BARRIERS TO MENTAL HEALTH SERVICE UTILIZATION BY IU MIEN AMERICANS

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BARRIERS TO MENTAL HEALTH SERVICE UTILIZATION BY IU MIEN AMERICANS

A Project

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Division of Social Work
Abstract

of

BARRIERS TO MENTAL HEALTH SERVICE UTILIZATION BY IU MIEN AMERICANS

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Lai F. Saechao

The role of culture has significant implications for mental health services and treatments for Southeast Asians. The Iu-Mien who immigrated as refugees of war from Laos experienced tremendous amounts of trauma prior to arriving in the United States. Many had direct exposure to war trauma, experienced pre and post migration trauma and acculturation stress. While mental illnesses are evident in the Mien community then and now, many do not seek services. This research project examined the low utilization rates of the Mien for mental health services as well as the cultural beliefs, values, attitudes, and behavior that may affect their utilizations. The findings from this study revealed that traditional methods of healings remain in practice in conjunction with Western treatments.

________________________________________, Committee Chair

Serge Lee, Ph.D., MSW

Date: _________________________________

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Chapter 1
THE PROBLEM

Introduction

As the United States becomes more and more ethnically diverse, understanding the complex interrelationships that exist between race and health is important. Currently, mainstream services often do not provide appropriate or adequate care for individuals and their families from ethnic minority groups with mental health problems (Atadjin & Vega, 2005; Surgeon General Report, 2001). Such a group is the Iu-Mien community, an ethnic minority group from which this researcher is a member of from Southeast Asia.

Because the Mien people are relatively new into the United States, the first having immigrated as refugees of war in the 1970’s, it is a group that is almost completely unrecognized by the dominant or majority of the population (Schulberg, 2005). This has resulted in very little outreach, understanding, and representation for the Mien people in the United States making them a greatly underserved group for mental health services (Kim, 2006; Ying, 2001).

Although there have been some studies done on the Mien among other Southeast Asian groups, their involvement in the Vietnam War, and their resiliency in the United States, there is a general lack of research done to explore mental illnesses within the Mien population, their perceptions and understanding of it, and the barriers they face on utilizing mental health services. Studies done in the past have focused primarily on other Asian groups such as the Chinese-Americans, Japanese-Americans, and Korean-Americans, who have been in the United States longer and are more assimilated into
mainstream American way of life (Kim, 2006; Uehara, Takeuchi, & Smukler, 1994). These groups often have more capability accessing resources, in turn, the utilization rates among them are much higher (Kim, 2006).

Research studies on the aforementioned group are much more limited. As a group, Southeast Asians are more vulnerable and susceptible to mental health problems as compared with other Asians due to their war, migration, and other adverse experiences that they have had undergone (Kim, 2006; Ying, 2001; August & Gianola, 1987). However, it is common knowledge among social service providers and mental health professionals for many years of the underutilization rates of mental health services by Southeast Asians. The disparities in mental health services and treatments available for different racial minority groups have also been well documented (DHHS, Surgeon General Report, 2001). But, unlike other minority groups such as the Latinos and African Americans who have more resources available to them, Southeast Asians and particularly the Mien and Hmong people who are relatively new in the country, often find themselves at a major disadvantage. Upon first contact with the United States, they are faced with the challenges of navigating through a completely different social structure as they are confronted with the laws, traditions, institutions, and the dominant American way of life. Many do not speak, read, or write English while having to deal with conflicting cultural values.

**Background of the Problem**

According to a report to Congress from the Office of Refugee Resettlement (2006), Southeast Asians remain the largest group among the recent groups admitted into
Southeast Asians have been arriving into the United States since the early 1960’s after the Vietnam War. The first groups to arrive were the Vietnamese, followed by the Cambodians, and Laotians. The Laotians were comprised of a mixture of lowland Laotians and the highland tribal people that included the Iu-Mien and Hmong people who were the last to resettle in the United States (Kim, 2006). In 2003, the U.S. Bureau of the Census noted that there are over two million Southeast Asians residing in the U.S. Approximately 32,000 of them are the Mien people living throughout the United States (Schuldberg, 2005).

As refugees of the Vietnam War, the Mien, Hmong, and other Southeast Asian groups were uprooted from their homeland and transported into a very different whole new way of life in America (Saetern, 1998). From living in an agrarian society to living in a technologically advanced one here in United States, the Mien people have had to overcome huge social and cultural obstacles. Such cataclysmic events present a high need for mental health care for the Mien people as War trauma, post-traumatic stress disorder (PTSD), major depressive disorder and other mental health disorders may result (Kim, 2006). Left untreated, the mental health disorders can have very serious consequences such as disability, distress, depression, and in extreme cases, suicide (Kim, 2006).

With each new Mien refugee or other Southeast Asian immigrants, the need to deliver culturally sensitive services to minority groups may help to increase mental health utilization rates by members of these groups. Minority groups such as the Mien
have different cultures that influence many aspects of their mental illness, such as how mental illnesses are perceived, and treated (Furuto, Biswas, Chung, et al, 1992). This includes how they understand, communicate and manifest their symptoms. Their style of coping, family and community supports, and their willingness to seek treatment are also affected (Furuto, Biswas, Chung, et al, 1992).

Mental service providers as well as social service providers need to be able to work with populations such as these who are especially vulnerable, understanding the traumatic experiences that they have undergone. Multicultural-education and trainings may necessary for clinicians and providers to deliver appropriate services. By being culturally educated, sensitive and aware, social workers and mental health providers can developed stronger rapport, trust, and relationship with ethnic minority groups.

Statement of the Research Problem

Mental illnesses are serious problems with potentially crippling effects. In the United States, mental illness is the number one cause of disability, accounting for more burden than even those associated with all forms of cancer (Davidson, Tondora, Lawless, et. al, 2009). Many Mien, like their Southeast Asian counterparts, have directly or indirectly experienced pre-migration and post–migration trauma, war trauma, and trauma related to being refugees and their encampment, adding many layers of suffering and stress to their lives. According to Kim’s (2006) study on mental health disorder among Cambodians, Laotians, Miens and Vietnamese, who migrated into the United States during the 1970s – 1980s, found that many of the refugees who experienced firsthand war and were at high risks for having War trauma such as PTSD. These
refugees stayed in refugee camps throughout Thailand (Kinzie, Boehnlein, Leung, et al., 1990). There in the refugee camps, freedom and life conditions were so horrible that they faced tremendous stressful life events and were uncertain of their futures (Hsu, Davies & Hansen, 2004; McDonald, 1997; Kinzie, Boehnlein, Leung et al., 1990). The Mien people who lived mainly in Laos had very little contact with modern society were the least prepared for life in the United States and tended to experience more psychological difficulties (Kim, 2006; Ying 2001). Upon arrival into the United States, poverty, illiteracy, prolonged dependency on welfare, sociocultural change and isolation, language barrier and loss of self-esteem exacerbates their struggles (Kinzie, Boehnlein, Leung et al., 1990) All are contributing factors that may lead to mental illnesses within the Mien community.

In the United States today, mental illness is evident within the Mien community; however, it has not been addressed adequately or even appropriately for many reasons. One of the main reasons is the difference in the understanding and perception of mental health and what mental illnesses constitute for the Mien people as opposed to the American or Western conception of mental illnesses. Another is the fact that there are very limited resources and professionals who are experienced in working with such a population. Barriers in language, mental health professionals who are cross culturally competent, and culturally sensitive services are evident. The few culturally sensitive services that does exist may be unknown to the Mien people. Problems accessing them may also include lack of health care that will cover mental health services and the stigma that is associated with seeking mental health services.
The researcher selected this topic due to the lack of empirical research conducted on this population, their perceptions of mental illness, and barriers faced by them while seeking to utilize mental health services. One of the main objectives is identifying common barriers that the Mien may have encountered as well as those that are preventing them seeking mental health treatments. Such services include psychotherapeutic counseling, psychological testing, and social support networking.

**Purpose of the Study**

The primary purpose of this study is to identify mental health services barriers by the Iu-Mien and their awareness of the mental health service programs. Due to the limited resources that are currently tailored to meet the needs of the Mien, it is hoped that the results of this study may also provide mental health professionals and other social service providers with the needed information, insight, and understanding on the Mien people and how to increase mental health service utilization by this population. Additionally, it is also hoped that the study will influence social service providers and mental health professions to conduct more in-depth evaluation in the ways of assisting the Iu-Mien and to deliver culturally sensitive services that will meet the needs of the Mien community.

The assumptions made to support the research objectives include: (1) Culture plays key roles in mental health, mental illness, and mental health services; (2) language barriers hinders the Mien to understand mental health disorders; (3) there is a lack of Mien trained mental health providers and, (4) The Mien people continue to rely heavily on traditional, non-western healings methods for their mental health needs.
Theoretical Frameworks

The ecological perspective (Payne, 2005) was used as the theoretical framework for the research project. As stated by Payne, the ecological framework focuses on the unique background experiences and contributions of ethnic groups and focuses on the interaction between people and how an individual is impacted by their environment in the way they think, perceive, and interact with others in the world. By understanding how one is affected by their environment, the individual is better equipped to make the necessary changes within themselves and or in their surroundings for a better life. This perspective is useful in which it takes into consideration the cultural aspects, such as the individual’s ethnicity, values, and beliefs, and their ways of communication on issues such as their mental health. It is holistic and recognizes that all systems past and present have impacted the development of an individual and their perceptions of the world (Payne, 2005). Any change at one part of a system will influence activity in another system. The fluid changes between systems allow social service providers and mental health professional flexibility when working with minorities. In addition, working with one member of the family on the benefits of receiving mental health services may impact the entire family and Iu-Mien community.

Given that the Mien and other Southeast Asian minority groups lack knowledge and resources within their new communities in America, the ecological perspective is important to consider because of their need to understand how individuals, groups, and systems interact and impact one another within their environment or society. This framework helps mental health providers to understand the cultural dynamics of the
Mien people, their historical experiences, and attempt to achieve equilibrium between the person and their environment.

From a multilevel of practice, the ecological perspective accounts for the macro, mezzo and micro impacts of the environment on the individual. For the Mien people, this can mean an acknowledgement and understanding of their war, prosecution, poverty, oppression in the refugee camps, and relocation experiences at the macro level. At the mezzo level, the Mien people’s experiences of families torn apart, communities, and homes destroyed during the Vietnam War with no social support. At the micro level, the psychological development of the Mien people can be understood from their experiences of starvation, war, and death of a loved one.

Bicultural Socialization will also be used in this research. De Anda (1984) explains that bicultural socialization is the process in which ethnic minority groups become acculturated into the dominant culture accepting values, perceptions, and normative behaviors while maintaining their own. Bicultural socialization is a theory that also recognizes that ethnic minorities need help in order to maintain their own cultural identity while functioning in the mainstream culture in America. Bicultural socialization highlights the similarities and differences between social groups and the cultural overlap that the Mien people may experience in the United States. Both theories address the significance of cross-cultural work. Their application to the research on mental health utilization by the Mien will be presented in the following sections.
Definition of Terms

The following are definitions of terms used throughout this research project.

