and Yeh (2008) found that "lower adherence to Asian values, lower levels of stigma, and higher relational-interdependent self-construal were associated with more positive help-seeking attitudes", which is promising to future applications of Asian health communication education. Conversely, another study found that factors such as cultural barriers and stigma attached to mental health problems are common factors that contribute to low mental-health-seeking behaviors in Asian American students (Han & Pong, 2015). With these findings, health professionals can formulate ways to aid in alleviating pressures that come with adherence to Asian values and stigma, along with fostering self-interdependence to promote more help-seeking attitudes. Understanding these potential implications is crucial to promoting good health practices because ineffective health communication can open grounds for low health literacy, increased risk of injuries, poor health practices, and even decreased use of health resources that are readily made available to the public (Vahabi, 2007).

Scientists and public health officials alike recognize the need to push for de-stigmatization of certain health topics in Asian communities and increase discussion about said topics. In Nepal, campaigns have been pushed to manage menstrual stigma and research has examined different coping strategies from Nepali women who have dealt with this age-old stigma (Crawford et al., 2013). The Pilot Project Tam An (inner peace in Vietnamese) has also been implemented to raise mental health awareness by engaging community resources in the Vietnamese population, with its goal to destigmatize mental health and promote accessing mental health treatment (Han et al., 2015). Other interventions included employing advisory communities that suggested measures to reduce stigma within families that had experience with

mental health, highlighting an effective way healthcare providers can aid families in managing stigma (Gaudine et al., 2009).

Exploring different studies that address different aspects of Vietnamese communication reveals different communications styles and experiences that foster different outcomes within the family. Each breakthrough allows us to further synthesize different interventions to improve health communication within Vietnamese families. Existing research is rich in defining stigma in various health communication situations, including mental health, for Vietnamese immigrants but lacks in areas such as sexual health, other stigmatized health topics, and in discussing the direct implications of non-communication due to Vietnamese culture. It is important to further examine Vietnamese American culture and the direct implications of non-health-communication. Therefore, the second research question and related hypotheses are presented:

*RQ2: How do family parenting styles affect Vietnamese Americans' willingness to communicate about health topics?*

H6: A*uthoritative* parenting style will be positively related with willingness to communicate about health topics

H7: *Authoritarian* parenting style will be negatively related with willingness to communicate about health topics

H8: *Permissive* parenting style will be negatively related with willingness to communicate about health topics

**Vietnamese Americans and Politics**

Political communication is a powerful mode of disseminating information, consisting of leaders, media, and citizens utilizing language and symbols to exert effects on political cognitions, behaviors, and public policy of a community (Perloff, 2018, p. 30). Vietnamese

American political communication is multi-faceted and complex as it factors in history, foreign policy, cultural values, and so much more. The differences in political communication between Vietnamese American immigrants and their children should be explored as U.S politics continues to evolve along with changes in the way politics is communicated in the U.S.

The Vietnam War was a tragic war that killed hundreds of thousands of civilians and more than 58,000 Americans from the early 1960s until the fall of Saigon in 1975 (Perloff, 2018, p.223). The media coverage of this war played a crucial part in the public's perception of the war; early coverage painted American soldiers as "brave men" and "the greatest soldiers in the world", but as independent journalists began viewing the battles more negatively, news media coverage began painting the war more critically as skepticism and negativity made their way into the minds of the American people. Because of the growing accessibility of news, including daily coverage of carnage, the once positively-painted war turned into a source of American public outrage (Perloff, 2018, p.223).

Despite Americans' negative sentiments of the U.S. involvement in Vietnam War, Vietnamese immigrants tend to be pro-U.S involvement and strongly anti-communist as most were refugees from a Communist government (Ling & Andrew, 2010, p. 576). It has been noted that Vietnamese differ from other Asian immigrant groups in the area of homeland political involvement; the Viet-Am community has often organized protests against political causes such as U.S. normalization of relationships with Vietnam in the 1990s, flying the national flag of Vietnam (most Vietnamese Americans insist on flying the South Vietnamese flag), and most recently, claims of election fraud in the 2020 presidential elections (Ling & Andrew, 2010, p. 576; Vera, 2021).

It shouldn't come as a surprise when data shows that Vietnamese American immigrants tend to be conservative in U.S. politics, drawing from anti-communist sentiments, Catholicism, and other various Republican values (Ling & Andrew, 2010). According to Linda Vo, a professor of Asian American studies at UC Irvine, the attitudes of anti-communism and anti-China weighs heavily on the minds of Vietnamese American immigrants due to the perception that the GOP is socially conservative and anti-communist, which aligns more with this group's values (Nguyen, 2020). However, this phenomenon is not as prominently reflected within U.S.-born or raised children due to little to no experience of what their parents experienced by fleeing from the homeland. Nguyen (2020) highlights the growing phenomenon of Vietnamese children actively feuding with their conservative parents, citing that while most of the U.S. born children have perceived Trump's coronavirus rhetoric to be racist, older Vietnamese Americans have been parroting phrases such as "Chinese virus" or "kung-flu" with enthusiasm.

The history of anti-China sentiment is woven into Vietnamese culture, spanning 1,000 years due to Chinese domination and threat to Vietnamese existence, according to Anh Thu Bui, a member of the Progressive Vietnamese American Organization (PIVOT) (Nguyen, 2020). This context, coupled with language barriers with older immigrants, leaves this population susceptible to misinformation and feeding into their own personal biases. Nguyen (2020) calls attention to a common phenomenon amongst Vietnamese users, citing talking points that claim "that the mainstream media perpetuates 'fake news', that the Democrats are weak or in cahoots with China, [and] that American universities (with money from China) are brainwashing their children". There have been reports of Vietnamese protestors who call for integrity in the election that their votes were stolen, "parroting Trump's false claims about widespread election fraud" (Vera, 2021). In most recent events, several Vietnamese American immigrants attended a rally

on October 9th, 2021 for former president Donald Trump, rallying to "take America back" and calling supporters to send a "message to the radical left a message they won't forget" (Coltrain et al., 2021). Some even revealed that they legally changed their family name from 'Tran' to 'Trump', stating that "when you have a king that really works hard, the people take over his last name" (Coltrain et al., 2021). These radical beliefs and claims made by Vietnamese American immigrant parents oftentimes clash with their U.S.-born children, who have access to higher English and technological literacy.

Given today's political climate and the boom of social media, many have flocked towards social media as a common means of political communication. Users have gravitated to technological tools such as TVs, laptops, and mobile phones in order to engage with political content, which has become a routine for many citizens during important political events and issues (bu.edu, 2018). The rise of technology allows the common user to easily access information quickly and efficiently, all with a simple touch of a button. Other studies have shown that both blog and SNS use is positively linked to political participation (Kim & Chen, 2016). This includes both Vietnamese American immigrant parents and their children. The difference, however, is both generations' varying levels of technological literacy.

Today's young adults grew up alongside the birth of the Internet, growing up with easily-accessible technology and political content. Generation Z, composed of individuals born after mid-to-late 90s, is diverse and on track to becoming the "most well-educated and is moving towards adulthood with a liberal set of attitudes and an openness to emerging social trends" (Graf et al., 2020). This, married with the use of social media, will contribute to a boom of a new social media culture of political participation. Political events such as the Black Lives Matter protests and the 2020 US presidential campaign are prominent online, so previous research

suggests that online political activities "strongly correlate to political awareness and offline political participation" (Ahmad et al., 2019). U.S-born Vietnamese Americans generally have more liberal sets of attitudes, which radically differ from their parents' conservative views. Nguyen (2020) recounts her own older family members and individuals online fearing the threat of anarchy during the Black Lives Matter protests, often playing into anti-Black tropes because of digesting misinformation online. As the younger generation is more literate in English and technology, along with having the inclination to participate politically, this can cause friction within the family as both generations become discordant in political views, sharing different values and political opinions. A concordant family, in this study, is when both Vietnamese American children and their immigrant parents share similar political views whereas discordant families hold polarizing political values between the two generations. Studying the varying political affiliations and levels of concordance is an important part of understanding family dynamics and the many implications of political concordance and discordance.

