

**The Influence of Hmong Americans' Acculturation and Cultural Identity on Attitudes Toward Seeking Professional Mental Health Care and Services in Comparison to Traditional Health Beliefs and Practices by Ethan Teng Xiong, Barry Dauphin and Carol Weisfeld, Hmong Studies Journal, 19(2)(2018): 1-45.**

**The Influence of Hmong Americans' Acculturation and Cultural Identity on Attitudes  
Toward Seeking Professional Mental Health Care and Services in Comparison to  
Traditional Health Beliefs and Practices**

**By**

**Ethan Teng Xiong, M.A.**

**Barry Dauphin, Ph.D., ABPP**

**Carol Weisfeld, Ph.D.**

**Department of Clinical Psychology, Ph.D. Program  
College of Liberal Arts & Education  
University of Detroit, Mercy**

**Hmong Studies Journal, Volume 19 (2), 45 Pages**

**Abstract**

The Hmong people have endured a long history of war-related trauma, and they have settled in different parts of the world. As a consequence, many Hmong people may have experienced various levels of psychological symptoms and have limited knowledge and resources for treatment and interventions. Issues of acculturation, cultural identity, traditional beliefs & practices, seeking traditional medical interventions, and religious beliefs may influence help-seeking behaviors from professional psychological services. Data, including demographic information, were gathered from two Hmong American churches located in southeast Michigan. The results showed that seeking professional services was correlated with both acculturation and traditional beliefs & practices. Acculturation and traditional beliefs & practices each contributed unique variance to help-seeking behaviors. This suggests that both low levels of acculturation and high levels of traditional beliefs & practices could result in people being less likely to seek mental health services. In this sample, Hmong Americans preferred God over traditional beliefs, such as Shamanism. The implications of these findings will be discussed.

**Keywords:** Hmong American Mental Health, Acculturation, Cultural Identity and Attitudes, Beliefs and Practices, Help-Seeking Behaviors.

## **A Brief Overview of The History of The Hmong People**

The Hmong people are a group of ethnic minorities that originated in China and have moved to other neighboring countries (e.g., Laos, Vietnam, and Thailand) since the 1700s due to wars, persecution and ethnic cleansing from the Chinese (Duffy, Harmon, Ranard, Thao, & Yang, 2004; Hamilton-Merritt, 1980, 1993; Lee, 1990). In the 1960s and 1970s, the Hmong once again faced political persecution, adjustment issues, and related war-torn traumas because of their involvement with the Vietnam- American War (Rairdan & Higgs, 1992). Due to the Hmong's involvement with the American Central Intelligence Agency (CIA) during the war, the communist government of North Vietnam and its regime (Pathet Lao and Vietcong) have targeted the Hmong people (Hamilton-Merritt, 1980, 1993; Lindsay, 2002). They began to migrate to the United States and other countries seeking resettlement in droves as the war came to an end (Fadiman, 1998; Mouanoutoua, Brown, Cappelletty, & Levine, 1991; Westermeyer, 1987, 1988, 1989; Ying & Akutsu, 1997).

Through a long history of war-torn trauma, malnutrition, and physical and mental health suffering, the Hmong survived and endured, though many had perished; they have had very few options but to seek resettlement in other countries such as Australia, France, Germany, South America, and the United States as early as the 1970's (Duffy et al., 2004; Lindsay, 2002; Chan, 1994). Many Hmong suffered various psychological disorders, such as post-traumatic stress disorder, anxiety, depression, and adjustment disorder, although they might not label their experiences this way. These disorders began to manifest and are known as psychological illnesses according to Western society (Westermeyer, 1987, 1988, 1989). The Hmong were not exposed to mental health care concepts of the West, and their primary source of physical and mental healing practices were through traditional healings of animalism as well as strong ties to

ancestral worship (Culhane-Pera, Her, & Her, 2007). The current Hmong population in the United States is estimated to be approximately 309,000, according to the 2017 American Community Survey 1-Year Estimates (ACS), with many residing in California, home to the largest population of Hmong in U.S, followed by Minnesota and Wisconsin, respectively (Pfeifer, 2008; Pfeifer, Sullivan, Yang, & Yang, 2012; U.S. Census Bureau, 2010). Given the historical background of the Hmong and their adjustment challenges in the U.S., including accumulative war-related traumas, Westermeyer (1986) concluded that the mental health rate dating from 1977 to 1988 among Hmong Americans was between 35% and 42%. By using Westermeyer's findings and data of estimated Americans' mental health disorders from the U.S. National Institutes of Mental Health (NIMH), Lee and Chang (2012) concluded that the current mental health prevalence rate among Hmong Americans is estimated at about 33.5%.