Southeast Asians: “people from Vietnam, Cambodia, and Laos, who are characterized by seemingly common factors, such as geographic region of origin, recent war experiences, and migration experiences” (Kim, 2006).

Mental Illness: Mental illnesses are “medical conditions that disrupts a person’s thinking, feeling, mood, ability to relate to others, and daily functioning” (NAMI Factsheet, 2009).

Refugee: According to the Refugee Act of 1980, Section 201, a refugee is, “any person who is outside any country of such person’s nationality or, in the case of a person living with no nationality, is outside any country in which such as person habitually reside and who is unable to or unwilling to return to, and is unable to avail himself or herself of the protection of that country because of persecution or a well-founded fear of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social or political group or political opinion” (ORR report 2006).

Immigrant: An immigrant is referred to as an alien that was lawfully admitted to the Unites States for permanent residence. They are also any lawful permanent residents who willingly emigrated from a different country into the United States in search of a better life.

Alien: refers to any individual who is not a citizen of the Unites States.
PTSD: According to the DSM IV TR (2000), posttraumatic stress disorder is the, “development of characteristic symptoms following exposure to an extreme traumatic stressors involving direct personal experience or an event the involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person”.

Perceptions: Mental image, intuitive cognition, comprehension, and awareness of the elements of environment through perceiving (Merriam-Webster Dictionary, 2008).

Acculturation: cultural modification of an individual, group, or people by adapting to or borrowing traits from another culture; it is the merging of cultures as a result of prolonged contact. (Merriam-Webster Dictionary, 2008)

Culture: defined as an integrated pattern of behavior shared among a group of people that includes ideology, thoughts, beliefs, speech, action, and artifacts. It is passed from one generation to the next through ceremonies, rituals, traditions. The primary purpose of culture is to give a general guideline for living and interpreting reality for a specific group of people (Livingston, Holley, Baton, et al, 2008).

Cultural Bereavement: “the experience of the up-rooted person . . . resulting from loss of social structures, cultural values and self-identity. . . . The person . . . suffers feelings of guilt over abandoning culture and homeland, feels pain if memories of the past begin to fade, but finds constant images of the past intruding into daily life. . . .It is not of itself a disease but an understandable response to the catastrophic loss of social structure and culture” (Davis, Kennedy, & Austin, 2009).
Culture Bound Syndrome: According to the DSM IV TR, Culture Bound Syndrome is defined as “recurrent, locality-specific patterns of aberrant behavior and troubling experiences that may or may not be linked to a particular DSM-IV diagnostic category” (pg. 898).

Cross-Cultural Competence: A culturally competence system, “acknowledges and incorporates-at all levels-the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs. It is also built on an awareness of the integration and interaction of health beliefs and behaviors, disease prevalence and incidence, and treatment outcomes for different patient populations” (Betancourt, Green, Carrillo, et al., 2003).

Refugee: According to the Immigration and Nationality Act in Section 10.1 (a), a “refugee” is defined as “any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of, that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. Refugees are permitted legal entrance into the United States in search of freedom, peace, and opportunity for themselves and their families (ORR report 2006).

Resettlement: “Permanent relocation of refugees in a place outside their country of origin to allow them to establish residence and become productive members of society
there. Refugee resettlement is accomplished with the direct assistance of private voluntary agencies working with the Department of Health and Human Services Office of Refugee Resettlement” (ORR report 2006).

**Summary**

The introduction, background of the problem, statement of the problem, purpose of the research project, theoretical frameworks used in the research are discussed in chapter one. The definition of terms that will be used throughout the research project as well as the limitations of the project are also included in chapter one. Chapter two will consist of literature review on three themes of the research: (1) The Mien’s cultural understanding and perceptions of mental health; (2) the accessibility of the mental health services to the Mien; (3) the communication and language barriers between the Mien and mental health providers. The gap in literature will also be included in chapter two. Chapter three is a description of the methodology used in this research project. It will consist of the research design, study population, sampling method, measurement instruments, data collection procedures, statistical analysis plan, and the protection of human subjects. Chapter four is a presentation and analysis of the data collected for the study. In chapter five the findings are discussed as well as the implications and recommendations for social service providers and mental health professions.
Chapter 2

LITERATURE REVIEW

Introduction

There have been numerous published literatures on the classic impacts of immigration, war, trauma, and the specialized problems of refugees and minority groups from Southeast Asia. Much of the researches completed were in concerned with the mental health status and needs of Southeast Asians as a result of their various traumatic experiences before and after their resettlements into the United States. Often the findings of these researches describe the low-utilization rates of mental health services by the refugees and inadequate social service programs that are tailored to meet the mental health needs of refugees who come from agrarian societies. As a result the literature review of this research project is organized into the following themes: (1) The history of the Mien; (2) acculturation stressors and bicultural socialization; (3) the Mien’s cultural understanding and perceptions of mental health; (4) cross-cultural competence by mental health service providers; and (5) the structural and communication barriers. The researcher believes that these themes of the research will help identify and explain some of the barriers that the Mien people face when seeking mental health services. The themes of this research also lend information on the current plight of the Mien and their need for culturally appropriate services and may offer guidelines for the development of such services. The literature review chapter of this research will also include the gaps in literature.
History of the Mien

The Iu-Mien are also known as the Mien, Yiu Mien, or the Yao, a Chinese term. To have a better understanding of the mental health needs of this group of people and their ongoing struggles in America, it is crucial that the history of the Mien, their life in Laos and Thailand, their pre- and post-migrational experiences and their involvement in the Vietnam War be explained. Today, the Mien people are recognized as one of many contemporary Southeast Asian minority groups who originated from China. There is relatively little literature written about the Mien people because of their lack in literacy and contacts with outside society. The few literature that exist documents the long migration of the Mien people from central China between 600 and 700 years ago (Schuldberg, 2005; Barker & Saechao, 1997). These documents discussed the vague migration of the Iu-Mien from the mountainous areas in Central China to West China due to taxes and their searches for freedom. There is an estimated 1.4 million Iu-Mien who still remain in China (Barker & Saechao, 1997). According to Barker and Saechao (1997), in the 1700’s, some Mien migrated to Vietnam while in the mid-nineteenth century other Mien moved to the highlands of Laos and Thailand. By 1945, there was an estimated 200,000 Iu-Mien in Vietnam, the second largest Mien population worldwide after China. At the same time in Laos and Thailand the Mien population was estimated to be around 50,000 (Barker & Saechao, 1997).

In the late 1960’s and early 1975’s, the Mien people became an important component of US war strategy in the Vietnam War. American forces and the United States CIA recruited the Mien and other mountain hill tribe’s people of Laos to fight
frontline against communist forces in Southeast Asia. The Mien and Hmong were among
the groups that were recruited under the Hmong leader Vang Pao (Schuldberg, 2005).
This provided the United Sates with intelligence, surveillance, as well as man power in
Laos (Saetern, 1998). In return, the Mien and other groups were promised with
protection from reprisals and if needed, relocation into the United States (Barker &
Saechao, 1997). When the war ended in 1975 with the victory of the Communist forces
in Indochina, the United States withdrew their forces leaving the Mien people, the
Hmong, and other Southeast Asian groups with no protection from prosecution by the
Pathet Lao communist government (Schuldberg, 2005; Hsu, Davies, & Hansen, 2004;
Ying, 2001). Many Mien in Laos were forced to flee escaping through the jungles of
Laos and across the Mekong River into Thailand where refugee camps were opened by
the Thai government to admit the waves of refugees coming in from the surrounding
countries. In this treacherous journey many Mien people died, some were captured, shot,
and killed by the Communist soldiers and others drowned in the river or died of
sicknesses related to the difficult travel (Hsu, Davies, & Hansen, 2004; Saetern, 1998,
Howard, 1989).

In order to successfully cross the Mekong River and survive the journey, they
had to be physically able and have enough money to pay for assistance or bribe the
border patrols. Those who were able to survive the perilous journey and admitted into
the refugee camps lived within a limited area of the barbed wire fencing under Thai
authority constantly guarded and surrounded by Thai soldiers (Saetern, 1998). The
restrictions were very harsh and the Mien people had very little freedom. They were
unable to farm or raise livestock of any kind, relying on Thai officials to distribute food given by United States to their families their entire stay (Saetern, 1998).

In 1980, the Refugee Act was passed, replacing the Immigration and Nationality Act, which defined what constitutes refugee status and the process of refugee entrance and resettlement (Schuldberg, 2005; Saetern, 1998; McDonald, 1997). Through this policy, the Iu Mien became eligible to apply for resettlement in the United States. Despite the harsh conditions of living in the camps and the poor treatment by Thai authority and government, many Mien people were reluctant to leave their homeland and go into a completely new and foreign country. Many Mien families stayed in refugee camps in Thailand for many more years before finally making the decision to come into the United States and were forced to reconcile living a different way of life from the one they had in their native home countries. By the late 1980’s, only about 15,000 Mien remained in Southeast Asia primarily in the hills of Laos (Barker & Saechao, 1997). The majority of the Mien, 85 % in Southeast Asia immigrated into the United States while others went to France or Australia (Barker & Saechao, 1997).

**Acculturation Stressors**

Acculturation is a prominent theme in the literatures as it relates to the Mien people and their mental health needs. Defined as a “cultural modification of an individual, group, or people by adapting to or borrowing traits from another culture”; or the “merging of culture as a result of prolonged contact”, (Mirriam-Webster Dictionary, 2008), acculturation and the difficulties of resettling into a new country creates psychological distresses for newly arrived immigrants and refugees directly impacting
their mental health (Beiser & Hou, 2006). Like other immigrants and refugees, the Mien people faced acculturation stress directly related to the loss of their family/social network, social isolation, shifting gender roles, racism, language barriers, and intergenerational conflicts (Fung & Wong, 2007; Moore & Boehnlein, 1991). The immigration into the United States and the transition from life in Laos and Thailand to the one in America was an especially difficult one for many Mien people further compounding their previous stressful events and trauma.

Prior to the Vietnam War, and their arrival to America, the Mien people were locked into their own culture, remaining mostly isolated from their host countries of Laos and Thailand, living peacefully in villages of about 200 people practicing subsistence agriculture (Barker & Saetern, 1997). They farmed on the slopes of mountains planting rice, corn, squash and a variety of vegetables (Saetern, 1998). Many Mien also raised livestock such as pigs, chickens, ducks, and cows. These provided daily food for the families. For most Mien raising livestock and farming was their only source of livelihood. Because the manual labor that comes with farming and caring for livestock was often demanding, the men, women and children were all required to work on the farms daily, taking up most of their time (Saetern, 1998). There was no time for school, resulting in most Mien being illiterate before their arrival into the United States (Barker & Saetern, 1997). Upon arrival into the United States, not only do the Mien experience a sense of loss of their homeland (Hsu, Davies, & Jansen, 2004) but they are also faced with the choices of remaining committed to their ethnic identity, abandoning their heritage and attempting to achieve full assimilation or compromise between their old and
new life (Beiser & Hou, 2006). These choices are often much more difficult for the elderly or older Mien generations who tend to have more difficulty with transitioning and assimilating and are often left behind (Moore & Boehnlein, 1991).