Very little literature has been found about inter-familial relationships when conflicts like this are present within the family, including the implications of living in a conflicting environment for both parent and child. Finding more insight into this phenomenon can allow grounds for education, improved communication, and better relationships within the Vietnamese American family. Therefore, the third research question and related hypothesis is presented:

*RQ3: How does political affiliation affect communication satisfaction within the Vietnamese American family?*

H9: Individuals from families with different political affiliations have lower satisfaction with communication than individuals from families with similar political affiliations

# Methods

## Participants

A total of 1738 participants began the survey. Of these, 155 were ineligible due to age (under 18) and their responses terminated. Because 100% survey completion was needed for the study's integrity, listwise deletion was used for the 712 incomplete surveys, leaving a final sample of 869 Vietnamese Americans between 18 and 36 years old from across the United States. The 869 participants each reported their age range, and 863 reported their exact age ($M$ = 24.34, $SD$ = 5.119). All eligible participants had Vietnamese American immigrant parents, were fluent in English, and lived in the United States. Participants predominantly self-identified as female (n=689), 151 males, and 25 genderqueer/gender nonbinary, 2 trans females, 2 trans males. The largest number of participants graduated with a Bachelor's degree (n=329), followed by having attended some college (n=237), obtaining a Master's degrees or higher (n=145), 102 have earned a high school diploma or GED equivalent, 40 received Associate's degrees, 10 completed some high school, 6 attended trade school, For participants' health insurance status, most were insured through their parents (n=411), 375 were insured on their own insurance, 27 were insured on another individual's insurance, 44 were not insured, and 12 answered 'other'. The majority of participants (n=849) were from the United States and a small number currently living in other countries (n=20). See Table 1.

## Procedures

Ethics approval (#2021-0662) was obtained before recruiting participants. This study utilized purposive sampling (e.g., Crews et al., 2019). Vietnamese Americans that had Vietnamese immigrant parents were invited to participate. The study was advertised through emails sent to admins of Vietnamese American Facebook groups, direct-messages to Vietnamese

Student Association Instagram accounts and various prominent Vietnamese American figures, and social media posts. Participants were self-selected and had an opportunity to enter into a drawing for one of five $10 Starbucks gift cards. All participants remained anonymous.

The survey was administered using QuestionPro (https://www.questionpro.com/). To begin, all participants were given information on the study and the opportunity to voluntarily agree to participation. Respondents filled out the demographics questionnaire and proceeded to answer questions based on their experiences as Vietnamese Americans. For more details on exact survey questions, see Appendix A.

## Measures

Participants completed several measures on the following constructs: parenting styles, family communication, communication satisfaction, willingness to communicate about health (including sexual and mental health) and politics, and parent-child political affiliation concordance.

### *Independent Variables*

The Parenting Styles and Dimensions Questionnaire (Robinson et al., 2001) was utilized to measure how respondents perceived their parents' parenting styles. The questionnaire consists of 36 Likert scale questions, with three subscales: authoritative, authoritarian, and permissive. The participants indicated their level of agreement with statements on a 5-point scale ranging from 1 (strongly disagree) to 5 (strongly agree). Higher scores indicated greater perceptions of the specific type of parenting style. Sample items included: "My parents would tell me they were proud of me every time I accomplished something" (authoritative), "My parents would scold or criticize me when I didn't meet their expectations" (authoritarian), and "My parents seemed unsure about how to solve my misbehavior" (permissive). Subscale reliabilities using

Chronbach's Alpha for the authoritative (α= .88), authoritarian (α= .90), and permissive (α= .71) were acceptable.

*Dependent Variables*

The Communication Satisfaction Questionnaire (Downs et al., 2007), a 10-item scale, was used to measure the participants' communication satisfaction between them and their parents, also utilizing Likert scale questions on a 5-point scale. Higher scores indicated greater communication satisfaction between participants and their parents. Sample items included "I am able to voice my opinion and hold discussions with my parents", "My parents communicate clear expectations for me", and "My parents often check in about my well-being in the family." Reliability for the full scale (α= .88) was acceptable.

The 12-item Willingness to Communicate Measure (Wright et al., 2007) was used to measure subjects' willingness to communicate about health information to family members, healthcare providers, individuals outside the family, and to participate in health maintenance. A sample item was: "I am comfortable talking about my health with my family members.". The same questions were utilized to focus on sexual health (12 items), mental health (12 items), and politics for participants (7 items) as well, with all being measured on a 5-point Likert scale. Some sample items were: "I am comfortable talking about my sexual health with my healthcare providers" and "I am a competent communicator when it comes to speaking to physicians about my mental health issues.". Higher scores indicated greater willingness to communicate about health information. Three items were reverse coded due to the negative wording of some questions. Reliability for the general willingness to communicate about health scale (α= .70) was acceptable after one item was dropped due to it not loading. Reliability for the willingness to communicate about sexual health scale (α= .67) was fair after one item was dropped due to it not

loading. Reliability for the willingness to communicate about mental health scale (α= .69) was fair after one item was dropped due to it not loading. Reliability for the willingness to communicate about politics scale (α= .61) was fair after one item was dropped due to it not loading. When it came to the willingness to actively participate in health maintenance, participants were more likely to be proactive in seeking out health information for themselves (M = 3.86, SD = 1.02) while remaining neutral when asked about their promptness to schedule health appointments (M = 2.90, SD = 1.25). Within the context of sexual health, participants were more likely to be proactive in seeking out sexual health information for themselves (M = 3.94, SD = .99) while remaining neutral when asked about their promptness to schedule sexual health appointments (M = 3.19, SD = 1.24). Within the context of mental health, participants were more likely to be proactive in seeking out mental health information for themselves (M = 3.85, SD = 1.04) while remaining neutral when asked about their promptness to schedule sexual health appointments (M = 2.89, SD = 1.28). Participants showed an interest in these types of health information but there are gaps between seeking this health information and taking action in getting an appointment. Some culprits that might explain the gap between the two involve perceptions of necessity, availability, and desirability of seeking out medical care (Taber et al., 2014). Traditional barriers in Taber and colleagues' study also included lack of health insurance and time constraints, along with fear of unfavorable evaluations from healthcare practitioners. In the context of political communication, respondents were more likely to take an active role in seeking out political information (M = 3.74, SD = 1.06).

The 15-item Family Communication - Conversation measure (Ritchie & Fitzpatrick (1990) measured respondents' varying levels of communications through statements in which they responded on a 5-point Likert scale based on their agreement. Higher scores indicated

higher levels of agreement towards the statement. A sample item was: “My parents encouraged me to challenge their ideas and beliefs.” Reliability for the full scale (α= .92) was acceptable.

The 24-item Family Communication - Conformity (Kranstuber Horstman et al., 2018) also prompted respondents to measure their agreements on a 5-point Likert scale when asked about their parents’ authority, control, values, and beliefs. A sample item was: “My parents become irritated with my views if they are different from their views.” Higher scores indicated higher levels of agreement towards the statement. Reliability for the full scale (α= .84) was acceptable.

Parent-Child Political Affiliation Concordance (PCPAC) rated participants’ own personal political affiliation and their parents’ political affiliation. Similar scores indicated the proximity of each generation’s political affiliation. Sample items included: “Rate your *personal* political affiliation (Very liberal, Liberal, Centrist, Conservative, Very conservative)”. Personal political affiliation leaned more liberal (M = 2.06, SD = .90) whereas parents’ political affiliation leaned more towards conservative (M = 3.73, SD = .94). Concordance was calculated by creating five separate variables, one if the parent and child were concordant with 5s (very conservative), one at 4s (conservative), one at 3s (centrist), one at 2s (liberal), and one at 1s (very liberal). A full concordance variable, valued at 1, was also created with the 121 pairs that were concordant at any number/political affiliation (1-5).

## Results

### Descriptive Statistics

SPSS version 27.0 was used for all statistical analyses. Before running the statistical models to test the hypotheses, the relationships between potential control variables and the

dependent variables were tested. Descriptive statistics and correlations for all variables appear in Table 2. I found significant correlations between authoritative parenting style and age ($r(869) = -.18$, $p < .001$); authoritarian parenting style and age ($r(869) = .11$, $p < .05$); permissive parenting style and age ($r(869) = -.07$, $p < .05$); willingness to communicate about health in general and age ($r(869) = .13$, $p < .001$); willingness to communicate about sexual health and age ($r(869) = .17$, $p < .001$); willingness to communicate about mental health and age ($r(869) = .13$, $p < .001$); and family communication (conversation) and age ($r(869) = -.12$, $p < .05$). The variables met the assumptions for the statistical tests ran in this study, as this study was purposive in nature and targeted based on known demographics.

I found significant correlations between authoritative parenting and education ($r(869) = -.08$, $p = .02$); permissive parenting style and education ($r(869) = -.08$, $p = .02$); willingness to communicate about health in general and education ($r(869) = .18$, $p < .001$); willingness to communicate about sexual health and education ($r(869) = .17$, $p < .001$); willingness to communicate about mental health and education ($r(869) = .16$, $p < .001$); and willingness to communicate about politics and education ($r(869) = .09$, $p < .01$).

I did not find significant correlations between gender and the dependent variables (authoritative, authoritarian, and permissive parenting, as well as communication satisfaction, willingness to communicate about politics, general, sexual, and mental health.)

