HMONG PERCEPTIONS OF HEALTH AND HEALING: SHAMANISM, MENTAL HEALTH, AND MEDICAL INTERVENTIONS

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Division of Social Work

Abstract

of

HMONG PERCEPTIONS OF HEALTH AND HEALING: SHAMANISM, MENTAL HEALTH, AND MEDICAL INTERVENTIONS

By

Yer Yang

This study explored how the Hmong understand and interpret illness, their perceptions of healing, and how they go about seeking treatment. Thirty voluntary participants were identified through snowball sampling and completed a survey that measured their language and cultural capacities, health experiences, and understanding of mental health. Through quantitative data analysis, the chi-square test of independence found a significant association between religion and mental health seeking behaviors of participants ($p<.043$). 44% of Christian participants said they have thought about seeking mental health treatment in the past compared to only 5% of Shamans. Recommendations of the study are to provide more education to the Hmong community about health (ie: mental health) in order to address stigma and mis-education. Another recommendation is to consider their cultural beliefs when explaining services and offering treatment.

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Date

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TABLE OF CONTENTS

Page

LIST OF TABLES

Tables Page

Chapter 1

INTRODUCTION

Mental health is a growing area of concern in many parts of the world (World Health Organization, 2008). Whether someone is born with a mental health disorder or develops one later on in life, a mental illness can significantly compromise the daily functioning and quality of life of that individual. According to the National Institute of Mental Health, 1 out of 4 people (25%) of the US population has a diagnosable mental illness in any given year. Though there is an increasing need for mental health services, the stigma and misconceptions that are associated with it continue to frame it in a negative light (World Health Organization, 2008; Corrigan, 2004). This ultimately deters those who are in need of services from seeking them (Shih, 2004).

Though help-seeking trends in many communities is generally low, studies show that Asian Americans have some of the lowest help seeking percentages when it comes to seeking out mental health. According to a study that explores the perceived mental health needs within the Asian immigrant adults, national mental health service reports show that about "17.9% of the general US population has used mental health services, as compared to 8.6% of Asian American adults" (Nguyen, 2011, pp. 526). Among the various ethnic groups categorized under Asian and Asian American, the Hmong have some of the lowest help seeking rates (Lee & Change, 2012; Collier, Munger, Moua, 2011). Though there may be various factors for these trends, these numbers are concerning due to the history of war and trauma the Hmong have experienced as well as

the abrupt transitions they had to make as being refugees (Nguyen, 2011; Saechao et al, 2011).

There have been a number of studies that explore how the Hmong in heavily populated areas such as the Midwest and the Central Valley go about seeking general health services and mental health services. There is, however, a lack of studies that focus on the populations in the northern California regions such as those in Sacramento and the Yuba County areas, which are large and continually growing communities (US Census). Their help seeking patterns, general perceptions of mental illness, and choices of how they seek out treatment for ailments and mental illness symptoms is largely unknown. There then, is a need for further studies of this specific demographic so that needed services can be provided, resources can be made more accessible, and mental health as well as general medical problems can be better addressed.

Background and the Problem

Populations that are in the greatest need of mental health services can be some of the most vulnerable. People living with mental illnesses who are from low to lower middle income countries carry even more of a burden due to the lack of resources and knowledge available to them (World Health Organization, 2008). This disparity not only exists internationally, but in well developed countries, like the United States, as well. As reported by Padilla-Frausto, Aydin, Streja et al., (2011), in California alone, there are about 2 million individuals who are in need of mental health services. Of this group, only about 51 percent actually receive services. With further disaggregation of the data, it is significant to note that the uninsured population makes up almost a quarter of this

identified group. Within this categorization of uninsured Californians who need services, only about 32 percent receive any kind of treatment at all. According to Westermeyer, 1989, immigrants and refugees who come from these backgrounds and resettle in the United States encounter an even greater difficulty when receiving mental health services. Readjustment factors, war trauma, and cultural barriers are some factors that add to the level of difficulty in the helping process for clinicians when working with immigrant and refugee clients. Refugee communities, such as the Hmong for example, are a growing population in the United States who need a specialized approach in order for them to meet their mental health needs.

The Hmong: War and Displacement

The majority of the Hmong who are now in the United States were a hills tribe people that lived in the mountainous regions of Laos (Vang, 2008). Previously a self-agrarian and preliterate society, this group of people relied mainly on what they could produce to sustain themselves (Vang, 2008; Lee & Chang, 2012). This lifestyle changed when they were recruited by the U.S. Central Intelligence Agency (CIA) to assist American soldiers during the Vietnam War. Once the CIA left Southeast Asia, it the Hmong devastated. Many were forced to live with the physical and mental traumas of being a war torn people and cope with losing key members of their families and clans (Tatman, 2004).

In addition to war trauma and dislocation, the Hmong were also subjected to further displacement. In an attempt to regulate the numbers of refugees and heighten the acculturation rates, a refugee dispersal policy was implemented. This policy limited the

number of immigrants per household and dispersed refugees throughout the country into urban and rural areas. It drastically impacted the already war torn group by disrupting their family and clan systems, structures that have been vital for support and sustainability (Tatman, 2004). The multiple layers of interruption in lifestyle without proper transition continue to affect this community. One of its manifestations is the increase in mental illnesses (Lee & Chang, 2012; Vang, 2005; Gensheimer, 2006).

The Hmong: Needs for and Barriers to Services

The Hmong population in 2010 surpassed 260,000 (US Census). This is a 40 percent increase from the previous decennial census and demonstrates the rapid growth of the Hmong population in the United States (US Census). Addressing the large population size of the Hmong community is necessary when evaluating their perspectives of health care as well as their needs. As populations increase, so do their needs for services. Due to the traumas of war and diaspora, physical hardships and malnutrition encountered during refuge as well as the numerous struggles of acculturation, the Hmong in the United States demonstrate a high need for healthcare access (Johnson, 2002; Lee & Chang, 2012; Tatman, 2004). Of the various health needs of this community, mental illnesses are some of the most difficult to address. The stigma of being *vwm* (crazy) and a lack of understanding of mental health deters many members of this community from accessing these particular services (Lee & Chang, 2012).

For many Hmong, the cultural and religious beliefs they uphold also deter them from accessing formal mental health services. Instead, those who experience mental health symptoms seek alternative treatment modalities such as herbal medicines, shaman,

prayer, and superstitions (Culhane-Pera, 2003). Many who still practice the indigenous religion turn to shamans for spiritual healing (Gensheimer, 2006; Lee & Chang, 2012). In a study conducted by Krolle et al. in 1989, the Hmong have high rates of mental illnesses (over 80 percent having symptoms of major depression) yet later studies administered by Chung and Line in 1994 suggest that their consummation of westernized medicine is only at 11 percent (Lee & Chang, 2012). There is a strong need then, to assess the mental health status of the Hmong and to identify the barriers that hinder them from meeting their mental health needs. In order to understand this status, it is important to firstly explore their current perceptions health and wellness, particularly around mental illnesses.

The differing perspectives of mental health as well as the cultural differences of how to address them hinders the quality of care that members of the Hmong community are receiving. Some, due to stigma, lack of mental health awareness, and their sole usage of alternative healing practices do not seek services at all (Johnson, 2002; Lee & Change, 2012). The challenge then, is to find ways to help the Hmong better understand mental wellness and adapt western models without having to compromise their indigenous traditions and beliefs.

Statement of the Research Problem

Language access, stigma, and limited culturally competent care make mental health services unappealing and difficult for the Hmong community to access. At the same time there are also many reasons such as the lack of understanding of what mental illness is, stigma both within their community and within the general American public

around mental illness, and their own denial of mental health services. The research, however, shows that the Hmong due to their experiences of war, trauma, and dislocation, have developed mental illnesses that would benefit from treatment. For this reason, there is a need to explore how the Hmong perceive mental illness and health in general so that services can be presented and implemented in a way that is more incuslive, accessible, and in tuned with how the Hmong understand and practice health and healing.

Study purpose

There are numerous factors that contribute to the disparities, lack of access, and underutilization of mental health care for Hmong refugee families. The historical context in which they arrived makes for one. The traumas of war, dislocation as well as the physical pain and malnutrition the Hmong had to endure have added to the increasing mental illnesses in the community. The resettlement process in which refugees were dispersed throughout the country resulted in minimal support and guidance. This acculturation process created stressors that ultimately resulted in mental health problems (Ensign, 1994; Cha, 2003; Tatman, 2004; Vang, 2005; Lee & Chang, 2012). Being introduced into an entirely new environment with little transitions to assist in acclimation in itself is difficult. Adding layers such as language barriers, poverty, racial tensions, and trauma (both physical and mental) make the adjustment even more difficult and increase the probability of developing mental illnesses (Cha, 2003).

The purposes for writing this paper are both personal and academic. As a second generation Hmong refugee, the author has experienced the cyclical traumas of the war and diaspora on her own family and community. For this reason her purpose for

conducting this research is to help contribute to the effort of improving services and increasing its accessibility to the larger Hmong community. A goal is to find innovative ways of presenting and providing mental health services to the Hmong that are inclusive of their beliefs and perceptions. Listed below are key aims goals for the paper:

1. Further explore the religious practices of the Hmong community and its implications on mental health
2. Better understand how the Hmong perceive mental health and how they go about seeking treatment
3. Learn what have and what have not worked when it comes to treating mental illnesses in the Hmong community
4. Propose ways to incorporate more cultural sensitive practices into the medical model in order to reach ethnic populations, such as the Hmong.