**Bicultural Socialization**

Bicultural socialization is a theory that highlights similarities and differences between social groups and the cultural overlap that may exist. It is an important theory to consider as it sheds light on the reason why many older Mien may be having a more difficult time with their new life in America. This theory was developed primarily by DeAnda (1984) in which she describes six factors that determine the process of successful bicultural socialization. The first factor is the degree of overlap between two cultures in regards to norms, values, beliefs, perceptions, and other such commonalities. The second factor is the availability of translators, mediators, and models who act as socializing agents for other members of the group. DeAnda (1984) explains that translators are the most effective agents in promoting dual socialization in which they are able to offer extensive information to the members of the ethnic group. Through sharing their experiences, providing information that facilitates understanding of values and perceptions of the majority culture, translators are able to convey ways to meet the behavioral demand of the dominant culture without compromising ethnic values and norms. Translators are also often a member of the ethnic minority group themselves. Mediators are individuals in the mainstream culture serving as providers of information and guide for the ethnic minority person. They may include persons serving in formal socializing agencies such as teachers, counselors, and social workers. Models are
individuals from the ethnic minority culture whose behavior patterns are consistent with
the dominant culture and serve as a pattern for others in the same culture to emulate.

The third factor notes the amount and type of feedback, positive or negative from
each culture in attempts to produce normative behaviors. The fourth factor describes the
conceptual style and problem-solving approach of the minority individual and their
connection with the valued styles of the majority culture. The fifth factor discusses the
individual’s degree of bilingualism and the sixth factor is the dissimilarity in physical
appearance from the majority culture.

In the United States, the Mien people are different from the Caucasians and the
dominant culture. Foremost is the conspicuousness of the Mien people’s physical
appearances compared to that of the majority of the population. Their belief systems,
values, norms, perceptions, culture, and language are also very different. Successful
biculural socialization calls for the overlap of all these and becomes difficult for
individuals from a minority culture to assimilate or adapt when there is insufficient
commonalities. It is important to keep in mind that while bicultural socialization is
possible, it is largely dependent on the interaction of the six factors outlined, accounting
for the different degrees and levels. Different individuals may be at different stages of
the bicultural socialization process in which some may be at the beginning stages where
they may be seeking commonalities between the Mien culture and that of the dominant
cultures. Others may be processing the differences and similarities between the Mien
culture and the dominant culture and creating their own normative behaviors to help
them adjust. And, others who may have established a degree of bicultural identity and
are becoming a part of the dominant culture at the same time as maintaining their own cultural identity. There may also be other Mien people who have not achieved any degree of dual identity and remain locked in the Mien culture. Second generation Iu-Mien are more likely to maintain a dual identity compared to the first generation or their immigrant family members and relatives.

*Culture and Perceptions of Mental Health by Iu Mien*

Livingston, Holley, Baton, et al, (2008) defined culture as an “integrated pattern of behavior shared among a group of people that includes ideology, thoughts, beliefs, norms, values, and speech passed down from one generation to the next through ceremonies, rituals, and traditions” (p. 2). Given this definition of racial and ethnic culture, the primary purpose and function of cultures is to provide a group of people with a general guideline for living and interpreting their realities. Livingston, Holley, Baton, et al, further concludes that, “Culture, in itself, is alive and is an extension of a group of people’s experiential reality. Culture is an entity rich with images, symbols, and belief systems that signal to the individual, on both a conscious and unconscious level, that not only is this a context whereupon the mores and traditions of one’s ancestors or elders have been kept, valued, and transmitted, it is also an entity essential and ideal for the reproduction, socialization, and correct orientation of successive generations” (p. 3).

In mental health issues, culture provides explanations of how people become mentally ill, how the illness should be treated, whether to seek services or not, and what type of services are sought. Culture also influences perceptions of what constitute as an acceptable treatment option, the coping styles and social support that individuals who
become affected with mental illness have, and how much stigma is attached to mental illness Matkin, Nickles, Demos, et al., 1996; Furuto, Biswass, Chung, et al, 1992). If help is sought for, these will all affect the interactions of the client and the healer. Mental health agencies and practitioners that do not understand or take into account the influence of culture on mental health and mental illness may deter minority groups from utilizing services and receiving the appropriate care they need (Surgeon General Report, 2001).

Studies of the impact of culture in mental health and help seeking behaviors done on non-Western culture suggest that the beliefs in the etiology of the illness often predicts if an individual will seek help (Fung & Wong, 2007). In examining explanatory models of illnesses in different culture, four domains are identified in the causation of mental illness by Fung and Wong. The first is the factors within the individual themselves such as their habits, behaviors, emotion and hereditary factors. The second are the factors in the environment, which includes the weather, pollution, bacteria and germs. The third is the perception of the illness as being caused by the actions of others such as interpersonal stress, or catching the illness from others and the carelessness of others. The fourth is the belief that mental illnesses are caused by supernatural factors that includes religious beliefs, beliefs in spiritual world, destiny, karma, and witchcraft, among other beliefs (Fung, & Wong, 2007).

Since their arrival into the United States, the Mien people have continued to retain their culture in the midst of a different one here in America. In order to do so, Mien refugees who first arrived in America re-grouped into large village-like
communities throughout the West Coast, primarily in Oregon and California where they are able to maintain ties to their culture, the Mien community, and their historical heritage (Barker & Saechao, 1997). Before coming into the United States, the Mien people had little or no exposure to westerners, their way of life, culture and perceptions of the world (Saetern, 1998). Therefore, upon arrival into the United States, the Mien people like their other Southeast Asian counterparts, had little or no knowledge of the beliefs and practices around the Westerns perceptions of mental health and mental health illness (Moore, Sager, Keopraseuth, et al, 2001). As stated by Moore & Boehnlein, in a study of psychiatric disorders among the Mien peoples, “their traditional rural culture remained essentially intact over many centuries” causing them to experience “the most extreme differences in beliefs, traditions, and values” than other refugee groups (p. 1030).

The Mien also had very little experience with the Western healthcare systems and are often confused about the roles of specialist (Moore, Sager, Keopraseuth, et al, 2001). Moore and colleagues stated further that the perception of mental illness occurring as a result of a chemical imbalance in the body or other illnesses such as Depression and PTSD is largely unknown to the Mien people. The etiology of illness and the appropriate treatments for the Mien people is vastly different from the Western models. Much of their understanding of health and healing is directly related to their religious beliefs in the spiritual world, the balance between yin and yang and their harmony with nature (Uba, 1992). For the Mien people, their religion is the core of their culture (Moore & Boehnlein, 1991). It is a mix of animistic beliefs in environmental and
supernatural spirits and ancestors worship along with the worship of the Taoist pantheon deities (Barker & Saechao, 1997). The spiritual world is seen to have direct influence over the lives of the Mien people, their well-being, health and happiness as well as their healing (Barker, & Saechao, 1997). They worship their ancestral spirits and see them as primarily helpful spirits who can offer protection and assistance in dealing with the spirit world. However, ancestral spirits can also be the cause of afflictions and illnesses when they are offended or not given the proper offerings of food and money for the spirit world. In such cases, where an ancestor or other spirit is believed to be the cause of illness, a Shaman or spiritual leader who is able to communicate in the spirit world is usually called for. The Shaman acts as an intermediary between the two worlds and treat the illness by performing spiritual ceremonies, rituals, and animal sacrifices such as chickens, pigs, and cows (Moore, Sager, Keopraseuth, et al, 2001). An offering of paper money is also included to appease and beseech the spirits for help to heal the illness (Moore, Sager, Keopraseuth, et al, 2001).

“Soul loss” is another phenomenon that many Mien believe to be a serious cause of mental illness. The Mien people believe that an individual has many souls or “hwen bach” that acts as a protection for their physical and spiritual well-being (Moore & Boehnlein, 1991). Parts of the soul can be lost as a result of being cursed, after an sickness, having a fearful or traumatic experience, having feelings of anger and grief or having their soul lead astray by evil spirits causing mental illnesses (Moore, Sager, Keopraseuth, et al, 2001). Evil spirit possession is believed to be another cause of mental
illness. The Mien people believe that evil spiritual possession can cause an individual to die, go crazy and or commit suicide (Moore & Boehnlein, 1991).

Although, religion and spirituality has not been a popular topic of discourse among mental health professionals and behavior scientists, it is important for many Southeast Asians and has critical implications for how they perceive themselves and maintain their psychological health (Livingston, Holley, Baton et al, 2008). Because they believe in a spiritual world that has a direct influence over their lives, the Mien people continually work on maintaining favor with ancestral and naturalist spirits to ensure good fortune, appease spirits, and heal sicknesses (Barker & Saechao, 1997). The Mien people’s cultural beliefs and practices in healing methods contribute to their separate identity (Moore, Sager, Keopraseuth, et al, 2001) and may prevent them from accessing western psychiatric care. They also tend to only consult western doctors after their traditional methods have failed (Moore & Boehnlein, 1991). Providers need to understand and respect their culture in order to encourage participation and utilization for mental health services.

Somatization

When Southeast Asians do seek help, many of them interpret psychological problems in physical terms in order to avoid the label of mental illness and the negative connotation it is associated with. This is called Somatization which is characterized by the expression of personal and social distress through bodily complaints and medical help seeking (Moore & Boehnlein, 1991). Lin, Carter, and Kleinman, (1985) pointed out that the refugee status was an important factor which differentiated patients with
somatization from patients with physical disorders. Refugee populations included in this study consisted of the Vietnamese, Laotian, and Mien. The study found that the Mien were more likely to experience and given the diagnosis of somatization than the Chinese and Filipinos. The findings suggest that refugees who have experienced the catastrophic consequences of war and were forced to uproot and migrate to a different culture unfamiliar to them as the Vietnamese, Laotian and Mien were subjected to, were more predisposed to somatization. In this study patients with somatization had excessive symptomatic complaints that magnified an existing disorder that they had, often had no detectable pathology, or an underlying mental disorder. These patients also made higher clinical visits, with the Mien and Laotians making the highest frequency of visits than other refugee ethnic groups. Mien patients were also more likely to have somatization than a physical disorder than any other group. The study also found that patients who had unrecognized depression made more clinic visits than those who were not. The researchers suggest and Mien somatization may be a reflection of their socio-economic distress, poor adaptation, and the overall low level of resources as the majority of the Mien and other refugee patients were generally poor, unemployed, and dependent on government aid. The difficulties surrounding migration as well as the poor underlying psychological health of these groups from previous trauma experiences are also reflected.

