HMONG SHAMANS AND MENTAL HEALTH: A COMPARISON ACROSS
ACCULTURATION LEVEL

A Project

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by
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Division of Social Work
Abstract

of

HMONG SHAMANS AND MENTAL HEALTH: A COMPARISON ACROSS
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This study explores how shamans’ level of acculturation and demographics influence their recommendations in health services to clients who have symptoms related to a mental health disorder. Seventy-eight participants were identified through the snowball non-probability technique to complete surveys that measured their level of acculturation, demographics, and recommendations of health treatment. Through quantitative data analysis, their level of acculturation, specifically language and media, had a higher influence in their recommendation of medical treatment. However, demographics did not make a significant difference, except their age. This study demonstrates the need to provide more outreach to shamans so they understand mental health and when to recommend them to clients.

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_______________________
Date

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Chapter 1

STATEMENT OF THE PROBLEM

Mental health is a prevalent issue in the United States. According to the National Institute of Mental Health, one fourth of the population has a diagnosable mental health disorder (Duckworth, 2013). In the United States, approximately, sixty percent of adults and half of youth who have a mental health disorder are not receiving the necessary care for their mental health (Duckworth, 2013). Being diagnosed with a mental health disorder comes with stigmas and misconceptions that are negatively viewed, which discourages individuals from seeking out the necessary services. Asian Americans who are one of the fastest growing racial groups in the United States make up approximately 15 million of the population and embody more than 100 different languages and dialects spoken in the U.S. (Africa & Carrasco, 2011).

Despite the growing numbers in the United States, many Asian Americans remain marginalized and continue to be confined in mental health services (Africa & Carrasco, 2011). In the National Latino and Asian American Study, over seventeen percent of Asian Americans disclosed having experience symptoms related to a mental health disorder (Nguyen, Shibusawa & Chen, 2011), however, only 8.6% of Asian American adult have use mental health services (Nguyen, 2011). The use of mental health services in the Asian American community is lower compared to non-Hispanic Whites (Nguyen et al., 2011) due to cultural values and norms that stigmatize and shame individuals who seek out resources. Moreover, there is a lack of bicultural understanding and culturally-competent providers, which discourages Asian Americans from seeking out support and
services (Africa & Carrasco, 2011). Although there is a low prevalence of mental health disorder in the Asian American community, they have higher levels of mental health symptoms experienced in a lifetime (Nguyen et al., 2011). For example, Asian American female youth, ages 14-24, have the highest rates of suicide in their age group (Nguyen et al., 2011). Furthermore, Asian American elders have higher rates of depression compared to non-Hispanics White elder counterparts (Nguyen et al., 2011). A study done by Yeung et al. (2004) found the overall prevalence of major depressive disorder in the Asian American community was over nineteen percent, which was proportional to or higher than the rates of White people. However, analyzing desegregated data, Southeast Asians suffer the highest rates of diagnosable mental illness (Sue, Cheng, Saad & Chu, 2012).

Southeast Asians are one of the many different ethnic groups in the United States with one of the highest rates of being diagnosed with a mental health disorder. As Southeast Asians have immigrated into the United States in different waves, the widespread relocation of families and trauma from the war has had a tremendous effect on their mental health (Tatman, 2004). A study done by Marshall, Schell, Elliott, Berthold and Chun (2005) measured the prevalence of psychiatric disorders within two decades of settling into the United States in the Cambodian refugee community. The study found the vast majority of the participants were exposed to trauma and violence. With nearly 99% of the Cambodian population experiencing near-death experiences due to starvation, 90% experienced the death of a family member or friend, and over half who were tortured during the war (Sue et al., 2012). Approximately 70 percent also reported being exposed to violence post-immigration and over sixty percent meeting criteria for
posttraumatic stress disorder (Sue et al., 2012). Another study by National Asian Women’s Health Organization (NAWHO) echoed the stigmatizing severity of mental disorder in the Southeast Asian Community, with seventy percent of Southeast Asians meeting criteria for major affective disorder, which includes the diagnosis for depression. (Africa & Carrasco, 2011). Despite these statistics, there has been an insignificant amount of research published that discusses the prevalence of mental health diagnoses in the Hmong community (Vega & Rumbaut, 1991). Lee and Chang (2012b) found the Hmong population was understudied in the context of mental health. Summarizing the statistic found by the U.S. National Institutes of Mental Health (NIMH), Lee and Chang (2012b) found that Hmong Americans’ mental health diagnosis were closer to being over 33 percent with depression, anxiety and posttraumatic stress disorder being the most prevalent. Generally, the Hmong population are lumped into aggregated data in mental health studies, which is an inaccurate depiction of the percentage of Hmong people who are diagnosed with a mental health disorder and utilizing mental health services.

Background of the Problem

Before the diaspora into the United States, Hmong people lived in Vietnam where they freely cultivated land and practiced their religion. When the Vietnam War started, the U.S. Central Intelligence Agency (CIA) enlisted Hmong people as soldiers to fight against Vietnamese soldiers (Collier, Munger & Moua, 2012). In exchange, the CIA promised to take Hmong people to the United States as refugees (Christian, Moua & Vogeler, 2008). On April 30, 1975, also known as The Fall of Saigon, the last American troops pulled out of Vietnam, leaving thousands of Hmong people to fend for their lives.
The Pathet Lao, a political organization, raided the lands of Vietnam, Laos, and Thailand where they murdered thousands of Hmong people (Fadiman, 1997; Gerdner, 2012). Many were forced into hiding or escaped into the refugee camps in Thailand where they retreated from political prosecution (Collier et al., 2012). After resettling into different countries and areas in Southeast Asia, Hmong people were slowly brought into the United States as refugees; the waves of refugees continued in waves up until 2007 (Collier et al., 2012). As of 2010, over 250,000 Hmong people reside in the United States (Hmong National Development, 2013). With nearly 91,224 Hmong people, California has the largest population of Hmong residents (Hmong National Development, 2013).

Not only are there a significant Hmong population diagnosable for PTSD and depression from the war, they are also diagnosable for adjustment issues and anxiety. Previous studies have found that mental health disorders are higher in Hmong American population than any other Southeast Asian refugee ethnic groups. Some of the major issues contributing to these disorders occurred post-immigration: family conflicts, intergenerational gap issues, cultural clashes, change in cultural practices, health concerns, barriers in health care, barriers in education, gang enhancement, poverty, suicide, and domestic violence (Lee, 2013). Families who experience these post-immigration issues sat in silence, unaware of resources they could access in the community. The maladaptive experiences negatively exacerbated their mental health. It led some of these disorder and issues in the Hmong community to negative affect their lives, as some of these concerns made it onto national news headlines (Lee & Chang, 2012). For example, in 1998, Khoua Her, a mother murdered her six children age 5 to 11
due to her lifelong struggle of oppression, depression, and gendered hierarchical culture (Johnson, 1998). Police had been called to her home fifteen times the year prior to the incident for domestic violence, however, there were no evidence of the mother harming her children. Following Her’s incident, in April of 2013, twenty-eight-year-old Kou Thao shot and killed fifty-eight year old Tong Pao Hang. Afterwards, he dismembered Hang’s head and stuck it in the trunk of his car where it was soon discovered by the police (Dirr, 2015). Officials were unsure if he could stand trial and wanted to further evaluate him for any mental health disorder. Another story that made recent national headline in September 2015 was the disappearance of Moua Vang. Vang staged her disappearance at a Farmers Market in Washington and flew out to Thailand where she hope she would escape the stress she was experiencing in the United States. She left her six children and husband but once she landed in Thailand, she changed her mind and bought a ticket back to the United States. She was located and stopped by Homeland Security and was interviewed by the police. Officials reported that she was stressed from her 12 hours a day, 6 days a week job and indicated signs of suicidal ideation (Kiggins, 2015). She was immediately admitted to a mental health facility for treatment and no charges were made for her staged disappearance (Kiggins, 2015). Simply put, mental health is an underlying but present issue in the Hmong community as these are just a few incidents that captured national attention.

Many Hmong families are from the lower socioeconomic class and qualify for federal health care, however, families continue to face barriers that prevent them from accessing mental health services (U.S. Census Hmong National Development, 2013).
Even though only 14.9% of the U.S. Hmong population are unable to access federal health insurance (Pfeifer, Sullivan, Yang & Yang, 2012), many Hmong people have health insurance to cover their health needs. Of the numerous needs in the Hmong community, mental health is not recognized and known by the community as a medical necessity, thus mental health services are least likely to be sought out. Mental health is one of the most difficult concerns that remains to be address in the Hmong community. Researchers have reported that the use of mental health services were likely to increase due to the generational differences and levels of acculturation; however, mental health has been continuously stigmatized by the Hmong community (Nguyen, 2011). Hmong people believe that those who are utilizing services for a mental health are considered *vwm*, meaning crazy in Hmong (Yang, 2003). Seeking out mental health services would not be a Hmong person’s primary treatment.

Instead, in the Hmong culture, the shaman partakes in the role of a psychologist and social worker. Through the use of animism and ancestor worship, Hmong people are encouraged to use different treatment modalities such as: herbal medicine, prayer, superstition, and shamans (Culhane-Pera, 2003). Many Hmong families who use these modalities direct their symptoms to shamans for spiritual healing (Gensheimer, 2006; Lee & Chang, 2012). Shamans are useful in helping Hmong people understand and heal from issues related to health, however, they can unknowingly harm clients when an urgent medical treatment is needed due to their different scope of practice.
Study Purpose

By using shaman as a guide for treatment, it is valuable, as they understand the complexities and boundaries of their scope of practice. Often, if one shaman cannot heal, he or she would refer clients to another shaman who they know who could help them. Thus, when issues are out of their scope of practice, they may or may not recommend treatment with western medical providers. The challenge in the Hmong community is adapting the practices of western mental health services when severe symptoms indicate an individual’s need for immediate medical attention. For this reason, there is an urgency to explore how to target the Hmong population about mental health services, while still incorporating the practice traditional beliefs. It becomes desirable for western mental health providers to collaborate with shamans to address the mental health needs in the Hmong community. By looking at Hmong shaman’s level of acculturation, we can gain insight to their knowledge of mental health disorders and mental health services. Moreover, we can also understand the different type of services shamans recommend to clients who have mental illness symptoms in comparison to a clinician's recommendation of services. As a result, we will see if shamans’ recommendations of health needs align with the recommendations of western health providers.

Theoretical Framework

In order to understand how the social background, cultural orientation and acculturation level of shamans impact their understanding of mental illness; the researchers utilized the ecological perspective and cultural theory. The cultural theoretical framework is based on the “organized pattern of values, beliefs, and behaviors
developed and transmitted over time by a social group” (Robbins, Chatterjee & Canda, 2012, p. 138). On the other hand, the ecological framework explains the interface between an individual’s life and its environment, which includes biological, psychological, social, and cultural domains (Germain & Gitterman, 1980; McCleroy, Bibeau, Steckler & Glanz, 1988; Xiong, 2012; Robbins, Chatterjee & Canda, 2012, p. 33).

The understanding of these frameworks will give health professionals insight into how important the shaman role is to the Hmong community. Traditionally, Hmong people practice a combination of spiritual belief systems between animism and ancestorship to maintain a harmonious and healthy life. It is through the shaman, txiv neeb or niam neeb, that Hmong people connect with spirits. Shamanism continues to be a cultural practice utilized in the United States. According to Gerdner (2012), older Hmong Americans (74%) and family caregivers (58%) retained the spiritual beliefs of animism and ancestor worship and will consult with a shaman over a physician. Therefore, the shaman’s role is significant in affecting Hmong people’s perspective on the utilization of mental health services. It becomes important to understand how cultural identity is important in the Hmong community, specifically with shamans, as they are the primary source of care. While, the ecological perspective looks at the micro, meso, and macro level impacting, shaping, and influencing individuals. Particularly, within shamans, we will be able to see how the framework is affecting their acculturation level based on their given experiences in their environment. It will identify how the environment has either supported them into utilizing more of the mental health domains in the United States or
retract from the services available. The framework will give insight to a holistic perspective that includes their transnational experience, bicultural assimilation, bicultural challenges, living environment, cultural and traditional beliefs, social status and network, family structure, and internal working model. Moreover, the ecological perspective will help understand how shamans’ acculturation level are then impacting their knowledge and recommendations of mental health services in the United States. Although the trajectory of acculturation levels may differentiate, through the lens of the ecological perceptive and cultural framework, we can understand how the Hmong culture is impacted by their environment since settling into the United States.

Both of the frameworks will be guided by acculturation models: Unidimensional model and Bidimensional model. Unidimensional model assumes that the individual became more acculturated to their host (or majority) culture, they became less enculturated to their native identity (Phinney, 1990; Tsai, Ying & Lee, 2000). The critique of unidimensional model is that it values assimilation to the host and disregards the importance of biculturalism for individuals who are oriented to both host and native cultures. The bidimensional model claims that individuals can be acculturated to their native (or minority) culture and their host (or majority) culture (Berry, 1995; Lafromboise, Coleman & Gerton, 1993; Phinney, 1990). For the purposes of this research, the focus is on the unidimensional model as we test the acculturation level of shamans. By doing this research, we hope to bridge and strengthen the support between shamans and western health clinicians to culturally and appropriately serve the Hmong population.
**Definitions**

**Shamanism.** A spiritual and traditional practice that encompasses animistic and spiritualistic beliefs to promote and maintain spiritual harmony, health, wellness and balance. In the Hmong communities around the world, shamanism is known as *ua neeb* and is practiced by Hmong shamans. Shamanism remains and continues to be an importance practice in the Hmong community despite the research and advancement in medicine.

**Shaman.** Hmong shaman is translated as *tsiv neeb* (male shaman) or *niam neeb* (female shaman). Shamans are chosen by the shaman spirits to bring harmony, health, wellness, and balance to themselves, their families, and their communities by several rituals not limited to rituals and chants, spirit calling, and animal spirit exchanges or sacrifices.

**Western mental health services.** According to the United States Department of Health & Human Services (2015), mental health services are programs, resources, and providers to address people’s emotional, psychological, and social well-being and to enhance their thought process, emotional state, and behavior. The services teach skills on how to handle stress, relate to others, and self-determination. Services are available for people in different life or developmental stages or ages.