I found significant correlations between authoritative parenting and health insurance ($r(869) = -.17$, $p = < .001$); authoritarian parenting and health insurance ($r(869) = .10$, $p = < .01$); communication satisfaction and health insurance ($r(869) = -.12$, $p < .001$); willingness to communicate about sexual health and health insurance ($r(869) = .07$, $p < .05$); and family communication (conversation) and health insurance ($r(869) = -.14$, $p < .001$).

## Hypotheses 1-3

The first three hypotheses examined the relationships between *authoritative* parenting style, *authoritarian* parenting style, and *permissive* parenting style with communication satisfaction. To test each hypothesis, I ran a stepwise regression model. Due to significant relationships with the other variables, age bracket, education level, and health insurance status were added to the model with *authoritative* parenting style; age bracket and health insurance status were added to the model with *authoritarian* parenting style; age bracket and education were added to the model with *permissive* parenting style; health insurance status to all models with communication satisfaction.

### *Hypothesis 1*

The first hypothesis predicted a positive relationship between *authoritative* parenting style and communication satisfaction. Age bracket, education level, and health insurance status were added to the model as controls. The model was significant, (adjusted $R^2 = .57$, $F(5, 863) = 228.07$, $p < .001$). *Authoritative* parenting style and age bracket were significant predictors. See Table 3 for predictor statistics.

### *Hypothesis 2*

The second hypothesis predicted a negative relationship between *authoritarian* parenting style and communication satisfaction. Age bracket and health insurance status were added to the model as controls. The model was significant, (adjusted $R^2 = .26$, $F(5, 863) = 60.75$, $p < .001$). *Authoritarian* parenting style and health insurance status were significant predictors. See Table 3 for predictor statistics.

### *Hypothesis 3*

The third hypothesis predicted a negative relationship between *permissive* parenting style and communication satisfaction. Age bracket, education level, and health insurance status were added to the model as controls. The model was significant, (adjusted $R^2 = .02$, $F(5, 863) = 4.22$, $p < .01$). *Permissive* parenting style and health insurance status were significant predictors. See Table 3 for predictor statistics.

### Hypotheses 4-5

The next two hypotheses examined the relationships between conversation orientation and communication satisfaction (H4) and conformity orientation and communication satisfaction (H5). Both hypotheses were supported: conversation orientation was positively correlated with communication satisfaction ($r(869) = .79$, $p < .001$; conformity orientation was negatively correlated with communication satisfaction ($r(869) = -.28$, $p < .001$).

### Hypotheses 6-8

The next three hypotheses examined the relationships between *authoritative* parenting style, *authoritarian* parenting style, and *permissive* parenting style with willingness to communicate about health topics. To test each hypothesis, I ran a stepwise regression model. Due to significant relationships with the other variables, age bracket, education level, and health insurance status were added to the model with *authoritative* parenting style; age bracket and health insurance status were added to the model with *authoritarian* parenting style; age bracket and education were added to the model with *permissive* parenting style; age bracket and education were added to all models with willingness to communicate about health topics.

### *Hypothesis 6*

The sixth hypothesis predicted a positive relationship between *authoritative* parenting style and willingness to communicate about health topics. Age bracket, education level, and health insurance status were added to the model as controls. The model was significant, (adjusted $R^2 = .10$, $F(5, 863) = 19.36$, $p < .001$). *Authoritative* parenting style, education, and age were significant predictors. See Table 4 for predictor statistics.

### *Hypothesis 7*

The seventh hypothesis predicted a negative relationship between *authoritarian* parenting style and willingness to communicate about health topics. Age bracket and education were added to the model as controls. The model was significant, (adjusted $R^2 = .05$, $F(5, 863) = 9.03$, $p < .001$). *Authoritarian* parenting style and education were significant predictors. See Table 4 for predictor statistics.

### *Hypothesis 8*

The eighth hypothesis predicted a negative relationship between *permissive* parenting style and willingness to communicate about health topics. Age bracket and education level were added to the model as controls. The model was significant, (adjusted $R^2 = .05$, $F(5, 863) = 8.80$). *Permissive* parenting style and education were significant predictors. See Table 4 for predictor statistics.

### Hypotheses 6-8- Additional Analyses

Several additional analyses were run to further probe the significant findings for hypotheses 6-8. Specifically, the additional analyses focused on willingness to communicate about health in two areas: sexual and mental health. Due to significant relationships with the other variables, age bracket and education were added to all models, and health insurance status

was added to the models including the variables of *authoritative* parenting style*, authoritarian* parenting style, and willingness to communicate about sexual health.

***Hypothesis 6 – Additional Analyses***

A model tested the relationship between *authoritative* parenting style and willingness to communicate about sexual health, with age bracket, education level, and health insurance status added to the model as controls. The model was significant, (adjusted $R^2 = .05$, $F(5, 863) = 9.85$ $p < .001$). *Authoritative* parenting style, age, and education were significant predictors. See Table 5 for predictor statistics.

A model tested the relationship between *authoritative* parenting style and willingness to communicate about mental health, with age bracket, education level, and health insurance status added to the model as controls. The model was significant, (adjusted $R^2 = .05$, $F(5, 863 = 10.59$, $p < .001$). *Authoritative* parenting style, age, and education were significant predictors. See Table 6 for predictor statistics.

***Hypothesis 7 – Additional Analyses***

A model tested the relationship between *authoritarian* parenting style and willingness to communicate about sexual health, with age bracket, education level, and health insurance status added to the model as controls. The model was significant, (adjusted $R^2 = .04$, $F(5, 863) = 7.29$, $p < .001$). *Authoritarian* parenting style, age, and education were significant predictors. See Table 5 for predictor statistics.

A model tested the relationship between *authoritarian* parenting style and willingness to communicate about mental health, with age bracket, education level, and health insurance status added to the model as controls. The model was significant, (adjusted $R^2 = .03$, $F(5, 863) = 6.06$,

$p < .001$). *Authoritarian* parenting style, education, and age were significant predictors. See Table 6 for predictor statistics.

***Hypothesis 8 – Additional Analyses***

A model tested the relationship between *permissive* parenting style and willingness to communicate about sexual health, with age bracket, education level, and health insurance status added to the model as controls. The model was significant, (adjusted $R^2 = .04$, $F(5, 863) = 7.25$, $p < .001$). *Permissive* parenting style, age, and education were significant predictors. See Table 5 for predictor statistics.

A model tested the relationship between *permissive* parenting style and willingness to communicate about mental health, with age bracket and education level added to the model as controls. The model was significant, (adjusted $R^2 = .03$, $F(5, 863) = 5.28$, $p < .001$). *Permissive* parenting style and education were significant predictors. See Table 6 for predictor statistics.

**Hypothesis 9**

The last hypothesis examined the relationships between political affiliation and communication satisfaction in one's family. It predicted that individuals from families with different political affiliations have lower satisfaction with communication than individuals from families with similar political affiliations. An independent-samples t-test was conducted to compare parent-child political affiliation concordance between concordant families and discordant families. There was a significant difference in communication satisfaction for concordant families (M=3.23, SD=.86) and discordant families (M2.81, SD=.80) conditions; t (867)=5.28, $p < .001$. These results suggest that individuals from families with discordant political affiliations have lower communication satisfaction than individuals from families with concordant political affiliations. See Table 7 for t-test results and Table 8 for frequencies.

### *Hypothesis 9 – Additional Analyses*

Three models also tested the relationship between three parenting styles and willingness to communicate about politics. The first model tested the relationship between *authoritative* parenting style and willingness to communicate about politics, with education level added to the model as a control. The model was significant (adjusted $R^2 = .04$, $F(2, 866) = 16.85$, $p < .001$). *Authoritative* parenting style and education were significant predictors. See Table 9 for predictor statistics.

The second model tested the relationship between *authoritarian* parenting style and willingness to communicate about politics, with education level added to the model as a control. The model was significant (adjusted $R^2 = .01$, $F(2, 866) = 4.44$, $p < .05$). *Authoritarian* parenting style and education were significant predictors. See Table 9 for predictor statistics.

The third model tested the relationship between *permissive* parenting style and willingness to communicate about politics, with education level added to the model as a control. The model was significant (adjusted $R^2 = .01$, $F(2, 866) = 4.40$ $p < .05$). *Permissive* parenting style and education were significant predictors. See Table 9 for predictor statistics.

## Discussion

Little research explores the different intergenerational communication styles in Vietnamese American communities, especially between immigrant parents and their U.S-born (or 1st generation) children. Therefore, this study contributes to this gap in literature.