Another research on disorder and somatization by Moore, Sager, Keopraseuth, et al (2001), through the Indochinese Psychiatric Program (IPP) in Portland, Oregon for the psychiatric care of Southeast Asian refugees, found that the most common primary
complaint was chronic pain by Mien patients. The study subjects consisted of 70 Mien and 30 Lao patients who were referred to the IPP from public health clinics and counselors in their communities. The study found that the Mien patients did not volunteer any psychological complaints, failing to report nightmares, panic attacks, depression or insomnia of their own accord despite their high prevalence. However, when asked specific questions, the Mien were able to describe emotional problems and reported clear symptoms of psychiatric disorders. The ethnic Lao group in contrast, spontaneously described emotional and other psychiatric symptoms consistent with the diagnostic criteria for mental disorder (DSM). The research also found that all of the subjects, including the Mien who complained of pain suffered from depression, either alone, with PTSD or with PTSD and psychotic symptoms. The Mien patients who had PTSD were also more likely to have multiple diagnoses of other psychiatric disorders. However, the Mien people showed the least improvement as compared to the Lao who were more receptive and responded favorably to treatment. Furthermore, despite the identification and treatment of the psychiatric disorders, Mien patients continued to report exclusively somatic complaints. The research found that as a group the Mien patients also had the most difficulties with medications, showed poor tolerance and response to antidepressants. The researchers suggest that physical responses may be part of the normative reaction to trauma and distress with each cultural group communicating the physical and emotional aspects of distress in different ways. For the Mien, the recognition of a “Mien somatic complaint syndrome” would assist medical and psychiatric care providers in understanding the Mien. This syndrome includes:
headache, backache, dizziness, chest pain, extremity pain and joint pain. Recognizing that the Mien express their physical distress but do not report psychiatric symptoms may require that further exploration and investigation should be done for both psychiatric and psychosocial causes of distress for the Mien. The discussion on this research suggest that the high somatization rates of the Mien may be due to mental health illnesses being highly stigmatizing in their cultures and psychiatric care is sought only after all other avenues of help including their own traditional healing methods have failed. The distrust of Western medicine by many Southeast Asians including the Mien often results in care that is provided to late (Moore, Sager, Keopraseuth, et al, 2001; Uba, 1992). When Southeast Asians decide to seek care, they are often confronted with unfamiliar and apprehensive diagnostic techniques and treatments used by Westerners and many often misinterpret and misunderstand their diagnosis (Uba, 1992).

Beyond western medical treatments, conversion to Christianity by roughly one-third of the Mien, in the U.S. has been an attempted solution for persistent health and mental health problems (Moore, Sager, Keopraseuth, et al, 2001). This has been frequently unsuccessful and many Mien people revert back to their traditional beliefs and healing methods (Moore, Sager, Keopraseuth, et al, 2001). However, many older generations of the Mien people continue to firmly adhere to their traditional views of mental illnesses based on their cultural background. As a result their awareness of the possible causes and consequences of mental illness is lacking and becomes a deterrent for seeking help. Furthermore, the traditional Mien culture discourages them from directly expressing emotional distress presenting barriers that alienates many who suffer
silently. For the Mien who has emotional and psychological issues, their symptoms may fester while they silently suffer with social stigma surrounding the issues of mental illnesses.

Cross Cultural Competence

The effects of culture permeates the entire field of mental health and is not limited to the understanding and perceptions of mental health illnesses by ethnic minority groups but also affects the design and the delivery of services that includes the diagnosis and treatments of mental illnesses. The Supplement to the Mental Health report by the Surgeon General (2001) recognizes that culture is one of the most important aspects of mental health illness and bears upon what people bring to the clinical setting and calls upon mental health providers to be culturally competent. Over the past 20 years, since the passing of legislation by the Joint Commission of Mental Health, which argued for the need for culturally competent human service professional in the counseling and clinical settings, programs and various policies have been enacted to train professionals to understand cultural differences and identify family strengths and various communities resources (Livingston, Holley, Baton et al, 2008). However, there has been much debate as to whether such legislations have been effective in the United States since its passing in 1979 given the increases in mental health-related problems among Southeast Asians and other minority groups such as the African Americans, Middle Easter communities, Asian/Pacific Islander, and the Latinos (Livingston, Holley, Baton et al, 2008). According to Livingston et al, (2008) those in the healing and human services profession working with ethnic minority families have only been trained to
understand superficial differences between culture and their unique paraphernalia such as the differences in clothing and food. Social service providers and mental health professionals are urged to develop a deeper understanding of the client’s culture by being culturally competent.

Cultural competence is a set of behaviors, attitudes, and policies that enables a system, agency, and or individuals to function effectively with culturally diverse clients and communities (Livingston, Holley, Baton et al, 2008). Such development of cultural competence will enable individual providers and organizations to be able to think, feel, and develop interventions that acknowledge, respect, and build on ethnic and sociocultural diversity (Livingston, Holley, Baton et al, 2008). Livingston et al (2008), describes a culturally competent counselor as someone who is 1.) aware of his or her own assumptions about human behaviors, values, and biases, 2.) able to understand the worldview of the culturally different client, and 3.) actively developing and practicing appropriate, sensitive, and relevant interventions strategies to work with culturally diverse clients. Given the importance of cultural competence in mental health services, its development by mental health professionals and social service providers can assist in the elimination of racial/ ethnic disparities in mental health care and the improvement of services that are culturally sensitive.

The ability for mental health practitioners to understand the wide-ranging roles of culture will enable them to deliver services that are more responsive to the needs of racial and ethnic minorities. Racial and ethnic culture is especially important in mental health issues, as the manifestations of symptoms, understandings, and perceptions of
mental illnesses are all derived from an individual’s culture. The cultural understanding of mental health issues bear upon whether Southeast Asian groups like the Mien people, will seek help in the first place or not, their preferred methods of healing, the types of help they seek, the coping styles and social supports they have, and how much stigma they attach to mental illness which are all derived from ones culture (Furuto et al, 1992). Consequently, different racial and ethnic cultural groups of people will differ in perceptions, understandings and manifestations of their emotional and psychological symptoms. The National Association of Social Workers (NASW) (2009) Code of Ethics recognizes that acquiring cultural competency is an ethical standard:

1.05 (a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.
1.05 (b) Social workers should have a knowledge base of their clients’ cultures and be able to demonstrate competence in the provision of services that are sensitive to clients’ cultures and to differences among people and cultural groups.
1.05 (c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

The dedication to serving a diverse community and providing culturally sensitive care, is not just limited to Social workers but also to most other fields and the need to cultivate
and acquire cultural competence is important to successfully working with minority groups such as the Mien.

*Structural and Communication Barriers to Services*

Besides cultural barriers to mental health care, structural barriers also exists that deters Southeast Asians from accessing mental health services. For years Asian Americans have been recognized as having lower rates of mental health service utilization (Fung, & Wong, 2007). The U.S. Surgeon General’s report on *Mental Health: Culture, Race, and Ethnicity*, concluded that minorities face numerous more barriers beyond those experienced by the general U.S. population. According to the Report (2001), nearly one out of two Asian Americans have difficulty accessing mental health services. About 21% of Asian American lack health insurance compared to 16% of Americans. The rate of Medicaid coverage for eligible Asian Americans and Pacific Islander is also below that of the Whites. Of those who are covered with health care insurance or have Medicaid, only 17% of Asian Americans experiencing problems sought mental health services. According to a study done by Shumway and Snowden (2005), lack of insurance, lack of English proficiency and racial/ethnicity, were three of the most significant barriers to mental health care in California. The study examined policies to address disparities in mental health access and treatment for different racial/ethnic groups and found that insured adults were twice more likely to receive care than those who are not insured. It also found that Whites had the most utilization of services compared to other racial/ethnic groups. Furthermore, the study found that those
who are proficient in English receive the needed care with 50% compared to only 9% of those who have limited English proficiency.

In California, approximately 40% of Californians speak a language other than English at home. A study conducted by Bloom, Masland, Keeler, et al (2005), on overcoming language barriers for public mental health services, suggest that bilingual providers and language-specific clinics or programs have a more positive effect on access to mental health services. Research by Beiser and Hou, (2001), on language acquisition and depressive disorders found that personal resources such as ability to speak the host country language, and social resources such as the availability of an ethnic community helps to safeguard against mental health. The research suggest that language proficiency protects mental health by facilitating social contact, decreasing dependence on others by promoting the development of new social resources, expanding an individual’s coping strategies, and by increasing a refugees sense of internal coherence (Beiser & Hou, 2001). However, the research also found that poor English language skills will in turn jeopardize mental function.

The ability to communicate with one another is critical for all aspects of health care. It is especially important in the area of mental health as it affect thoughts, moods, and behavior (DHHS Surgeon General Report, 2001). The diagnosis and treatment of mental disorders depend greatly on verbal communication and trust between patient and clinician. With many Mien elders unable to speak English, language barriers is one of the major issues they are facing. The inability to clearly communicate their symptoms and concerns can be frustrating so much so that refugees, like the Mien will avoid
Western health care altogether (Uba, 1997). In many cases, bilingual staffs are unavailable and often the children of these immigrants and refugees must take on the role of interpreter. Betancourt, et al., (2003), explained that in any health care system, a lack of interpreter services or culturally/linguistically appropriate services and materials leads to patient dissatisfaction, poor comprehension and compliance, and ineffective or lower quality care.

Other structural barriers such as economic, educational and transportation barriers also exist to deter minority groups from seeking and utilizing services. These affect their current mental health and contribute to their lower economic, social, and political status. In the Surgeon General Report (2001), minority groups such as Southeast Asians are confronted with mental health care disparities that also stem from their historical and present day struggles with racism and discrimination. As stated by Moore and Boehnlei (1991), the Mien people have suffered much trauma over the last 40 years that included repeated geographic dislocations, extensive human, material and symbolic losses that have all greatly impacted not just their mental health but their overall health. Diversity and equality of opportunity is an inherent value in the America and by identifying all types of barriers including structural barriers for mental health services, the disparities in the availability, accessibility and utilization of mental health services can be gapped by not only the Mien people but all minority groups.

*Gap in Literature*

Serious investigations of mental health problems with Southeast Asian groups did not begin until 20 years ago. Although some investigators found significant mental
health problems among Southeast Asians, they were not widely recognized by social service providers, other researchers, and policy makers. There is very little research done on the Southeast Asians and their mental health needs. Those studies that are completed on Southeast Asians often tent to group the Vietnamese, Cambodians, Laos, Mien and Hmong into one homogenous category resulting in misunderstandings, stereotyping, and over generalization (Kim, 2006).

While Southeast Asians have had similar experiences it is important to keep in mind that, the Mien, Hmong, Vietnamese, Laotian, and Cambodians are all different ethnic groups, each with its own unique and distinct cultures, language, values, and customs. More studies on the Mien ethnic minority group and their unique experiences and perspective on mental health and mental health issues are needed in order to develop a better understanding of this group of people and their mental health needs. This research project was completed in order to decrease the gap in research for the Mien people and to help with the possible development of services that are culturally appropriate and acceptable to the Mien people. The researcher also hopes to help mental health professionals and their agencies to increase utilization rates by the Mien people with the knowledge it provides on the cultural perception of mental illness by the Mien people. The promotion of mental health services may improve the lives of the Mien community.

Summary

It is essential that all aspects of mental health systems be reflective of diversity and attempt to strive for cultural competence. Culturally and linguistically competent
mental health system is necessary to effectively addressing the needs of consumers and families with diverse values, beliefs, ethnicity, religion, and language. Such competence will help providers to develop culturally appropriate outreach and treatment options for the Mien community that will increase their utilization of mental health services. Aside from cultural barriers, the lack of familiarity with American or Western medicine, lack of proficiency in the English language, can result in ignorance of available mental health care for the Mien. Lack of financial resources to pay for services such as health care coverage, difficulty in getting to health care facilities, and transportation issues also act as deterrents to accessing mental health care by the Mien.