**First generation.** 1st generation refers to immigrants born outside the country (Min & Kim, 2002; Vang, 2014). In this research, first generation refers to participants born outside of the United States.
1.5 generation. 1.5 generation refers to immigrants born to 1\textsuperscript{st} generation immigrants and immigrated to a new country before or during their early teens (Harklau, Losey & Siegal, 2009). The term 1.5 is special to the experiences and characteristics they bring from their home country but continue to assimilate, socialize, and acculturate in the new country. As result, they are in between 1\textsuperscript{st} and 2\textsuperscript{nd} generation. In this research, 1.5 generation immigrants refers to participants born somewhere else and immigrated to the United States.

Second generation. 2\textsuperscript{nd} generation refers to immigrants born to first generation immigrants (Min & Kim, 2002; Vang, 2014). In this research, second generation refers to participants born in the United States to first generation immigrants.

Acculturation. Acculturation is a term used to describe the process of change in the cultural practices, views, and beliefs of individuals as a result of living or coming in contact with the host culture (Yoon, Langrehr & Ong, 2011; Vang, 2014). In this research, acculturation refers to the participants’ level of change into the Western society and culture in the United States.

Assumptions

Through this research, we are making the assumption that western mental health services will benefit the Hmong community. Moreover, we are also making the assumptions that the collaboration between shamans and western mental health services will better serve Hmong population when it comes to treatment modalities. With these assumptions, we will explore how the shamans processes the following surveys and
vignettes. Based on the outcome, the more acculturated the shamans, the more likely they will recommend integrated care in the western mental health care.

**Study Limitations**

Although the research will have its contribution to more available disaggregated data on the Hmong community, it will also have its limitations. This research will explore the shamans’ understanding of mental health rather than exploring the specific mental health disorders experienced in the Hmong community. It will also not examine the different types of treatment individuals utilize for particular symptoms. This research also does not explore the different clinical suggestions and approaches for particular mental health disorders when working with the Hmong population.

**Statement of Collaboration**

Kaeo Vang and Soua Moua are working together on this project to establish additional literature on Hmong Shamans and Mental Health: A Comparison Across Acculturation Level. Both authors have equally collaborated and contributed to the efforts to conduct this research project.
Chapter 2

LITERATURE REVIEW

In this chapter, both the researchers are examining and analyzing literatures focusing on different themes connected to Hmong history, Hmong shamans, mental health, and acculturation. This chapter is divided into four major themes. The first section is focused on mental health in the United States, which includes (1) Mental Illness in the United States and (2) Mental Health Issues in the Asian American Community. The second section targeted pre-immigration of Hmong people, which includes (1) Origin of Hmong people and (2) The Secret War. The third section discussed post-immigration, which includes (1) Resettlement in the United States (2) Acculturation Issues and (3) Mental Health in the Hmong Community. The fourth section emphasize the practice of Shamanism, which includes (1) Spirituality (2) Shamanism and alternative healing (3) Shamanism vs. Western Medicine Treatment and (4) Shamans and Mental Health.

Mental Health in the United States

According to National Alliance on Mental Illness (NAMI) (2016), mental illness is a condition that alters an individual’s pattern of thinking, feeling and mood. It may affect his or her ability to relate to others and function psychologically and emotionally. A mental health condition is not the outcome of an individual event that causes him or her to experience symptoms related to a mental health diagnosis. Rather, research suggest that a mental health condition is multiple, intertwined causes happening over time (NAMI, 2016).
Mental Illness in the United States

Mental health is a major problem in the United States due to the health care disparities. It has been a long, rooted racial issue in the U.S. from the time of slavery. However, when the passage of the Civil Rights Act in 1964, and American Disability Act 1990 (Congress, 2016) were enacted, it became two of the major transformation to accept people with disabilities and end discrimination so individuals can access spaces, such as treatment for mental health disorders. Over the 20th century, mental illness has increased. McNally (2011) reported in 1915, 2-3% of the general population were diagnosable with a mental health disorder such as anxiety and depression. McNally also reported 20% of the general population could be diagnosed between 1950-1970, and 71% of young adults in the 1990s. According to the U.S. Surgeon General, Galson (2009) reported 20% of women and 13% of men from the U.S. population were affected by depression. Galson’s research also found 10% of women and 3.6% of men to be diagnosed with Post Traumatic Stress Disorder (PTSD), and 6% of women and 3.1% of men suffer some type of panic related disorder. From the National Institute of Mental Health, Ken Duckworth (2013) estimated in a given year, roughly 61.5 million Americans could have a diagnosable mental illness and roughly 13.6 million Americans live with severe mental illness such as schizophrenia, major depression or bipolar disorder. As evident by the statistics presented over the 20th century, the percentage of mental health has increased tremendously.

Scholars attributed the rise in mental illness diagnoses in the United States to multiple factors. One, with the laws implemented it opening more opportunities for
individuals to be diagnosed with a mental health disorder that previously were unable to access the services. Some scholars claim the development and new version of the Diagnostic Statistics Manual contributed to the continuum of further and expanded diagnoses (Fernando, 1995; Pierre, 2012; Yang, 2003). Another factor that also contributed to the rise in mental health was due to events occurring in the 1960’s into the 2000’s. There was an uprise in Southeast Asian immigrants migrating to the United States, an international war with Iraq, and the September 11 tragedy that impacted the lives of many individuals (Pols & Oaks, 2007; Kim & Kim, 2014; Nicassio, 1985); all of which had more people meeting criteria for a mental health disorder. Due to all these events and changes in law policies, it opened up more possibilities for people to receive more appropriate services. McNally (2011), and Pierre (2012) reported the advancement in medical treatments and trainings to address medical needs in underserved communities brought more culturally competent providers to serve marginalized community in their mental health diagnosis.

**Mental Health Issues in the Asian American Community**

Though mental health has been changing over the years to be more accessible to the general population, there are still factors hindering the use of mental health services in ethnic communities. According to the 2010 U.S. Census, the Asian population increased by roughly 50% between 2000 and 2010. This population grew more than any other population groups in that time period. Asian American, which encompasses multiple ethnic groups, continue to face emotional and psychological distress (Lin & Cheung, 1999). The idea of the model minority reinforced and stereotyped all Asian
Americans as the racial group who have strong work ethic and supportive family members (Kim et al., 2014). It mythologized Asian Americans as the well-established racial group with no social and economic issues. However, not all Asian Americans fit into the model minority myth, specifically Southeast Asians, as the label takes away the opportunity to receive the necessary help from community resources and governmental support (Kim et al., 2014). Due to the label, the resources are allocated unequally and prejudicially into agencies and organizations (Kim et al., 2014), which intensified the mental health symptoms from the Asian American community.

Moreover, there are associated stigma, underutilization of mental health services, access to resource, cultural barriers and clash that prevent under-served population to seek out treatment (Zuvekas & Taliaferro, 2003). Approximately half of Southeast Asians have a prevalence of being diagnosed for PTSD and over seventy percent with anxiety and depression disorder (Mollica et al., 1987). Carlson and Rosser-Hogan (1993) studied the prevalence of mental health disorders in the Cambodian community and found 80% met criteria for depression and 88% for anxiety disorder.

Asian Americans have an underutilization pattern that could be understood through their help-seeking behaviors: disclosing information regarding their health and where they go to seek for help (Zhang, Snowden & Sue, 1998; Lee, 2013). Asian Americans are self-reliant when experiencing high levels of stress. They are less likely to seek conventional western practitioners to cope with symptoms related to a mental health issue. If the individual could not rely on self-help, they sought guidance through family and community. They turned to traditional practices and rituals to alleviate from
symptoms associated with health (Lin & Cheung, 1999). They view family as the primary unit of care and support (Lin et al., 1999). When seeking out help through western providers it meant drawing clear boundary of confidentiality, which excluded family from treatment harming the therapeutic relationship and possible disengagement (Lin et al., 1999). Moreover, Asian Americans do not see the mind and body as dualities, rather an unity, which is why they focus more heavily on physical health than emotional stress (Lin et al., 1999).

Specifically for Southeast Asians there are other barriers altering their ability to use mental health. A big part of the struggle was dealing with economic and academic achievement (Kim & Kim, 2014). Vietnamese, one of the more established Southeast Asian ethnic groups, have an estimated 27.1 percent living in poverty compared to the 20 percent of Chinese and 12.3 percent of Filipinos (Kim et al., 2014). However, these statistics does not account for all the other Southeast Asian communities living in poverty. Southeast Asian fall under the lower social stratification, which disabled them from having less power and privilege to resources, while experiencing more exposure to vulnerability, trauma, and re-traumatization (Kim et al., 2014). Furthermore, there is a cultural difference in the scope of practice in western medicine to traditional beliefs, financial cost of affording the services that were not covered through insurance, transportation, and interpreters (Kim et al., 2014). All these barriers and issues prevented Southeast Asian communities, including the Hmong population, from seeking mental health providers.
Pre-Immigration of Hmong People

Hmong, which means “free people,” is an ethnic group from Southwestern China and Southeast Asia (Allen, Matthew & Boland, 2004). The Hmong people have a difficult history to recall, as their history has been orally told from generations to generations. The earliest recollection of the origin of Hmong people started in China (Tatman, 2004).

Origin of Hmong People

Historically, Hmong people have lived and cultivated lands in different parts of China and later in Southeast Asia; they are a nomadic group and do not have a country to call their own (Tatman, 2004). The earliest documentation of Hmong history was in 2700 B.C. where they lived in China (Fadiman, 1997). Hoang-ti, a Chinese emperor, thought that Hmong were too barbaric to be governed under the same laws as the Chinese (Fadiman, 1997). Instead of allowing Hmong to live peacefully in the same area, he decided to have them executed. Those who were not executed were summoned to have their body parts decapitated. The Chinese retaliated against the Hmong; however, the Hmong fought back. This happened in a continuous cycle, until the Hmong decided to move from their rice field of Yangtze and Yellow rivers into the higher altitude of the mountains (Fadiman, 1997). This is how Hmong people became known as “Miao,” or “Meo” a derogatory name to call the Hmong. In moving into the mountains located in higher altitude they were able to seclude themselves from others and continue their ethnic practices and preserve their race (Fadiman, 1997).
Eventually through the war with the Chinese, Hmong people learned how to be warriors. They created their own weapons, using poisoned arrows and other weapons to help them fight against the Chinese who retaliated (Fadiman 1997). After another long battle with the Chinese, the Hmong sought safety in migrating into Kweichow and Szechuan (Fadiman, 1997). In the sixteenth century, the Ming Dynasty built a smaller version of the Great Wall of China stretching for one hundred miles, ten feet tall, to keep the Hmong from leaving Kweichow. Although the Hmong were contained in an area, the Chinese never controlled them.

The Chinese tried to sinicize Hmong people by converting the Hmong to Chinese. They wanted the Hmong to wear Chinese clothing, practice their language, cut their hair in order to achieve similar physical looks, and forbid Hmong to practice their spirituality beliefs (Fadiman, 1997). Fearing that they would be prosecuted, some Hmong followed the laws implemented by the Chinese. There were other Hmong who refused to follow the law and fought against the Chinese. Ch’ien-lung, the emperor at the time, wanted those who rejected to follow the rules to be executed. The Hmong general, Sonom, who rejected to be sinicize was caught and brought to the emperor where he and his family members were decapitated. They had their heads displayed for public humiliation (Fadiman, 1997). Although Hmong people lived in China practicing their culture and religion for a long time, after the murder of Sonom they were slowly driven out of China due to war and prosecution (Fadiman, 1997).

It was not until the beginning of the nineteenth century, the Hmong decided that they had enough and moved into Indochina. Although some Hmong people stayed in
China, about half a million Hmong immigrated into Southeast Asia, settling into the borders of Vietnam and Laos. Through their journey, they walked over other countries and its borders, familiarizing themselves with the land (Fadiman, 2004).

**The Secret War**

Hmong people settled in Vietnam and Laos, in villages, living in remote areas close to family and clan members (Allen et al., 2004). Hmong people continued to practice an agrarian lifestyle in the highlands (Gerdner, 2012). However, starting in the 1960’s, the Vietnam War intensified into Laos, in the geographical areas where Hmong people lived. Through the center of Laos and Vietnam ran the Ho Chi Minh Trail, which was the main route where military supplies were being transported by the communist forces into Vietnam. The U.S. were unable to send military forces into Laos to attack the supply routes because Laos decided to remain neutral during the war. Despite Laos decision to stay neutral, the U.S. entered Laos and recruited the Hmong to fight with the U.S. military. The U.S. Central Intelligence Agency (CIA) made an agreement with General Vang Pao, a Hmong clan leader, that Hmong people would fight alongside in the war with the U.S. The Hmong were convinced communism posed a threat to their individualistic and communal autonomy (Gerdner, 2012). In return the U.S. would aid the Hmong even if they failed the mission in winning the fight between the Viet Cong, Communist North Vietnamese, and Pathet Lao, the communist group in Laos (Thao, 1999; Fadiman 1997). Approximately 400,00 Hmong men and boys were recruited into what was known as, “The Secret War” to work alongside the U.S. Central Intelligence Agency (CIA) fighting in the Vietnam War. The U.S. strategically sent the Hmong
people to counter attack Pathet Lao in disbursing more weapons to the Viet Cong through the Ho Chi Minh Trail. They fought with the United States as soldiers and pilots to stop Communist takeover (Gerdner, 2012).

However, the war did not yield in their favor and the United States pulled out of Vietnam on April 30, 1975, known as The Fall of Saigon (Lee & Chang, 2011). When the CIA left Vietnam, the Hmong were devastated. The Pathet Lao and the Vietcong retaliated against the Hmong and other Southeast Asians who fought with the United States or who were against communist parties (Keown-Boma, 2004). They were left to fend and relocated in a war zone; they were forced to flee across the borders of Laos and into Thailand (Collier, Munger & Moua, 2011). Through their journey from Vietnam into Laos and Thailand, approximately every family had lost at least one loved one through the war (Meredith & Rowe, 1986).

Through resettlement efforts, Hmong people sought out asylum in other countries as refugees in hopes to save their lives and preserve their cultural identity (Gerdner, 2012, Lee & Chang, 2011). Hmong people fled into Thailand living in refugee camp where only half of the original 500,000 members of the Hmong tribe in Laos survived (Merdith & Row, 1986; Wang, 2005). However, Hmong people living in the refugee camps in Thailand were never allowed to become permanent residents of the country (Allen, et al., 2004). In the 1990’s, the official United Nations refugee camps closed in Thailand and Hmong people were expected to return to Laos or emigrate to other residing countries (Allen et al., 2004). Many people were not ready to leave the country so a Buddhist monastery opened their doors to Hmong refugees (Allen et al., 2004). Hmong people
lived in tiny huts, forming small villages with their clan members. Those who choose not to stay in Thailand sought asylum in the United States where they were disbursed into different parts of the United States.