Theoretical framework. The main theory utilized to support the research topic the strengths based perspective. The strengths based perspective (as cited by Schriver, 2011) stems from the alternative approaches of practice. It stresses the importance of social workers respecting the client's views of themselves and their situations. This way of thinking demands a shift from a pathological approach in which the practitioner is viewed as the professional and sole authority to one where the client's perceptions and decisions are central to the intervention (Schriver). Using the strengths based approach necessitates that the social worker recognize the resilience of the client and engage in dialogue that is empathic and inclusive that facilitates equality. It also calls for the crafting of a plan that

is a collaborative effort with the client (Schriver). This modality empowers the client to directly engage in a life changing process that also fosters leadership.

Often times treatment plans or research are developed focused on the subject's deficits. Although acknowledging challenges is important to identifying what changes need to occur, recognizing individual and community strengths is vital for a suggestions and proposals that are sustainable. Especially when working with a community that has a history of displacement and oppression, such as the Hmong, it is important to focus on the positive attributes. People from this particular community have already experienced numerous instances of subjugation. They have been forcibly uprooted from their homes and even persecuted. Focusing on problems and dictating how to fix them is an approach that disregards individual autonomy and even perpetuates the cycle of oppression. The strengths perspective then is very useful in working with this specific population.

This theory is especially relevant to this area of research. The purpose of this study is to better understand the resources that are already present and to learn how they can be utilized to improve the mental wellness of this community as a whole. Exploring shamanism and how it is used to heal ailments is central to comprehending the beliefs and perceptions of this community that uses it as a dominant healing. The strengths perspective is important because it will help to frame this research in a way where all knowledge and practices are valued. It will also be conducive to the goal of learning about the perceptions and status of the Hmong regarding mental health. It will encourage the incorporation of traditional practices into interventions that may be based on the

medical model. This will promote healing approaches that are more comprehensive, collaborative, and likely to be sustainable.

Definition of Terms. Mental disorders is cited by clinical psychologist, Richard McNally, per the American Psychiatric Association's Diagnostic and Statistical Manual IV (text revision), as "behavioral or psychological syndromes, clusters of co-occurring symptoms, which cause significant distress or interfere with a person's ability to function in everyday life, or both" (McNally 2011, p. 3). For the purpose of this study, mental disorders, mental illness, and mental health problems will be used interchangeably.

Stigma is defined as "the situation of the individual who is disqualified from full social acceptance" (Rao et al 2009, pp. 585). Self-stigma is "the internalized cognitive, emotional, and behavioral impact of others' negative attitudes on a person who possesses a devalued characteristic" (Rao et al 2009, p. 585; Moses 2010). For the purposes of this study and consistency in language, self-stigma will often be generalized under stigma.

Assumptions. The premise for this research is that there is a lack of or low utilization of mental health care in the Hmong community. Though individuals may be accessing services to an extent, this overall study is focusing on the discrepancies within service. Another premise of this study is that many individuals of the Hmong community may be mis- or ill-informed in terms of understanding what mental illness is and how treatment is implemented. Considering the varying levels of acculturation into mainstream American society, this study also assumes that members of the Hmong community, irrespective of religious preference, still utilize some aspect of Hmong cultural healing. Also important

to note is the assumption that problems generalized to Southeast Asian refugees are also experienced by the Hmong.

Social work research justification. In addition to direct services and policy change, research and scholarly work are also essential components of social work. This research in its respect will contribute to the knowledge of social work in terms of expanding the knowledge and know-how of providing mental health services to the Hmong community. It details a comprehensive exploration of how the Hmong in general view and understand health and healing and also discusses their cultural practices and treatments. This study will aid readers and practitioners in the profession to better understand the stories of the Hmong, their various struggles, practices, as well as resiliencies so that more holistic programs and treatments can be created to serve their needs. From this study, individuals in the social work practice can also learn about what has helped a group of people sustain itself for centuries and perhaps even utilize practices of this community into their own professional development as well as with their clients and communities. Information in this study can also be applicable to other ethnic, immigrant, and refugee groups.

Study limitations. Though this writing will have its contributions, it also has its limitations. It will not thoroughly explore the various illnesses in the Hmong community. Though it does provide some insight on how the Hmong view health and healing, it does not explore the types of illnesses, including mental illnesses, which are prevalent in the community. It does not detail the treatments individuals from this community use to heal particular ailments and does not investigate the utilization of healthcare services depending on age, gender, or socio-economic status. This research also does not provide

clinical suggestions or treatment models on how to approach particular mental disorders when working with Hmong clients.

Chapter 2

LITERATURE REVIEW

This chapter of the paper provides an introduction of mental illness and its impact on the general American population. It explores general perceptions of mental health including stigma. Before discussing perceptions of health and healing in the Hmong community, particularly that of mental health, it is important to first understand the backdrop of mental health in the United States. This framework is critical in understanding how general societal norms and opinions in America shape and influence ethnic communities that live in this country. Also discussed is a brief history of mental health and how it has evolved over the years.

A portion of the literature review touches upon how communities of color, especially Asian Pacific Islanders, Southeast Asians, and the Hmong, understand and go about utilizing mental health services. While acknowledging the dominant experiences and opinions of Americans, it is also important to distinguish inter-cultural differences, practices, and experiences due to the diversity of communities residing in this country.

A significant section of this chapter focuses specifically on the Hmong. It discusses the use of shamanism in the Hmong community as an instrument for healing illness in general. Provided is a brief history of shamanism and its role in healing. While this is addressed, also explored are the perceptions of healing within the Hmong community. This portion of the literature review provides a general overview of the status of mental health in the Hmong community as well. Though members of the Hmong community do utilize varying health remedies and services, shamanism still

remains the cornerstone of how the Hmong understand illness and go about seeking treatment (Cha, 2003). Given their history and perceptions of health and healing, this section investigates how the cultural beliefs and practices of the Hmong impact and influence their utilization of mental health services and health care services in general.

Covered in this last portion are the experiences of health care providers in working with this particular group in mental health care settings. Suggestions proposed to increase the receptiveness, accessibility, and participation of this community in respect to mental health are also be visited.

Mental Illness in the United States

Mental illness affects the lives of almost fifty percent of Americans at some point or another (McNally, 2011). Though an increasing problem for other countries as well, the United States has some of the highest instances. Over time, scholars have found that mental health diagnoses such as depression have increased dramatically over the decades, depression specifically affecting about 20 percent of those born between the 1950s to the 1970s as compared to only 2-3 percent of those who were born prior to 1915 (McNally, 2011). These numbers have over the years only increased. Through research that has utilized the Taylor Manifest Anxiety Scale on groups of college students over several decades, it was founded that the average college student in the 1990s was 71 percent more anxious than that of a college student in the 1970s (McNally, 2011).

Some scholars attribute the rise of diagnoses in the United states to various factors including: a shift in understanding and treating mental illness, the added diagnoses since the first Diagnostic Statistics Manual, societal changes which have disrupted many of the

traditional support systems, and the improved training for mental health professionals in properly diagnosing patients (Mowbray & Holter, 2002; McNally, 2011; Pierre, 2012). As cited by clinical psychologist, Richard McNally, per the American Psychiatric Association's Diagnostic and Statistical Manual IV (text revision), mental disorders are "behavioral or psychological syndromes, clusters of co-occurring symptoms, which cause significant distress or interfere with a person's ability to function in everyday life, or both" (McNally, 2011, p. 3). McNally in his work discusses what mental illness is, the increasing prevalence of diagnoses, and some of the theories as to why or how mental illnesses develop. For the purposes of this research, mental disorders and mental illness will be used interchangeably.

Psychiatry, also known as mental health treatment, has undergone significant changes and is continuously morphing. For over a century, the treatment for the mentally ill has mainly been institutionalization and isolation. Over the years, the treatment model has changed and mental health services currently resemble much more of continuum (Fernando, 1995; Pierre, 2012). Many have critiqued this widening of the field. Some scholars have found that there exist arguments among health care professionals and the general population that mental illnesses have over the years been defined too broadly, pathologizing normal reactions to life situations, stressors, and even crises (McNally, 2011; Pierre, 2012). Many scholars and professionals in the field, however, say there is a need for categorizing experiences that patients undergo and can be helpful if the proper treatment and considerations are taken (Fernando 1995; Kurasakai, Okazaki, & Sue, 2002; Mowbray & Holter, 2002; McNally, 2011; Pierre, 2012).

One turning point for mental health that was not only an ideological stride in its beginnings but that dramatically changed what we now understand as mental illness and psychiatry is the Community Mental Health Centers Act in 1963 (CMHC Act) (Grob, 2005). This act that was passed during President Jimmy Carter's term was a significant piece of legislation that changed who sought out and received mental health treatment. It played a pivotal role in decreasing the number of individuals admitted into psychiatric wards and also assisted in the shift of mental health care. More traditionally, mentally ill patients had severe symptoms and were removed from their communities and isolated. The CMHC act reoriented care providers to the community level and changed the power dynamics between political officials, psychiatrists, and health facilities (Grob, 2005). Since this shift, there as been increased direction of mental health treatment to outpatient settings and a shift from a mostly pathological and medical approach to treating mental illness to a more holistic and ecological perspective (Mowbray & Holter, 2002; Grob, 2005).

In more recent years, professionals and service providers are seeing a need to rather than be "symptoms-thinking", learn to be "needs-thinking" (Fernando, 1995, p. 1). This approach is one that shifts from a reactive treatment of illness to one that focuses on wellness and prevention. There is also a call for multi-disciplinary teams so that patients can receive the most effective and congruent care for their needs, rather than being solely treated one symptom at a time. From the research it seems that in less than a century the views on mental illness have seemingly improved and the treatment modalities have become more community and strength based. Though there has been progress, the

history of mental illness and the misconceptions thereof continue to shape and impact treatment as well as the perception and acceptability of individuals with mental illnesses.

Stigma in Mental Health

Though mental health has over the years undergone numerous changes and transformations in terms of diagnosis, treatment, and even acceptability in the general population, there is still stigma associated with its name. Its roots linked to confinement, severe impairment, and schizophrenia makes it difficult to remove the negative connotation constantly paired with it (Shih, 2004; Moses, 2010; McNally, 2011).