This literature review also placed a strong emphasis on the need for social service providers and mental health professionals to understand and respect the cultural values, beliefs, and practices of minority groups such as the Mien in order to foster trust and encourage such a group to seek services. It is imperative that more researches on the mental health needs of the Mien people are completed in order to identify and eliminate the various barriers that may exist to deter them from seeking services. As an uprooted group of people that has experienced various traumas, mental health illnesses in the Mien community needs to be properly address as the illnesses can be very debilitating for those who are suffering.
Chapter 3

METHODOLOGY

Introduction

This research study attempted to understand the low utilization rates of the ethnic Mien minority for mental health services. The study was designed to explore the reasons, beliefs, attitudes, and values that prevented the Mien from utilizing existing mental health services. This study also focused on the multidimensional challenges that the Mien people are forced to face with at all periods of their pre and post migration experiences. The methodology section of this research project covered the methods used and consists of the following sections: (1) Study Design; (2) Study Population and Sample (3) Measurement Instruments; (4) Data Collection Procedures; (5) Statistical Analysis Plan; (6) and Human Subjects.

Study Design

Currently, with very little known about the Iu-Mien people, their war and subsequent immigration experiences into the United States, the research was designed as a qualitative exploratory study to acquire more knowledge and understanding of this ethnic minority group and the possible factors that are preventing them from utilizing mental health services in the Sacramento region. The exploratory study design is appropriate for this topic as it seeks to “provide a beginning familiarity” with the issues of the underutilization of mental health services by the Mien people (Rubin & Babi, 2008, p. 136). Exploration of this topic where there has been very limited research
performed in the past, will enhance social workers knowledge of the mental health needs of the Mien people with references to the Southeast Asian community.

The qualitative study design is appropriate for this research project as it is naturalistic, flexible, with no intervention, utilizing in-depth interviews and questionnaires, include participant-observation, and is exploratory (Rubin & Babbi, 2008). This method ensures a deeper understanding and consideration of the experiences of the Mien people in the context of their perceptions and opinions of mental illness and mental health service utilization.

The researcher conducted the investigation directly with the participants through face-to-face interviews each one lasting about an hour long. The interview allowed the researcher to observe and collect both verbal and non-verbal responses directly from the participants giving the researcher more control during the interview. Furthermore, the interview was completed in a question and answer format allowing the researcher to modify and adjust each interview differently to enable participants to elaborate when necessary. This direct communication with the participants has the advantage of empowering the participants to respond in their own words as the expert while the researcher assumes the role of the learner.

The intentions of the researcher is to develop a better understanding of the Mien’s cultural beliefs and its impacts and influence on their utilization for mental health services in order to enable change and improve current delivery of services and practices to better suit the needs of the Mien people. The research was also conducted in the hopes
that this research may be of use to social work practitioners, mental health providers, and other social service providers who are working with Mien people.

Study Population and Sample

The study population consisted of refugee adult Mien men and women who immigrated into the US because of the Vietnam War. These individuals all speak Mien and are familiar with Mien customs, traditions, and values. The participants also all live in Sacramento, California and were refugees turned to either legal permanent residents or naturalized citizens who have resided in the United States for more than 5 years. Most of them have never had any formal education and speak very little English. As a result, the interviews were conducted in the Iu-Mien language with the exception of one participant who also spoke English. The respondents of this study consisted of 4 Mien women and 3 Mien men between the ages of 37-66 years old for a total of 7 participants. They were interviewed in a natural environment of their choosing.

The researcher utilized the non probability purposive sampling method for this research project. This sampling method is compatible with this research project as the research focused only on Mien refugees living in the United States and their subjective thoughts, opinions, beliefs, reasons, and perceptions of mental health illnesses and the barriers to services. Respondents were eligible to participate in the study if they are 18 years of age or older, live in Sacramento, have resided in the United States for at least 5 years.
Data Collection Procedures

The researcher chose the eight participants with the belief that data collected from them will yield the most comprehensive understanding of the subject. Each participant was contacted by the researcher by telephone contact for their participation in the study as human subject. An interview was scheduled by the researcher and conducted around the availability and location of the participant’s preference. The researcher introduced herself and explained the purpose and procedure of the study. The researcher explained the option of not participating or withdrawing at any time and participants were notified of their right to decline answering any question or decline being taped recorded. The participants were provided with a list of mental service agencies and other Asian community resource in the case that the interview questionnaires caused discomfort. The researcher then handed out the consent forms to be signed and the interview questions began. The consent forms were collected with the data responses and stored in an envelope. A cover letter for the consent to participate was given to each participant (see Appendix A). The letter detailed what the researcher explained about the purpose of the research project, the procedure, the possible risks and benefits of participating in the study, and the participant’s rights to withdraw as well as the confidentiality.

All interviews were taped recorded in this research project. The researcher engaged the client in a question and answer format and asked for elaboration, clarification, and took the dictation of the participant’s answers. The questionnaires were designed to interview Mien Americans with focus on three investigative areas: (1)
Mien’s cultural understanding and perceptions of mental health and mental health illnesses; (2) the accessibility of the mental health services; and (3) the communication and language barriers between the Mien and mental health providers. The questionnaire also asked for the demographic background of the participants (birth place, age, and years in the United States, education, and marital status.

**Measurement Instruments**

The measurement instruments used in this research project was the interview questionnaires for collecting data (see Appendix B). The purpose of the questions was to help the researcher focus on specific topics of this research. The questionnaires were developed by the researcher and geared to assisting in gaining in-depth understanding of the issues surrounding the low utilization rates of mental health services by the Iu Mien. The questionnaires organized into four different parts or themes of the research.

The first part contained 7 questions and collected information about the participant’s background. Each participant identified their age, marital status, number of children they have, the preferred language spoken at home, the country of origin, the age of immigration into the United States, and the number of people the participants came with into the United States. The data collected from this first section gave the researcher the demographic information of the participants. The second part of the questionnaires focused on the participants, thoughts, perceptions, and understanding of mental health and mental health illnesses. This section has four exploratory, open-ended questions and asked participants about their thoughts on the origin of mental illnesses. The third part of the questionnaires explored the ability of the participants to access mental health
services. This section contained questions about healthcare insurance, knowledge of how to access mental health services and if the participants know of friends, families, or other Mien who had experience with mental health illness. The forth and last part of the questionnaire deals with the participant’s language and communication. This section asked if participants are able to speak English or not and their ability to seek services if language is a barrier. This section also asked the participants about their perceptions on current mental health service and includes questions about their opinions on the importance of providers who understand the Mien culture or is able to speak in the Mien language.

The researcher also used an audio tape recorder with the permission of the participants. All eight participants were informed about being audio taped and gave their permission to the researcher to be audiotaped with a signed consent.

Data Analysis Plan

Data from the completed interviews were translated and transcribed into English. The researcher analyzed and categorized the information collected by identifying the common themes, classified common perceptions of mental health illness, mental health services and providers, and analyzed the accessibility of mental health services.

Protection of Human Subjects

The proper process and procedures for approval of human subjects protection was submitted and approved from the Committee for the Protection of Human Subjects at the Division of Social Work at California State University of Sacramento (CSUS) in order for the data collection of this research to begin. The researcher completed the
application form requesting a review by the Sacramento State Committee for the Protection of Human Subjects, which detailed the purpose of the research project, the sample population for the research, informed consent to participate in the research, the protection of the rights as a human subject, the protection of confidentiality and anonymity. The interview questionnaires developed by the researcher and her thesis advisor, and a list of mental health resources in the Sacramento Area were also submitted for review. A panel reviewed the researcher’s application, the committee found this project to be at minimal risks to participants, and all documents were approved. The approval number for this research project is 09-10-036. The collection of data by the researcher began after the notice of approval by the committee in November 2, 2009.

To maintain confidentiality and participant’s identity, no identifying information was sought from the participants and data collected were stored away in a secure location of the researcher’s home. Information was reported in the research without identifying the participants. Permission to tape record all the interviews was granted by the participants in the consent form prior to doing so. All the materials used in the research including the interview data, consent forms, were destroyed after the research was completed.

Summary

This is an exploratory research study that used a qualitative method to explore the Mien people’s perceptions mental health and their beliefs, values, and attitudes that may be preventing them from utilizing mental health services. The study consisted
refugee men and women who immigrated from Laos or Thailand and who reside in Sacramento. The researched utilized non-probability purposive sampling method and sought only adult Mien participants who have resided in the United States for more than 5 years. The participants are protected under the Protocol for the Protection of Human Subjects. Raw data collected using the interview/questionnaires and analyzed. A discussion of the research findings is completed in the following chapters.
Chapter 4
FINDINGS/ OUTCOMES/ RESULTS

Introduction

This chapter includes the participant’s subjective perceptions and understandings of mental illnesses, the symptoms and causes they associate with it and the barriers that they face while attempting to utilize mental health services. Different questions were asked during the interview regarding the participants understanding of mental illnesses and they were asked to define and describe mental illnesses and their thoughts on proper treatment options. Participants were then asked about their awareness of programs or services and if they know how to access them. They were also asked if they have any friends, families or other Mien people they know who may be suffering from a mental illness. Based on the responses generated, the following themes were identified as common and consistent with most of the interviews: lack of knowledge on how to access care, transportation barriers, language barriers, and the need for mental health professionals who are culturally competent and aware of the Mien people and their history. The names of all participants have been changed and fictional names are given to ensure confidentiality.

INTERVIEW SUMMARY FOR CASE 1

Demographic Data

Mr. A is a 37 year old married Mien Christian man. Mr. A has two children ages 16 and 20. He was born in Thailand and came to the United States at the age of 17 years old. He arrived as a refugee from Thailand to the United States by himself to be able to
marry his wife who also moved to the United States with her family. Most of Mr. A’s family members are farmers who remained in Thailand where they own an orchard farm. Mr. A has been back to Thailand to visit his family with his wife and plans on returning soon. He is able to speak Mien, Thai, and English fluently. Mr. A’s is the only interview that was completed in English and the only participant who has been educated in America. The interview with Mr. A was completed on December 15, 2009 at a Sacramento community center.

*Understanding and Perceptions of Mental Health and Mental Health Illnesses*

As a younger Mien who has been able to assimilate into mainstream American culture, Mr. A has different views of mental health and mental illness. When asked what his first thoughts of mental illness are, Mr. A responded that, “I have to think in two different ways. One way is the Mien. We don’t have mental health. Mien people don’t have mental health.” In this he referred to even the limited vocabulary that the Mien people have in describing mental illnesses. Two of the most common words the Mien use to express that an individual has a mental illness are “nizang” and “butv ndin.” Both words refer to someone being “crazy.” There are also no words to described much of the mental health conditions and diagnoses in the Mien language. As a result Mr. A stated that Mien people “do not know” what mental health illnesses are.