Post-Immigration

As promised at the beginning of the war between the CIA and General Vang Pao, Hmong people were sponsored into the United States. The United States Citizenship and Immigration Services (INS) decided how Southeast Asian, including the Hmong, was going to be disbursed into the U.S. known as the “scattering policy.”

Resettlement into the United States

They initiated an average of eight members per family to immigrate together to live in one household. INS, however, realized there were a large number of members within each family. Clans consisted of immediate family members and extended members. Clans form and shape the principles, roles, values, and attitudes of the Hmong life; they are the backbone of preserving cultural identity and beliefs (McInns, 1991). Clan leaders, which are predominantly men, are chosen by member from the clan to guide and support the rest of their community. Clans are divided and identified through surnames. There are a total of 18 clans with different surnames: Chang, Cheng, Fang, Hang, Her, Kue, Khang, Phang, Lee (Li, Ly), Lor, Moua, Song, Thao (Thor), Vang, Xiong, and Yang (Thao, 1999). The size of the clan member varies based on the amount of members located in a concentrated area and the different dialect spoken. Due to the high volume of clan members and family members, INS divided the extended families into smaller nuclear families. This policy separated families from their familiar
communal system in which families lived close by relative who one another during stressful and chaotic times (Cha, 2003).

Hmong people started settling into the United States in different waves starting in the late 1970’s, 1990’s up until the 2000’s (Cha, 2003). When the first waves of Hmong refugees came, they were split into different areas of the United States. The scattering policy was implemented to disburse a small percentage of Southeast Asians refugees into different areas to ensure one place did not have a high dispositional rate of low-income families. Moreover, it would support the Hmong to better assimilate and acculturate (Cha, 2003). Individuals, agencies, and church groups all over the United States helped sponsored the first round of refugees coming in the 1970’s. Federal programs were offered to support Hmong refugees to ensure a smooth transition into a new country. For example, many Hmong were able to find housing, become employed and get an education through different programs. Hmong people also benefited from other federal programs like Medicare, Medi-Cal, Food Stamps, and WIC program, which helped financially support families from the lower socioeconomic class. Scattering, however, did not last very long for many Southeast Asian families. Hmong people wanted to live and be supported through their clan members and relatives, which lead to a new migration where they slowly populated and influx specific areas of the United States. The U.S. government was forced to reconsider its scattering policy with Southeast Asian families. Families who arrived afterwards were able to resettle in areas where they had relatives to support them. With approximately 252,000 Hmong living in the United States, the most
concentrated Hmong population resides in California, Minnesota, Wisconsin, North Carolina, and Michigan (Gerdner, 2012; Vang, 2014).

**Acculturation Issues**

Weine (2011) states the mental health of immigrants is higher upon arriving to the host country because they face a multitude of issues when acculturating. Acculturation is the process in which immigrants learn to adapt to the dominant culture while adjusting to their new life (Vang, 2014). Acculturation becomes important in adapting to the norms and functions of the society. It helps with financial survival, social acceptance and maintaining one’s well-being (Vang, 2014). Acculturation happens gradually through generations. Eventually, the further the generations, the more likely they will take on more of the values, practices, and cultures from the dominant culture. Unfortunately, not all immigrant and generations experience the same trajectory (Berry, 2001). There are different things to take account when looking at the levels of acculturation: tie to their cultural network, socioeconomic class when arriving to the host country, age when he or she arrive, his or her generation, and so on (Vang, 2014). Acculturating in the United States for many refugees became challenging especially for Hmong families who wanted to continue to preserve their traditional beliefs (Lee & Yuen, 2008). Although many have slowly tried to accustom themselves into the mainstream culture and practices, their experiences resettling into a new country has had maladaptive issues. They experienced war, displacement, resettlement, and culture shock along with other symptoms from resettling in an unfamiliar area (Vang, 2014).
Pre-immigration, many Hmong who survived the war suffered from trauma leaving their homeland. They were wounded, tortured, abused, incarcerated, and isolated (Lee & Lu, 1989). Many of them witnessed the death of their loved ones and experienced maltreatment during the war and in refugee camps (Hamilton-Merritt, 1933; Lee, 2013; Gensheimer, 2006). They eventually faced unresolved grievance, and hypervigilance due to the war (Hamilton-Merritt, 1933; Lee, 2013, pg. 2; Gensheimer, 2006). They also experienced post-immigration struggles, which worsen their psychological well-being. Even after the resettlement period and second migration in the United States, families were still concentrated into low-income neighborhoods where they encountered conflicts in acculturation and access to resources. Refugees continued to struggle to adjust and assimilate themselves into mainstream American society. Exacerbating the multiple stressors faced in acculturating, some of the disadvantages faced in the Hmong community were family conflicts, intergenerational gaps, cultural clash, adjustment issues, health concerns, barriers in healthcare, barriers in education, mental health issues, suicide and domestic violence (Lee, 2013; Gensheimer, 2006; Nicholson, 1997).

The Hmong came with very few skills fit for the workforce in urban areas (Cha, 2003). Hmong Americans had the highest of unemployment rates and were the highest ethnic group classified in the lower socioeconomic class (Yang, 2003). Culturally, families were valued through a patriarchal and hierarchal system. Hmong men were expected to provide financially for their families while women were expected to stay home. Majority of the men specialized in agriculture, which required for them to stand for many hours and work. Fortunately, they were able to manipulate the same skills,
emerging themselves into jobs that were similar (Yang, 2003). However, since migrating to the United States, the dynamics of roles have been challenged for women. Although Hmong women were only skilled in sewing, garment making, cleaning, and caretaking it became financially rewarding in the workforce where jobs required these skills (Tatman, 2004). Many first generation parents eventually worked in jobs that did not require the use of English to financially support their children.

It has been estimated that approximately eighty percent of Hmong people who entered the United States are illiterate. Hmong people did not have a written language until the 1950’s and educational opportunities in Southeast Asia were limited (Allen et al., 2004). Hmong people only had a strong oral history; as historical events are documented onto their traditional clothe, also known as paj ntaub, which were carried with them throughout their travels from Southeast Asia to the United States (Cha, 2003). Upon entering the U.S., many Hmong people came hoping to pursue higher education. The Hmong have moved progressively in their educational attainment since the 1990’s. In the 1990’s, about 11% of the population had a high school diploma and less than 3% had a Bachelor's Degree (Census, 2015). Starting in the 2000’s there was an increase in education attainment, with approximately twenty eight percent holding a high school diploma, eleven percent holding an Associate Degree or Bachelor's Degree and less than two percent holding a Master’s Degree (Census, 2015). However, this is a small percentage of the population attaining their education and acculturating to the English language.
Education was a challenge for many first generations. Living in the United States, there was an educational gap and intergenerational challenge with parents and children. The education gap was contributed to the cultural values and practices. According to Hwang and Ting (2008), immigrants who are less acculturated are at higher risk for poor social, academic performance, and psychological maladjustment than those who are more acculturated. Hwang and Ting (2008) explained those who are foreign born and grew up in their country of origin before leaving to a new country experience acculturative stress that impacts their ability to compromise with their new life, therefore will delay their acculturation process. This effect is correspondent to the unidimensional model of acculturation (Cabassa, 2003; Hwang & Ting, 2008; Tsai, Ying & Lee, 2000). The unidimensional model explains that first generation immigrants experience a linear acculturation process that involves the possibility of losing some of their culture of origin to assume the dominant culture (Cabassa, 2003; Hwang & Ting, 2008; Tsai, Ying & Lee, 2000).

Due to the unidimensional model, younger generations struggled and encountered intrapersonal conflict and familial stress in trying to balance the host’s culture over their native identity. According to Bosher (1997), Hmong youth living in the United States who identified themselves as Hmong Americans embraced their ethnic and cultural identity as Hmong and American. The acculturation process that explains the phenomenon for Hmong youth is highlighted by the bidimensional model of acculturation, in which the Hmong youth, 1.5 generation and 2nd generation, experience and balance two identities independently. In one study, Hmong children had a difficult
time balancing family obligations and academics (Lee, 2001; Lee, 2005). They had to do household chores, interpret, babysit younger siblings and drive parents to their appointments (Lee, 2001; Lee, 2005), which clash with academia. Bosher (1997) also found that despite these youth identifying as both Hmong and American, they hold a strong desire to continue practicing the beliefs in the Hmong culture. However, the process to balance both identities has been an acculturation issue that have increased causing family problems between generations (Tatman, 2004). Lee and Greene (2010) found Hmong people who identified higher levels in reading, speaking and writing English had higher rates of acculturation levels. In comparison, the Hmong adults who arrive as first generations had difficulty learning the language, lower levels in reading, speaking and writing English, thus had lower acculturation levels. The internal and external cultural conflicts between Hmong youth and their parents exacerbate their ability to assume the new culture, way of life, and methods of healing.

**Mental Health in the Hmong Community**

Since arriving to the United States, there has been a clash in seeking mental health treatment among the Hmong elders, as the medical model used in western medicine is not aligned to the traditional practices in the Hmong community (Pinzon-Perez, 2006). In the late 1970’s and early 1980’s, scholars documented the mental health needs and diagnostic information prevalent in the Southeast Asian community. The Hmong were collectively clustered with the Vietnamese, Laotians, and Cambodians; each of whom came from different ethnic background. Clustering ethnic groups into aggregated data made it difficult to differentiate mental health needs and services necessary for each group.
However, due to the stress in acculturating during the pre-immigration and post-immigration periods, mental health issues were very similar. The mental health illnesses impacting their well-being were post-traumatic stress disorder, adjustment disorder, depression and anxiety (Lee, 2013; Gensheimer, 2006). In one of the few studies conducted on the Hmong population, Westermeyer (1988) wanted to identify common diagnosis occurring in the community. Westermeyer (1988) found one of the primary diagnosis was not PTSD or other war-related trauma but was chronic adjustment disorder due to their movement into a new country. He also found the Hmong population he studied had a psychiatric rate of 43%, which is double of the general U.S. population. He also found 97% of 100 participants experienced high level of stress (1989), which attributed from acculturation. Another study done by Nicholson (1997) studied the effects of migration on refugees. He found the most profound levels of stress within the Southeast Asian community, including the Hmong, were from acculturation (Nicholson, 1997). Despite the research done in the Southeast Asian community, Lee and Chang, who conducted a systematic study on the mental health status of the Hmong population from 1979 to 1997 found that there is an insignificant amount of research published (Lee & Chang, 2012). They also found high level of mental health issues among Hmong refugees such as adjustment disorder, depression, and anxiety (Lee & Chang 2012), which aligned with the mental health disorders of other Southeast Asian groups. With the issues in mental health, there were problems that specifically arose in hindering the Hmong community: language barriers, awareness on mental health symptoms, and cultural clash.
Asian Americans, particularly Southeast Asian refugees, do not have the language capabilities to access proper treatment. Hmong people have a different view on their overall understanding of health status. In Vietnam and Laos, they were not exposed to western medicine, the human body, and its functions (Johnson, 2002), which complicated and limited their understanding of mental health. When Hmong refugees arrived, there was a barrier in translating and interpreting the Hmong language to the English language and the English language to the Hmong language. Services were not provided appropriately to meet the needs of Southeast Asians. Particularly in the Hmong culture, there is no word in the Hmong language for mental illness. Mental health translated in Hmong is *mob hlwb* or *xiam hlwb*, which means “the pain in the brain or damage to the brain”. These translations denote negativity and are stigmatizing to an individual who is labeled as the following. When mental health is discussed in the community especially in the context of *mob hlwb*, it withdraws Hmong people away from mental health treatments (Her, 2012). Language barriers became a major factor in the Hmong communities’ ability to access the services available to them. The inadequate access to culturally appropriate services and mental health literacy available makes it challenging to navigate for the Hmong (Elliott, Sribney, Giordano, Deeb-Sossa, Sala & Aguilar-Gaxiola, 2009).

It also became difficult to educate the older generation of Hmong adults about the symptoms and words associated with depression, anxiety and posttraumatic stress disorder (Her, 2012). The first generation of Hmong people do not know how to seek for help and where to seek for help for symptoms related to a mental illness. They understand symptoms related to PTSD as a feeling and not an illness. They were unaware of how to
articulate the symptoms as an issue related to mental health, thus, they disregard and minimize it. Moreover, it would ruin the reputation of the family or community, as it embarrassing to be ill (Lee, 1999). When symptoms related to a mental health disorder recur, instead of relying on mental health professional, Hmong people turn to shamanism as a source to cure and understand their symptoms. They are accustomed and familiarized with the interventions associated to shamanism, as it provides specific, concrete solutions to address the problems (Meredith & Rowe, 1986; Nishio & Bilmes, 1987). They trust a shaman’s guidance to heal issues related to health and conflict. Thus, they saw shamans as an alternative coping strategy for treatment.

**Shamanism**

Hmong people have traditionally practiced both animism and ancestor worship. Through animism, they believe earthly structures like streams, rocks, and trees have their own spirits (Livo & Cha, 1991). The Hmong also believe in ancestor worship, a traditional belief that involves the interrelations between living in the physical world “yaj ceeb” and the deceased world “yeeb ceeb” (Gerdner, 2013).

**Spirituality**

There are different types of spirits embodied and responsible for personal or familial misfortune. These spirits include ancestor, nature, evil, and house (Tatman, 2004). They believe disease, death, and misfortune has a supernatural cause (Livo & Cha, 1991; Tatman, 2004). Hmong people believe that people have multiple souls that must be in tranquility in order to maintain good health (Gerdner, 2012). It is theorized that one soul rest by the head, one by the torso, and another by the leg. When a person
dies, one of the soul will stay by his/her grave to watch over the body, one soul goes to heaven to join his/her deceased ancestors, and another stays in the physical world to be reincarnated as a human or an objects such as a rock (Gerdner, 2012). There are also other beliefs that an individual may have less than or more than three souls embodying the human serving the same functions (Cha, 2003).

When a soul has been separated from one’s body, the individual will get sick, and it will become harder to treat the illness (Cha, 2003). When an individual becomes sick, it can be conceptualized in three different way. One, an evil or bad spirit may have followed the person home and attached itself to the human. Two, a bad spirit is torturing the person’s spirit. Three, the person's soul is displeased with the residing body and leaves the human, which is known as “poob plig,” fallen soul (Gerdner, Tripp-Reimer & Yang, 2008). In some cases, some souls may retract from the human body due to loud noises from being frightened, feared, and grief. Later in this chapter, a discussion of Lia’s case illustrates the phenomenon of poob plig to a Hmong family in California.