### **Traditional and Contemporary Hmong Family**

The Hmong's traditional way of life is comprised of a hierarchical social structure system that is based on a patriarchal belief. Currently, there are 18 Hmong clans (Cooper, 1998; Lee & Tapp, 2010), with two major classes (Green Hmong and White Hmong), which are distinguishable by dialect, clothing designs, and geographical region (Cooper, 1998; Duffy et al., 2004; Lee, 1990; Lee & Tapp, 2010). A typical Hmong family usually consists of a husband, wife, children, and often include the parents of the husband. It is customary for the Hmong to have many generations living together in one household. Each family member has a role with specific set of responsibilities and is expected to abide by them without question (Cooper, 1998; Duffy et al., 2004; Lee & Tapp, 2010; Livo & Cha, 1991). Age plays a major factor in determining one's status and extends from the immediate family outward to the community.

Typically, all males have more authority than females, and older males have more authority than younger males, including every member in their clan; this extends through the immediate community. Hmong male elders from the family or the clan often provide all support and interventions or solutions, with a primary aim to uphold continual relations for the family and its clan (Cooper, 1998; Duffy et al., 2004; Lee & Tapp, 2010; Livo & Cha, 1991).

Ultimately, the husband has more authority than that of his wife, and of the grandparents, including the husband's own father. The level of the husband's authority and status depends on his age, experience, intelligence, and charisma; however, his level of education exceeds all qualities (Duffy et al., 2004; Livo & Cha, 1991). The husband is looked upon as the head of the household, and he is the sole bread winner, while the wife is responsible for completing household chores, including cooking, raising children, and caring for the whole family (Cooper, 1998; Duffy et al., 2004; Lee & Tapp, 2010; Livo & Cha, 1991).

The grandparents and children usually have different but expected responsibilities in a traditional Hmong family. For instance, the grandparents function as a care taker for the family, including providing social and financial support, helping to keep up with the household chores, and caring for the children of their sons and daughters. Grandparents are often seen as the pillars in the home and are revered for their knowledge and wisdom, not just within the family of origin, but extending through their clan and the immediate community. The roles of sons and daughters are typically expected to mirror that of the parents, including maintaining household chores from daughters, and financial support from sons. The oldest child is expected to take on the most responsibilities and obligations for providing unconditional support for the well-being of the family (Berry, 1980). Sons and daughters are not only looked upon as role models, but also are highly encouraged to obtain higher education so that they may provide better financial support

for the family and be self-sustaining when they move out of the home and have a family of their own (Berry, 1980).

The contemporary Hmong American family has undergone drastic changes in many ways since settling in America compared to the traditional Hmong American family. The changes are largely due to shifting socio-cultural, political, and economic factors beyond the traditional Hmong family system (Bliatout et al., 1985; Ng, 2008). The patterns and structure of Hmong family systems, and family members' roles, seem to evolve to reflect different facets of the American mainstream culture, including options to either assimilate to the norm of the host country or to remain within their cultural identity and traditional beliefs and practices. Within this sphere of new opportunity, many Hmong families have struggled with the acculturation process; thus, this has created a cultural clash between parents and their adolescents (Kim, Chu & Lee, 1987; Lor & Chu, 2002; Rick & Forward, 1992; Williams & Westermeyer, 1983; Xiong, Detzner, & Rettig, 2001). Young Hmong have learned to adapt quickly to the mainstream culture, including forming their own identity and attitude that reflect the norm of the host country while shedding or embracing their traditional identity. Husbands' and wives' roles seem to become more equitable, and each are expected to provide equal amount of support for their family (Berry, 1980; Ghuman, 1997; Padilla, 1980; Phinney, 1990; Westermeyer, 1989). The level of change depends on the level of acculturation, cultural identity, and other factors, including length of stay in the U.S. (Berry, 1980, 1988, 2003).

Despite having common struggles faced by many Hmong immigrants, there seems to be an increased level of assimilation in the host country, with many Hmong Americans succeeding in furthering social, educational, political, and economic development (Cha, 2003; Fang, 1998). However, there are many other Hmong Americans struggling to succeed in the U.S. and to

function adequately in many capacities, such as medical and mental health care and services. Part of their struggles may be related to familiarity, including cultural norms and expectations, language barriers, employment opportunity, and access to basic resources.