The issue of mental illness is something that he stated traditional Mien believes to be caused by “demon possessions” or spiritual afflictions”. With demon possession or evil spirit possession, Mr. A stated that the individual is “not normal,” “can become crazy” and that the condition is “hard to reverse”. However, after having lived in the
United States for 18 years, he felt that his perception of mental health has changed largely due to the education he received here. According to his “other way of thinking” about mental health, based on the American or “educational way,” Mr. A is aware that mental illnesses are due to an individual’s psychological function and “people’s mind”. He listed a “few factors” that he believes to be the causes of mental illnesses- genetic disposition, substance abuse, traumatic experiences like crime and violence, natural disasters, and health issues.

Mr. A described the common signs or symptoms of an individual suffering from mental illness as doing things that are “not appropriate” such as doing drugs, committing crime, and not being employed or earning any income. In short, he believed that it can be “those who are not meeting society’s standards.” And, while he acknowledged that while he tended to “put value in how western culture address mental health” he still has to “understand the Western, and the oral traditional way” of thinking about mental health.

Another cause of mental health disorder that Mr. A discussed is due to many older Mien in the community including his older relatives being “homesick.” He stated that for these older Mien who lived most of their childhood and adult life in Laos or Thailand, many often garden in their backyard and “tend to plant, a lot of plants that they have in their homeland” to help cope with their homesickness. Furthermore, Mr. A states that they also keep chickens and other animals to help them “regain their memories” of their homeland.
Access to Mental Health Services

Mr. A has healthcare insurance for himself and his whole family through his employment. However, he has never sought mental health services for himself or knows where to seek services. Mr. A has also never helped seek services for his family members, a few, who he believes may be experiencing sadness and loneliness. Mr. A shared that he knows of many Mien in the community who “really need mental health services but does not get it.” When asked for the reason why these individuals do not seek services, Mr. A responded that it is “probably because they don’t know where” to get the help. Mr. A acknowledged that although he has the option of seeking services from having healthcare insurance, he stated that many Mien like “the older folks don’t really have medical coverage or they have other barriers that will prevent them from seeking medical help therefore, it potentially damages their mental health.”

While discussing the “other barriers” to service, Mr. A also spoke of the stigma that the Mien people have for mental illnesses. Mr. A stated that the Mien community will “discredit” someone suffering from mental illness as “crazy” and “they will forget you, they tend to put you aside, pay no attention, no service, no treatment, no medication. They just let you go. Just discredit you.” Mr. A explains that because of this many Mien, especially the older generation, “may not want to admit they need help” and may resort to “self medicating and using alcohol.”
Communication / Language Barriers and Cultural Competency of Mental Health Service Providers

Mr. A is able to speak, read, and write English fluently and does not rely on his two teenage children to translate for him. However, he felt strongly that not speaking English is a definite barrier to accessing mental health services and explains that this is a reason why many of the older Mien in the community do not get the help they need. Mr. A stated that “If I don’t speak English I probably don’t understand mental health.” He concluded that his ability to speak English allowed him to be able not only communicate his mental health needs to a provider but also understand any illnesses he may have. While he is able to speak English, he still believed that it is important that a mental health provider can understands and able to speak to him in his own Mien language. Mr. A also stated that “culture is crucial” and that a mental health provider should understand his Mien culture and heritage in order to successfully help him if he needed.

INTERVIEW SUMMARY FOR CASE 2

Demographic Data

Mr. B is a 53 year old Mien man. He is separated from his wife whom he had 7 children with. Mr. B was born in Northwestern Laos in a small mountainous village known as Lua Namtha. He left Laos and moved to another village in Northern Thailand after the end of the Vietnam War. Mr. B lived in Thailand with his family for about 10 years as a farmer. In 1994, Mr. B came to the United States at around the age of 48 with his wife and children and arrived in Sacramento, California where he remains today. The interview with Mr. B was conducted in the Mien language as Mr. B reportedly only
speaks Mien and Hmong and understands little English. The interview with Mr. B was conducted in December 17, 2009 in his home.

Understanding and Perceptions of Mental Health and Mental Health Illnesses

Mr. B’s first thoughts of mental illness are feelings of “Sadness. Sadness about my parents and family who didn’t come.” Mr. B’s mother passed away in Laos while he was here in the United States. His father remains in Laos today, and has since remarried. Mr. B described the symptoms of mental illness as “melancholy, being tired, thinking a lot, and feeling sad.” He also believed that mental illness can be manifested in someone being “dizzy, can fall, go lame, and have a stroke.” Mr. B believed that people become mentally ill due to “thinking a lot, feeling sad, spirit affliction, having weak blood, and drug use.” He concluded that individuals experiencing mental illness should seek help.

Access to Mental Health Services

Mr. B stated that he has MediCal and is currently taking anxiety medications for “being sad, not being able to sleep, and thinking a lot.” He knew of friends who are also experiencing mental illnesses, a few who may also be taking medications. Mr. B stated that going to the hospital first by calling the ambulance where they have medications is a way to seek services. He believed that the medication he is currently taking has been helpful to him to “not think too much, sleep better, and not get angry”. Mr. B has been on the medication for more than 10 years. He stated that when an individual is angry but does not get the help they need, they can hurt themselves or other people.
Communication / Language Barriers and Cultural Competency of Mental Health Service Providers

Mr. B does not speak English and looks to the members of the Mien community for help with translation on any doctor’s visits. He felt that when seeking services it is very difficult to communicate with his doctors and believed that his inability to speak English is a barrier. He explained that he is unable to communicate in his own words, thoughts and feelings and has to rely on the interpreter to translate to the doctors and back for him. He felt that the translation services are good but complicated and would prefer to be able to speak directly to the doctors. He would like for mental health providers to be able to speak to him in Mien and also understand his culture to be able to help him.

INTERVIEW SUMMARY FOR CASE 3

Demographic Data

Mrs. C is a 55 year old married Mien woman. Mrs. C was born and raised in a small Mien village called Mouang Sing in Laos. Mrs. C left Laos with her husband and his family, fleeing to northern Thailand after the Vietnam War. In Chiang Rai, Thailand, where Mrs. C lived for 12 years, she gave birth to seven children. One was born without breath while the other died at the age of five after a sudden unknown illness. After her youngest child was born, in 1988, Mrs. C, her husband, their 5 children and her parent-in-laws applied to resettle in the United States. While waiting for approval, Mrs. C and her family were moved into two refugee camps. The first was called Chiang Khom Camp and the second was called Phanat Nikhon where they stayed for a couple months
each. In 1990, at around the age of 27, Mrs. C and her family arrived to Sacramento California where she has remained since. Mrs. C does not speak English and the interview was conducted in the Mien language on December 18, 2009 at her home.

Understanding and Perceptions of Mental Health and Mental Health Illnesses

Mrs. C is a firm believer that the causes of mental health illnesses are due to spiritual afflictions. Mrs. C stated that she follows the traditional religious beliefs of ancestor and animist worship. She shared that she calls in a Shaman for many different rituals. Mrs. C explained that an individual can become mentally ill when their spirit is “misled” or wronged, making them ill. To correct this, Mrs. C stated that a religious ceremony or ritual has to be done in order to help the person’s soul “find the right path” back to the person’s body. She explained that a stronger or higher Shaman may need to perform certain rituals especially if the soul of the individual suffering has been lost due to evil spirits. However, she also believed that mental illnesses can be the result of “too much thinking, feeling sad, and from having a weak spirit”. The person that comes to Mrs. C’s mind when discussing mental illness is her sister-in-law. Mrs. C’s husband’s younger sister has been in treatment for a mental illness to help “control her anger” and keep her from “hurting other people”. In describing a person who may be suffering from a mental illness, Mrs. C stated that they may “look sad, worried, angry, or be sick.”

Access to Mental Health Services

In answer to the question of whether or not she has medical or healthcare insurance, Mrs. C stated that she has MediCal. However, she does not know where to seek mental health services for herself or her family. In the past six months, the only
family Mrs. C knows of who has looked sad was her sister-in-law who is in treatment with medications for symptom control and reduction. She believed that the treatment for her sister-in-law has been helpful but the side effects were too strong and “sometimes makes her stick her tongue out” and her sister-in-law cannot close her mouth. She also knew “a lot of Mien” who are “sad” due to “having to leave their homeland countries and families behind, not being able to speak English, being poor, having problems with their children, and having marital problems”.

*Communication / Language Barriers and Cultural Competency of Mental Health Service Providers*

Mrs. C stated that she does not speak English but has adult sons and daughters who are able to translate and read her mails for her. Mrs. C felt that her inability to speak English is a barrier to accessing mental health services and believes that being able to speak English will help her communicate better to a provider. Mrs. C also felt that it is important for mental health providers to understand the Mien culture and be able to speak her language. She would like to be able to talk to mental health providers in Mien since she has been unable to learn English and feels that she is “too old to learn” now.

INTERVIEW SUMMARY FOR CASE 4

*Demographic Data*

Mrs. D is a 66 year old widowed Mien woman. Mrs. D was born and raised in a small village in Laos. Mrs. D’s late husband was a Vietnam Veteran who fought for the Central Intelligence Agency (CIA). Mrs. D, her husband and two teenage daughters left Laos and fled to Thailand after the war ended. After living in Thailand for several years,
Mrs. D and her family immigrated to the United States when she was around the age of 30 years old in 1974. In the United States, Mrs. D gave birth to her youngest daughter.

Mrs. D is monolingual and does not speak any languages other than Mien and reportedly has a hard time understanding English. The interview with Mrs. D was completed on January 4, 2010 at her home in the Mien language.

**Understanding and Perceptions of Mental Health and Mental Health Illnesses**

Mrs. D believed that the symptoms of mental illness are excessively crying, behaving oddly or “crazy”, and feeling “very sad” and lonely. Her first thoughts of mental illness, is someone who is “crying a lot” or feeling depressed and their inability to be consoled. She believed that the causes of mental illnesses are due to the death of a loved one and spirit afflictions, both of which requires rituals to be performed to cleanse the afflicted person’s spirit to heal.

**Access to Mental Health Services**

Mrs. D has been receiving MediCal benefits since her arrival into the United States. However, she has never sought for or received any mental health treatments but has helped a family member with seeking services in the past. Mrs. D believed that the treatment this family member received has been helpful to them and that the experience was a positive one. She stated that she knows where to seek services and shared that she can go to her regular or primary care physician for help. Mrs. D is aware of family and friends in the Mien community who may be suffering from mental illness. In the past six months, she believed she knows of a family member who has been sad and wanted to be left alone. Mrs. D also noticed friends who have become angry for unnecessary reasons.
Communication / Language Barriers and Cultural Competency of Mental Health Service Providers

Mrs. D does not speak English but has her youngest daughter and her grandchildren who she lives with translate for her. Despite the fact that Mrs. D stated that she knew of how to access mental health services, she believed that her inability to learn and speak English is a barrier to accessing services. She believed that being able to speak English can help her to explain herself more clearly to the providers. Mrs. D feels that she is too old now to be able to learn English and believed that it would be very nice if mental health providers can speak to her in her language. She feels that it is important for health care providers and mental health professions to know about the Mien culture, the customs, traditions, and values.