It is believed ancestors are guarding and protecting the lives of the living family members. In return, the family members must pay homage to the deceased ancestors every year (Gerdner, Cha, Yang & Tripp-Reimer, 2007). Homage included burning paper money and sacrificing animals to their ancestors through the help of a shaman. Souls and ancestors play a significant role in the Hmong community; their perception of health includes the psychical aspect and spirit of an individual. Therefore, when a person’s health is in jeopardy, the Hmong will turn to its traditional practices and ask a shaman for support. Shamans embody the role of the Hmong community’s practitioners.
Shamanism and Alternative Healing

A shaman, “tu ua neeb,” overlook the whole clan’s mental, spiritual, and physical health (Gerdner, 2012). More frequently, there are more male shamans than there are female shamans. Shamans are chosen by spirits, which is often accompanied by a serious illness. The individual’s sickness will be prolonged and medicine would not be able to treat the illness. The individual may also experience dreams where spirits will give him or her signs indicating that he or she has been chosen as a shaman with special powers. When an individual does not understand what is happening in these dreams, he/she may call a shaman to diagnose the person’s illness. Then he or she finds out about the new identity they must embody. If the person decides to fulfill the calling, he/she must proceed with years of training assisting and shadowing another shaman (Cha, 2003). Moreover, he or she must fulfill the duties associated to shamanism and observe all the rules associated with his or her specific calling, as spirits will ask for specific accommodations. Duties and rules may be demanding, however, they must be followed. For example, the shaman’s food must be washed, stored, and prepared well. Moreover, he or she may not walk under a drying rack where clothes are placed, as this offends the spirits who accompany him or her wherever he or she goes. If the chosen shaman decides to not fulfill the calling, he or she may continue to get worse. The individual may feel as if he or she is dying from the illness, and are continuously harassed by the spirits.

The process of becoming a shaman has been passed down orally from father to son. When this happens, the shaman will get really sick where he knows he will die. With his son by his bedside, the shaman will give him a bowl of magic water to drink (Cha,
The magic water is known as “lub pas zaj,” the dragon pond, which invites and calls the dragon to rest at the pond, the bowl of magic water (Cha, 2003). If the process is done right and appropriately, the dragon will sit at this pond where it will be a powerful spirit ally to the shaman. The son will then drink the “dej zaj,” dragon water, so the son will carry on the magic of the shaman in their bloodline to keep the powers in the descent line (Cha, 2003). The ultimate goal is the son will become a shaman, embodying the same powers of his father. However, if that does not happen, then the hope is for the shaman to be reborn into the family of his son and retain the same powers in his previous life (Cha, 2003). Simply, shamans serve as the interdisciplinary between the physical being and spiritual world (Cha, 2003). A shaman’s job is to perform spiritual healing and stabilized spiritual harmony with one’s health (Cha, 2003).

According to Iverson and Krab (1993), shamans have three different ways healing people: spiritual, herbal and body manipulation. The type of healing depends on the client's sickness. Typically, spiritual rituals are performed with various aches/pains, and mental health issues such as depression. It is believed that shamans have capability to travel from the physical world “yaj ceeb,” the world in which humans lives, into the unseen/deceased world, “yeeb ceeb” (Gerdner, 2012). During the spiritual intervention, the shaman will perform a “ua neeb saib” which is a diagnostic ceremony to determine to source of the problem. Detecting the issue may take hours depending on the illness and the shaman’s travel into the deceased world. When the issue is detected, the “ua neeb saib” is followed by a “ua neeb kho,” a traditional healing ceremony. In the “ua neeb kho” ceremony, animals such as pigs, cows and chickens are sacrificed as offerings to the
spirits. If the shaman is successful in returning the person’s spirit, the individual will recover from his/her illness. However, if the soul is not retrieved during the shaman’s spiritual journey, or in the ceremonies that following the initial one, then it is believed that the person will die (Cha, 2003).

However, if an individual's illness is not correlated to spiritual healing, instead herbs and organic substances are used for healing (Cha, 2003). Hmong people feel comfortable using herbal medicine, western medicine, or variety of Thai or Chinese medicine (Cha, 2003). Because Hmong people lived in Southeast Asia for such a long period of time, they have become accustomed to using Thai and Chinese medicine as a remedy for their sickness. Medicine that are effective for specific illness, such as headaches, are shared among family members so other Hmong people can also use the herbal medicine when experiencing similar symptoms. Traditional practices have continued and have been maintained in the United States among Hmong communities. In many cases, most Hmong stop taking medicine when the symptoms have disappeared or when they feel better (Cha, 2003). The belief of taking medication after the symptoms are no longer present is foreign to Hmong people. Studies have suggested that Hmong people do not rely heavily on western medication, as they have different side effects causing more negative symptoms. Hmong people believe that medicine should not give the person negative side effects when they are already experiencing symptoms from the sickness.

Lastly, body manipulation is also present in the community’s treatment process. When experiencing headaches, backaches, stomach aches, and fevers that can be cured
through body manipulation, then the shamans uses the technique of “coining,” “cupping,” or “spooning” to help reduce the symptoms. Hmong people are not the only ones who utilize these remedies, these techniques are common in the Southeast Asian community. According to McInnis (1991), “coining” and “spooning” technique is idea of using a flat object to scrape the surface of the individual’s skin to drive away bad spirits. On the other hand, “cupping” is the practice of using cups to absorb the surface of the skin performed on one’s back to draw out pain or fever.

With these three types of healing treatments, Hmong people continue to practice shamanism in their community as part of healing and treatment (Xiong, 2012). Since coming to the U.S., Hmong people have shifted cultural practices and some families started practicing Christianity, which have created rifts in families who continue to practice traditional animism and ancestor worship. Although there have been shifts in practices, acculturation to utilize western mental health services have not had a great significance.

**Shamanism vs. Western Medicine Treatment**

The Hmong are highly influenced through community experiences and continue to use services that they have been accustomed to practicing. One example the clash of shamanism and western medicine treatment happened in Merced, California with a Hmong family in the 1970’s and 1980’s. Lia Lee, one of the daughters was playing with her sister, when her sister closed the door and frightened her. Moments later it caused the Lia to experience epilepsy. Her parents took her to the hospital and she was diagnosed
with epilepsy; however, in Hmong traditional belief, the parents thought that Lia’s spirit was frighten away and needed to be returned to her through spiritual calling.

There was a big clash in cultural understanding and language barrier, which created issues through Lia’s recovery. Lia had multiple medications prescribed to her and her parents were not able to give the medication in the correct amount of dosage because there was a lack of understanding. The parents did not speak English so when the medication was handed to her legal guardian, the parents nodded as if they understood how much medication should be given to their daughter. The parents also saw the medicine giving Lia more negative side effects, which conflicted with their cultural practices, so they discontinued the intake of medication. Lia’s health condition worsen and a Child Protective Services (CPS) report was made to have Lia taken away from her parents so she could receive the necessary medical care for her health.

After the doctors and nurses understood the circumstances, the child was return to the care of her parents. A spiritual ritual was performed and Lia was given strings, which were tied on her hands, to protect her from bad spirits. However, in returning to the hospital for care, the nurses cut off the string due the lack of understanding the cultural significance of them. Eventually, Lia’s condition worsened and she became brain dead due to the continuous seizure experienced (Fadiman, 1997). Due to this experience, Hmong people have a harder time trusting doctors and social workers especially in the line of mental health treatment.
Shamans and Mental Health

Even though Lia’s case occurred years ago, the Hmong have shifted in utilizing the healthcare system the United States. Some Hmong people prefer the most advanced technological treatments offered by western health care providers (Cha, 2003). Despite the changes, there is a need to continue to establish responsive and diverse services to educate the importance of cultural competency among providers. As illustrated, there is a need for further studies on shamans to find culturally responsive treatments to build partnership with the Hmong community. Moreover, there needs to be more studies in shaman’s ability to recognize mental health and services, as shamans remain the first responders to attend Hmong people's’ mental health concerns (Gerdner, 2012). Furthermore, there needs to be alliances establish with shamans in order to understand how to treat clients who are Hmong, as they still prefer to consult with shamans before visiting doctors (Gerdner, 2012). Thus, shamans can be used to increase the awareness of how viable the medical attention option is in treating mental illness in the Hmong community. In an effort to further and increase research information and resources on the Hmong community and to build a partnership between shamans and western clinicians, this paper’s research examines what demographic characteristics and acculturation level may impact Hmong American shamans’ ability to recognize mental health and treatment recommendations.
Chapter 3

METHODOLOGY

This chapter outlines the methodology and research design used in the study. It contains sections on the participants, the instruments used, and the procedure for data gathering and data analyzing. The chapter concludes with synthesizing the data and the program used to analyze the data.

Hypothesis

We conducted a quantitative questionnaire survey to a Hmong shaman sample in California to test how acculturation level, cultural orientation, and characteristics that influence Hmong shamans’ understanding and ability to recognize mental health and their treatment recommendations. The hypothesis tested was, the more acculturated shamans are in Western culture, the more likely they recommend similar treatments as western mental health providers.

Study Objectives

The objective of this research explores how culture and acculturation level influence Hmong shamans’ mental health knowledge and their treatment recommendations for the Hmong families they serve in California. To measure the objective, the researchers utilized and relied heavily on snowball non-probability sampling technique to recruit as many shamans as possible to capture a varied range of participants, acculturation levels, and experiences with mental health diagnoses. The participants must self-identify as an active Hmong/Hmong American shaman, a resident of California, and 18 years and older. Resident means the participant has an active
address in California during the implementation of this instrument. The shamans are to complete the quantitative survey that encompasses questions that ask their demographics, acculturation level, and assess and provide treatment recommendations for clinical mental health cases. The clinical cases are a reference and comparison point as they are assessed by Licensed Clinical Social Workers in California. The purpose of the data is used to analyze how acculturation level and demographic background influence shamans’ assessment and their treatment recommendations for mental health clinical cases compared to mental health provider’s recommendations. The goal of this research is to highlight and provide more insight on what factors contribute into how a shaman understands mental illness.

**Study Design**

The research approach that is most appropriate for this topic is the exploratory and descriptive research design. This experiment is to explore how acculturation has impacted shamans understanding of mental illness in the Hmong community in California. The experiment also tries to describe what is happening in the Hmong community in more detail, explores what are the contributing factors and missing parts to expand shamans’ outlook on mental health. Though there has been research conducted on the Hmong community and their perception, accessibility on mental health challenges and resources, there is still limited information that investigates how level of acculturation impacts someone’s ability to recognize the needs and experiences of mental health. The exploratory and descriptive research design combined will allow recognition of the current existing groundwork in the Hmong community in addressing mental health
and to elaborate on what and how these approaches can be understood (Dudley, 2011). The research will provide a basis for building a deeper understanding of how shamans identify and treat mental health challenges, and as a result, allow for western mental health providers to meet the Hmong community efficient, cultural competent care, and partnerships to address mental health.

The facilitation of this research approach includes quantitative data collection to capture an objective measurement of what and how Hmong shamans address mental health. This approach allows for a deeper understanding of the problems and what factors influence their assessment and treatment recommendations. The objective is collected through a survey approach which participants are to select what applies to them and their experiences. The survey addresses questions that include demographic background, acculturation level, and a study of clinical cases. The research survey is a cross-sectional study to capture a quick conceptualization of the approaches. This approach is not to establish causal relationships; rather, it is to describe the relationship and/or characteristics regarding the research objective.

**Sampling and Data Collection Procedures**

Snowball non-probability sampling was the approach to acquire responses to surveys. Snowball non-probability sampling was the best approach to the research due to the sensitive nature of the participants. The requirements for shamans to participate are they must self-identify as a Hmong/Hmong American shaman, resident of California, and are 18 years and older. Hmong shamans are not readily accessible unless there was a close relationship, family connection to them or a type of membership to the shaman.
Membership is obtained through birth, adoption, marriage, and through ethnic identification to the community (Centers for Disease Control and Prevention, 2008). The researchers relied on their membership to the Hmong community to obtain the shamans trust and responses to the surveys.

Seventy-eight Hmong shamans (41 male, 37 female; 38 participants are in the age range of 18-39, 40 participants are in the age range of 40-70+, SD=1.56, range=18 to 70+ years) participated in the study. Participants were recruited through a variety of methods to create a large and representative sample of the Hmong California shamans as possible. Participants were recruited from student organizations, social media, public and private community events (Hmong New Year, non-profit organizations, family cultural ceremonies, and funerals) and by word of mouth through family and friends throughout California. The first wave of participants were made through recommendations and referrals by family and friends. The participants identified and made referrals to potential participants as well. There is no incentive to participate in the study.

The GEQ was provided in both English and Hmong. The survey examines the various characteristics that may contribute to acculturation and factors that may impact a shamans’ mental health awareness or treatment recommendation. Participants completed a quantitative survey which consists of three sections: 1) Demographics, 2) Acculturation Measure-General Ethnicity Questionnaire (American and Hmong abridged versions), and 3) Five clinical case study. The participants who required administration of the survey in all Hmong were the older participants. It was assumed that the younger participants had some understanding of elementary English and Hmong. No participants reported any
difficulty understanding the different sections and questionnaires. The questionnaires were presented the same way and order. The participants only provided their responses at one specific point in time. Participants are to participate in the survey once. Due to the limitations of this project, there is not examination of the test-retest reliability of the survey.

**Measurement Instrument**

The research instrument was the quantitative questionnaire survey. It contained a total of 58 multiple-choice questions and with acculturation questions using a scale range answering option. The survey has three different sections: 1) Demographics, 2) Acculturation Measure-General Ethnicity Questionnaire (American and Hmong abridged versions), and 3) Five clinical case study.

**Five clinical cases**

To examine shamans’ knowledge of mental health in the Hmong community, there are five clinical case studies provided in the quantitative survey to assess which treatment recommendations shamans would recommend for a particular set of symptoms. The clinical cases were written by the researchers with the symptoms provided by the Diagnostic and Statistical Manual of Mental Health Disorders: DSM-5 (American Psychiatric Association, 2013). The following are the cases used in the study:

**Case 1.** Kenny, 46 years old, married, three children (17, 14, 10 y.o.), and lost his job 6 months ago. Individual expressed thoughts of killing himself because he feels worthless. He does not get along with two older kids and there are marital problems. He
isolated himself since job loss. For the past three weeks, individual has avoided friends and family. He states, “I want to hang myself and get the misery over with.”