In a health stigma study that included five hundred eleven participants, stigma was defined as "the situation of the individual who is disqualified from full social acceptance" (Rao et al 2009, pp. 585). The work goes further into describing "self-stigma" which is "the internalized cognitive, emotional, and behavioral impact of others' negative attitudes on a person who possesses a devalued characteristic" (Rao et al, 2009, p. 585; Moses, 2010). Self-stigmatization can lead to lowered self-esteem and a negative perception of oneself which in turn can cause depression, anxiety, and other mental health related symptoms. Though many chronic illnesses and medical conditions are shadowed by and yield some level of stigma and self-stigma, studies show that individuals who attribute their mental illness to biological and medical explanations often have lower rates of self-stigma and better quality of living. This means that mental illnesses that have no biological or medical connections are more highly stigmatized and less positive outcomes (Rao et al, 2009; Moses, 2010).

Self-stigma can be a point of distress for individuals and is often exacerbated by societal norms, judgment, and differential treatment. Studies show that individuals who have an illness or characteristic that is stigmatized, undesirable or unaccepted also face discrimination and barriers in their daily living such as roadblocks to opportunities and even access to resources (Shih, 2004). Mental health stigma can deter individuals struggling with a mental illness to seek services and work toward recovery due to the fear of being rejected by society, the lack of information about mental illness as well as treatment, and the anticipated disadvantages and barriers associated with having a diagnosis (Shih, 2004; Moses, 2010).

Mental health, though its own specialization, is still strongly connected to medical care. In communities that utilize alternative healing practices, it is important to also consider their understanding of health and healing if a community focused and interdisciplinary approach to healing is what is being sought out. In addition to facing stigma in the United States, ethnic communities themselves have additional lenses and experiences that add to the complexity of their help seeking factors (DuBray, 1993; Weine, 2011). For many Asian families in the United States, mental illness can be highly stigmatized and be seen as bringing shame to families due to its general view as being a hereditary disease (Nguyen, Shibusawa, & Chen, 2012).

Additionally, the somatic manifestations of mental illnesses can impact how they are viewed while also informing how patients go about seeking treatment. Due to the lack of discussion of specific symptoms such as depression or the understanding of how psychological distress can cause symptoms such as body aches, headaches, or dizziness,

many ethnic communities characterize and treat their mental illness symptoms with traditional methods. The Hmong in particular turn to traditional medicine and shamans which dramatically affects their utilization of mental health services (Cha, 2003). Furthermore, the stigma of being *vwm* (crazy) and a lack of fully understanding what mental illness is deters many members of this community from accessing services as well. Rather than seeking formal mental health treatment, ethnic communities such as the Hmong may be utilizing other modes of treatment (Cha, 2003; Lee & Chang, 2012; Nguyen, Shibusawa & Chen, 2012).

Understanding of Mental Health in Asian American Communities

Mental health as aforementioned has an overall negative image due to the long history of institutionalization and isolation of patients. The stigma associated with it as well as the many misunderstandings of what it is deters individuals in need of services from seeking them. With this overall sentiment of mental illness and mental health treatment as a backdrop, it is important to note that Asian American communities in addition have another layer of complexities to consider when attempting to understand how mental health treatment is perceived, impacts, and has changed for these communities over the years. These intricacies transcend that of the mainstream American communities that are in motion within the black and white dichotomy. To simplify, cultural differences and political experiences make for two factors that complicate mental health in Asian American communities (Shih 2004; Harris, Edlund, & Larson, 2005; Moses, 2010; Nguyen, Shibusawa, & Chen, 2012).

The passage of the ACMHA in 1963 changed the landscape of mental health and redistributed power from the state to local communities. Other important legislation that impact Asian communities and help to understand their experiences with mental health specifically are the Civil Rights Act of 1964 and the 1965 Immigration Act. The Civil Rights Act is responsible for a shift in how people of color in general were treated and advocated for their rights. Historically heavily discriminated with laws and policies in place that particularly targeted them, Asian Americans gained many rights after the Civil Rights Act was ratified (Nguyen, Shibusawa, Chen, 2012).

The Immigration Act of 1965 resulted in a large influx of Asians to the United States. Previously met with discriminatory quotas meant to regulate the Asian populations in the United States, this law removed these regulations. These laws and the Asian American movements that sparked around the time of the Civil Rights movements pressured the government and served as advocacy for the Asian and Asian American community in the United States. This set in motion the support garnered when Southeast Asians began resettling in the United States post the Vietnam War (Tatman, 2004; Nguyen, Shibusawa, Chen, 2012). In the recent decades, the Asian and Asian American population in the United States has grown substantially.

Currently Asian Americans make up about 5 percent of the United States. As recorded by the 2010 decennial US Census, there is an estimated 17.3 million US residents of Asian descent. 5.6 million of this population reside in California, the most heavily Asian and Asian Pacific American state in the US. Per a study done in 2010, the estimated number of Southeast Asians was about 1.8 million in 2004, about 13 percent of

the 14 million Asian Americans recorded in 2004 (Lee, Lytle, Yang, & Lum, 2010; Nguyen, Shibusawa, Chen, 2012).

Though there have been milestones in the last few decades, there is still much work to be done in order to make mental health resources more accessible. Despite the improvements made to help this population access services, there are still barriers that inhibit them from seeking help for mental illness. One explanation is their lack of understanding of what mental illness is and what mental health treatment entails. Another are their cultural practices that may not have been amended to take into account the various impacts of immigrating and taking refuge to the United States has implicated. Many Asian communities have religious or spiritual beliefs that inform their understanding of health and healing. In this way, psychological symptoms are not directly addressed and are attributed to the imbalance of the spirit. Unless the physical symptoms are also addressed with the emotional and psychological symptoms, many Asian and Asian American patients are not likely to accept or complete mental health treatment (Ensign, 1994; Lo, 1997; Cha, 2003; Collier, Munger, Moua, 2012; Nguyen, Shibusawa, Chen, 2012).

Additionally, the disparities within the Asian American community must also be addressed to understand the lack of understanding of mental illness as well as the low help seeking trends. Though the US Census shows that the median household income for single-race Asians is $67,000, this number does not yield true for all subgroups within this umbrella category. 20 percent Laotians and Cambodians per a 2010 study were reported as being below the poverty line while about 33 percent of Hmong were reported

as below the poverty line. This disparity in income is a demonstration of the varying needs within the diverse Asian American umbrella. For the Hmong specifically, the influx of a more recent wave of refugees from the Wat Tham Krabak refugee camp in Thailand in 2004 has also complicated the needs of these people (Lee, Lytle, Yang, Lum, 2010).

For Southeast Asians who took refuge in the United States, namely the Hmong, their family and community structures that had sustained them were greatly affected by war. Experiences of death, loss, war trauma, and many violent exposures have resulted in symptoms consistent with depression, anxiety, and PTSD such as nightmares (Hsu, Davies, Hansen, 2004). Their refugee status is also another stressful factor to consider. Different from immigrants, refugees do not have the option of returning to their homeland and having a safe place to reside free of persecution. For communities like the Hmong who were self-sustained farmers, their social supports were heavily disrupted, causing further stress which exacerbates mental health symptoms, many traditional families unable to distinguish psychological symptoms from social issues (Collier, Munger, Moua, 2012).

From the literature alone, it is clear that many Asian Americans, particularly newer arriving communities such as Southeast Asian refugees do not have the language capabilities to access appropriate resources. At the same time, many services are not presented or provided in a way that is compatible with their needs and understanding. Though generations and families that have been able to acculturate have higher seeking rates and are able to navigate systems more effectively, there are still families that are not

privileged to be able to do the same (Nguyen, Shibusawa, Chen, 2012; Collier, Munger, Moua, 2012). Though mental illness in general is variably understood in the United States, complicated histories and experiences informed by cultural differences and past legislation are additional stressors that serve as barriers to Asian Americans reaching a basis of understanding of mental illness and treatment.

HMONG RELIGIOUS PRACTICES AND TRADITIONAL HEALING

Shamanism in the Hmong Community

To better understand the impact of religion and traditional healing in the Hmong community, it is first important to have a general understanding of shamanism. In exploring traditional healing in Hmong refugee communities, Ensign (1994) in his dissertation provides historical information of this religious practice. His findings, consistent with that of other scholars suggests that shamanism is a derivative of the term "saman," meaning "one who is excited, raised or moved" (Ensign, 1994, p. 5; Lo, 1997). Shamanistic practices have been traced back through markers, such as paintings, to the beginning stages of humanity and are believed to be one of the oldest religious practices. Individuals who have the authority to dictate shamanistic ceremonies are called shamans. In general, a shaman's healing function is to enter into another consciousness and world through a trance (either heavens or underworld) to perform healing ceremonies for sick or troubled individuals (Ensign, 1994).

Shamanism in the Hmong community has numerous beliefs and practices. Lo (1997) in his master's thesis explores the usage of shamanism in Hmong traditional healing and provides detailed documentation of the various ceremonial types. Similarly

to Ensign, Lo's research indicates that the early forms of shamanistic practice originated in what is now Siberia. Hmong shamans have varying styles and approaches to performing their ceremonies. They utilize diverse tools, altars, and even have different specific beliefs regarding the spirit and healing. Many shamans believe there are varying numbers of souls each person has, some stating each person only having one soul, while others believe there are three or even more (Lo, 1997; Cha, 2003). The Hmong who still practice the traditional religion believe in three levels of being, the sky or heavens, an earthly existence, and the underworld. Though separate, these realms are also intertwined. This results in the inevitable encounter (both intentional and unintentional) of beings or spirits in the world with that of another. When such a situation arises, there becomes a spiritual imbalance that is taboo that must be resolved by one who can travel and function in all worlds, a shaman.