### Interpretations

H1 examined the relationship between *authoritative* parenting styles and communication satisfaction, predicting a significant positive relationship. This hypothesis was supported. This finding was expected as previous research shows that authoritative parenting styles are

associated with more open communicative practices within families. In Givertz & Segrin's study (2012), parental behavior and young adult child self-identity were analyzed, and results found that family adaptability, family cohesion, and open family communication were all products of authoritative parenting and were positively associated with parents' and young adults' family satisfaction. Families' ability to maintain cohesion, open communication, and adaptability to challenges that threaten the harmony within the family leave less room for miscommunication and conflict. This, in return, can increase communication satisfaction. The variance for this model was high, which may not be as homogenous as one would've hoped. Age bracket also played as a significant predictor, which could be explained by the increased amount of experience and developmental stage in life, paving the way for more mature conversations with parents.

H2 examined the relationship between *authoritarian* parenting styles and communication satisfaction, predicting a significant negative relationship. This hypothesis was supported. Asian parenting can be perceived as authoritarian, as surface manifestations of Asian parenting can seem unyielding, cold, and non-democratic. Past studies examined the differences between European-American mothers and Chinese immigrant mothers' parenting styles, highlighting that Chinese-immigrant mothers expressed warmth and emphasis on interdependence and child obedience (while European-American mothers expressed more western values of individuality, open-expression, and respect) (Vu et al, 2018). There is a stark difference between Asian-American children experiencing Eastern culture of interdependence and child obedience and European-American children's experience of a more authoritative, individualistic, and openly expressed parenting style. Vietnamese American children could be forced in a position to compare their own upbringing with their non-immigrant families who may have a more

authoritative approach to raising children, therefore opening grounds for lower communication satisfaction.

There have been several insights into understanding authoritarian parenting styles and lower communication satisfaction within Vietnamese American communities. The recent concept of the *Tiger Mother* has been coined to describe mothers that utilize a strict parenting philosophy, oftentimes perceived as "non-democratic, brazen, and less affectionate toward their children" (Nguyen et al., 2014). This phenomenon can be attributed to Confucian-oriented values found in Asian cultures, especially Chinese and Vietnamese culture, where values are placed on strong worth ethic and high academic achievement to serve as tools on the route to self-improvement (Chao & Tseng, 2002). Confucianism's foundations are also rooted in ambitious standards, high directedness, and strict discipline (as opposed to warm signs of affection such as physical affection or praise). Along with Confucianism's values, the drive to survive economically and culturally in a new host country for Vietnamese immigrants can also push parents to work towards securing their children's future through means of hard work and academic achievement. Cultural values pertaining to maternal warmth can also be culprits to the archetype of tiger mothers, as Eastern mothers are encouraged to instill solemnity and self-control within their children and in the parental role as well (Wu, 1996). Due to this expectation, Eastern mothers are reluctant to express warmth openly or directly or express verbal positive comments and praise towards their children (Ho, 2010; Cheah & Li, 2010). The use of praise towards children is frowned upon because it is believed to threaten parental authority and fuel the child's pride; pride is thought to negatively influence the child's motivation for self-improvement, which negates the Confucian principles of personal achievement. These

perceptions lead to these mothers utilizing less praise, which in return, could paint a cold image of a tiger mother.

The variance for this model was not as big as authoritative parenting styles, which portrays a slightly more homogenous set of answers from participants. Health insurance status was also a significant predictor, which suggests that familial health plays a vital part in family satisfaction and strengthens previous studies' findings that familial interrelatedness of health affects family satisfaction and stress levels (Institute of Medicine, 2002).

H3 examined the relationship between *permissive* parenting styles and communication satisfaction, predicting a significant negative relationship. This hypothesis was supported, strengthening previous research that examined permissive parenting styles and family functionality. Matejevic et al. (2014) also found that permissive parenting styles were positively correlated with familial enmeshment, where boundaries and expectations were unclear and muddy; this gives way to children feeling suffocated due to the parents' excessive need for closeness and cohesion. This finding supported the characterization of permissive parenting, in which familial cohesion is high, but also follows with an extremely high level of flexibility (chaotic). This means that "togetherness is present but the roles and rules are either unclear or constantly change, which ultimately means lack of stability" (Matejevic et al., 2014). The chaotic nature of the parents' roles and rules can give a sense of instability and unreliability to the children, which in return can reduce communication satisfaction between parent and child. Variance in H3 was quite low, which shows the homogenous nature of participants' answers.

Family Communications Patterns Theory were explored in H4 and H5. They examined the relationship between family communication (conversation) and family communication (conformity) with communication satisfaction. These two hypotheses were supported;

conversation orientation was positively correlated with communication satisfaction and conformity orientation was negatively correlated with communication satisfaction. This confirms and extends previous research as a study done by Punyanunt-Carter (2008) explored college-aged daughters' reports of family communication styles and relationships with their fathers, particularly their communication satisfaction towards each other. Results showed that conversation orientation was associated with daughters' and fathers' communication satisfaction. Another study explored young adults in Japan and the United States' family communication patterns and conflict between young adults and their parents; results also found a strong positive correlation between conversation orientation and communication satisfaction for both countries, whereas conformity orientation showed a strong negative correlation between conformity orientation and communication satisfaction for Americans (Shearman & Dumlao, 2008). These studies have suggested that there is increased communication satisfaction where there is mutual understanding and reciprocity of communication and alternatively, little communication when there's high conformity, causing conflict or distance between families (Punyanunt-Carter, 2008).

H6 examined the relationship between *authoritative* parenting styles and willingness to communicate about health topics and was supported, confirming previous research that shows that "authoritative parenting is distinguished by reciprocity, mutual understanding, and flexibility" (Sorkhabi, 2005, p.559). This willingness to communicate health topics, therefore, comes from the mutual trust shared between the parent and child nurtured by this parenting style. Sorkhabi continues to explain that authoritative parents pursue goals by supporting autonomy (defined as opportunities that foster children's abilities to meet their obligations without parental control or assistance). Therefore, the child will be more likely to exercise proactivity in communicating many topics, including potential health topics. The R2 power within H6 is good

but not as strong as the other models tested before. Differences in perceptions in health could be a predictor as to why the regression model wasn't as strong; further studies should be encouraged to examine other factors such as cultural nuances that may affect willingness to communicate health. According to the data, education levels and age were also significant predictors, which could be attributed to the amount of education and experience earned through various levels of education and ages.

Additional analyses were conducted to explore the relationship between authoritative parenting styles and willingness to communicate health topics, specifically sexual and mental health. The model for sexual health was significant. *Authoritative* parenting style, age, and education were significant predictors. See Table 5 for predictor statistics. This comes to no surprise, as many studies have explored the relationship between authoritative parenting and health communication, especially sexual and mental health. One study viewed the influence of authoritative parenting style and mothers' perception of daughters' risk on communication about sex. Results showed that authoritative parenting styles was related to the number of topics communicated, pointing to the importance of parenting style in determining the appropriate time for parents to communicate to their children about sexual and other risk behaviors (Askelson et al, 2011). Keeping an open line of communication about sexual health topics between parent and child and engaging in age-appropriate conversations continually prove to be helpful in maintaining sexual health for the child. When visiting the topic of mental health, the model was significant. *Authoritative* parenting style, age, and education were significant predictors. See Table 6 for predictor statistics. This was also expected, as many studies exploring the authoritative parenting style in relation to communication about mental health have also found relationships. One study compared the effect of parenting style on self-concept, psychological

health, and quality of life of children with authoritative, permissive, and authoritarian parents. Results showed that there was a significant impact on parenting styles and mental health, showing that children raised with authoritative parenting styles had better mental health than children raised with authoritarian and permissive parenting styles (Niaraki, 2013). Improved mental health can allow children to be more open to discussing their personal struggles and possibly open the willingness to communicate about mental health.

H7 examined the relationship between *authoritarian* parenting styles and willingness to communicate about health topics, predicting a negative relationship between the two. This hypothesis was supported, confirming previous research showing that authoritarian parenting emphasizes orderliness and structure, obedience without discussion or reason, and close surveillance of a child's behavior, commonly used in highly restrictive parents (Givertz & Segrin, 2014). Because of this, children may not be able to establish bonds of trust with their parents and can hide their different health issues or concerns in fear of potential repercussions from their restrictive parents. This could further stem into health issues such as sexual health (discussing reproductive health, risk for STIs, unwanted pregnancies, etc.) or even mental health (struggles with depression, schoolwork, family history of mental illnesses, etc.). The variance in this model is low, which is desirable in this study as it indicates homogeniety within participants' responses.