INTERVIEW SUMMARY FOR CASE 5

Demographic Data

Mrs. E is a 64 year old single Mien woman who identified herself as half Chinese and half Mien. She was born and raised in a small mountain village called Namwatt in Laos. Mrs. E and her family left Laos for Thailand after the Vietnam War and stayed in a refugee camp in Northern Thailand. In 1984, Mrs. E, her youngest son, and her middle daughter immigrated into the United States arriving in San Jose, California where she lived for 13 years. Mrs. E has a total of six children most of whom are married except her youngest son who she currently lives with. The interview with Mrs. E was completed on January 5, 2010 at her home in the Mien language.
Understanding and Perceptions of Mental Health and Mental Health Illnesses

When asked about what she believed to be the causes of mental illnesses, Mrs. E’s first response was that they were the result of spiritual afflictions. The person who is afflicted then becomes “sad, unhappy, or discontent”. In describing the common signs or symptoms of mental illnesses, Mrs. E mentioned that the person will look “anxious, be sad, may be crazy, angry and may become violent or steal.” Mrs. E believed that a ritual is needed in order to cleanse the person's spirit in which a pig or chicken is sacrificed. She stated that in Laos or Thailand, there are herbal plants that can also be used to help in healing the afflicted person but here in the United States, much of the plants cannot grow. When talking about her homeland countries, Mrs. E. reported that she would like to go “back home.” She would like her son to take her to see her home in Laos where she grew up in and visit relatives who remained in Laos but feels that she may be too old to do so safely.

Access to Mental Health Services

Mrs. E reportedly has MediCal and sees a regular doctor but has never sought or received mental health services in the past. When asked if Mrs. E knows where to seek help for mental illnesses, she replied that she does not and will usually call in a shaman to perform a ritual for hers or her family’s illnesses. Mrs. E named several rituals that can be done to help in the healing of possible mental illnesses. In the past six months, Mrs. E identified one of her daughters as being very angry. She reflected that this daughter had been complaining of pain in her legs and arms and being unable to “do anything” or “hold anything for a long period of time.” Mrs. E also believed she knows
of other Mien in the community who are suffering from possible mental illness and names a woman whom she said was “crazy”.

Communication / Language Barriers and Cultural Competency of Mental Health Service Providers

Mrs. E does not speak any English but can speak Mien and Mandarin. Her son whom Mrs. E lives with often translates for her. Mrs. E believed that not speaking English makes it very hard for her to seek any kind of services including mental health services. Mrs. E has never driven a car. Her son who she lives with, works full time while her other children and grandchildren live in nearby cities. As a result, Mrs. E relies on her son to become available to take her to appointments due to a lack of English proficiency and transportation. She would also ask extended family members or friends when her son is unable to take her. She felt that speaking English will help her get better treatment by being able to communicate directly to mental health professionals and being able to understand them. She also believed not only should health care provider or mental health practitioners know her Mien cultural but should also be able to speak her language. She stated that knowing her cultural background will help them understand and be familiar with her preferred healing practices and the practices of the Mien community as whole.

INTERVIEW SUMMARY FOR CASE 6

Demographic Data

Mr. F is a 58 year old married Mien man who self identified as a former Vietnam veteran and a Mien Shaman. Mr. F is one of 14 children. He has six brothers, the who
oldest fought for France during the French colonial period, and three others who also fought in the Vietnam War with him. Mr. F is the second youngest son with only one younger brother. His elder brothers have all passed in Laos and Thailand. Mr. F had seven sisters, only four came to America, and only the youngest two are currently alive. Like his siblings, Mr. F was born and raised in Mouang Sing village in Laos. At the age of 17, Mr. F was recruited to fight in the Vietnam War along with three of his older brothers and friends. After six years of fighting in the war when it ended, Mr. F left Laos and escaped to Thailand with his family to avoid prosecution from the Laos communist government. In Thailand, Mr. F met and married his wife whom he has two children with. He lived there for more than 10 years longer as a farmer prior to entering a refugee camp to resettle in America. He came to Sacramento, California in 1990 with his children, wife and parents. Today, Mr. F has been able to get his citizenship in America as a veteran of the Vietnam War. Mr. F speaks Mien, Laos, Thai, Hmong and a few other hill tribe languages. The interview with Mr. F was completed on January 7, 2010, at his home in the Mien language.

Understanding and Perceptions of Mental Health and Mental Health Illnesses

In talking about mental illnesses, Mr. F mentioned the feelings of sadness in thinking about all the people he “left behind” in Laos and Thailand. He felt that he “cannot forget” all of those people. Some were friends, who fought with him in the war and many were families who died and were buried there. When hearing the word mental illness and the reasons why people may become mentally ill, Mr. F believed that the experience of fighting in the war can cause the illnesses. He also believed that “thinking
a lot, having no money, being poor, being divorce or having problems in marital relationships and being afflicted by the spirits” all cause mental illnesses of varying degrees.

Access to Mental Health Services

Mr. F has MediCal and sees a regular physician for ongoing treatment as a diabetic. He is currently not receiving any veteran services from the County and does not believe that he had ever received any services through the VA. He never sought for or received any mental health services for himself or for his family. When asked if he was aware of where he can get help for himself or families if needed, Mr. F stated that he will go to his primary care physician. In the past six months, Mr. F believed that his sister, a few of his friends and his wife, have experienced sadness, anger and wanted to be left alone. Mr. F also stated that he knew of a relative who is currently receiving treatment in Sacramento that he believed is for mental health issues. He believed that this relative had an overall positive experience with the treatment and that the relative has benefited from it. However, he does not feel that everyone needs medicine. He stated that “if the doctor know what is wrong” with a sick person and they prescribe medicine that works, then “that is good.” But, he would recommend the person to “do a ritual” to find out why he or she was sick instead of “taking medicines all the time.” He continued on to say that when an individual seek medical help for any reason, “the doctors only give medicine” which sometimes “do not work” or “make them sicker.”
Communication / Language Barriers and Cultural Competency of Mental Health Service Providers

Although Mr. F is able to speak several Southeast Asian languages, the English language still eludes him. Upon arrival into the United States, Mr. F was around the age of 38 years old and had attempted to learn English by attending adult school with little success. He felt that not speaking English is a barrier to accessing mental health services if he chose to seek it. Mr. F’s son and daughter provide him with translation but he believed that it is important for a mental health provider to be able to speak to him in a language he knows, that way he can “understand them, and they can understand me.” He also believed that it is important for a mental health provider to understand his culture and his background.

INTERVIEW SUMMARY FOR CASE 7

Demographic Data

Mrs. G is a 40 year old married Mien woman. Mrs. G has two children and was also born in Laos. Mrs. G has six siblings, two older brothers, two younger sisters and two younger brothers. Her older brothers and one of her sister was also born in Laos while Mrs. G’s youngest sisters and brothers were born in Thailand where she lived for about 7 years. Mrs. G was married at the age of 18 and had two young children with her husband when she came to America at around the age of 21 years old. She left a few years before her family and who immigrated to America in 1993. Mrs. G left behind her parents and younger siblings who remained in Thailand awaiting approval for resettlement in the U.S. A few months prior to immigrating into the United States, Mrs.
G’s father died. The interview with Mrs. G was completed on January 7, 2010 in the Mien language.

Understanding and Perceptions of Mental Health and Mental Health Illnesses

Mrs. G believed there are many causes of mental illnesses. Her list of the etiology of mental illnesses included, feeling sad, not knowing the English language, not being able to find a job and work, not having education and being poor. Mrs. G also mentioned that here in America, “it is not like Thailand or Laos where you can build your own home, and own your own land”. She talked about living in a house that she does not own, and being unable to find a job because her “English is not good” and she “did not go to school.” Symptoms she identified as mental illness is someone who is “crazy, sad, or angry.”

Access to Mental Health Services

Mrs. G also has MediCal with her family. Like the other participants, Mrs. G has never sought or received mental health services for herself. She has also never aided any family or friend in seeking services but does know of extended family members who may need mental health services. She mentioned that her nieces, sisters, and brothers may need mental health services as they sometimes looked sad, wanted to be left alone or are angry for an extended period of time. Mrs. G also knew of members in the Mien community who are currently receiving mental health services and felt that they are probably effective as treatments.
Communication / Language Barriers and Cultural Competency of Mental Health Service Providers

Mrs. G stated that she only knows how to speak a little English but cannot read or write it. Mrs. G’s felt that she does not have a family member that can translate for her when she needs it. She stated that she often has to find a translator from the Mien community who is willing to go with her to appointments and translate for her. She felt that this is an inconvenience and believed that being able to speak English and communicate her needs is much more preferable. She believed that it would be “good” for mental health providers to be able to speak to her in her own language but that she has not met any doctors or health care professionals yet who can. Mrs. G also felt that it is important for them to understand her culture as it would help them to understand “me and what I need.”
Chapter 5
CONCLUSIONS AND RECOMMENDATIONS

Overview

The Mien people are relatively new in the United States. As such, there is very limited research available about them, their mental health status and needs as a group. As a member of the Mien community in Sacramento, this researcher is aware of mental illnesses within the community as well as the underutilization of existing mental health services. The researcher conducted this study to learn about the perceptions of mental health illness by the Iu Mien, their thoughts and opinions and the barriers that may be preventing them from utilizing services. The research was also completed in the hopes that there could be more collaboration between social service providers, mental health professionals and the Mien in addressing their mental health needs for the development of culturally competent services for this ethnic minority group. Collaboration among the groups may also demystify mental illnesses and make mental health services more accessible to the Mien.

Overall Findings

The qualitative findings of this research suggest that there are varied understandings of mental illnesses and its causes. Some common themes that emerged from the data found that mental illnesses are believed to have transpired as a result of grieving for the death of a loved one, homesickness from having to leave their homeland country of Laos and Thailand, the affliction of a bad spirit, and from living in poverty. This suggests that the Mien people may be aware of the environmental causes of mental
illnesses. The findings also indicated that the Iu Mien continue to maintain a traditional world view of mental health stemming from their religious beliefs of a spirit world that has direct influence on their health. Five out of seven of the Mien participants in this study continued to believe that the source of illness is due to being afflicted by bad spirits. As a result of their beliefs in the etiology of mental health illness, it may prevent them from seeking out Western modalities of treatment as the Mien people will address mental illness through the use of a Shaman first. Furthermore, many of the participant’s perceptions of mental illness is often someone who is “crazy” or “sick”.

Although only one of the participants in this research project has ever sought mental health treatments, and only one participant has assisted a family member in seeking treatment, the other participants are accepting of Western treatment modalities as well. It is also evident that mental illnesses exist in the Mien community as many of the participants knew of family, friends, and or members of the Mien community who may be experiencing symptoms of mental illness or have already received treatment. The participants of this study who received mental health services or knows of other Mien people that have been treated tend to believe that they were effective. This perception may lead to the utilization of both methods of healing and social workers, health care professionals and medical personals need to be aware and respectful of this in order to facilitate the healing in a meaningful way for the Mien. However, Lack of knowledge on how to access mental health was experience by four out of the seven participants in the study. The three who stated that they knew of how to access mental health would do so through their primary care physician one suggested calling 911.
Although all of the participants in this study stated that they have healthcare insurance of some type, literature review has been consistent in the findings that a lack of healthcare insurance continues to be a significant barrier to accessing services for many Asians and Southeast Asian minority groups. More advocacies for policies are needed in order to ensure that at risk groups such as Southeast Asians have the healthcare coverage they need in order to eliminate barriers to services. Other structural barriers that exist to deter six of the seven participants from seeking and utilizing mental health services is language barrier. Only one participant is able to speak English while the rest do not. As a result many reported to relying on family members, friends and other members in the Mien community to translate for them. Agencies need to provide proper translators for the Mien in order to encourage utilization of services. Another structural barrier identified in this research project, is the lack of transportation. Not only do many of the participants rely on family or friends for translation, they also rely on them for transportation to any appointments they have. Creative solutions for how to provide transportation for the Mien, especially the older generations need to be developed in order to make utilization of mental health services more accessible.