Shamans are a highly respected figure in communities. In the Hmong culture, shamans are chosen by shamanic spirits of former shamans who have lived and passed on. Though there are some individuals who gain shamanic abilities without being recruited by spirits, those individuals must undergo training from a willing shaman who is willing to share his or her celestial spirits (Lo, 1997). These voluntary shamans are also believed to be less powerful and effective. For those who are selected to become shamans, the process is multifaceted. Some receive dreams and are visited by spirits through that means. Others first become ill, either physically, psychologically, and even experience near death experiences (Ensign, 1994). Once they undergo these processes, they are then taught by their shamanistic spirits (Ensign, 1994; Lo, 1997).

Within Hmong shamanism there are varying levels of abilities and techniques. Not only are these abilities obtained by merely being chosen by spirits (Ensign, 1994), but an individual must also undergo rigorous training to reach higher levels. This process of learning and acquiring skills is taught through the consultation with a current master shaman and the guiding shamanic spirits. To reach the spirit world, shamans must also have helpers who create a tempo with tools such as gongs and hand bells so that a gradual transition can be made by the shaman to a different consciousness (Cha, 2003, Lo, 1997). This painstaking process of becoming a shaman is one that aids the garnering of respect for shamans. Due to their spiritual connection, they have a strong influence in shaping not just the perceptions of health in the Hmong community, but also are leaders in the preservation of culture (Ensign, 1994).

Perceptions of Healing: Seeking a Shaman

Hmong who practice Shamanism believe in the centrality of spiritual balance in (Ensign, 1994). They believe that there are numerous spirits in living and non living beings and objects. In general, there are spirits that guide and protect while there are others that are innately malevolent and evil. When there is a spiritual imbalance or an unfavorable spiritual encounter, the occurrence will result in an ailment or negative event such as a physiological illness, a personality or mood change, or even bad luck. The shaman, who is specially chosen and is guided by celestial spirits, is then called upon to mend the spiritual imbalance and rid individuals of sickness or misfortune (Ensign, 1994).

There are varying perspectives on the specificities of rituals, however, one fact is constant, shamans are primary consultants for the Hmong community when they encounter illness, stress, and misfortune. The dominant Hmong perception of illness is that they are caused by supernatural forces. Some perceived root causes of unfavorable outcomes are the wavering of the souls, encounters with wild spirits, or unfulfilled offerings to ancestors and deceased family members. The shaman then is called upon for insight to diagnose the cause of the problem and then to address it by partaking in spiritual communication (Ensign, 1994; Lo, 1997; Cha, 2003; Tatman, 2004). In this way, the Hmong believe that the curative catalyst is supernatural and spiritual as was the original cause.

Though the Hmong also believe in natural and organic causes of illness, or seek other traditional healers such as herbalists or masseurs, shamans are thought to possess divine abilities and are consulted most frequently for diagnoses and treatments. When a shaman is called upon, he will first give a diagnosis. Based on the accuracy of the diagnosis, the shaman will return to complete a spiritual ceremony, one where often times an animal is sacrificed. Since the Hmong believe all living and some nonliving things have souls, the soul of the animal sacrificed is used as an offering, spiritual replacement, or protection for the human's soul (Cha, 2003; Lo, 1997).

DIFFERING CONCEPTIONS AND UNDERSTANDINGS OF HEALTH

The Medical Model and Misunderstandings

Johnson, a medical professional, conducted a two year study later published in 2002 that explored popular beliefs and practices of the Hmong. In this study, which

consisted of interviews, focus groups, and consultations, it was founded that the differences in traditional Hmong practices and western biomedical perspectives made for a lack of understanding that had negative outcomes (Johnson, 2002). Due to the spiritual beliefs and superstitious practices, there seemed to be cultural clashes even in situations where family members wanted to stay with members of their family at the hospitals when nurses found that to be intrusive and unnecessary. There were other much more serious instances comprised in this research which included a story of a family receiving a court order that impeded the authority of the parents to deny chemotherapy they were told may not save their daughter's life. Johnson implies in this research that there may have been miscommunication which resulted in such an ordeal. Implications of continued misunderstanding are the lack of a cultural bridge as well as language constraints (Cha, 2003).

In addition to the general health perspectives, the complex clan system in which the Hmong operate also makes for complicated and difficult situations (Johnson, 2002; Cha, 2003). Unlike in western families where medical decisions are made by the family, such decisions for a Hmong patient would have to be made in consensus by the family's clan leaders. With the varying healthcare experiences, the community based decision making style, the historical context of turning to alternative healing methods, and the fear of experimental or failing procedures, Hmong families may and have denied operations and treatments. Though this research is specific to a biomedical practice, there are correlations that can help mental health practitioners when working with Hmong consumers.

In terms of understanding the conception of mental health in the Hmong community, there is still much work to be done. Tatman (2004) in a journal article discusses the effects of refuge and resettlement on the group and the implications of learning to work with this population. A significant finding in his work is the concept of etiquette. In sessions with counselors or when meeting with practitioners, Tatman finds that Hmong consumers tend to be especially agreeable. This he terms as "Yes statements" (Tatman, 2004, p. 228). This gesture seen as polite by the Hmong can be misunderstood by western practitioners as affirmation or compliance. In addition, Hmong mental health consumers also have a different perspective of medication. It is taken to treat symptoms. When the symptoms are in remission or when the medication does not yield immediate results, many Hmong clients may cease to continue taking them. In general, there is a large gap surrounding culture and language as well as perspectives of health and healing that impairs the quality of health and mental health services for the Hmong population (Johnson, 2002; Cha, 2003; Tatman, 2004).

Mental Health Status of the Hmong Community

In the last few decades there has been an increasing amount of research produced in assessing the mental health status and needs of the Hmong community. Westermeyer is a psychologist who has conducted some of the most comprehensive studies on mental health in refugee and migrant communities. His studies indicate that "refugees have consistently shown some of the highest rates of psychopathology among all types of migrants" (Westermeyer, 1989, p. 88). Symptoms of depression are mostly commonly

indicated through surveys while psychiatric clinics that serve refugee communities have high diagnoses of major depression for these populations.

Even within the academic research that is available, however, the knowledge is still quite limited. More recent works also critique their consistency. Lee & Chang (2012) in their joint work, regarding the mental health status of Hmong Americans in 2011, highlight the disparities in information and data. In this research they shed light on the various studies that have been conducted as well as the inconsistencies of their results. Through their analysis they demonstrate significantly varying data such as a drastic drop of over 50 percent in the diagnosis of post traumatic stress disorder within a two year time frame.

One significant implication of these conflicting data is their negative effects on the understanding of mental health in the Southeast Asian community. This in turn affects the types of services offered as well as the quality of services this population receives. Another significant finding is that the pre- and post-migration experiences continue to cause stressors that negatively impact Hmong Americans regardless of their generation (Lee & Chang, 2012, Westermeyer & Williams, 1986). Though the Hmong compared to other Southeast Asians have larger proportions of individuals diagnosed with major depressive symptoms, they tend to be the least likely to access mental health services (Lee & Chang, 2012; Nguyen).

Other studies continue to show that Hmong Americans have a higher likelihood of being diagnosed with a mental illness. Some of the more commonly diagnosed mental illnesses are post traumatic stress disorder, chronic acculturation syndrome, and

depression . Despite their war trauma, acculturation or post-migration stressors are some of the most prevalent causes of mental illness in this community (Tatman, 2004; Vang, 2005; Lee & Chang, 2012).

Lee & Chang in their research specify the various acculturation difficulties to be things related to navigating within the new country in order to achieve basic day to day necessities. The migration resulted in significant changes to the traditional, patriarchal, and clan systems that have been placed to mitigate stressors. The reversal of traditional roles (such as gender roles and the roles of parent and children) has strongly impacted the interpersonal relations within a Hmong family as well as depressive symptoms and feelings of helplessness (Tatman, 2004; Vang, 2005).

Suggestions for Mental Health Providers

With mental health as a seemingly new concept to the Hmong, there continue to be efforts to establish the need this community has for services as well as efforts to educate the importance of cultural competency among health care providers.

Scholars and professionals have deemed mainstream treatment modalities and approaches to be inappropriate when being used by Hmong consumers (Gensheimer, 2006). Some critiques are that they do not consider distinguishing factors such as Hmong etiquette and mannerisms, and the differing conceptions of time. Often agency requirements hinder the success of Hmong providers which can affect the receptiveness of the Hmong consumer as well as their decisions to return. This work highlights the struggles of Hmong mental health providers. It also demonstrates how the models employed by mental health agencies may not be taking into consideration the various

barriers that exist when working with this specific population. Some recommendations are to conduct further studies that capture the experiences of Hmong health care providers so that more holistic and comprehensible models and interventions can be adopted. An awareness and consideration of cultural and spiritual beliefs then is crucial to providing quality mental health care (Gensheimer, 2006; Nagai, 2008; Nguyen, Shibusawa & Chen, 2012).

While considering historical and cultural beliefs of the Hmong, scholars propose ways in which counselors can be more effective when working with Hmong clients. Some suggestions made are that there needs to be a change in therapeutic techniques wherein the advice or recommendations are more concrete. Many Hmong are unfamiliar with counseling and their cultural practices do not favor detailed self-disclosure (Tatman, 2004). Due to the clan system functions as well as the usage of alternative forms of healing, the Hmong may also not perceive mental health providers to be potential sources for aid (Ensign, 1994; Tatman, 2004; Cha, 2003). Scholars then focus on the importance of cultural competency in understanding the communication patterns of the Hmong, their community perceptions of mental health (which can be stigmatized), and their worldviews. At the same time it is just as important to acknowledge the cultural differences, the negative perceptions of mental illness, and the different manifestations (whether they be emotional, behavioral, or physiological). Lacking these components can result in interventions that may negatively impact the client and/or therapeutic process.