Additional analyses were conducted to explore authoritarian parenting styles and willingness to communicate about sexual and mental health. The sexual health model was significant, showing a negative correlation between willingness to communicate sexual health and *authoritarian* parenting style. *Authoritarian* parenting style, age, and education were significant predictors. This was expected, as several studies have explored the relationships

between the parenting styles and willingness to communicate in general. According to Hoskins (2014), authoritarian parents "exhibit low levels of trust and engagement in their child, discourage open communication, and engage in strict control". When viewing this with a sexual health lens, this may mean that authoritarian parents can exhibit low levels of trust in their children's romantic relationships, discourage open communication about sexual health, and engaging in strict control of curfew, friend groups, and other various hallmarks of being an adolescent. A study was conducted in which parenting practices and styles were explored in relation to sexual health in Tanzania, revealing that most parents exercised an authoritarian parenting style, putting the children at risk of becoming less forthcoming to their parents and engaging in constructive conversations about sexual health (Kajula et al., 2015). Parents were reported using mostly punitive measures to prevent sexual behavior, emphasizing the importance of abstinence coupled with parental supervision and surveillance of friendships. This, in return, puts adolescents more at risk as they fear punishment, limiting their options should they get pregnant, contract diseases, or encounter other issues regarding their sexual health and reducing the chances of accessing proper health interventions (Kjula et al., 2015). In the context of mental health having a negative correlation with authoritarian parenting, the model was significant. *Authoritarian* parenting style, education, and age were significant predictors. Examining mental health with Hoskin's findings of authoritarian parenting can also predict that authoritarian parents discourage open communication about their children's mental health. Milevsky and colleagues (2007) examined parenting styles in adolescents and their associations with self-esteem, depression, and life satisfaction, finding that adolescents from most Caucasian authoritarian families exhibit poor social skills, higher levels of depression, and low levels of self-esteem. This is quite indicative of the child's willingness to communicate about their own

mental health, given the unwelcome environment that their authoritarian parents have created for their children.

H8 examined the relationship between *permissive* parenting styles and willingness to communicate about health topics, predicting a negative relationship between the two. The model was significant. There seems to be a lack of research exploring the relationships between permissive parenting styles and willingness to communicate about health topics, but one can pull some inferences from existing data. Permissive parenting involves overindulgence and historically, is not associated with positive child outcomes (Baumrind, 1991). Further research has strengthened Baumrind's permissive parenting archetype, revealing that parents who practice lax or inconsistent parenting were more likely to have children who indulged in unsafe behaviors and were at risk of being subject to physical maltreatment (Rodriguez, 2010; Jinnah & Stoneman, 2016). This risk of maltreatment and inconsistent parenting may cause children to not trust their parents in regard to their health.

Additional analyses were conducted to explore the relationships between permissive parenting styles and willingness to communicate sexual and mental health topics. The sexual health model was significant. *Permissive* parenting style, age, and education were significant predictors. As mentioned before, permissive parenting fosters a chaotic environment for the child because of the fluidity of parental roles and rules, giving a sense of instability (Matejevic et al., 2014). Other researchers have also added that permissive parents behave in an affirmative manner towards the children's impulses, desires, and actions, which could lead children to not feel compelled to talk about topics such as mental or sexual health (Hoskins, 2014). Hoskins has explored the implications of permissive parenting styles and found that adolescents from permissive families report a higher frequency of substance use, less engagement in school, and

school misconduct due to low self-esteem and lack of behavioral control. Using these findings and viewing them with the interest of sexual health in mind, adolescents may act in risky sexual behavior from lack of sexual health communication. In the context of mental health, the model was significant. *Permissive* parenting style and education were significant predictors.

Parent-child political affiliation concordance (PCPAC), was also examined. H9 predicted that parents and children with concordant political affiliation would have higher levels of communication satisfaction that discordant parent and child political affiliations. This hypothesis was supported. This comes to no surprise, as several studies uncovered that the growing U.S political polarization attributed to strained family ties (Chen & Rohla, 2018). One study, conducted by Chen & Rohla (2018), viewed Thanksgiving dinners attended by residents from opposing-party precincts, citing the fact that the dinner parties were 30-50 minutes shorter than same party dinners. Nationwide, it was found that "34 million hours of cross-partisan Thanksgiving dinner discourse were lost in 2016 owing to partisan effects" (Chen & Rohla, 2018). Communication satisfaction suffered for discordant Vietnamese-American families, as conflicting views began to cause alarm, confusion, and embarrassment during the January 6th, 2021 insurrection at the U.S capitol. According to Esguerra of Vice news, the yellow and red-striped flag South Vietnam was flown prominently during the 'Stop The Steal' rallies held outside the U.S capitol. Southeast Asian American social media users expressed their outrages online, calling shame to those supporting the former president's harmful rhetoric (Esguerra, 2021).

Further analyses examined how individuals from different parenting styles perceived their willingness to communicate about politics. The first model tested the relationship between *authoritative* parenting style and willingness to communicate about politics, with education level

added to the model as a control. The model was significant. *Authoritative* parenting style and education were significant predictors. This comes to no surprise, as previous research has explored the relationships between authoritative parenting and various aspects of political communication. Murray and Mulvaney (2012) examined parenting styles, socialization, the transmission of political ideologies, and partisanship, finding that parenting styles play an instrumental role in political ideology transmission. Specifically, authoritative parents find more success due to the nurturing environment that authoritative parents provide, allowing the child to gain autonomy in choosing their political preferences and build trust in creating constructive conversations (Murray & Mulvaney, 2012). Therefore, children may be more open to communicating about politics with their parents without overcoming many barriers.

The second model tested the relationship between *authoritarian* parenting style and willingness to communicate about politics, with education level added to the model as a control. Results were significant with a*uthoritarian* parenting style and education as significant predictors. Researchers have been fascinated with authoritarianism and politics for decades, particularly paying attention to the growing polarization of U.S politics. In an interview with Johnathan Wiler, a professor at the University of North Carolina, it was found that in 1992, Republicans and Democrats were not distinctively different in their parenting styles, but have increasingly grown more sorted out, with Democrats leaning towards less authoritarian political views whereas Republicans embraced the authoritarian political views (McBride, 2019). More authoritarian groups, Wiler suggests, are less tolerant of gay rights, minority groups, or any groups that may not fit into what a true "American" is to them, viewing the world as black or white and prefer simple and straightforward fixes to complex issues. The manner in which participants answered political questions strongly correlated with the way they answered

parenting questions. Because of the authoritarian nature of intolerance and open discussion, one could suggest that children of authoritarian parents may be less inclined to discuss politics due to difficulties in political conversations.

The third model tested the relationship between *permissive* parenting style and willingness to communicate about politics, with education level added to the model as a control. The model was significant. *Permissive* parenting style and education were significant predictors. There are very few studies that explore the relationship between permissive parenting styles and political communication, but existing research shows that permissive parenting exhibits the weakest role across all parenting styles when it comes to the exchange of political information between parent and child (Murray & Mulvaney, 2012). This could open the possibility of allowing the child little to no barriers to communicating political information and boosting the willingness to communicate political information or deter the child from communicating due to a less ideal situation for reciprocating political discourse. Further research should continue exploring implications of permissive parenting and willingness to communicate political information.

One may ask, where is this discordance coming from? From the surveys, personal respondents' political affiliation leaned more liberal (M = 2.06, SD = .90) whereas their parents' political affiliation leaned more towards conservative (M = 3.73, SD = .94). This was expected, as Vietnamese immigrants tend to be pro-American involvement and strongly anti-communist as most were refugees from a Communist government (Ling & Andrew, 2010, p. 576). This political preference not only draws from anti-communist sentiments, but also Catholicism, and other various Republican values (Ling & Andrew, 2010). However, this trend is not as

prominently reflected within U.S.-born or raised children due to little to no experience of what their parents experienced by fleeing from the homeland.

Another glaring factor that can explain the extreme polarization of political affiliation within Vietnamese American families is the exponential rise of misinformation, filled with false claims, half-baked conspiracy theories, and pseudoscientific theories (Naeem et al., 2020). For example, John Oliver recently brought light to the fact that Vietnamese Americans have such a lack of official news in Vietnamese to the point where man end up on YouTube watching extremely biased news channels that are notorious for sharing fake news. This causes rifts within Vietnamese American families as immigrant parents digest misinformation from biased Vietnamese content creators that hold a monopoly on the community's news sources, leaving children who are more fluent in English and digesting a broader range of news conflicted with their parents' viewpoints. Recognizing these shortcomings within the Vietnamese American community presents the dire need to apply public pressure on platforms to combat misinformation and increase interventions in maintaining the health of the family.

**Implications**

Findings from this study can offer insight into where the Vietnamese American population is lacking in terms of health, political, and familial communication. Public health officials should use these findings to feel a pulse on how this community is communicating about their health. Creating concrete health initiatives in both Vietnamese and English while targeting Vietnamese American-dense areas can be a first good step towards improved health communication. Implementing innovative ways to educate this community about important health topics such as sexual and mental health can reduce stigma and improve knowledge about these health issues. Since willingness to communicate about health may affect specific health-

related behaviors, like seeking health care from practitioners, it is important to understand how antecedents like family conversation patterns developed in childhood may affect one later in life. When looking in a political communication lens, findings from this study show the lowered communication satisfaction within discordant families, especially ones where Viet Am parents leaned more conservative while their children adopted liberal ideologies. This could be applied to other cultures that also have people fleeing from communist governments, including Cuban Americans.