**Case 2.** Samantha, female, 14 years of age, single, lives with mother. Parents split up when she was 4 years old. Individual states, “I have anxiety going to my dad’s house. I prefer to stay with my mom.”

**Case 3.** Amanda female, 35 years old, single, no job, is from the lower socioeconomic class. Individual stated, “I see spiders everywhere. They climb and bite me every night.” She states, “The CIA is watching me through the light bulbs in my apartment.”

**Case 4.** Adam, male, 30 years old, single, is from the lower socioeconomic class. He states, “I have a lack of motivation to continue doing the things that I enjoyed doing. I like to lie around and be by myself.”

**Case 5.** Mindy, female, 25 years old, married, is experiencing symptoms that causes her to want to repetitively pick her skin and hair. She states, “I’m scaring people away and can’t seem to understand why I am experiencing these symptoms.”

Case 1 has depressive symptoms. Case 2 has symptoms of an anxiety disorder. Case 3 includes episodes closely related to a person experiencing psychosis or schizophrenia episode. Case 4 includes symptoms of someone who is depressed. Case 5 shows symptoms of a person who could be diagnosed with anxiety disorder. All cases have symptoms that fall under a spectrum disorder.

For each case, participants have three options of treatment recommendations: 1) *Medical Attention*, 2) *Spiritual Healing*, 3) *Other _____*, and 4) *Medical Attention and*
Spiritual Healing. Medical attention includes medication, medical, and mental health treatment. For the purposes of this research, spiritual healing is defined in the shaman’s scope of practice, which involves spirits, the loss of souls, and cultural healings or *uа neeb*. The “Other _____” option is for participants to make their own recommendations, which could include herbal and acupuncture treatment among others. The fourth option is a combination of the first and second option. Although option four was not listed in the final draft of the survey, it was considered as an option after interviewing shamans and discussing it with research advisor. Researchers noted shamans’ answers in the survey and placed it into the final data collection.

After statistical analysis and with approval of research advisor, the treatment recommendation options were recategorized into medical seeking behavior or non-medical seeking behavior. The two new classifications are 1) Medical Attention, includes the original Medical Attention and the Medical Attention and Spiritual options, and 2) Non-Medical Attention, includes Spiritual Healing and Other options. The two new categories are assessments of help-seeking behavior, which is consistent to topics presented in the previous chapter.

The five cases in the survey were provided to Licensed Clinical Social Workers in local mental health facilities in Sacramento, California. The purpose is to demonstrate how someone with who has assumed the western medical values would recognize mental health challenges and recommend treatment. All five mental health providers recommended *Medical Attention* for all the cases. The mental health providers’ responses are used as a reference point to compare and contrast the similarities and differences of
the shamans’ responses. The data and comparison give insight into the characteristics shamans and mental health providers recognize based on their treatment recommendations. In addition, the data is used to inform providers what diversity and cultural sensitive and responsive approaches could be accomplished to establish effective care for the Hmong community.

**Acculturation Measurement**

To test acculturation level among Shamans and the characteristics that may influence their understanding of mental health, we sought a measurement of acculturation and cultural orientation. The measurement instrument is known as the General Ethnicity Questionnaire (GEQ) (Tsai, Ying & Lee, 2000). The GEQ was created by Tsai, Ying, and Lee (2000) to measure cultural orientation in the Chinese/Chinese American community in the United States. The internal reliability and validity alpha in the original research was high (alpha = .92) with a total sample size 353 (Tsai, Ying & Lee, 2000). The GEQ has been adopted to this research with permission from Jeanne Tsai (2016). In this research, the GEQ has been adopted into two versions, an English version (Appendix C: GEQ English version) and a Hmong translated version (Appendix D: GEQ-Hmong version). The two instruments were exactly the same and administered in the same way.

There are 38 questions to measure shaman acculturation and cultural orientation. Participants used a scale rating system from 1 = *strongly disagree* to 5 = *strongly agree* (for other ratings, see Appendix C and D) to rate how much they agree with the questions/statements about their acculturation level and cultural orientation. Question 5, *I am embarrassed/ashamed of American culture*, the ratings were recoded for consistency
with the rating system (the higher the average, the more acculturated and the lower the rating the less acculturated the participant). For questionnaires that inquired about language proficiency, the scale ranged from 1 = very much to 5 = not at all (for other ratings, see Appendix C and D). The language proficiency ratings were re-coded during the analysis for consistency.

The instrument is self-reported responses in which the participants are asked to rate their level of engagement to various domains of culture. For example, shamans who report speaking English more, engage more with Americans in the community, and participate in more American hobbies and activities are considered more acculturated to the Western culture than shamans who report speaking English less, engage less with Americans, and participate in less American hobbies and activities. The acculturation level is the calculated average scores of all the questionnaire ratings, the higher ratings, the more acculturated the participant (Tsai, Ying & Lee, 2000).

There are six distinct cultural domains that were tested for acculturation and cultural orientation. The original research the GEQ was created tested the following domains: 1) English language use and proficiency (Language), 2) affiliation with American people (Social Affiliation), 3) participation in American activities (Activities), 4) pride in American culture (Pride), 5) preference for media in English (Media), and 6) preference for American food (Food) (Tsai, Ying & Lee, 2000). All the GEQ questionnaires were not included in the acculturation and cultural assessment. Items 3, 8, 9, 23, 29, and 25 were dropped from the data analysis, as they were dropped in the original research (Tsai, Ying & Lee, 2000); these items did not satisfy any of the six
cultural domains. These domains are the factors that assess the participants’ level of acculturation (Tsai, Ying & Lee, 2000).

The GEQ instrument reliability and validity (Cronbach’s alpha) for this research was significantly high, alpha = .943. In the original research, the reliability and validity alpha = .92 (Tsai, Ying & Lee, 2000). Their test-retest reliability and validity alpha was .62 after testing the participants after one month of providing their initial responses (Tsai, Ying & Lee, 2000). The alpha is significantly lower in the test-retest; as with other measures of acculturation and cultural orientation, the test-retest reliability and validity alphas were found to be lower (Phinney, 1990). Due to the time limitation of this research and the limited access to participants, there was no test-retest conducted.

**Demographic Questionnaire**

The demographic questionnaires are to collect statistical characteristics and social background information on the participants. Demographic questions include the following information: generation level, age, sex, marital status, education level, family size, socioeconomic status, literacy, years of residency in the United States, religious background and practices, social involvement in the community, occupation, ethnic identity, and number of spiritual consultation per month. The demographic illustrates and captures the varying degrees of participants. The data is used as a control variable in the research.

In the data analysis process, six demographic variables were chosen for further analysis in this research study. They are age, gender, generation, residency in U.S.A., education, and marital status. The rating options for age, gender, and generation remained
unchanged. Residency in the U.S.A. was changed into two groups, *Less than 20 years* and *More than 20 years*. Marital status was also changed into two categories, *Married* and *Non-Married*, which includes single, divorced, and widow/widower ratings. Education ratings were changed to three categories, which include *None, HS or Less*, and *More than HS*; the education ratings were adjusted into the three new categories according to their education level.

**Protection of Human Subjects**

This research study was approved by the California State University, Sacramento Institutional Review Board (IRB) on October 14, 2015 with the protocol number: 15-16-019 (Appendix B). The application process, the research design, measurement instrument and data collection were thoroughly discussed between the researchers and research advisor. The proper citations were provided for measurement instruments. Participants were informed about the study and consented to the research study. They were also informed that they had access to contact the researchers and research advisor for questions and concerns. The researcher also informed the participants that their response hard copy are secured then destroyed after the research study is written.

**Data Analysis**

The data collected was thoroughly and diligently entered for analysis. The IBM SPSS Computer Version 23 software, provided by California State University, Sacramento, was used to review and analyze the survey responses. The researchers were provided extensive consultation, review, and guidance from the research advisor to complete the analysis process.
SPSS allowed for a detailed analysis and report on the data collected. First, a descriptive analysis was conducted. We analyzed the responses to the clinical cases. Next, we analyze the responses to the clinical cases against the GEQ acculturation and cultural orientation test. Last, we control all variables with demographic characteristics. The software allowed a critical investigation into the multiple variables, which are discussed in the results section of this paper.
Chapter 4

STUDY FINDINGS AND DISCUSSION

After forty years of residing in the United States, there has been little research conducted on the Hmong community. There are limited research on the people, their values, culture, behavior, and health among other topics. There is a need for more research in this community as it continues to grow with a majority of the population only having reached the second generation. In efforts to contribute to the limited research studies, this paper focuses on Hmong mental health and how it is recognized and the treatment recommendations. Hmong people have limited knowledge of what mental health means. There is no language to identify what mental health is and what cultural practices or treatments the community could use to address mental health challenges. Despite the new developments in mental health spectrums, comprehensive laws and policy changes, and increased opportunities for access to medical insurance and services, the Hmong American community continues to face challenges in the utilization of mental health services. The barriers include stereotypes, unequal resource allocations, stigma, help-seeking behaviors, trust, and differences in cultural and western approaches to treat illness, and socioeconomic stratification in the Asian American community. Due to these barriers, it is essential to explore mental health treatment in the community.

To investigate this topic, we conducted a quantitative survey on Hmong American shamans in California. Shamans are the sole health providers in the community; western medical treatments are seen as an alternative treatment. Shamans hold a highly regarded position and role in the community, thus, it is important for western clinical providers to
collaborate and build partnership with them to grasp an all-inclusive approach to work closely with the community. The premise of this research is to provide western clinical providers some background on how Hmong shamans’ understand mental health; an investigation of what factors may impact and influence their ability to recognize mental health conditions and treatment recommendations. In studying the backgrounds of Hmong American shamans, health providers gain insight into a culturally sensitive and diverse approach to respond to Hmong people and their mental health challenges.

**Overall Findings**

Seventy-eight Hmong American shamans participated in the study. The age ranges of the participants are 18 and older, and are practicing shamanism. The following sections are the data’s descriptive frequency distribution.
Table 1

*Frequency Distribution of Demographics*

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Status</td>
<td></td>
</tr>
<tr>
<td>Non-Married</td>
<td>37.20%</td>
</tr>
<tr>
<td>Married</td>
<td>62.80%</td>
</tr>
<tr>
<td>Education Level</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>15.40%</td>
</tr>
<tr>
<td>High School or less</td>
<td>35.90%</td>
</tr>
<tr>
<td>More than High School</td>
<td>48.70%</td>
</tr>
<tr>
<td>Residency in the USA</td>
<td></td>
</tr>
<tr>
<td>Less than 20 years</td>
<td>28.20%</td>
</tr>
<tr>
<td>More than 20 years</td>
<td>71.80%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>52.60%</td>
</tr>
<tr>
<td>Female</td>
<td>47.40%</td>
</tr>
<tr>
<td>Generation</td>
<td></td>
</tr>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; generation</td>
<td>55.10%</td>
</tr>
<tr>
<td>1.5 generation</td>
<td>26.90%</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt; generation</td>
<td>17.90%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>18-28</td>
<td>24.40%</td>
</tr>
<tr>
<td>29-39</td>
<td>24.40%</td>
</tr>
<tr>
<td>40-49</td>
<td>16.70%</td>
</tr>
<tr>
<td>50-59</td>
<td>16.70%</td>
</tr>
<tr>
<td>60+</td>
<td>17.90%</td>
</tr>
</tbody>
</table>

The sample data collected reported 37.2% are Non-Married and 62.8% are Married (see Table 1). The marriage status of Hmong in the U.S. national population reported 55.6% fit under the Non-Married category and 44.3% are in the Married category (Hmong National Development, 2013). The numbers are not consistent with national percentages.

Data from the sample shows that 48.7% of participants have more than a high school education, 35.9% of participants have a high school education or less, and 15.4%
of participants have no formal education (see Table 1). The data cannot be compared to the U.S. data as the numbers vary between states (Hmong National Development, 2013). The data’s distribution is not consistent with California’s educational attainment averages for the Hmong community. In 2010, California reports 82% of Hmong Americans aged 25 years or older has a high school graduate or higher and 5.6% of Hmong Americans aged 14 to 24 years old not enrolled in school, have not graduated from high school, or are high school dropout (Hmong National Development, 2013).

The sample data show 28.2% of participants have less than 20 years of residency and 71.8% of participants have more than 20 years of residency in the U.S. (see Table 1). The Hmong population in the U.S. has shown a tremendous increase in the past 30 years. The Hmong National Development (2013) reports between 1990 (94,439), 2000 (186,310, a 97% increase), and 2010 (260,073, a 40%), the U.S. Hmong population count increased 175% from 1990 to 2010. Currently, the largest Hmong population is found in California (91,224), Minnesota (66,181), and Wisconsin (49,240) (American Community Survey, 2010; Hmong National Development, 2013). The sample data displays similar trends with the U.S. Hmong population.

The gender distribution (see Table 1) of the sample favors males (male, 52.6%; female, 47.4%). The distribution differs from the total U.S. population in which 49.2% are male and 50.8% are female and from the U.S. Asian population in which 47.8% are male and 52.2% are female (Hmong National Development, 2013). Although, the distribution is different from national general population distributions, it is consistent
with Hmong population distribution since the 1990, 2000, and 2010 Census, with 51% are male and 49% are female (Hmong National Development, 2013).

The generation data collected from the sample shows 55.1% of participants identify as first-generation, 26.9% of participants identify as 1.5 generation, and 17.9% of participants identify as second generation (see Table 1). The U.S. Hmong population is a relatively young group compared to the U.S. national population and U.S. Asian population age averages. The age distribution is illustrated below.

The data collected shows a slight even spread among the ages in the sample (see Table 1). Age categories are as follow: 18-28 (24.4%); 29-39 (24.4%); 40-49 (16.7%); 50-59 (16.7%); and 60+ (17.9%). Forty-eight percent of the sample selected age group younger than 39 years of age and 51.2% as 40 years old and older. The data is consistent with the Hmong population age trend in the United States in the past 20 years (Hmong National Development, 2013). The Hmong National Development (2013) and the Hmong Cultural and Resource Center (2004) reported the considerably young U.S. Hmong population, 56% were under 18 years of age in 2000, has dropped to 43.1%. The total U.S. population under 18 years of age is 24.2% and U.S. Asian population is 25.8% (Hmong National Development, 2013). The data collected indicates there is a slight decrease in the number of Hmong shamans in the United States. Hmong National Development (2013) claims the change is likely due to the slow decreasing of fertility rates, household sizes among the Hmong community over the decade.
Specific Findings

In this section, there is an illustration of the findings on the data collected. There are three different analyses. First analysis reports on the clinical cases in this study, which are the dependent variables. Dependent variables are tested against independent acculturation variables in the second analysis. Lastly, the dependent and independent variables are analyzed in conjunction with control variables, which are the participants’ demographics. These three analyses depict what possible characteristics may impact the sample’s recognition and treatment recommendation for mental health. Below are the frequency distributions of the data collected.