In addition, the validation of the Hmong consumer experiences and beliefs is central to their receptivity to treatment. Finding ways to affirm the cultural and spiritual beliefs while promoting a bicultural identity of being American and Hmong are necessary attitudes and techniques that will improve the communication between counselor and consumer. "In doing so, they [counselors] will serve as educators of American traditions and customs while also supporting the maintenance of native identities" (Tatman, 2004, p. 231).

Many scholars and professionals who have studied the health experiences of the Hmong community encourage the acknowledgement, acceptance, and incorporation of traditional healing and shamanism (Ensign, 1994; Tatman, 2004; Gensheimer, 2006). Through the study of Koepke and Hare (2000), Tatman states that 52 percent of the Hmong still use spiritual and shamanic rituals. Understanding the spiritual beliefs and not mistaking them for "psychotic content" then is central to not only distinguishing cultural beliefs from psychotic behavior, but also conducive to incorporating alternative healing methods that have yielded favorable results for Hmong mental health consumers (Ensign, 1994).

Though migrants have their own resources they can draw upon, it is also important to highlight the limitations that are present. Westermeyer in a 1989 study discusses the advantages and disadvantages of client self-help practices. Interventions from a client's frame of reference can help to bridge the discrepancies between two cultures, but can also have unfavorable consequences. An example given that exemplifies this was the suicide of a Native American man who was not cured by a

traditional healing ceremony though he had very strong spiritual beliefs (Westermeyer). In these situations, the client can fall into self-blame if a ritual that is famed as curative is unsuccessful. Interventions then must be planned with consideration of the specific cultural and traditional beliefs of the population while focusing on the extent of the problem at hand as well as the current and future unmet needs of the group (Westermeyer, 1989). Being mindful of possible outcomes and risks of treatment are also vital to planning programs and interventions that are thoughtful and effective.

Chapter 3

METHODS

Study Objectives

The objectives of the research were to obtain a diverse and varied response pool. For the reason the research utilized the quantitative, non-randomized snowball sampling. A varying pool of participants was desired in terms of age, sex, religious preference, education attainment, and marital status. The purpose of the data collection was to varying responses regarding perceptions of health, healing, and mental health based on age, acculturation, access to health care, and understanding of mental illness.

Study Design

The research approach most appropriate for this topic is the exploratory research design and facilitated quantitatively and qualitatively in nature. Though there has been research conducted on the perceptions of wellness in the Hmong community and the various mental health problems that they face, there is still very limited information that further explores this particular population's needs and experiences in mental health. Specific areas of research that are still lacking are knowledge about the accessibility of mental health services to this population, their perceptions of and engagement in services, as well as the methods that can be used to increase participation in services. Exploratory research will help to further ascertain the problems that have already been identified by past research as well as provide a basis for building on that knowledge with more current information (Yegidis, Weinback, & Myers, 2012). Yegidis and colleagues explain that this model can help to specify and better conceptualize the problem.

Sampling Procedures and Data Collection Procedures

Snowball sampling was the procedure employed to acquire responses to surveys. The first few participants were identified by the researcher. They then were asked to identify potential participants who they presumed would also meet the basic criteria for the research study. In this way "the sample is compiled as the research progresses" (Yegidis, Weinbeck, & Myers, 2012, p. 208). The basic criteria for research subjects in this study were: participants must be a Hmong adult and be comfortable responding to questions regarding mental health. Once the contact information of prospective subjects were acquired, the researcher contacted individuals and administered the survey in a public location. If the respondents could not read or write, the researcher verbally posed and translated responses. Though the intended research model is mainly quantitative, these situations where translations were necessary resulted in a bit more of a qualitative research approach. This approach was followed until a sample size of 30 was obtained.

Measure Instruments

The instrument used was a questionnaire. It contained 25 questions, most of which were scaling. There was a demographic portion that asked age, sex, religious preference, marital status, and educational background of the respondent. Following the scaling questions, there were a few multiple choice questions and select all that apply questions as well as one open-ended response questions that asked respondents to define what they believe mental illness is.

The questions were divided into subsections. The various categories it covered were acculturation such as language and cultural identification of the client, personal

health questions, family health questions, and mental health questions. A portion asked specific questions about the participant's own mental health. More specifically, significant portions of the survey focused on how respondents felt mental health is generally perceived in the Hmong community, their choice of treatment when they are ill, and how they go about making health decisions.

The survey and informed consent were constructed with the guidance of this writer's project advisor. There were numerous discussions about risk levels of the survey, coherence in subtopics, as well as significant topics to cover that could be captured in a quantitative survey. Various review processes with the project advisor yielded a survey that was suitable for submission into the IRB committee. In general, the goal of the questionnaire was to obtain information from a small sample of Hmong adults. It inquired about their own mental health, their perceptions of mental health, and their choices of treatment for general illness.

Data Analysis

The data from the scaling questions were entered into SPSS for analysis. It took several sessions to enter and analyze the data. Extensive review and guidance was provided from this writer's project advisor to complete the analysis process. Through this program, the frequencies of each response and percentages as well as chi-square tests for independence were generated. The relationships between the variables are discussed in Chapter 4 of this study research.

Protection of Human Subjects

The application for the protection of human subjects was worked on by this writer and her project adviser over the duration of several weeks prior to the submission date. The IRB application itself was submitted electronically for the advisor's review and suggestive changes several times. The first draft underwent substantial changes in terms of content, wording and formatting.

The survey portion of the application was amended several times as well. The formatting, sensibility in its progression and themes, as well as its content were constantly rethought. Some of the questions in the first draft asked too specifically about mental health and created a possibility of exceeding minimal risk for the participants. Due to the nature of the research, surpassing this risk level would not have been necessary or desirable. The thesis advisor helped this writer to hone in on the purpose of each question and aided in rewording the survey content so that it would address the research questions and topics without placing any research participants at high risk.

The informed consent form was constructed with the guidance of the human subjects template guide made available by the office of graduate studies. Due to the mental health component of the survey, participants were provided mental health resources in both the Sacramento and Yuba Counties. In the case that participating in the research triggered any symptoms or a crisis, the participants would have a resource available in their respective counties to contact for assistance. The participants were also informed briefly on the content of the research. It was clearly stated that there would be no monetary incentives for the participants and no personal gain for the researcher. The

researcher and thesis advisor's contact information were included in the final informed consent form submitted to the human subjects review committee that was final approvied on November 30, 2012.

The application for the protection of human subject was first submitted October 26, 2012. It was first approved November 1, 2012 with three conditions: clarity of whether there is a conflict of interest, an amendment of the consent form to add the contact information of the thesis advisor, and to correct item 9 of the application from "exempt" to "minimal risk." The application conditions were reviewed with this writer's thesis advisor immediately and the requested changes were made. To better address the first condition, this writer discussed more explicitly how she would avoid conflict of interest by utilizing snowball sampling and not asking very closely relatives such as parents and grandparents to participate in the research. The advisor's email address was included in the consent form to satisfy the second condition. Item 9 of the human subjects application was already stated as "minimal risk" but EXEMPT under 45 CFR 46.101(b)(2) and so there were no further changes made to this portion. The application with amendments was resubmitted and accepted without any conditions. The human subjects application was officially approved on November 30, 2012 and assigned the approval number of 12-13-033.

Delimitations

Due to the time frame as well as lack of funding, there are a number of limitations to this study. Some of these limitations are the small sample size, the narrow range in geographical location that is covered, a lack of thorough studies due to the short time

frame of less than a year, and a higher probability of shortfalls in the questionnaire itself due to a lack of time for revision.

In terms of the questionnaire, the limited time frame can hinder the ultimate goal of generating quality questions that will be conducive to the research. Having less than a year to perform to create a questionnaire and collect data, there is no real opportunity to administer pre and post tests. This can compromise the results of the questionnaire and provides no additional opportunity to re-administer a second questionnaire if it is improved.

The snowball sampling method that will be employed can also be time consuming due to the contact and consent process. Rather than an approach such as convenience sampling where many questionnaires can be administered at a time without any pre-qualification process, subjects in the snowball sampling are more thoughtfully chosen. The lack of funding for incentives can also prolong the process of gathering willing participants. This can consume excess time and create a buffer between the administration of each questionnaire, potentially delaying the generation of data.

Another limitation of this study is the sample size. This small sample of less than 60 may not be representative of the larger population. The limited geographical region that can be covered in this research will yield data that is not inclusive of the larger Hmong population since the experiences and perceptions of a people can also be heavily influenced by environment. In essence, there is no time to cover reliability and validity issues.

Chapter 4

STUDY FINDINGS AND DISCUSSIONS

Given the lack of studies centered around general perceptions and understanding of mental illness and mental health in the Hmong community, this study explores how the Hmong go about seeking treatment for illness. A premise of the study is that by understanding how the Hmong understand illness and utilize healing and treatments in general, a better understanding of how they perceive and treat mental health symptoms will also be better understood. A general briefing of the history of mental health is also laid out to provide a context of how the Hmong fit into the greater Asian American banner within the Untied States. Stigma is also explored. In so doing, a more comprehensive lens of how policies have shaped the landscape of ethnic communities and mental health is better understood. Addressing stigma allows the reader to see how general stigma surrounding mental health treatment in the United States as well as stigma that already exists within cultures decrease mental health help-seeking trends in the Hmong community.

Per the research, it is highly important to consider the refugee status of the Hmong and the disparities that exist within the Asian and Asian American categorization. The history of trauma, war, and dislocation have greatly impacted and increased mental illness of the Hmong as well as affected their culture and support systems. Acculturation, language barriers, and stressors in resettlement have also influenced the evolution of this community. Despite these changes since their arrival, their cultural and religious

practices as well as history still influence how they perceive western ideologies about healing and how they continue to make decisions regarding health.