### **Beliefs and Practices**

The Hmong have two major religious belief systems: traditional and new practices. Spiritually, the Hmong have traditionally practiced animism, the belief that earthly structures (rocks, trees, hills, rivers, valleys, lakes, and so on) have specific embodiment of spirits of their own (Livo & Cha, 1991). There are several types of spirits the Hmong believe to be responsible for the misfortune when angered or the protection for the health of the individual and the family. These spirits can be of nature, ancestors, the house, or evil in nature (Livo & Cha, 1991). Traditionally, the Hmong believe in two separate but connected worlds; the natural and the spirit world (Tatman, 2001). When an individual becomes sick or displays psychological symptoms, it is often believed that certain spirits have lured the person's soul away from their body and into the spirit world. The person's soul must be retrieved, usually done by a shaman, or the person may experience death from illness. The Hmong engage in these practices to maintain the soul with its body (Johnson, 2002). There are numerous traditional rituals and practices to appease the upset spirits (Livo & Cha, 1991).

A primary ceremony called, *Tu-ua-neng* (Shaman) is often performed to determine the source and cause of the individual's illness or to replace the lost soul, or to offer payment in exchange for the cure that resulted from the illness (Cooper, 1998; Johnson, 2002; Lee & Tapp, 2010). The ceremonies require the shaman to transcend into the spirit world in search of the lost soul; once found, necessary requirements are needed to placate the spirit causing the illness. This process is usually done by burning cut-out papier mache in the form of a human in an effort to

confuse or trick the spirit into releasing the person's soul back to their original body. However, this may not be accomplished without sacrificing animals as payment. The Hmong commonly sacrifice animals for the soul of the sick person, such as chickens, cows, or pigs for their value and strength to battle the spirit in the spirit world (Johnson, 2002). Many considered these ceremonies to be of great value and with high healing potential. Many report improvements in their symptoms. The costs can range from \$300 to as much as \$1000 or more depending on the type of ceremony (diagnosis or healing), including additional fee for the shaman and sacrificial animals (Johnson, 2002).

### **Christianity**

The Hmong have a concept of god or deity in their traditional belief systems although they often engage in highly ritualistic beliefs and practices through traditional animism and ancestral worship (Duffy et al., 2004). The traditional rituals usually include sacrifices made as offerings throughout the year for occasions, such as birth, death, marriages, or a New Year celebration. For many Hmong, the Christian faith means getting rid of the traditional beliefs and practices, including the idea that death is not final, but rather the spirit and soul continue to live apart from the body. The Hmong believe strongly that the spiritual realm cannot be separated from a traditional Hmong life. In the Christian belief system, there is only heaven and no uncertainty of reincarnation, but those who follow Jesus will live with him after the final day of his resurrection victory. Moreover, to put faith in Christ means to cast away the belief of spirits and the traditional animistic religion. A devotion to the Christian faith means the Hmong people's animistic paraphernalia that are core to the shaman rituals need to be discarded, and the manipulation of spiritual power needs to be shifted to the power of God (Duffy et al., 2004).

According to Duffy et al. (2004), many Hmong have converted to Christianity, and the number of converts has grown since the 1950s. It was estimated that by 1953, about two thousand or more Hmong people had converted from Shamanism to Christianity (Duffy, 2007) with one half of the Hmong residing in the United States considering themselves as Christians (Duffy et al., 2004). According to Desan (1983), it was estimated that about 1/3 of the Hmong population in the United States practiced Christianity with many different denominations. One denomination with the largest number of members is the Christian Missionary Alliance Church. In contrast, there were about 2/3 of Hmong who reside in the United States who still practice Shamanism and the traditional Hmong animist religion (Desan, 1983). Many Hmong who immigrated to the United States may have been sponsored by Christian churches or members of the church, who then converted the Hmong whom they have helped to settle in their community. It is suspected that many Hmong have increasingly converted to the Christian faith and slowly become dislodged from their original practices and beliefs (shaman rituals) as they continue to assimilate to the host country. Also, it is possible that many Christian converts still maintain some aspects of traditional beliefs although this is an area that has received little research attention.

### **Hmong Mental Health Literature Review**

In order to have a better picture of the symptoms and disorders that continue to impact the Hmong, Lee (2013) conducted a meta-synthesis of academic journal articles accessing research trends of Hmong mental health issues using forty-eight published journal articles from 1983 through 2012. The findings revealed several similar themes, which included family and adjustment issues, substance abuse, depression, anxiety, and other mental health problems associated to mental health (e.g., supportive factors, treatment effectiveness, strengths and



resiliency and help seeking attitudes). Further analysis showed depression was studied the most often followed by adjustment issues and anxiety. Family issues were found to be the least studied. Regardless of which mental health issues are studied most often, it remains that the Hmong were reported to have higher levels of psychosocial issues and were more likely to maintain their cultural of origin and traditional practices compared to other refugees from South East Asia (Ying, Akutsu, Zhang, & Huang, 1997). This may indicate a behavioral pattern in the Hmong, which reveals an inability to be open to other forms of treatment due to adjustment problems. For the Hmong youth generation, a research finding revealed that acculturation yielded little impact and showed no significant difference between genders and acculturation issues with their parents (Bahrassa, Juan, & Lee, 2012). Moreover, Xiong, Rettig, and Tuicomepee (2008) found no level of significant difference between delinquent and non-delinquent adolescents in terms of acculturation issues.