Table 2

Frequencies of Clinical Cases

<table>
<thead>
<tr>
<th>Clinical Cases</th>
<th>Frequencies of Medical Attention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 1: Depression</td>
<td>82.1%</td>
</tr>
<tr>
<td>Case 2: Anxiety</td>
<td>64.1%</td>
</tr>
<tr>
<td>Case 3: Psychosis</td>
<td>82.1%</td>
</tr>
<tr>
<td>Case 4: Depression</td>
<td>57.7%</td>
</tr>
<tr>
<td>Case 5: Anxiety</td>
<td>83.3%</td>
</tr>
</tbody>
</table>

*Note:* Frequency compared to shamans who recommended “spiritual” only or “other” only.

The participants report a rate of 57.7% or higher to medical seeking treatment recommendations to all the clinical cases (see Table 2). For cases 1, 3, and 5, there is a higher frequency for Medical Attention, which includes medical attention and/or medical and spiritual attention. Cases 2 and 4 are lower in frequencies in recommending Medical Attention; however, the frequencies rate are higher than 50 percent. Although the frequencies are different, the case vignettes are also different in its presentation. After reviewing the data, case 1 and 2 have stressors that are causing the clients to experience
the symptoms. In case 1, the father had lost his job, had marital issues, and family issues that lead to suicide ideation and case 2 had indications of adjustment disorder due to a divorce, which are both stressors causing the symptoms. However, case 3, 4, and 5 have no indicated stressors; the symptoms are caused without any identified adjustments in their lives. Case 3 experienced psychosis, case 4 has symptoms related to depression, and case 5 experienced anxiety; all cases which experienced symptoms related to a mental health disorder abruptly without stressors. Regardless, all the vignettes did not specified the mental health disorder; instead it indicated symptoms related to a mental health illness, allowing room for shamans to interpret the symptoms and recommendations. Overall, the licensed clinicians rated 100% medical attention for all the cases, which is not consistent with most of the recommendations done by the shamans. The inconsistency is more significant in case 2 and 4, as roughly six out of ten shamans’ recommendations do not align with the licensed clinicians.
<table>
<thead>
<tr>
<th>Acculturation</th>
<th>Subcategory</th>
<th>Language</th>
<th>Social Affiliation</th>
<th>Activities</th>
<th>Food</th>
<th>Media</th>
<th>R Square</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Score</td>
<td>Case 1</td>
<td>0.017**</td>
<td>-0.025</td>
<td>-0.050</td>
<td>0.01</td>
<td>0.031*</td>
<td>0.240***</td>
</tr>
<tr>
<td></td>
<td>Case 2</td>
<td>0.010</td>
<td>0.000</td>
<td>0.075**</td>
<td>0.007</td>
<td>0.054**</td>
<td>0.182***</td>
</tr>
<tr>
<td></td>
<td>Case 3</td>
<td>0.017**</td>
<td>-0.022</td>
<td>-0.063*</td>
<td>0.016</td>
<td>0.027</td>
<td>0.160***</td>
</tr>
<tr>
<td></td>
<td>Case 4</td>
<td>0.019**</td>
<td>-0.012</td>
<td>-0.032</td>
<td>0.026</td>
<td>0.000</td>
<td>0.123**</td>
</tr>
<tr>
<td></td>
<td>Case 5</td>
<td>0.011</td>
<td>-0.010</td>
<td>-0.017</td>
<td>-0.020</td>
<td>0.012</td>
<td>0.112**</td>
</tr>
</tbody>
</table>

*: p<.10, **: p<.05, ***: p<.01

Case 1: Depression, Case 2: Anxiety, Case 3: Psychosis, Case 4: Depression, Case 5: Anxiety

The self-reported acculturation ratings were analyzed in two ways. In first analysis, the overall total score of acculturation questionnaires and ratings were tested for significance. For all the clinical cases presented, acculturation level shows significance (see Table 3). This indicates medical seeking behavior among the participants is high when they have a higher level of acculturation to American culture. The statistical significance (p<0.05) in medical seeking behavior were in cases 3 (p<0.01), case 4 (p<0.05) and case 5 (p<0.01). The second analysis examined acculturation level in six subcategories: language, pride, social affiliations, activities, food and media. The significant categories are language, activities, and media. Language shows the same level of significance in cases 1 (Language: p<0.05, Activities and Media: p<0.10), case 3 (Language: p<0.05), and case 4 (Language: p<0.05, and Activity: p<0.10). Media shows
significance in case 1 and 2. Although activities show negative and statistically significant coefficient, in cases 1, 2 and 4, implying that the dependent variable value becomes smaller by single unit increase of independent variable, which is contradicting to our hypothesis. There is a marginal significance in type 1 with stressors, but a stronger significance in type 2 without stressors. However, the overall impact of acculturation measure was still significant due to the subcategories The subcategories language and media’s measurement assesses the participant's’ familiarity and exposure to Western culture and values (see questions 1, 2, 11, 26, 27, 28, 30, 34, 35, 36, 37, and 38 for language and questions 31, 32, and 33 for media in appendix C). For example, one of the language questions asked, “I am familiar with American cultural practices and customs” signifying that shamans understand how Americans practice different aspects of their life (i.e. health care). However, with activities, it focuses entirely on social affiliations and hobbies. One of the questions ask, “I listen to American music,” which does not identify into the scope of medical practice. Thus, even if they are scoring higher in activities, there is no clear relationship between acculturation and medical seeking behavior. The focus of these questions could explain the significant relationship between acculturation and medical attention as they target level of exposure to American culture and practices. Although subcategory activities significance suggests an opposite effect on acculturation and medical attention (see questions 15, 16, and 17 for activities in appendix C).

Overall, 2 out of 6 subcategories illustrated significance between acculturation and medical attention in 4 out of the 5 cases. The subcategories with significance affected the overall total score of acculturation.
### Acculturation Only

<table>
<thead>
<tr>
<th>Case</th>
<th>Total Score</th>
<th>R Square</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.002*</td>
<td>0.031*</td>
</tr>
<tr>
<td>2</td>
<td>0.003*</td>
<td>0.030*</td>
</tr>
<tr>
<td>3</td>
<td>0.004***</td>
<td>0.116***</td>
</tr>
<tr>
<td>4</td>
<td>0.004***</td>
<td>0.044**</td>
</tr>
<tr>
<td>5</td>
<td>0.004***</td>
<td>0.082***</td>
</tr>
</tbody>
</table>

### Acculturation with Controls

<table>
<thead>
<tr>
<th>Case</th>
<th>Total Score</th>
<th>R Square</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-0.007***</td>
<td>0.380***</td>
</tr>
<tr>
<td>2</td>
<td>-0.006*</td>
<td>0.081</td>
</tr>
<tr>
<td>3</td>
<td>-0.002</td>
<td>0.165***</td>
</tr>
<tr>
<td>4</td>
<td>-0.006*</td>
<td>0.093*</td>
</tr>
<tr>
<td>5</td>
<td>-0.002</td>
<td></td>
</tr>
</tbody>
</table>

#### Gender (compared to males)
- Females: -0.011, -0.020, 0.060, 0.025, 0.055

#### Education (compared to High School or less)
- None: -0.200, -0.196, -0.145, 0.174, -0.18
- More than HS: 0.195, 0.248, 0.104, 0.357*, 0.134

#### Age (compared to 60+)
- Age:18-29: 0.631***, 0.235, 0.132, 0.492, -0.071
- Age:29-39: 0.646***, 0.227, 0.197, 0.45*, 0.002
- Age:40-49: 0.477***, 0.299, 0.266, 0.401, 0.013
- Age:50-59: 0.409***, -0.021, 0.072, 0.166, -0.097

#### Residency in USA (compared to less than 20 years)
- 20+ years: -0.175*, -0.141, -0.094, -0.043, -0.125

#### Generations (compared to 1st generation)
- 1.5 gen: 0.078, 0.223, 0.206, 0.29, 0.227
- 2nd gen: 0.022, 0.055, 0.232, 0.037, 0.238

*: p<.10, **: p<.05, ***: p<.01

The acculturation only analysis shows significance in all cases (see Table 4). The higher the acculturation level, the more likely medical attention is recommended among the participants. However, acculturation significance pattern was not maintained after acculturation analysis with demographic variables. The acculturation total with demographic variables resulted in negative and statistically significant coefficients in...
case 1, 2, and 4, which oppose the hypothesis. Case 3 and 5 share negative p value, however, they are insignificant. As a result, the more significant the overall demographic control variables, shamans would least likely recommend medical attention. For example, as shown in case 1, the demographics for age and residency, caused the p value to decrease resulting in a negative and statistical significance. This indicates the demographic variables are not consistent with the acculturation effect. This inconsistency in statistical significance between acculturation level and demographic variables could be explained by the participants’ disproportionate demographic distribution. As seen in case 1, there is a significant finding with age. Specifically in case 1, with the client who is experiencing depression, the younger the shamans compared to 60 years and older, the more likely they prefer medical attention. Combined to the Residency in USA (20 years or more), which shamans would less likely recommend services, and generation (compared to 1st generation), a positive coefficient, is the overall generational difference when it comes to perceiving medical attention.

The acculturation level and clinical case responses are altered by specific demographic control variables (see Table 4). In case 1, compared to shamans who are 60 years and older, the younger shamans, between the age of 18 to 59 (p< 0.05), indicated a statistically significance on medical attention recommendation. However, the longer the participants’ residency in the state, they have a negative and statistical significance, which means the longer they have resided in the U.S.A, they recommended opposite of the hypothesis. Age group between 29-39 (p<0.10) compared to 60 years and older, high school education compared to someone with some high school education or less, showed
positive significance in case 4. Overall, the control variables have a negative and statistical significance on the shamans’ recommendation of medical attention, which implies that demographic information are in less favor of medical attention. Essentially, their level of acculturation is the only variable impacting their recommendations for medical treatment.

**Interpretations to the Findings**

The overall findings from this research indicate that language, media, and activities impacted shamans’ acculturation level to a certain degree, thus impacting their judgment to suggest or reject medical attention. The acculturation levels of shamans are explained by the unidimensional model of acculturation, where the host culture influenced the individual to embrace some orientation to the dominant cultural and healing practices. For example, in Table 3, with type 1 versus type 2 cases, it allowed shamans to make recommendations based on stressors. Stressors are in case 1 and 2, however, the cases had different significance. With case 1, 82.1% recommended medical attention, while case 2, only 64.1% recommended medical attention (see Table 2). Although 2 out of 3 cases were higher in significance in type 2, cases 3 (82.1%), case 4 (57.7%), and case 5 (83.3%), they also had difference in their recommendations (see Table 2 and Table 3). Overall, type 1 and type 2 did not make a difference in explaining how shamans would recommend treatment. The treatment recommendations depend case by case on the factors affecting their symptoms for shamans to understand what suggestions to make to clients.
When the level of acculturation was analyzed with the control variables, specifically age; it made a negative and statistical significance in medical treatment recommendation for case 1 and 4 (see Table 4). However, it did not show any significance in any of the other case vignettes presented. All the control variables, gender, education, age, residency in the United States, and generation did not make any significant impact for shamans to more likely recommend medical attention.

Acculturation with demographic variables have the opposite effect on the hypothesis; the more acculturated the shamans, the less likely they favor medical attention. For example, if all shamans shared the same demographic characteristics, then acculturation is negatively associated in favor to medical attention (see Table 4). Historically and culturally, Hmong people have practiced communal support, so when practicing traditional rituals, shamans learn from one another. Simply put, they learn how to treat clients in similar ways. When the illness is out of their scope of practice, they either refer out to other shamans or to medical providers, which is something that they have shifted in practicing since moving to the United States because western medicine is new to them.

As seen in Table 4, many of the demographic variables have positive insignificant coefficients, which shows some level of consistency in favor of western medical values. Although generation is not significant, looking at age and years in the United States, it seems like younger shamans who live in the states a shorter period of time tend to support medical attention, assuming that they have similar level of acculturation. This may suggest that the younger shamans may be more willing to agree and accept the opinion from the medical providers like LCSW and doctors. Thus, with more years in
acculturating into American society, it would allow for continuous integration of western medicine into their traditional practices, as shown through the bidimensional model and with Hmong people only residing in the United States for forty years. Instead, it was the level of acculturation that impacted their recommendations of medical attention, and not their demographics. According to the data collection, we can infer that the higher the level of acculturation, the more likely the shamans in this study will recommend medical treatment.

**Summary**

As the research has indicated, the acculturation measures of language, media, and food made a significant impact to the acculturation level of the shamans. These specific acculturation impacted the shamans recommending medical attention as a treatment for clients. Moreover, when the demographic of the shamans’ age, anyone younger than 60 years old, was compared with the level of acculturation the more likely shamans recommended medical treatment as well. However, the other demographics did not make a significant difference in altering their judgment in treatment.

Unfortunately, our sample size does not meet the reliability and validity of the original research. Moreover, the sample size in the study does not represent the generalized population of Hmong shaman’s level of acculturation and recommendations. This suggest the need to do further outreach, education, and restructuring in mental health services to integrate shamans so they could also understand the symptoms related to mental health disorders.
Chapter 5

SUMMARY AND RECOMMENDATIONS

The major findings of this specific research is looking at the perception and understanding of shamans’ practice of healing, health, and mental illness while considering their level of acculturation and its influence on their recommendations on services. There were collected information on the demographics of the shaman population, varying acculturation questions, and the five different cases involving symptoms related to a mental health disorder. Despite all the changes that have happened from the Secret War, dislocation, resettlement periods, and acculturation into the United States, shamans carry and sustain the embedded cultural practices passed down from generations. As mentioned, acculturation happens through generations where individuals can integrate more of the dominant culture’s values and practices. However, immigrants do not experience the same trajectory in acculturating. For many traditional Hmong people, they continue to practice the spiritual healing and traditional practices that have been ingrained into their lives 100% (n=78). When issues arise related to health and healing, they seek out consultations from shamans. Shamans are a primary source of care that engrains changes in seeking out alternative healing. By interviewing shamans, it gives a scope into the different kinds of consultation advice they will give to their clients.