Overall Findings

There were a total of 30 Hmong individuals who participated in this research study. As the reported by the respondents, their ages ranged from 21 to 53 with the median age being 30.47 years and a standard deviation of 8.303 years (See Table 1 and 2).

Table 1

Age of Participant

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	21	2	6.7	6.7	6.7
	23	3	10.0	10.0	16.7
	24	2	6.7	6.7	23.3
	25	3	10.0	10.0	33.3
	26	3	10.0	10.0	43.3
	27	1	3.3	3.3	46.7
	29	2	6.7	6.7	53.3
	30	3	10.0	10.0	63.3
	31	1	3.3	3.3	66.7
	32	2	6.7	6.7	73.3
	34	1	3.3	3.3	76.7
	35	1	3.3	3.3	80.0
	37	3	10.0	10.0	90.0
	48	1	3.3	3.3	93.3
	51	1	3.3	3.3	96.7
	53	1	3.3	3.3	100.0
	Total	30	100.0	100.0	

Table 2

Age Statistics

N	Valid	30
	Missing	0
Mean		30.47
Median		29.00
Mode		23[a]
Std. Deviation		8.303

The gender identification of participants was 14 (53%) male and 16 (47%) female, resulting in a balanced response pool in terms of gender diversity. Important to note is that the sex was indicated on a fill-in basis (See Table 3).

Table 3

Sex of Participant

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	14	46.7	46.7	46.7
	Female	16	53.3	53.3	100.0
	Total	30	100.0	100.0	

When inquired about the participant's marital status, 60% (n=18) reported that they were married. Though separated and divorced were available options, there were no responses given for those two categories (See Table 4).

Table 4

Marital Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Single	18	60.0	60.0	60.0
	Married	12	40.0	40.0	100.0
	Total	30	100.0	100.0	

Religious preference was listed as either Shamanism, Christianity, or Other with a space provided for further specification. Specific directions were to choose one option. Of the 30 respondents, 19 (67.9%) respondents stated they practiced Shamanism while 9 (32.1%) respondents reported themselves as Christian. Two (6.7%) respondents stated they practice both Shamanism and Christianity. Due to the directions of the survey and for data analysis consistency purpose, those two responses were not included in the sample and are noted as missing (See Table 5).

Table 5

Religious Preference of Participant

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Shamanism	19	63.3	67.9	67.9
	Christianity	9	30.0	32.1	100.0
	Total	28	93.3	100.0	
Missing	System	2	6.7		
Total		30	100.0		

An educational level question was also included in the survey entitled “Highest Level of Education Attained.” The responses were on a fill-in basis. They ranged from

"No degree, High school diploma/GED equivalent, Associate's degree, Bachelor's Degree, Master's Degree, to Professional Degree." 3 (10%) participants reported having no degree. The majority of participants (90%) had at least a high school diploma or equivalent degree. 56.6% (n=17) of participants completed at least a two year degree. In addition, 15 (49.9%) respondents had at least a Bachelor's Degree, one of which completed a Master's Degree and another a Professional Degree (See Table 6).

Table 6

Highest Degree Attained

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No Degree	3	10.0	10.0	10.0
	High School Diploma/GED Equivalent	10	33.3	33.3	43.3
	Associate's Degree	2	6.7	6.7	50.0
	Bachelor's Degree	13	43.3	43.3	93.3
	Masters Degree	1	3.3	3.3	96.7
	Professional Degree	1	3.3	3.3	100.0
	Total	30	100.0	100.0	

Language and culture were variables to consider in this study as well. The majority of the respondents said they understand Hmong well (96.7%). 26.7% (n=8) strongly agreed that they speak Hmong well while 63.3% (n=19) agreed that they speak Hmong well. Two respondents answered neutral to the statement (See Table 7 and Table 8).

Table 7

I can understand Hmong well

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	13	43.3	43.3	43.3
	Agree	16	53.3	53.3	96.7
	Neutral	1	3.3	3.3	100.0
	Total	30	100.0	100.0	

Table 8

I can speak Hmong well

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	1	3.3	3.3	3.3
	Strongly Agree	8	26.7	26.7	30.0
	Agree	19	63.3	63.3	93.3
	Neutral	2	6.7	6.7	100.0
	Total	30	100.0	100.0	

In response to the statement "I can speak English well," 90% (n=27) of participants agreed or strongly agreed. Only 1 respondent disagreed while 2 respondents were neutral to the statement (See Table 9).

Table 9

I can speak English well

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	17	56.7	56.7	56.7
	Agree	10	33.3	33.3	90.0
	Neutral	2	6.7	6.7	96.7
	Disagree	1	3.3	3.3	100.0
	Total	30	100.0	100.0	

In terms of culture, 96.7% (n=29) agreed or strongly agreed with culture being valuable to them. 83.3% (n=25) stated that American culture was valuable to them. Important to note is the 14 strongly agree responses for the value of Hmong culture as compared to the 9 strongly agree responses for the value of American culture (See Table 10 and Table 11).

Table 10

Hmong culture is valuable to me

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	14	46.7	46.7	46.7
	Agree	15	50.0	50.0	96.7
	Neutral	1	3.3	3.3	100.0
	Total	30	100.0	100.0	

Table 11

American culture is valuable to me

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	9	30.0	30.0	30.0
	Agree	16	53.3	53.3	83.3
	Neutral	3	10.0	10.0	93.3
	Strongly Disagree	2	6.7	6.7	100.0
	Total	30	100.0	100.0	

In a crosstabulation analysis, religious preference and how the respondents valued the Hmong culture, 22% (n= 8) who identified themselves as Christian, strongly agreed to the statement “Hmong culture is valuable to me” as compared to 53% (n=10) of participants identified with Shamanism (see Table 12).

Table 12

Religion of Participant * Hmong culture is valuable to me

Count

		Hmong culture is valuable to me.			Total
		Strongly Agree	Agree	Neutral	
Religion of Participant	Shamanism	10	9	0	19
	Christianity	2	6	1	9
Total		12	15	1	28

Table 13

Case Processing Summary for Table 12

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Religion of Participant * Hmong culture is valuable to me.	28	93.3%	2	6.7%	30	100.0%

Table 14

Chi-Square Tests for Table 13

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.853[a]	2	.146
Likelihood Ratio	4.161	2	.125
Linear-by-Linear Association	3.276	1	.070
N of Valid Cases	28		

a. 4 cells (66.7%) have expected count less than 5. The minimum expected count is .32.

As displayed in Table 14, the chi square test of independence shows that despite the observed difference in religion and how participants valued Hmong culture from the data collected, there is not a significant association statistically (Chi-square= 3.853, df=2, p>.146).

Specific Findings

Due to unforeseen issues with the survey format, many correlation studies were unable to be generated. The scaling question responses on the survey would have been central to the chi square analyses. However, due to being formatted ranging from "strongly agree to strongly disagree" rather than from "strongly disagree to strongly agree," there were coding difficulties that made some of the data and data generations unusable. Despite this problem, however, there were significant findings that are important to note and are still relevant to this study based from a few chi square tables that were produced.

From the descriptive statistics provided in table 6 to table 10, it can be assumed that all respondents can understand and speak Hmong to some extent, the majority being able to do so more than not. The majority of respondents also are able to speak English well. The responses to the two questions that gauge how much respondents value Hmong and American culture suggests that though most respondents put value on both culture, more respondents than not are more in-tuned with the Hmong culture. Also important to note is the difference in how individuals who identify as shamanism "strongly agree" to

valuing Hmong culture whereas individuals who identify as Christian "agree" to the statement.

Religion then played a role in how participants responded to certain questions based on the observed data. When asked if participants have considered seeking mental health treatment in the past, most respondents who identified with Shamanism responded with either neutral (32%) or disagree/strongly disagree (63%). Only 1 respondent (5%) agreed to the statement. This is compared to the 44 percent of respondents who identified with Christianity agreeing to thinking about seeking mental health services in the past. Of these respondents 56 percent disagreed or strongly disagreed to the statement. This difference is substantial with a difference of 39 percent in an affirmative response to the statement (See Table 15).

Table 15

Religion of Participant * In the past, I have thought about seeking mental health services

Count

		In the past, I have thought about seeking mental health services.				Total
		Agree	Neutral	Disagree	Strongly Disagree	
Religion	Shamanism	1	6	7	5	19
	Christianity	4	0	3	2	9
Total		5	6	10	7	28

The chi-square test of independence was used to examine the association between religious preference and mental heath seeking behavior. The result of the chi-square shows that there is a significant difference between them (x^2=8.154, df=3, p<.043).

Table 16

Case Processing Summary for Table 15

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Religion of Participant * In the past, I have thought about seeking mental health services.	28	93.3%	2	6.7%	30	100.0%

Table 17

Chi-Square Tests for table 16

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.154[a]	3	.043
Likelihood Ratio	9.568	3	.023
Linear-by-Linear Association	1.418	1	.234
N of Valid Cases	28		

a. 7 cells (87.5%) have expected count less than 5. The minimum expected count is 1.61.

Among these same participants, about 63% (n=12) of participants identifying with Shamanism and 67% (n=6) of Christians agree or strongly agree that seeking mental health treatment is looked down upon in their communities (See Table 18).

The chi-square test of independence was used to examine the association between religion and whether or not respondents felt mental health treatment was looked down upon in their communities. The result of the chi-square shows that there is not a significant difference between them (x^2=494, df=4, p >.974) (See Tables 19 and 20). Regardless of religion, more than half of participants thought seeking mental health services was looked down in their communities.