Theoretically speaking, this study extends the application of established theories in a more contemporary context. Specifically, the findings of this study give insight into how Baumrind's parenting styles theory is challenged when studying Asian cultures and their family parenting styles. Baumrind's parenting styles theory offers a Westernized approach to viewing parenting styles and does not examine cultural nuances that remain rich in Vietnamese American culture (including themes of Confucianism, the Vietnamese diaspora experience, and the prominent collectivist values that weave through Vietnamese culture).

The large sample size allowed for more accurate means to be extracted, along with identifying outliers that could skew the data and provide smaller margins of error. This data also gives closer insights to the population of Vietnamese Americans, whereas previous studies largely focused on examining East Asian American communities, especially Chinese American populations. Tapping into a large sample of Vietnamese Americans allows us to get a more intimate look at the cultural nuances of this community's culture. Results in this study could also offer insight into other diasporic cultures in the United States, such as South Korean Americans.

**Limitations and Future Directions**

The reflective accounts of some of the survey questions are retrospective in nature, which could open grounds for skewed recounts by biases in memory. In future studies, introducing a longitudinal study with young children of Vietnamese American immigrant parents and following them throughout adulthood while administering surveys every couple of years would eliminate flawed recounts by lapses in memory. A repeat study in 20 years assessing different types of parenting styles again can prove to be beneficial as well, when children of immigrant parents grow up and start their own families.

Participants that answered the survey were overwhelmingly female, which can prevent the data from accurately reflecting the population. Gender roles are heavily enforced within Vietnamese culture, especially towards females (Nguyen et al., 2014). In return, females' experiences and social expectations may differ from males' experiences as Vietnamese Americans. Future studies should continue studying this population but should strive to include more male-identifying individuals as well.

Within the survey instrument, questions that pertained to the willingness to communicate were somewhat problematic, necessitating some items being dropped for poor loading scores. While some previous research indicates that items have had to be dropped in the past (Brannon & Rauscher, 2018), it is unknown which items are the problematic items throughout the literature. This phenomenon should continue to be examined, and future research should also investigate other potential measures.

There were also certain questions posed that expected answers based on childhood experiences while other questions expected answers based on present-day experiences. This caused a bit of confusion among participants and may have affected how they answered certain

questions. In future studies, introducing childhood-specific sections (as well as present-day related questions) could eliminate this confusion and allow respondents to answer questions to the best of their ability.

One of the glaring limitations of this study was the Western-centric lens that Baumrind's parenting styles, the framework for the parenting style questions within the survey instrument, which limits the many nuances of strict "tiger parenting" as mentioned in the discussion. On the surface, Vietnamese American children may answer questions about their family's parenting styles with the perception of restrictiveness and control, which may appear to be consistent with an authoritarian parenting style. Nguyen and colleagues (2014) dove deep in exploring the nuances of strict Vietnamese parenting and found that the motivations behind strictness and rule establishment came from concern for personal development within education and training (and rules for non-education were negotiable!). This can be explained through Confucian-collectivistic values of honor, reality of adjusting to a new host country, and the idea that high education is a means for financial security and social mobility. In this study, researchers' findings support the "growing concern which suggests that parenting styles under Baumrind's typology are inaccurate for cross-cultural populations" (Nguyen et al., 2014). Future research must consider creating new measures to effectively research Asian parenting styles, respecting cultural nuances commonly found in Eastern cultures. The uninvolved parenting archetype was also not explored in the study; only permissive parenting styles were examined. Future studies should explore permissive parenting and the implications that could pose for immigrant generations and their children.

Finally, as this study focused on children's perspectives, the voices and stories of immigrant Vietnamese American parents were not examined. Future studies should continue

exploring health and political communication among Vietnamese American immigrants, focusing on their communication satisfaction, recording communication challenges they experience, and offering interventions that future health officials can use for this understudied community.

This study uncovered a lot of findings from an understudied population, allowing opportunities to continue expanding in researching parenting styles and communication satisfaction among Vietnamese American generations.

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Table 1

*Demographics*

| Variable | Levels | # of Participants | % of Participants |
|---|---|---|---|
| Gender | Female | 689 | 79.3 |
| | Male | 151 | 17.4 |
| | Gender queer / Gender Nonbinary | 25 | 2.9 |
| | Trans female | 2 | .2 |
| | Trans male | 2 | .2 |
| Education | Some high school | 10 | 1.2 |
| | High school diploma/GED equivalent | 102 | 11.7 |
| | Some college | 237 | 27.3 |
| | Trade/vocational/technical | 6 | .7 |
| | Associate degree | 40 | 4.6 |
| | Bachelor's degree | 329 | 37.9 |
| | Master's degree or higher | 145 | 16.7 |
| Race/Ethnicity | Black | 0 | 0 |
| | White | 1 | .1 |
| | Hispanic | 0 | 0 |
| | Native American | 0 | 0 |
| | Asian | 844 | 97.1 |
| | Pacific Islander | 0 | 0 |
| | Other | 24 | 2.8 |
| Age | 18-24 | 472 | 54.3 |
| | 25-35 | 397 | 45.7 |
| Health Insurance | Insured (through parents) | 411 | 47.3 |
| | Insured (on own insurance) | 375 | 43.2 |
| | Insured (on someone else's insurance, not parents' or own) | 27 | 3.1 |
| | Not insured | 44 | 5.1 |
| | Other | 12 | 1.4 |

Table 2

*Descriptive Statistics and Intercorrelations*

| Variable | *M* | *SD* | Age | Edu | Gen | HIns | Authve | Authan | Perm | CS | WCHG | WCSH | WCMH | WCP | Conv | Conf |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Age | 2.46 | .50 | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| 2. Edu | 4.76 | 1.83 | .58*** | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| 3. Gen | 1.25 | .53 | -.01 | -.04 | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| 4. HIns | 1.70 | .86 | .50*** | .32*** | -.01 | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| 5. Authve | 2.50 | .73 | -.18*** | -.08* | .03 | -.17*** | -- | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| 6. Authan | 3.91 | .72 | .11** | .04 | .01 | .10** | -.60*** | -- | -- | -- | -- | -- | -- | -- | -- | -- |
| 7. Perm | 2.20 | .62 | -.07* | -.08* | .02 | .01 | .01 | -.06 | -- | -- | -- | -- | -- | -- | -- | -- |
| 8. CS | 2.87 | .82 | -.06 | .01 | .01 | -.12*** | .75*** | -.50*** | -.07* | -- | -- | -- | -- | -- | -- | -- |
| 9. WCHG | 3.32 | .59 | .13*** | .18*** | -.07 | .00 | .22*** | -.08* | -.10** | .30*** | -- | -- | -- | -- | -- | -- |
| 10. WCSH | 2.74 | .56 | .17*** | .17*** | -.06 | .07* | .09* | .00 | -.03 | .13*** | .56*** | -- | -- | -- | -- | -- |
| 11. WCMH | 3.01 | .60 | .13*** | .16*** | -.02 | .04 | .15*** | -.06 | -.03 | .21*** | .55*** | .51*** | -- | -- | -- | -- |
| 12. WCP | 3.12 | .75 | .03 | .09** | .06 | -.02 | .16*** | -.04 | -.05 | .21*** | .34*** | .24*** | .29*** | -- | -- | -- |
| 13. Conv | 2.25 | .80 | -.12** | -.04 | -.02 | -.14*** | .77*** | -.48*** | .00 | .79*** | .29*** | .14*** | .22*** | .30*** | -- | -- |
| 14. Conf | 3.73 | .44 | -.01 | -.03 | -.03 | .05 | -.31*** | .51*** | -.11** | -.28*** | -.04 | -.05 | -.08* | -.10** | -..29*** | -- |

*Note:* Age = age bracket; Edu = education; Gen = gender; HIns = health insurance status; Authve = authoritative parenting style; Authan = authoritarian parenting style; Perm = permissive parenting style; CS = communication satisfaction; WCHG = willingness to communicate general health; WCSH = willingness to communicate sexual health; WCMH = willingness to communicate mental health; WCP = willingness to communicate politics; Conv = conversation orientation; Conf = conformity orientation