Overall in the 5 cases, the more acculturated the participants are in the total acculturation score, the more likely they would recommend medical treatment. Many of participants indicated their final decision to treat the vignettes through both medical treatment and/or spiritual treatment with clinical case one 82.1%, case two, 64.1%, case
three 82.1%, case four 57.7% and case five 83.3%. These cases were split into two different type of cases, type 1 with stressors and type 2 without stressors; however, both of the types showed no consistency. There is no clear pattern how the two type of cases were recommended treatment. Type 1 cases show no consistency in symptom recognition, as there is a disparity in the percentage of medical attention seeking behavior, which is a 1 out of 2 cases. Thus, there is also no clear relationship whether or not the stressors influence which treatment is recommended. Type 2 cases indicated 2 out 3 cases showing some consistency in symptom recognition as these three cases were presented without stressors. Overall, the participants recommended medical treatment depending on the case and not based on stressors. However, the results infer the higher the level of acculturation, they will recommend medical treatment, even if it does not align 100% with licensed clinical social workers.

Looking at the overall acculturation score, 5 out of 5 cases aligned with the hypothesis, however, the acculturation subcategories illustrated a 4 out of 5 cases distribution of significance. There was at least one significant relationship between six of the subcategories of acculturation in all four cases, but in case 5 it showed no significance at all in any of the subcategories. The distribution significance is in language and media, which is 2 out of 6 subcategories. Even though there were disparities in the subcategories, the participants’ overall acculturation score significantly, which confirms the hypothesis of this research. The more acculturated the participants, the more likely they recommended medical attention. Though this significance may be convincing, the
multiple regression analysis distributed contradicted the results when the cases and acculturation level are measured against demographic variables.

When comparing their level of acculturation to their demographics, the variables that made a positive statistical difference were age and education. Although generation is not significant in the multiple regression, looking at age and years in the United States, it seems like younger shamans who live in the United States a shorter period of time would recommend medical attention, assuming that they have similar level of acculturation. This could suggest that the younger shamans may be more willing to agree to the western practices of medical attention, aligning in the direction of LCSW.

**Implications for Social Work**

From this research study, there are several implications. One, there is a limited amount of effort in promoting and educating health awareness in the Hmong community, specifically with shamans. Communities are not as informed about the health issues, stereotypes, symptoms, and stigmas that are faced in communities of refugees, especially with Hmong people. There needs to be active work done to correct any falsified information so Hmong people can better understand the general information and make better informed judgment in alleviated health concerns in their community. Moreover, it would allow for shamans to broaden their understanding of the different health options in the United States for symptoms related to mental health. Furthermore, it would create a partnership with practitioners and shamans to understand how to serve the client with the most culturally competent treatment.
Another implication is the limited amount of research conducted in the scope of social work and shamans. Despite all the medical information and mental health finding, there are limited information pertaining the issues affecting the Hmong population in acculturating, mental health utilization, and shamans recommending mental health services as an alternative healing process. More research needs to be done to account for the acculturation changes in the Hmong community, use of western medicine, and use of mental health providers.

In addition, at the policy level, there needs to be more grants directed and allocated towards outreaching to the Hmong community so there are more consumers fusing and understanding the services associated with mental health. When there are research showing the prevalence of mental health in the community, yet a lack of utilization, a well thought out plan should be examined and implemented to engage the community.

**Study Limitations and Recommendations for Future Study**

This study was limited in a number of ways. First, we administered our measurement instrument in both English and Hmong. We do not know whether our participants’ responses would differ if they had completed the questionnaires in just one language. There is extensive research in the counseling domain suggesting that language affects and influences participant responses (Guttfreund, 1990; Altarriba & Santiago-Rivera, 1994). It is possible that participants completing the instruments in different languages have altered their cultural orientation during the time of the survey. In another study, Yang and Bond (1980) found that their Chinese bilingual participants who
completed their cultural identity instruments in English identified more with their Chinese culture and heritage than when they completed the instrument in Chinese. Yang and Bond (1980) claims that their participants’ results were due to the fluidity of identity and cultural orientation. As we can understand, language and perception of identity and cultural orientation can be salient and fluid, and they can have an impact on research. In addition, it is possible the assumption of participants’ language proficiency affected the responses. As seen in this research, language has a significant impact in acculturation. Despite the evidence and data collection, we wish future studies should examine how the responses would turn out when participants provide responses to two tests in different languages.

Second, our study was limited to self-report responses. Self-report data are often information we have quick access to in our conscious aspect of cultural processes. According to Rogler, Cortes & Malgady (1991), cultural processing occurs in both our consciousness and unconsciousness in nature. Thus, it is possible that there are certain aspects of culture that were inaccessible due to the context and social situation while administration of instrument. Future studies should consider additional methodologies to access stronger influences on the meanings and cultural orientation of a particular culture.

In addition, cultural orientation, cultural identity, acculturation level, cultural process is constantly changing (Marcia, 1980; Phinney, 1990), so in a future study it should invest in longitudinal studies to capture the more dynamic nature and evolution of cultural change and orientation. Include a test-retest reliability assessment to reflect reliability and validity to questionnaires. According to Tsai, Ying, and Lee (2000),
participants may rate their responses based on their latest encounter of another person who shares similar cultural characteristics from the same region or with someone who does not demonstrate any membership or cultural characteristics from their background or heritage. To avoid this effect, operationalize and control the reference group(s) for a more accurate examination of which factors and characteristics explain or show relationship to their responses, acculturation level, and cultural orientation. Although there are not many experimental methods to manipulate the conceptions of culture and cultural identity, however, Christian, Gadfield, Giles & Taylor (1976), supports this hypothesis in addressing a more accurate measurement of cultural orientation.

Third, due to the nature of the research project and its limitations, the sample size was rather small (n=78). Tsai, Ying, and Lee’s (2000) sample size was n=353. Tsai (2016) recommended a sample size of n=80 or more for data significance in the GEQ acculturation and cultural orientation assessment. Our original goal sample size was n=100; we were successful in a gathering a sample of n=78. A larger pool may contribute a more accurate and varied response, which could significantly alter the data collection; this research is not generalizable to the Hmong American shaman population. Future studies should consider a larger sample size in measurement of acculturation and cultural orientation extending beyond one geographical location for sampling. This research was limited to Hmong shamans in California only. Hmong people relocated into different states after arriving to the United States post Viet Nam War (Cha, 2003). Tsai, Ying, and Lee (2000) recommend geographical distance sampling increase the accuracy in cultural orientation assessment.
Fourth, the GEQ’s assessment of acculturation level and cultural orientation of being westernized was limited in cultural domains. In this study, language and media were the two domains that showed significance. Future studies should include other cultural domains such as specific values, beliefs, behavioral studies, and norms. The increase in cultural domains would achieve a more comprehensive and varied acculturation and cultural orientation assessment (Tsai, Ying & Lee, 2000).

Fifth, although the five clinical cases were written with symptoms gathered from the DSM 5, the cases are limited in its presentation and are not as thorough as the cases presented in clinical assessment workbooks (e.g. The Clinical Assessment Workbook: Balancing Strengths and Differential Diagnosis, 2nd Ed. 2015, by Pomeroy, Elizabeth or DSM 5 Made Easy, 2014, Morrison, James). It is possible that the cases presented were limited in expanding criterions and specifiers to indicate mental health concerns. Future studies should consider using cases presented in clinical settings, articles or books.

Sixth, this research was not an assessment of mental health concerns in the Hmong community nor the prevalence of utilizing mental health services. There is a limited language and knowledge of mental health in the Hmong community is a barrier in recognizing symptoms and appropriate treatment overall (Cha, 2003; Gerdner, 2012; Gensheimer, 2006; Pinzon-Perez, 2006; Xiong, 2012, Zuvekas & Taliaferro, 2003). Future studies should consider a qualitative investigation of how Hmong people understand mental health and if they have a mental health illness. Historically, qualitative information have been passed orally down generations, which is how they practice their values and beliefs as well as their recommendations on health issues. Thus, a qualitative
investigation of Hmong people’s understanding about mental health treatments would prove beneficial, as they resort to their own cultural and traditional practices to address social and medical concerns (Cha, 2003; Gerdner, 2012). Based on the shaman’s explanations of their recommendations and the analyzed data, the researchers believe that the shamans are looking at these vignettes based on their own scope of practice; however, the information was not collected as it was not the goal of this research. As stated, the shamans have been practicing shamanism for a long time and carry these practices into the United States where they have sustained it. The bidimensional acculturation model best illustrates the shamans’ acculturation in their treatment practices in a host culture. Even with Hmong people’s forty years of residence in the U.S., shamans recognize the value of their own cultural orientation and treatment practices in relations with western medical approaches. Although the controls had individually varied and levels of acculturation has different trajectory throughout generations, the Hmong community have familiarized and integrated themselves in western treatment values. Despite shamans being the primary practitioners for many Hmong families, most shamans understand when a symptom is not related to their practice and needs to be referred out. Shamans’ practices, which were explained to the researchers during the survey, could help explain the recommendations they suggest. Thus, it is important to also bring in qualitative research as well.
Conclusion

The major finding in this research is the recommendations of health services by shamans based on the level of acculturation and demographics. Though there has been some research at the mental health of Hmong people pre-immigration and post-immigration, there are very few research done on shaman’s recommendations of mental health services.

Furthermore, despite the different demographic information retrieved from participants, it does not affect their view of recommending medical treatment as an alternative way of receiving services. Instead, shamans’ level of acculturating affected their chances of recommending medical treatment. From this research, we can conclude from our sample that shamans will more likely recommend medical treatment if they are more acculturated in language, media, and activities—education, gender, and generations, a few of their demographic information, does not alter their suggestions. Also, there is no clear consistency in the type of cases. Shamans do not based their treatment recommendations on mental health stressors, but a case-by-case evaluation. Nevertheless, stigmas, misconceptions and a lack of understanding mental health are hindering the Hmong population’s use of mental health services. With the findings from this research, we hope the information would shed light and give direction to future studies to thoroughly examine how the Hmong community perceives and manages mental health. Thus, this can create more culturally appropriate and competent services to engage Hmong shamans and individuals.
Appendix A

Participant Informed Consent

Study Title: Hmong Shamans and Mental Health: A Comparison across Acculturation Level

Dear Participant,

You are invited to participate in a research study to measure how the acculturation level impacts Hmong shamans’ knowledge of mental health disorders. Your input, perspective, and knowledge on this matter as a shaman in the Hmong community is important and may benefit future health providers to understand mental health illness in the Hmong community.

Our names are Kaeo Vang and Soua Moua, and we are second year graduate students from the Division of Social Work Department, California State University, Sacramento. Your contribution will help our research and greatly benefit the mental health community. We highly appreciate your time.

Your participation in this project is voluntary. Even after you signed the informed consent document, you may decide to leave the study at any time. You may choose to skip any questions you wish not to answer, and/or discontinue participation in the research at any time. By choosing to complete and return the survey, you give us your implied consent to participate in the research and for us to use your responses.

There are no known sociological or economical risks with your participation in the study. The survey questions are designed to ask general demographic questions, acculturation, and your perspectives, attitudes, opinions, and beliefs on five case studies. There is a minimal risk that the participants might feel embarrassed regarding some of the questions and their understanding and knowledge as a provider in the Hmong community. There is the risk that people may come across your paper survey, which could breach confidentiality; however, the survey questions do not ask any identifier questions or information that could trace back to the participant. The researchers will maintain the participant’s identity and ensure anonymity. Your responses will be kept confidential and safe at all times, where the researcher are the only individuals with access. Your answers will be reported in an analysis at the end of the research. Upon completion of research, your surveys will be destroyed on June 15, 2016.

If you have any questions about the research at any time, please contact us. Our contacts are Kaeo Vang, (510) XXX-XXXX, kaevang@csus.edu or Soua Moua, (916) XXX-XXXX, souamoua@csus.edu. You may also contact Kisun Nam, Ph.D., our research advisor/chair at (916) 278-7096, or knam@csus.edu. For questions about your rights as a participant in this research study, please contact the Office of Research Affairs,
California State University, Sacramento, (916) 278-6402 or (916) 278-5674, or email research@csus.edu or irb@csus.edu.

Your signature below indicates that you have read and understood the information provided above, that you willingly agree to participate, that you may withdraw your consent at any time and discontinue participation at any time.

Researchers will provide a copy of the informed consent to participant.

Signature ___________________________ Date ___________________________
Appendix B

Human Subjects Approval Letter

CALIFORNIA STATE UNIVERSITY, SACRAMENTO
DIVISION OF SOCIAL WORK

To: Soua Moua & Kaeo Vang

Date: October 14, 2015

From: Research Review Committee

RE: HUMAN SUBJECTS APPLICATION

Your Human Subjects application for your proposed study, “Hmong Shamans and Mental Health: A comparison across acculturation level”, is Approved as Exempt. Discuss your next steps with your thesis/project Advisor.

Your human subjects Protocol # is: 15-16-019. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Research Review Committee members Professors Teiahsha Bankhead, Maria Dinis, Kisun Nam, Francis Yuen

Cc: Nam
Appendix C

English Survey

Demographic Questionnaire:
Generation
• □ 1st generation
• □ 1.5 generation
• □ 2nd generation
Age:
• □ 18-28
• □ 29-39
• □ 40-49
• □ 50-59
• □ 60-69
• □ 70 years or older
Sex:
• □ Male
• □ Female
Marital status:
• □ Single
• □ Married
• □ Divorced
• □ Widow/Widower
Education Level:
• □ None
• □ Unknown
• □ Some School
• □ High School Graduate
• □ Some College
• □ College Graduate
• □ Graduate Level Education (Masters, Doctorate)
Family size: (total)
• □ 1-3
• □ 4-6
• □ 6-8
• □ 9 or more
Estimated Annual Income:
• □ 0-10,000
• □ 10,001-20,000
• □ 20,001-30,000
• □ 30,001-40,000
• ___40,000 or more

How fluent are you in Hmong (reading and writing)?
• ___Not at all
• ___Some
• ___Fluent

How fluent are you in English (reading and writing)?
• ___Not at all
• ___Some
• ___Fluent

Number of years in the United States:
• ___1-10
• ___11-20
• ___21-30
• ___31-40

How many people do you consult monthly?
• ___1-3
• ___4-6
• ___6-9
• ___10 or more

How many community organizations are you involved in?
• ___0
• ___1
• ___2
• ___3 or more

How would you identify yourself?
• ___Hmong
• ___American
• ___Hmong-American
• ___Asian
• ___Asian American

What is your current occupation?
• ___Education services (i.e. teacher, counselor, tutors)
• ___Retail (i.e. wholesale trade)
• ___Manufacturing (i.e. construction, warehouse)
• ___Health care services (i.e. hospital, clinic)
• ___Agriculture (i.e. farmer)
• ___Business/ Finances (i.e. insurance company)
• ___Other

What is your religious preference?
• ___Animism
• ___Christianity
• ___Catholicism
• __Buddhism
• __Atheist
• __Other

Please use the following scale to indicate how much you agree with the following statements. Circle your response.