Table 18

Religion of Participant * Seeking mental health services is looked down upon in my community

Count

		Seeking mental health services is looked down upon in my community.					Total
		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	
Religion of Participant	Shamanism	6	6	4	2	1	19
	Christianity	3	3	2	1	0	9
Total		9	9	6	3	1	28

Table 19

Case Processing Summary for Table 18

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Religion of Participant * Seeking mental health services is looked down upon in my community.	28	93.3%	2	6.7%	30	100.0%

Table 20

Chi-Square Tests for Table 19

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.491[a]	4	.974
Likelihood Ratio	.793	4	.939
Linear-by-Linear Association	.110	1	.740
N of Valid Cases	28		

a. 8 cells (80.0%) have expected count less than 5. The minimum expected count is .32.

When asked about whether or not someone in their family has had mental health problems, 32% (n=6) of Shaman participants responded with a yes. When asked the same question, 44% (n=4) of Christian respondents said yes. The difference is not drastic but there is a difference of 12% among the two categories of responses (See Table 21).

The chi-square test of independence was used to examine the association between religion of respondents and the mental help seeking histories of their families. The result of the chi-square shows that there is not a significant difference between them (x^2 =.440, df=1, p >.507) (See Tables 22 and 23).

Table 21

Religion of Participant * Has someone in your family had mental health problems?

Count

		Someone in your family had mental health problems?		Total
		No	Yes	
Religion of Participant	Shamanism	13	6	19
	Christianity	5	4	9
Total		18	10	28

Table 22

Case Processing Summary for Table 21

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Religion of Participant * Someone in your family had mental health problems?	28	93.3%	2	6.7%	30	100.0%

Table 23

Chi-Square Tests for Table 22

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.440[a]	1	.507		
Continuity Correction[b]	.058	1	.809		
Likelihood Ratio	.434	1	.510		
Fisher's Exact Test				.677	.400
Linear-by-Linear Association	.425	1	.515		
N of Valid Cases	28				

a. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 3.21.
b. Computed only for a 2x2 table

When asked about how respondents and their family go about seeking treatment for illness, 32% (n=6) of respondents identifying with Shamanism said they utilized hospitals and medical doctors, 5% (n=1) said they asked for the help of shamans, 42% (n=8) utilized Hmong medicine, and 21% (n=4) used over the counter medications. 44% (n=4) Christian respondents said they consulted hospitals or medical doctors, 11% (n=1) said they use Hmong medicine and herbs, 33% (n=3) utilize Christian prayer, and 11% (n=1) use over the counter medication (See Table 24).

The chi-square test of independence was used to examine the association between religion and how participants and their families go about treating illness. The result of the chi-square shows that there is not a significant association between them (x^2=9.253, df=4, p >.055). It is important to note, however, that these results were on the borderline of whether or not they were statistically significant (p<.05).

Table 24

Religion of Participant * When someone from your family is sick, how do you usually go about seeking treatment?

Count

		When someone from your family is sick, how do you usually go about seeking treatment?					Total
		Medical Doctor	Shaman	Hmong Medicine	Christian Prayer	Over Counter Drugs	
Religion of Participant	Shamanism	6	1	8	0	4	19
	Christianity	4	0	1	3	1	9
Total		10	1	9	3	5	28

Table 25

Case Processing Summary for Table 24

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Religion of Participant * When someone from your family is sick, how do you usually go about seeking treatment?	28	93.3%	2	6.7%	30	100.0%

Table 26

Chi-Square Tests for Table 25

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.253[a]	4	.055
Likelihood Ratio	10.421	4	.034
Linear-by-Linear Association	.013	1	.909
N of Valid Cases	28		

a. 8 cells (80.0%) have expected count less than 5. The minimum expected count is .32.

Interpretations of the Findings

The overall findings implicate that religious preference does impact to some degree how individuals perceive and go about seeking treatment. In terms of the raw data, individuals who practiced Shamanism identified more strongly with their Hmong culture, associated family health symptoms less with mental illness, considered in lesser instances about seeking mental health help themselves, and utilized at higher rates traditional medicine and traditional healing. Individuals who associate themselves to Christianity also had strong Hmong values but identified less strongly with them though statistically there was no significant association between religion and the valuing of Hmong culture. The willingness of Christians to seek mental health services were higher and though still utilizing traditional medicine and herbs, were less likely to do so as compared their Shaman counterparts. For this correlation study of religion and the thought of seeking self-help for mental health services, there was a statistically significant association.

An important variable that should be addressed is that Christians had a higher response to understanding what mental illness is. Participants identifying as Shaman had some neutral (16%) and strongly disagree (11%) responses to the question whereas 89% of Christians agreed/strongly agreed that they understand what mental illness is.

One last significant finding to mention is that despite religious differences, both groups of respondents stated that mental health services is looked down upon in their communities. 63% of participants identifying with Shamanism strongly agreed/agreed to the statement "seeking mental health services is looked down upon in my community." Similarly, 67% of participants identifying with Christianity responded the same. The data suggests that despite gender, religion, age, or marital status, mental illness is still highly stigmatized in the Hmong community, which may continue to deter individuals from seeking out services despite having mental health symptoms.

Summary

As the research has indicated, though cultural practices are utilized in Hmong communities in conjunction with modern medicine, traditional means of healing and treatment remain the primary choice of treatment regardless of religion (Cha, 2003). Though other identifying variables were included in this research study, religious preferences was one of the identifying characteristics that yielded the most significant difference in responses among participants.

Unfortunately this study was very limited. The small sample size does not fully represent the general Hmong population in the Sacramento and Yuba Counties. Due to language barriers and caution over what could be lost over translation, surveys were only

administered to English speaking individuals. This greatly impacted results due to the lack of inclusion of older Hmong adults. Though varying depending upon participant background, one important finding of this study is that regardless of sex, religious affiliation, and age, mental illness is still highly stigmatized in the Hmong community. This suggests the need for further outreach, education, and restructuring of services to mitigate some of the negative perceptions as well as to incorporate more cultural practices into existing treatment models.

Chapter 5

DISCUSSION

Summary of Study

The major findings of this research are that perceptions of health, healing, and mental illness in particular, are viewed differently by the Hmong compared to that of mainstream America. This is despite age, gender, religious belief, and varying acculturation levels. Though cultural practices that have been engrained in their daily activities for centuries have changed over time due to war, dislocation, and resettlement, many values and practices of the Hmong remain the same. For treatment, the Hmong despite their age, still believe in and utilize spiritual healing and traditional medicine. One hypothesis was that younger and more acculturated survey participants would respond with individualistic responses such as utilizing over the counter medications, consulting with doctors instead of traditional healers, and making their own health decisions. Contrary to this assumption, many younger and more acculturated respondents still turned to their families to assist in health decisions and even selected traditional medicine or shamans as their primary treatment choice. Many respondents indicated making the final decision about their health treatment plans but took into consideration their family's concerns and cultural beliefs.

Much of the literature focused on mental health diagnoses and practices in older Hmong adults and did not include children or young adults. In this way, though responses from participants regarding perceptions of health, healing and treatment for illness were consistent with the literature, there is a lack in research and suggestions on

how mental health should be implemented for the Hmong across age, gender, religion, and educational level. It is important to note then that despite age and acculturation levels, the literature holds true for the data collected in this research study.

Consistent with the literature review, stigma or being considered "vwm" (crazy) is still an issue in this community despite age, religious preference, gender, and education level. A majority of respondents stated that seeking mental health services is looked down upon in their communities. Though most respondents checked a number of feelings and emotions such as "always worrying," "being stressed," "lack of motivation," or "difficulty falling asleep," only 18% (n=5) of respondents ever considered seeking any kind of mental health assistance.

Furthermore, though 80% (n=24) of respondents stated that they know what mental illness is, the commentary section at the end of the survey suggested otherwise. Some of the responses were accurate with the definition of mental illness mentioned in chapter one, though a number of respondents associated mental illness more so with developmental delay. Some respondents even used words such as "stupid" and "dumb" to define mental illness, which is consistent with how mental illness is stigmatized and commonly misunderstood.

Though the study questionnaire did not ask questions that focused specifically on improving health and mental health treatment, the literature suggests that Hmong cultural beliefs must be considered and incorporated into treatment modalities in order to increase patient motivation and compliance with treatment. The research indicates that education on medical practices and illnesses and framing that explanation consistently with their

perceptions of healing can increase their understanding of their illness and also increase their consistency in treatment participation.

One last important finding to discuss is access to healthcare. Only 43% (n=13) of respondents stated they had healthcare coverage they could rely on. Of the 30 participants, 60% (n=18) stated they worry about their health but are worried they cannot pay for services. 33% (n=10) responded neutral to the statement and only 2 respondents (6%) disagreed or strongly disagreed. In addition to a lack of understanding of illnesses and treatments as well as stigma, healthcare access is also one factor that deters members of the Hmong community from seeking services and treatment for their ailments and health concerns.

In general, the research hypotheses of conflicting understandings of health and healing, stigma particularly surrounding mental illness, and the lack of culturally appropriate services are still issues that the literature suggests still negatively impact treatment for the Hmong community. Though there has been some motion to promote cultural competency, there is still too little information about health beliefs, understanding, and treatment preference of this community.

Implications for Social Work

From this research study, there are several social implications. At the micro level, there is a limited effort on promoting health awareness in this community. Though members of the community may feel they are informed about health issues, false health information, stereotypes, and stigma are affecting how many communities, particularly the Hmong in this study, understand and seek help for health concerns and illnesses.

There needs to be more active work within the social work community then to correct any false health information so communities are better informed about the truths of their illnesses and health conditions. This may alleviate any falsified stereotypes in general and also help patients and consumers to make more sound judgments and more well informed treatment decisions. Such education needs to be implemented not only at the micro level within agencies, but also at the macro level which will produce a momentous movement in correctly educating individuals on health issues which influences their choices and treatment decisions.