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

Table 3

*Summary of Regression Analysis for H1, H2, H3*

Communication Satisfaction

| Variable | *B* | SE *B* | β | t |
|---|---|---|---|---|
| **Authoritative** | | | | |
| Age Bracket | .11 | .05 | .07* | 2.26 |
| Education | .02 | .01 | .05 | 1.64 |
| Health Insurance Status | -.04 | .03 | -.04 | -.68 |
| Authoritative | .85 | .03 | .76*** | 33.22 |
| **Authoritarian** | | | | |
| Age Bracket | .07 | .06 | .04 | 1.12 |
| Health Insurance Status | -.10 | .03 | -.10** | 4.68 |
| Authoritarian | -.16 | .06 | -.14** | -2.87 |
| **Permissive** | | | | |
| Age Bracket | -.08 | .08 | -.05 | -1.08 |
| Education | .03 | .02 | .07 | 1.71 |
| Health Insurance Status | -.12 | .04 | -.12** | -3.14 |
| Permissive | -.08 | .05 | -.07 | -2.02* |

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

Table 4

*Summary of Regression Analysis for H4, H5, H6*

Willingness to Communicate about Health Topics

| Variable | *B* | SE *B* | β | t |
|---|---|---|---|---|
| **Authoritative** | | | | |
| Age Bracket | .14 | .05 | .12** | 2.65 |
| Education | .05 | .01 | .15*** | 3.76 |
| Health Insurance Status | -.04 | .03 | -.06 | -1.65 |
| Authoritative | .20 | .03 | .25*** | 7.45 |
| **Authoritarian** | | | | |
| Age Bracket | .06 | .05 | .05 | 1.22 |
| Education | .05 | .01 | .15*** | 3.71 |
| Authoritarian | -.08 | .03 | -.09** | -2.75 |
| **Permissive** | | | | |
| Age Bracket | .04 | .05 | .03 | .84 |
| Education | .05 | .01 | .15*** | 3.68 |
| Permissive | -.08 | .02 | -.09* | -2.56 |

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

Table 5

*Summary of Additional Regression Analysis for Sexual Health Variable*

Willingness to Communicate about Sexual Health

| Variable | *B* | SE *B* | β | t |
|---|---|---|---|---|
| **Authoritative** | | | | |
| Age Bracket | .16 | .05 | .14** | 3.18 |
| Education | .03 | .01 | .10* | 2.41 |
| Gender | -.06 | .04 | -.06 | -1.72 |
| Health Insurance Status | -.01 | .03 | -.01 | -.36 |
| Authoritative | -.09 | .03 | .12*** | 3.54 |
| **Authoritarian** | | | | |
| Age Bracket | .14 | .05 | .13** | 2.80 |
| Education | .03 | .01 | .10* | 2.49 |
| Gender | -.06 | .04 | -.05 | -1.62 |
| Health Insurance Status | -.02 | .03 | -.03 | -.67 |
| Authoritarian | -.01 | .03 | -.02 | -.46 |
| **Permissive** | | | | |
| Age Bracket | .14 | .05 | .23** | 2.76 |
| Education | .03 | .01 | .10* | 2.50 |
| Gender | -.06 | .04 | -.05 | -1.62 |
| Health Insurance Status | -.02 | .03 | -.03 | -.68 |
| Permissive | -.01 | .03 | -.01 | -.18 |

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

Table 6

*Summary of Additional Regression Analysis for Mental Health Variable*

Willingness to Communicate about Mental Health

| Variable | *B* | SE *B* | β | t |
|---|---|---|---|---|
| **Authoritative** | | | | |
| Age Bracket | .13 | .05 | .11* | 2.39 |
| Education | .04 | .01 | .12** | 2.88 |
| Gender | -.02 | .04 | -.02 | -.65 |
| Health Insurance Status | -.02 | .03 | -.02 | -.61 |
| Authoritative | .14 | .03 | .17*** | 5.1 |
| **Authoritarian** | | | | |
| Age Bracket | .11 | .05 | .09 | 1.96 |
| Education | .04 | .01 | .12** | 2.95 |
| Gender | -.02 | .04 | -.02 | -.50 |
| Health Insurance Status | -.03 | .03 | -.04 | -.99 |
| Authoritarian | -.06 | .03 | -.07* | -2.01 |
| **Permissive** | | | | |
| Age Bracket | .10 | .05 | .08 | 1.77 |
| Education | .04 | .01 | .12** | 2.98 |
| Gender | -.02 | .04 | -.02 | -.50 |
| Health Insurance Status | -.03 | .03 | -.04 | -1.05 |
| Permissive | -.02 | .03 | -.02 | -.53 |

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

Table 7

*t-test Results Comparing Parent-Child Political Affiliation Concordance on Communication Satisfaction*

| PCPAC Concordant | N | Mean | SD | t | df | p |
|---|---|---|---|---|---|---|
| Yes | 121 | 3.23 | .86 | 5.28 | 867 | .000 |
| No | 748 | 2.81 | .80 | | | |

Table 8

*Frequencies of Parent-Child Political Affiliation Concordance by Child-Reported Political Affiliation*

| Political Affiliation | Number of Concordant Individuals |
|---|---|
| Very Conservative | 3 |
| Conservative | 18 |
| Centrist | 37 |
| Liberal | 59 |
| Very Liberal | 4 |

Table 9

*Summary of Additional Regression Analysis for Politics Variable*

Willingness to Communicate about Politics

| Variable | *B* | SE *B* | β | t |
|---|---|---|---|---|
| **Authoritative** | | | | |
| Age Bracket | .01 | .07 | .01 | .11 |
| Education | .05 | .02 | .11** | 2.69 |
| Gender | .09 | .05 | .06 | 1.90 |
| Health Insurance Status | -.02 | .03 | -.02 | -.60 |
| Authoritative | .17 | .04 | .17*** | 4.93 |
| **Authoritarian** | | | | |
| Age Bracket | -.02 | .07 | -.02 | -.34 |
| Education | .04 | .02 | .12** | 2.78 |
| Gender | .10 | .05 | .07* | 2.01 |
| Health Insurance Status | -.03 | .03 | -.04 | -1.01 |
| Authoritarian | -.04 | .04 | -.04 | -1.21 |
| **Permissive** | | | | |
| Age Bracket | -.04 | .07 | -.02 | -.51 |
| Education | .05 | .02 | .12** | 2.76 |
| Gender | .10 | .05 | .07* | 2.02 |
| Health Insurance Status | -.03 | .03 | -.04 | -.99 |
| Permissive | -.026 | .04 | -.05 | -1.32 |

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

Appendix A

Questionnaire

**Instructions:** Please indicate your agreement with the following statements:

Parenting styles- Adapted from PSDQ (Robinson et al., 2001) and Baumrind's Parenting Styles
*Measured on Likert scale, 1 being very unlikely → 5 being very likely

1. Authoritative items
    a. Factor 1: Warmth & Involvement
        i. When I was a child, my parents would express affection by hugging, kissing, and holding me.
        ii. My parents would tell me they were proud of me every time I accomplished something.
        iii. My parents would encourage me to talk about my troubles.
        iv. My parents would apologize to me whenever they make mistakes.
    b. Factor 2: Reasoning/Induction
        i. My parents would explain the consequences of my behavior.
        ii. My parents would tell me how they feel when I exhibited good/bad behavior.
        iii. My parents would talk it over with me when I exhibited bad behavior.
    c. Factor 3: Democratic Participation
        i. My parents would take my opinions into account when it came to family plans.
        ii. My parents would encourage me to express myself freely even when I disagreed with them.
        iii. I would be given opportunities to contribute to family rules.
    d. Factor 4: Good Natured/Easy-going
        i. My parents were generally easy-going and relaxed with me.
        ii. My parents show patience with me.
        iii. I can joke around with my parents.
        iv. My parents respect my opinions by encouraging me to express them.
2. Authoritarian items
    a. Verbal Hostility
        i. My parents would explode in anger towards me.
        ii. My parents would yell or shout whenever I would misbehave.
        iii. My parents oftentimes would disagree with me.
        iv. My parents oftentimes would argue with me.
    b. Corporal Punishment
        i. My parents would use physical punishment as discipline.
        ii. My parents would guide me through punishments more than reason.
    c. Non-Reasoning, Punitive
        i. My parents would punish me by taking privileges away from me with little to no reason.
        ii. My parents would use threats as punishments with little to no reason.

iii. My parents would use the phrase "Because I said so" instead of reasoning with me.

d. Directiveness
   i. My parents would tell me what to do.
   ii. My parents would demand me to do things.
   iii. My parents would scold or criticize me to make me improve.
   iv. My parents would scold or criticize me when I didn't meet their expectations.

3. Permissive items
   a. Lack of follow-through
      i. My parents would threaten to punish me but never followed through with it.
      ii. My parents would give in to me if I caused a commotion about something.
      iii. My parents would bribe me to bring about compliance.
   b. Ignoring misbehavior
      i. My parents would allow me to distract others.
      ii. My parents would allow me to annoy others.
      iii. My parents would ignore my misbehavior.
   c. Self-confidence
      i. My parents would find it hard to discipline me.
      ii. My parents were afraid that if they disciplined me, I would not like them anymore.
      iii. My parents seemed unsure about how to solve my misbehavior.