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<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
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1. I was raised in a way that was American. 1 2 3 4 5
2. When I was growing up, I was exposed to American culture. 1 2 3 4 5
3. Now, I am exposed to American culture. 1 2 3 4 5
4. Compared to how much I negatively criticize other cultures, I criticize American culture less. 1 2 3 4 5
5. I am embarrassed/ashamed of American culture. 1 2 3 4 5
6. I am proud of American culture. 1 2 3 4 5
7. American culture has had a positive impact on my life. 1 2 3 4 5
8. I believe that my children should read, write, and speak English. 1 2 3 4 5
9. I have a strong belief that my children should have American names only. 1 2 3 4 5
10. I go to places where people are American. 1 2 3 4 5
11. I am familiar with American cultural practices and customs. 1 2 3 4 5
12. I relate to my partner or spouse in a way that is American. 1 2 3 4 5
13. I admire people who are American. 1 2 3 4 5
14. I would prefer to live in an American community. 1 2 3 4 5
15. I listen to American music. 1 2 3 4 5
16. I perform American dance. 1 2 3 4 5
17. I engage in American forms of recreation. 1 2 3 4 5
18. I celebrate American holidays. 1 2 3 4 5
19. At home, I eat American food. 1 2 3 4 5
20. At restaurants, I eat American food. 1 2 3 4 5
21. When I was a child, my friends were American. 1 2 3 4 5
22. Now, my friends are American. 1 2 3 4 5
23. I wish to be accepted by Americans. 1 2 3 4 5
24. The people I date are American. 1 2 3 4 5
25. Overall, I am American. 1 2 3 4 5

Please use the following scale to answer the following questions. Circle your response.

<table>
<thead>
<tr>
<th></th>
<th>Very Much</th>
<th>Much</th>
<th>Somewhat</th>
<th>A little</th>
<th>Not at all</th>
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26. How much do you speak English at home? 1 2 3 4 5
27. How much do you speak English at school? 1 2 3 4 5
28. How much do you speak English at work? 1 2 3 4 5
29. How much do you speak English at prayer? 1 2 3 4 5
30. How much do you speak English with friends? 1 2 3 4 5
31. How much do you view, read, or listen to English on TV? 1 2 3 4 5
32. How much do you view, read, or listen to English in film? 1 2 3 4 5
33. How much do you view, read, or listen to English on the radio? 1 2 3 4 5
34. How much do you view, read, or listen to English in literature? 1 2 3 4 5
35. How fluently do you speak English? 1 2 3 4 5
36. How fluently do you read English? 1 2 3 4 5
37. How fluently do you write English? 1 2 3 4 5
38. How fluently do you understand English? 1 2 3 4 5

5 Cases

1. Kenny, 46 years old, married, three children (17, 14, 10 y.o.), and lost his job 6 months ago. Individual expressed thoughts of killing himself because he feels worthless. He does not get along with two older kids and there are marital problems. He isolated himself since job loss. For the past three weeks, individual has avoided friends and family. He stated, “I want to hang myself and get the misery over with.”

Medical Attention _____
Spiritual Healing______
Other________

2. Samantha, female, 14 years old, single, lives with mother. Parents split up when she was 4 years old. Individual states, “I have anxiety going to my dad’s house. I prefer to stay with my mom.”

Medical Attention _____
Spiritual Healing______
Other________

3. Amanda female, 35 years old, single, no job, is from the lower socioeconomic class. Individual stated, “I see spiders everywhere. They climb and bite me every night.” She stated that the CIA is watching her through the light bulbs in my apartment.

Medical Attention _____
Spiritual Healing______
Other________
4. Adam, male, 30 years old, single, is from the lower socioeconomic class. He stated, “I have a lack of motivation to continue doing the things that I enjoyed doing. I like to lie around and be by myself.”

Medical Attention _____  
Spiritual Healing_____  
Other________

5. Mindy, female, 25 years old, married is experiencing symptoms that causes her to want to repetitively pick her skin and hair. “I’m scaring people away and can’t seem to understand why I am experiencing these symptoms.”

Medical Attention _____  
Spiritual Healing_____  
Other________
Appendix D

Hmong Survey

Cim X: Kev nyob noj haus, kev kawm, kev noj naav:

Phaaj + Phaum, Luj hlub teb chaws meskas
  • ___Phaum 1
  • ___Phaum 1.5
  • ___Phaum 2

Noob nyoog
  • ___18-28
  • ___29-39
  • ___40-49
  • ___50-59
  • ___60-69
  • ___Laus tshaj 70 xyoo

Poj niam/txiv neej
  • ___txiv neej
  • ___poj niam

Cuab yig
  • ___tsis muaj txij nkawm
  • ___muaj txij nkawm
  • ___sib nrauj
  • ___txij nkawm tas sim neej

Kev kawm
  • ___tsis taw kawm
  • ___tsis muab cuv cia
  • ___kawm tsis tas
  • ___kawm tag high school
  • ___tseem kawm qib siab
  • ___kawm qib siab tsis tiav
  • ___kawm tiav qib siab
  • ___kawm tiav qib siab tshaj 6 lub xyoo nce (Masters, Doctorate)
  • ___Graduate Level Education

Tsev neeg, khaub khuas
  • ___1-3 leej
  • ___4-6 leej
  • ___6-8 leej
  • ___tshaj 9 leej

Nyiaj xyoo
  • ___0-10,000
  • ___10,001-20,000
  • ___20,001-30,000
• ____30,001-40,000
• ____ntau tshaj 40,000
Paub lus hmoob meej npaum cas? (nyee thiab sau)
• ____Tsis paub kiag
• ____paub me ntsis
• ____paub meej
Paub luc meskas meej npaum cas? (nyeen thiab sua)
• ____Tsis paub kiag
• ____paub me ntsis
• ____paub meej
Nyoob teb chaws miskas tau pes tsawg xyoo?
• ____1-10 xyoo
• ____11-20 xyoo
• ____21-30 xyoo
• ____31-40 xyoo
Pes tsawg tus neeg koj saib thiab kho tuaj ib hlis.
• ____1-3 leej
• ____4-6 leej
• ____6-9 leej
• ____tshaj 10 leej
Koj koom tes nrog rau pes tsawg lub koos haum?
• ____1 lub koos haum
• ____2 lub koos haum
• ____3 lub koos haum
• ____tshaj 4 lub
Koj muab koj tus kheej ntau qis li cas?
• ____Hmoob
• ____Miskas
• ____Hmoob-Miskas
• ____Lwm yaam Asian nyob huv miskas teb (nplog, nyab laj, suav…)
Koj txoj hauj lwm yog dab tsi?
• ____txhawb nyobrau sab kev kawum (xib fwb qlia ntawv)
• ____kiab khw (muag khoom)
• ____manufacturing (khu kev, khu hlau, txav av, xaws tshuab)
• ____tshawb huv sab kev noj qab haus huv (kho mob, kuaj kaus hniav)
• ____ua liaj teb
• ____lag luam
• ____lwm yam
Koj txoj kev ntseeg yog dabtsi?
• ____kev ua neeb ua yaig
• ____Christianity
• ____Catholicism
• ____Buddhism
• ____Atheist--tsis muaj kev ntseeg
Siv qhov kev ntsuam xyus hauv qab los teb cov lus seb koj ntseeg li cas. Khij lub vaj voog uas koj xaiv.

1. Kuv loj hlob ntawm txoj kev qhuab qhias raws meskas. 1 2 3 4 5
2. Thaum kuv loj hlob, kuv paub txog meskas txoj kev coj kev ua neej. 1 2 3 4 5
3. Tam sim no, kuv paub txog meskas txoj kev coj kev ua neej. 1 2 3 4 5
5. Kuv txaj muag thiab tsis tso siab rau meskas tej txuj ci kab lig kev cai. 1 2 3 4 5
6. Kuv txaus siab thiab txhawb meskas li txuj ci kab lig kev cai. 1 2 3 4 5
7. Meskas tej txuj ci kab lig kev cai tau txhawb nqa lub neej mus rau qhov zoo. 1 2 3 4 5
8. Kuv ntseeg tias kuv cov me nyuam tsum nyeem, sau, thiab hai lus meskas. 1 2 3 4 5
9. Kuv ntseeg tias kuv cov me nyuam tsum tis npe meskas xwb. 1 2 3 4 5
10. Kuv mus ncig chaw uas muaj meskas. 1 2 3 4 5
11. Kuv paub txog meskas li kab lig kev cai thiab kev coj. 1 2 3 4 5
12. Kuv thiab kev tus txiv/poj niam coj li meskas. 1 2 3 4 5
13. Kuv qhuas/nyiam meskas. 1 2 3 4 5
14. Kuv xum nyob rau ib koog chaw xyaw meskas 1 2 3 4 5
15. Kuv mloog nkauj meskas. 1 2 3 4 5
16. Kuv nthuav txuj meskas txoj kev seev cev. 1 2 3 4 5
17. Kuv komk nrog meskas txoj kev ua si. 1 2 3 4 5
18. Kuv komk kev zoo siab rau meskas hnb tshawj xeeb (holidays). 1 2 3 4 5
19. Nyob tom tsev, kuv noj zaub mov meskas. 1 2 3 4 5
20. Tom kiab khw noj mov, kuv noj mov meskas. 1 2 3 4 5
21. Thaum kuv tseem yog me nyuam yau, kuv cov phooj yog meskas. 1 2 3 4 5
22. Tamsim no kuv cov phoojywg yog meskas. 1 2 3 4 5
23. Kuv ntshaw kom meskas muaj txoj kev tog txais kuv. 1 2 3 4 5
24. Kuv tham tib neeg meskas. 1 2 3 4 5
25. Kuv yeej yog meskas. 1 2 3 4 5
Siv qhov kev ntsuam xyuas hauv qab los teb cov lus seb koj ntseeg li cas. Khij lub vaj voog uas koj xaiv.

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<td>Ntau</td>
<td>Qee Zaus</td>
<td>Me Ntsis</td>
<td>Tsis muaj/tsis ntau/tsis yog</td>
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</tr>
</tbody>
</table>

26. Koj hais lus meskas ntau npaum cas tom tsev? 1 2 3 4 5
27. Koj lais lus meskas ntau mpaum cas tom tsev kawm ntawv? 1 2 3 4 5
28. Koj lais lus meskas ntau mpaum cas tom hauj lwm? 1 2 3 4 5
29. Koj lais lus meskas ntau mpaum cas thauj koj thov koob hmoov? 1 2 3 4 5
30. Koj lais lus meskas ntau mpaum cas nrog phooj ywg? 1 2 3 4 5
31. Koj saib nyeem, thaib mloog meskas hauv T.V. ntau npaum cas? 1 2 3 4 5
32. Koj saib nyeem, thaib mloog meskas hauv yeeb yaj kaib ntau npaum cas? 1 2 3 4 5
33. Koj saib nyeem, thaib mloog meskas hauv xov tooj cau ntau npaum caas? 1 2 3 4 5
34. Koj saib nyeem, thaib mloog meskas hauv lus ntawv lus paj huam ntau npaum cas? 1 2 3 4 5
35. Koj txawj hais lus meskas ntau npaum caag? 1 2 3 4 5
36. Koj txawj nyeem lus meskas ntau npaum caag? 1 2 3 4 5
37. Koj txawj sau lus meskas ntau npaum caag? 1 2 3 4 5
38. Koj nkag siab lus meskas npaum caag? 1 2 3 4 5

1. Kenny, ib tus txiv neej muaj 46 xyoo, muaj caub yig muaj me nyuam (me nyuam noob nyooog 17, 14, 10) tau poob hauj lwm 6 lub hli dhau los. Nws tau seev txog txoj kev txo nws txoj sia vim nws tsis pom txoj kev muaj kev sib raug zoo nrog rau ob tug me nyuam hlob thiab muaj kev cov nyom ntawm nws tus poj niam. Nws tau muab nws tus kheej nrug ntawm nws tsev neeg txij thauj tau poob hauj lwn. Nws tau hais tias "kuv xav dai taug thaib muab txoj kev nyuaj siab no tshem tawm."

Mus xyuas kws khob mob____
Mus nrhiav neeb nvhaiw yaig______
lwm yam________


Mus xyuas kws khob mob____
Mus nrhiav neeb nvhaiw yaig______
lwm yam________

Mus xyuas kws khob mob____
Mus nrhiav neeb nvhaiu yaii____
lwm yam______

4. Adam, ib tug txiv neej muaj 30 xyoo, tsis muaj cuab yig, txom nyem nyiaj txiag. Tau hais tias "Kuv tsis muaj siab ua cov khoom uas kuv ib txwm ua. Kuv xav nyob pw thiab nyob ib leeg." Ib tus poj naim muaj 25 xyoos, muaj cuab yig muaj ib tus mob uas us rau nws pheej khawb thiab dawj nws daim tawv nqauj thiab dob nws cov plaub hau. “Kuv ua rau tib neeg ntshai thiab nrug ntawn kuv tiamsis tsis nkag siab tias ua cast us mob no thiaj li tshwm sim.”

Mus xyuas kws khob mob____
Mus nrhiav neeb nvhaiu yaii____
lwm yam______

5. Mindy, ib tus poj naim muaj 25 xyoos, muaj cuab yig muaj ib tus mob uas us rau nws pheej khawb thiab dawj nws daim tawv nqauj thiab dob nws cov plaub hau. “Kuv ua rau tib neeg ntshai thiab nrug ntawn kuv tiamsis tsis nkag siab tias ua cast us mob no thiaj li tshwm sim.”

Mus xyuas kws khob mob____
Mus nrhiav neeb nvhaiu yaii____
lwm yam______
References


Her, C. (2012). Lost in translation: When 'mental health' becomes 'damaged brain'.