At the more macro level, there needs to be more research conducted in the field of social work. Whether it be medical health, mental health, or alcohol and other drugs, there is a very limited pool of information about how these issues are affecting the Hmong population in general, what their specific needs are, and how they are responding to them. If policies are being implemented without taking into considerations what actual needs of the community are and without meeting the community where it is, what may seem to be effective policies may not be as effective as they are projected to be and may even inflict more harm.

Recommendations for Future Research

One future study to consider is the dependence of second generation on the first generation in terms of treating ailments. Though survey participants stated that they utilize and uphold Hmong culture and traditional practices, a survey on how much they actually know about these practices would be an interesting take on this research. It will gauge how their decisions may change over time as the first generation, who are much

more knowledgeable of herbal medicines and traditional healing ceremonies, are no longer around to guide the process. Evaluating how their responses may change without these key players who bridge them to their cultural roots will be crucial to gauging and projecting how health perceptions and decisions will change over time for this particular group as well as figuring what further research needs to be done to preserve knowledge and traditional practices. If even without the first generation, the second generation will continue to uphold traditional practices, what can be done now to document cultural practices so they can be passed down and continued for future generations. What decisions as health care providers and professionals can be made to include these values in treatment?

Though religious differences was the focus of this study research due to results from the data collected, it seems educational level and gender also affect how strongly respondents identified with particular cultures. A study on how educational attainment and gender affect access to healthcare, general knowledge on health issues, and treatment decisions will be helpful in gaining a clearer snapshot of this community.

Studies that focus more specifically on mental illness diagnoses, treatment models, and receptiveness of services will be conducive to gauging what has worked for this community and what changes need to be made to make mental health education and services more successful.

In addition, studying more specifically and documenting how the Hmong view, understanding, and treat particular illnesses will also be instrumental in gaining insight on their beliefs, practices, as well as what has worked and what has not worked for them. In

this sense, a more holistic approach can be implemented so that differing treatment models do now ignite frustration but fruitful conversations that result in more inclusive and well thought out solutions.

Limitations

Though this writing will have its contributions, it also has its limitations. Due to the limitations of time, access, and a lack of funding, the pool of participants was rather small (n=30). A larger pool may have contributed to a more accurate and diverse response pool which may have changed significantly the data generated from the surveys. This research study was also limited in capacity to ask personal health questions due to risk factors. Due to its quantitative nature, the data collected did not collect suggestions from respondents in how to improve health services or how to be more inclusive of personal and cultural beliefs in treatment.

This research study also does not explore specifically the types of illnesses that are most prevalent and affecting this community as well as how the community itself goes about treating them with traditional and/or modern medicine. It does not detail the treatments individuals from this community use to heal particular ailments and does not investigate the utilization of healthcare services depending on age, gender, or socio-economic status. This research also does not provide clinical suggestions or treatment models on how to approach particular mental disorders when working with Hmong clients.

Conclusion

The major finding of this research is that perceptions of health, healing, and mental illness in particular, are viewed differently by the Hmong compared to that of mainstream America. Though cultural practices that have been engrained in their daily activities for centuries have changed over time due to war, dislocation, and resettlement, many values and practices of the Hmong remain the same. For treatment, the Hmong despite their age, still believe in and utilize spiritual healing and traditional medicine and turn to family when making health decisions. In general, the research hypotheses of conflicting understandings of health and healing, stigma particularly surrounding mental illness, and the lack of culturally appropriate services are still issues that the literature suggests still negatively impact treatment for the Hmong community. Though there has been some motion to promote cultural competency, there is still too little information about the health beliefs, understanding, and treatment preference of this community that take into consideration the diversity within this specific group.

In addition, stigma or being considered "vwm" (crazy) is still an issue despite age, religious preference, gender, and education level. A majority of respondents stated that seeking mental health services is looked down upon in their communities. Though most respondents checked a number of feelings and emotions such as "always worrying," "being stressed," "lack of motivation," or "difficulty falling asleep," only 18 percent (n=5) of respondents ever considered seeking any kind of mental health assistance. Furthermore, despite stating that they understand what mental illness is, many respondents when asked to describe mental illness associated it with developmental

delay, some respondents even using words like “dumb” in their definition. From this research study it can be concluded that many members of the Hmong community are ill or mis-informed about health issues including mental illness which further stigmatize seeking services. Stigma, mis-education in conjunction with lack of access to affordable health care continue to deter members of the Hmong community in this study to seek health services.

Appendix A

Survey Informed Consent

Consent to Participate in Research

You are being asked to participate in research which will be conducted by Yer Yang, a student in Social Work at California State University, Sacramento.

The study will explore the perceptions and experiences of the Hmong in the Sacramento area regarding health, healing, and mental health. You will be asked to complete several questions about your language and culture, you and your family's experiences with healthcare, and your understanding of mental illness. The questionnaires may require up to an hour of your time.

Some of the items in the questionnaire may seem personal, but you do not have to answer any question you do not want to. Some questions may also cause discomfort and have the potential to evoke undesirable thoughts or feelings. In these instances, resources are provided below.

If you reside in the **Yuba or Sutter Counties**, please contact Sutter Yuba Mental Health Services at (530) 822-7206, Monday - Friday from 8am to 5pm. They can be reached after hours at (530) 673-8255 or (888) 923-3800.

If you reside in the **Sacramento County**, please contact the Sacramento County Adult Mental Health Services at (916) 875-1055, Monday - Friday between the hours of 8am and 5pm. If you need immediate attention and it is after business hours, please call (888) 881-4881.

There may not be immediate benefits from participating in this research study. However, the information gathered will help to provide insight on how the Hmong population view and respond to health, healing, and mental illness. The study can help healthcare providers to offer services that are more culturally sensitive and inclusive of the beliefs of the Hmong community.

The researcher will make the rights to privacy and safety of the subjects a top priority. No identifiable information such as name, home address, social security number, or telephone number will be collected. The surveys will not be seen or handled by any other individual except the researcher and the faculty advisor. All of the information on the surveys will immediately be entered into a secure computer system and appropriately destroyed.
Due to the lack of funds available for the research, you will not receive any compensation for participating in this study.

If you have any questions, you may contact Yer Yang at (xxx) [redacted] or by email at [redacted]@gmail.com and/or the faculty advisor, Serge Lee, PhD at leesc@saclink.csus.edu.

Your participation in this research is entirely voluntary. Your signature below indicates that you have read this page and agree to participate in the research.

_____ _____

Participant Signature Date

Appendix B

Human Subjects Approval Letter

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

DIVISION OF SOCIAL WORK

To: Yer Yang Date: 11/30/2012

From: Committee for the Protection of Human Subjects

SACRAMENTO STATE

RE: YOUR RECENT HUMAN SUBJECTS APPLICATION

We are writing on behalf of the Committee for the Protection of Human Subjects from the Division of Social Work. Your proposed study, "Hmong Perceptions of Health and Healing: Shamanism, Mental Health, and Medical Interventions."

__X_ approved as **_ _ X _EXEMPT ____ MINIMAL RISK _____**

Your human subjects approval number is: 12-13-033. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Professors: Maria Dinis, Jude Antonyappan, Teiahsha Bankhead, Serge Lee, Kisun Nam, Maura O'Keefe, Dale Russell, Francis Yuen

Cc: Lee

Appendix C

Survey Questionnaire

Age: ____ **S**ex: _____ Marital Status ***(circle one)***: **Single / Married / Divorced / Separated**

Religious Preference *(circle one)***:** Shamanism / Christianity / Other *(specify):*_____

Highest Level of Education Attained:
_____

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Language and Culture					
1. I can understand Hmong well.					
2. I can speak Hmong well.					
3. I can read and write Hmong well.					
4. I can speak English well.					
5. I can read and write English well.					
6. Hmong culture is valuable to me.					
Personal Health					
7. I feel it is important to seek help when I am not feeling well.					
8. I regularly see my physician.					
9. I feel comfortable at doctor visits.					
10. I understand everything the doctor says to me.					
11. I make my own decisions about my healthcare treatment plans.					

12. I have health insurance coverage that I can rely on when I need it.					
13. I worry about my health but am afraid I cannot afford to pay for services and care.					
Family Health					
14. I have a family member who has visited the emergency room.					
15. People in my family visit their primary care physicians regularly.					
Mental Health					
16. I understand what mental illness is.					
17. Seeking mental health services is looked down upon in my community.					
Statement	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
18. I have or know someone who has sought out mental health services.					
19. I think there are people in my family who would benefit from mental health services.					
20. In the past I have thought about seeking mental health services.					

ADDITIONAL HEALTH QUESTIONS

21. Generally when someone from your family is sick, what treatment do you first seek out?

    a. Medical doctor or hospital
    b. Shaman/Traditional Healer
    c. Hmong or Oriental medicine/herbs
    d. Christian prayer
    e. Over the counter drugs
    f. Other (specify):_____

22. On most occasions, how does your family go about making significant health decisions?

    a. Individuals make their own decisions
    b. The parents make the decisions
    c. Our whole family makes decisions together
    d. We utilize the clan system to make health decisions
    e. We do not talk about health problems at all
    f. Other (specify): _____

23. Has someone in your family ever had one of these health problems? (Check all that apply)

    a. ___mental illness
    b. ___diabetes
    c. ___high cholesterol
    d. ___high blood pressure
    e. ___stroke
    f. ___heart problems
    g. ___kidney failure
    h. ___alcohol addiction
    i. ___drug addiction
    j. ___cancer → (please specify if known): _____

24. Have you ever had any of the following experiences/emotions? (Check all that apply)

a. ___Loneliness
b. ___Lack of motivation
c. ___Excessive worry
d. ___Always feeling stressed
e. ___Feeling isolated
f. ___Easily frustrated
g. ___Experience loss of appetite
h. ___Difficulty falling asleep

25. To me, mental illness is:

_____

_____

_____

_____

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