<u>Communication Satisfaction (COMMSAT)- Adapted from Downs et al., 2007</u>

*Measured on Likert scale, 1 being strongly disagree → 5 being strongly agree

1. My parents communicate clear expectations for me.
2. I know what my parents expect of me.
3. My parents keep me informed about family matters.
4. My parents value my opinion on family plans.
5. My parents often check in about my well-being in the family.
6. I am able to voice my opinion and hold discussions with my parents.
7. My parents are approachable.
8. My parents make an effort to understand my feelings and opinions.
9. My parents are open to initiating conversations.
10. My parents make an effort to show their appreciation for me.

<u>Parent-Child Political Affiliation Concordance (PCPAC)</u>

1. Rate your *personal* political affiliation:
   a.

| Very liberal | Liberal | Centrist | Conservative | Very conservative |
|---|---|---|---|---|

2. Rate your *parents'* political affiliation
   a.

| Very liberal | Liberal | Centrist | Conservative | Very conservative |
|---|---|---|---|---|

Willingness To Communicate About Health (WTCH)- Adapted from Wright et al. (2007)

*Measured on Likert scale, 1 being strongly disagree → 5 being strongly agree

1. Willingness to communicate health with family members
    a. We frequently talk about health issues within the family.
    b. I am comfortable talking about my health with my family members.
    c. I only disclose health issues to family when I need to.
2. Willingness to communicate health with healthcare providers
    a. I am comfortable talking about my health with my healthcare providers.
    b. I have difficulty communicating my health issues with my healthcare providers.
    c. I am a competent communicator when it comes to speaking to physicians about my health issues.
    d. I only disclose health issues to healthcare providers when I need to.
3. Willingness to communicate health with people outside the family
    a. I frequently talk about health issues with my friends.
    b. I am comfortable talking about my health with my friends.
    c. I only disclose health issues to friends when I need to.
4. Willingness to actively participate in health maintenance
    a. I am proactive in seeking out health information for myself.
    b. I am quick to make an appointment to talk with a physician when I am not feeling well.

Willingness To Communicate About Sexual Health - Adapted from Wright et al. (2007)

*Measured on Likert scale, 1 being strongly disagree → 5 being strongly agree

1. Willingness to communicate sexual health with family members
    a. We frequently talk about sexual health issues within the family.
    b. I am comfortable talking about my sexual health with my family members.
    c. I only disclose sexual health issues to family when I need to.
2. Willingness to communicate sexual health with healthcare providers
    a. I am comfortable talking about my sexual health with my healthcare providers.
    b. I have difficulty communicating my sexual health issues with my healthcare providers.
    c. I am a competent communicator when it comes to speaking to physicians about my sexual health issues.
    d. I only disclose sexual health issues to healthcare providers when I need to.
3. Willingness to communicate sexual health with people outside the family
    a. I frequently talk about sexual health issues with my friends.
    b. I am comfortable talking about my sexual health with my friends.
    c. I only disclose sexual health issues to friends when I need to.
4. Willingness to actively participate in sexual health maintenance
    a. I am proactive in seeking out sexual health information for myself.
    b. I am quick to make an appointment to talk with a physician when I am not feeling well sexually.

Willingness To Communicate About Mental Health - Adapted from Wright et al. (2007)

*Measured on Likert scale, 1 being strongly disagree → 5 being strongly agree

1. Willingness to communicate mental health with family members
    a. We frequently talk about mental health issues within the family.
    b. I am comfortable talking about my mental health with my family members.
    c. I only disclose mental health issues to family when I need to.
2. Willingness to communicate mental health with healthcare providers
    a. I am comfortable talking about my mental health with my healthcare providers.
    b. I have difficulty communicating my mental health issues with my healthcare providers.
    c. I am a competent communicator when it comes to speaking to physicians about my mental health issues.
    d. I only disclose mental health issues to healthcare providers when I need to.
3. Willingness to communicate mental health with people outside the family
    a. I frequently talk about mental health issues with my friends.
    b. I am comfortable talking about my mental health with my friends.
    c. I only disclose mental health issues to friends when I need to.
4. Willingness to actively participate in mental health maintenance
    a. I am proactive in seeking out mental health information for myself.
    b. I am quick to make an appointment to talk with a physician when I am not feeling well mentally.

Willingness To Communicate About Politics (WTCP)- Adapted from Wright et al. (2007)

*Measured on Likert scale, 1 being strongly disagree → 5 being strongly agree

1. Willingness to communicate politics with family members
    a. We frequently talk about politics within the family.
    b. I am comfortable talking about my political stances with my family members.
    c. I only disclose political stances to family when I need to.
2. Willingness to communicate politics with people outside the family
    a. I frequently talk about politics with my friends.
    b. I am comfortable talking about my political stances with my friends.
    c. I only disclose political stances to friends when I need to.
3. Willingness to actively participate in politics
    a. I am proactive in seeking out political information for myself.

Family Communication - Conversation – Adapted from Ritchie & Fitzpatrick (1990)

*Measured on Likert scale, 1 being strongly disagree → 5 being strongly agree

1. In our family of origin, we often talked about topics like politics and religion where some persons disagreed with others.
2. My parents would often say something like “Every member of the family should have some say in family decisions.”
3. My parents often asked my opinion when the family talked about something.
4. My parents encouraged me to challenge their ideas and beliefs.
5. My parents often said something like “You should always look at both sides of an issue.”
6. I usually told my parents what I was thinking about things.
7. I could tell my parents almost anything.

8. In our family we often talked about our feelings and emotions.
9. My parents and I often had long, relaxed conversations about nothing in particular.
10. I really enjoyed talking with my parents, even when we disagreed.
11. My parents encouraged me to express my feelings.
12. My parents tended to be very open with their emotions.
13. We often talked as a family about things we did during the day,
14. In our family, we often talked about our plans and hopes for the future.
15. My parents liked to hear my opinion, even when I didn't agree with them.

Family Communication - Conformity – Adapted from Kranstuber Horstman et al. (2018)

*Measured on Likert scale, 1 being strongly disagree → 5 being strongly agree

1. Respecting parental authority
    a. My parents expect us to respect our elders
    b. In our home, I am expected to speak respectfully to my parents.
    c. My parents have clear expectations about how a child is supposed to behave.
    d. When I am at home, I am expected to obey my parents' rules.
    e. My parents insist that I respect those who have been placed in positions of authority.
    f. My parents emphasize certain attitudes that they want the children in our family to adopt.
    g. In our home, my parents have the last word.
    h. My parents expect me to trust their judgment on important matters.
    i. I am expected to follow my parents' wishes
2. Experiencing parental control
    a. My parents feel it is important to be the boss.
    b. My parents become irritated with my views if they are different from their views.
    c. My parents try to persuade me to views things the way they see them.
    d. My parents say things like "You'll know better when you grow up."
    e. My parents say things like "You may not understand why we are doing this right now, but someday you will."
    f. My parents say things like "My ideas are right, and you should not question them."
3. Adopting parents' values and beliefs
    a. In my family, family members are expected to hold similar values.
    b. I am expected to adopt my parents' views.
    c. My parents encourage me to adopt their values.
    d. Our family has a particular way of seeing the world.
    e. I feel pressure to adopt my parents' beliefs.
4. Questioning parents' beliefs and authority
    a. I am expected to challenge my parents' beliefs.
    b. In our home, we are allowed to question my parents' authority.
    c. My parents encourage open disagreement.
    d. In our home, we are encouraged to question my parents' authority.

**Demographics**

Age
What is your age?

Race
What is your race? Please use the blank to add any information you think is important.

1. Black, _____
2. White, _____
3. Hispanic, _____
4. Native American, _____
5. Asian, _____
6. Pacific Islander, _____
7. Other _____

Ethnicity
What is your ethnicity?

1. Hispanic or Latino
2. Not Hispanic or Latino
3. Other _____

Education
What is your highest level of education?

1. Some high school
2. High school diploma/GED equivalent
3. Some college
4. Trade/vocational/technical
5. Associates degree
6. Bachelor's degree
7. Master's degree or higher

Gender
What is your gender (click one that best describes your current gender identity)?

1. Female
2. Male
3. Gender queer/Gender non-binary
4. Trans female
5. Trans male

Family of Origin
How many parents did you grow up with? Please fill in the blanks to describe if they were male or female.

1. Two, a _____ and a _____
2. One, a _____
3. More than two _____
4. Other _____

Health Insurance Status

What is your health insurance status?

1. Insured (through parents)
2. Insured (on own insurance)
3. Insured (on someone else's insurance, not parents' or own)
2. Not insured
3. Other _____

Zip Code

What is your zip code?

_____