All the participants in this research project would like mental health practitioners to be able to speak to them in their own language and understand their culture. Cultural competency trainings, programs and assessments designed specifically for Southeast Asians to help identify mental health needs should be advocated for. A multicultural staff of providers is also recommended in servicing the Mien people.
Implication for Social Work Practice and Future Research

The results of this research project revealed that there is a great need for culturally competent services for the Mien. The study found that while mental health illnesses are evident in the Mien community, many do not seek services for a number of reasons. One of the most significant is the lack of mental health providers that understand the Mien culture, their traditions, customs, and values, their historical experiences in trauma, pre and post migration stresses. It is important for social workers and other social service providers to conduct more research on the Mien people and their mental health needs and the barriers they encounter while trying to seek treatment in order to increase utilization. The current state of knowledge about the Mien people, their perception and understanding of mental illness and all the barriers that they encounter for mental health services are insufficient. Qualitative, in-depth investigations are recommended as the researches will provide them with the knowledge needed in order to tailor services and programs to better meet the needs of the Mien. Changes in the micro, mezzo, and macro levels are needed in order to provide culturally competent services for this group of people.

On the micro levels, barriers such as language need to addressed. Agencies need to have providers and staff that can speak in the Mien language. This would allow the Mien to be able to communicate with providers in ways that are otherwise impossible and in their own words. By providing services in the Mien language, the Mien may be more inclined to seek services and feel more comfortable expressing their needs. Trust and relationship building may also come more easily for better care. On the mezzo level,
providers can access existing family resources and help individuals expand healthy supportive networks. Providers who understand Shamanism may also seek to incorporate it as part of the healing. They can also help facilitate the individual’s awareness of other support programs in the community. Furthermore, agencies can provide more education for staff to increase cultural competency of providers in working with the Mien people. This may provide them with a better understanding of the obstacles that the Mien have in obtaining services, such as their acculturation level, the stigma that is associated with mental illnesses for the Mien, and the spiritual beliefs that the Mien have related to their mental health. At the macro level, social workers can provide more advocacies for the development of programs and policies that is better suited to the needs to the Mien people.

Study Limitations

Due to limited research and literature on the Mien people, this research project utilized literature on Southeast Asian ethnic groups such as the Vietnamese, Cambodians, Laotians, and Hmong people who have had similar war and immigration experiences; however, the study project is restricted to only members of the Iu-Mien population. As a result, the findings of this research project cannot be generalized to other groups. This research project also only focused on the experiences of seven Iu Mien in Sacramento, California and the results may not apply to Mien in other areas. Due to the small sample size, the research project may also not reflect or be representative of the Mien community as a whole and may make it difficult to justify any
claims. The interview questionnaires used to collect data in this study was also not a standardized instrument and therefore may lack reliability in the findings.

Conclusions

The results of this research project found that there are significant differences between members of the Mien community in their definitions, perceptions, and treatments of mental illnesses from that of Western mental health practitioners. The Mien participants in this study continue to maintain their traditional belief system of the spiritual causes of mental health disorders while Western mental health practitioners approach mental health illnesses based on specific definitions and observations of behaviors according to those prescribed by the Diagnostic and Statistical Manual of Mental Disorders (DSM). The alternative method of healing may deter them from seeking services. However, the Mien are also open to Western treatments and mental health practitioners assisting members of the Mien community should be cognizant of the differences the Mien have in their understanding of mental health and remain open to concurrent treatments. They need to respect the Mien’s traditional method of treatment and recognize that it has value to them and help facilitate their psychological and emotional healings. Structural barriers to utilization of services are often the most difficult to bridge and language barriers is shared by all the participants except the youngest participant who is able to speak English. More research on this group of people, their perception of mental illness and they barriers they encounter while seeking utilization may lead changes at the micro, mezzo, and macro that are needed in order to
provide culturally competent quality services for the Mien living in Sacramento, California.
APPENDIX A

Consent to Participate

You are being invited to participate in a research project that will be conducted by Lai F. Saechao, a graduate student in the Masters of Social Work at California State University, Sacramento (CSUS), Division of Social Work. This research project will serve several purposes. The researcher is interested in exploring barriers to mental health service utilization by the Iu-Mien people. The results will provide mental health providers and other social service providers with more information and understanding on how to increase mental health service utilization by the Mien. The knowledge may help providers to become more culturally sensitive and attuned to the different needs of the Iu-Mien.

PROCEDURE:

After reviewing this form and agreeing to participate, the researcher will schedule a time and place that is convenient for you. The interview should take place for approximately an hour. It will be audio taped. The taped will be transcribed and then destroyed. As a voluntary participant, you may refrain from answering any question or to stop the interview at any time without any consequences. No inducements of any kind will be given for participating in this research.

RISKS:

The discussion of some of the topics of the interview may illicit an emotional response and you will be asked to recall certain events and facts about your life and experience in
America. If you need assistance after the interview, a list of mental health support services will be provided.

BENEFITS:

This project will add to the knowledge about the Mien people and help mental health professionals and social service providers increase utilization rates of mental health services by the Iu- Mien. Please note that no compensation of any kind will be given for participation in this research project.

CONFIDENTIALITY:

The researcher will protect the confidentiality and anonymity of the participant. The consent forms and the data (notes and audio tape) will be stored separately in secured locations. During the process of this project, the researcher and her thesis advisor will have access to the data collected. The final product of this research will not include any names or any identifying information. All data will be destroyed upon the completion of this project.

RIGHTS TO WITHDRAW:

As a voluntary participant of this research project, you have the right to refrain from answering any question during the interview. You also have the right to withdraw from the research at any time.
CONSENT TO PARTICIPATE AS A RESEARCH SUBJECT

I have read the descriptive information on the Research Participation cover letter. I understand that my participation is completely voluntary. My signature indicates that I have received a copy of the Research Participation cover letter and I agree to participate in this research.

I, ______________________________________________ agree to be interviewed. I understand that there is a possibility that I will be audio taped.

Signature: ___________________________________________________

Date: _______________________________________________________

Contact:

If I have any questions or concerns regarding my participation, I will be able to contact the researcher.

Lai F. Saechao: 916-505-6208

Email: lfs23@csus.edu

If I need further assistance, I may contact the thesis advisor of the researcher

Serge Lee, Ph. D., MSW

c/o California State University, Sacramento

916- 278-7065

Email: leesc@csus.edu
For professional help in the greater Sacrament County, please contact the following locations…

1. La Familia Counseling Center, Inc.
   5523 34th Street
   Sacramento, CA 95820
   Phone: 916-452-3601
   TDD: (800) 735-2929 or 711
   Email: anitab@lafcc.com
   URL: http://www.lafcc.com/about.html

2. Asian Pacific Community Counseling Center
   7273 14th Ave # 120-B
   Sacramento, CA 95820
   Phone: 916-383-6783
   URL: http://www.apccounseling.org/

3. Sacramento County Mental Health
   2150 Stockton Blvd
   Sacramento, CA 95817-1337
   Phone: (916) 875-1000
   URL: http://www.sacdhhs.com/

4. Southeast Asian Assistance Center (SAAC)
   Address: 5625 24th Street
   Sacramento, CA 95822
   Office: 916. 421-1036
   Fax: 916. 421-6731
   Monday – Friday: 8:00 am - 5:00 pm
   Email: seacenter@sbcglobal.net
   URL: http://www.saaccenter.org/

5. California State University, Sacramento - Center for Counseling and Diagnostic Services Sacramento State Student Health Center
   6000 J Street
   Sacramento, CA 95819
   Mon- Fri: 10: 00 AM – 11:30 A.M and 1:00 PM-2:30 PM
   916-278-6252
   URL: http://www.csus.edu/psysrv/resources.htm
APPENDIX B

Interview Schedule / Questionnaire

PART I: Demographic data

1. What is your age?

2. What is your marital status?

3. Do you have children?

   If yes, how many? __________

4. What is the preferred language you speak most at home?

5. Where were you born?

   Country of birth: _________________________________

6. If you were not born in the United States, how old were you when you left
   your birth country?

7. Including yourself, how many people came all together?

PART II: Understanding and perceptions of mental health illness by the Mien.

The next several questions I will ask you for your views and perceptions about
the term mental health.

1. When hearing the word mental health, what is the one important thing that
   comes to your mind? Essentially, I want you to describe to me, how you
   understand the word mental health and mental illness?

2. Can you describe to me the common signs, which in America is call
   symptoms of mental illness to me?
3. After being in the United States for many years, has your perceptions about mental illness changed?

   If Yes_______ Please explain

   If No _______Please explain

   Don’t know________

4. Please give me your personal reasons why people become mentally ill?

PART III: Iu Mien’s access to mental health services

1. Do you have medical insurance / healthcare insurance?

2. In the past six months, has a family member of yours looked sad and wanted to be left alone?

   Yes________________ Please Explain

   No________________ Please Explain

   Don’t know_________

3. Do you know where to seek for help if you or your family member needs mental health services?

   Yes________________

   No________________

   Don’t know________

4. In the past six months, has a friend of yours ever become angry for unnecessary reason?

   Yes________________ Please Explain

   No________________ Please Explain
5. If yes to questions 2 or 3 above, have you ever assisted in seeking help for the family member or friend?
   Yes_______________ Please Explain
   No_______________ Please Explain
   Don’t know_________

6. If yes, what do you think about the treatment that the family member or friend received? Do you think the treatment was helpful or not helpful?

7. Have you or your family ever been treated for mental illness?
   If yes, how long ago?_____________________________________
   Where was it? __________________________________________
   Did you or the family member have a positive or negative experience?
      Positive_______________ Please Explain
      Negative_______________ Please Explain
      Don’t know___________

8. In addition to your family members, do you know someone within the Mien community who is receiving mental health treatment?
   Yes_______________
   No_______________
   Don’t know_________

PART IV: Communication and Language

1. Do you know how to speak English?
2. If no, do you have a family member who interprets for you?

3. Do you feel that not speaking English is a barrier to accessing mental health services?
   Yes ___________ Please Explain
   No ___________ Please Explain
   Don’t Know __________

4. Do you think that speaking English will help you in communicating your mental health needs to a provider?

5. Is it important that a mental health provider understands your culture?

6. Is it important that a mental health provider speaks your language?
   Yes ___________
   No ___________
   Don’t Know __________
REFERENCES