Past researchers often studied acculturation or enculturation separately (unilinear model) or use them both (bilinear model) when comparing relationships with other variables. Acculturation was initially defined as, “those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups” (Redfield, Linton, & Herskovits, 1936, p.149). Enculturation was originally defined as the process of socialization, including the maintenance of one’s indigenous cultural norms, values, concepts, and salient ideas (Herskovits, 1948). Acculturation was first conceptualized as a unilinear culture behavior, which states that the internalization and engagement in a host culture by an individual, leads to losing ties to the culture of origin (Gordan, 1964). On the other hand, the bilinear model of acculturation states that the increase of a second culture does not necessary decrease the

adherence to the culture of origin and vice versa (Kim, 2007). According to Miller, Yang, Hui, Choi, and Lim (2011), their study concluded that high acculturation with low enculturation were associated with better mental health, as found by the unilinear model, whereas only high acculturation was related to mental health for the bilinear mode. Studies have shown that there is a relationship between acculturation and enculturation, and an individual's attitude toward seeking professional psychological help suggests that high enculturation was related to less help-seeking behavior (Kim & Omizo, 2005). Contrary to previous studies, Miller et al. (2011) found a significant relationship between high behavioral enculturation and better mental health. The findings further showed that there are some significant differences between high values acculturation and better mental health issues. Finally, Miller et al. (2011) found that mental health was associated with high behavioral enculturation and high acculturation stress, while attitude toward seeking professional psychological help was associated with both high behavioral and high values acculturation.

However, with the relative research conducted thus far regarding the adjustment of the Hmong people, acculturation and cultural identity processes remain a vital area to be explored, such that underlying mental health adjustment concerns may be better understood relative to the general population. Studies on the Hmong acculturation process in the U.S. have found mixed results. In a study done by Xiong and Jesilow (2007), those with early settlement (1975-1977, and 1978-1982) showed higher adjustment levels to U.S. society, whereas later arrivals (1982-1986, and 2003-2006) reported lower level of adjustment. Some problem areas stemmed from cultural conflict associated with social isolation to the U.S. societal norm at large, as well as issues surrounding traditional medicine usage (e.g., herbal remedy). It may be helpful to clarify what constitutes early and late arrivals. Xiong and Jesilow (2007) talked about early and late

arrivals and reported adjustment levels in their study but did not provide a timeframe about what was meant by early and late. Other researchers, such as Duffy et al. (2004) reported timeframe but did not provide information about adjustment. It is reasonable to conclude that for these researchers, early arrivals were from 1975 onward and those coming later arrived after 1982.

The capability of the Hmong to adapt and assimilate to an unfamiliar country with new culture and customs may pose various obstacles for the Hmong and further contribute to psychological problems. A study by Lee and Green (2010) revealed that in general the Hmong could hold onto their tradition and culture, yet they had less problems accepting and adapting to the host's culture. Hmong individuals with a high level of adaptability have been linked to a low risk of depression issues compared to those Hmong who have lower levels of adaptability. These results may be related to their willingness to seek outside resources as well as within the Hmong community to gain further support (Hirayama & Hirayama, 1988). It is unclear what the rates of adaptability are among the Hmong population, though.

The test of the Hmong's psychological adjustment to a new country may play a role in their willingness to cope with distressing psychological symptoms, such as depression, and other debilitating disorders. Depression symptoms were reported to be highest among Hmong Americans (80.4%) compared to other Southeast Asian groups, such as Laotian (59.2%), Vietnamese (54.1%), and Cambodian (70.7%) (Kroll, Habenicht, Mackenzie, & Yang, 1989). Symptoms of depression experienced by Hmong in the United States were investigated in the 1980's by Westermeyer (1989), who stated that there was minimal to extreme stress experienced by the Hmong due to migration and war-related issues. Furthermore, mental health issues, such as paranoia, somatization, and hostility issues were of concern to the Hmong as they slowly assimilate to the U.S.'s culture. Westermeyer, Bouafuely, Neider, and Callies (1989) stated that

of the three mental health concerns under study, somatization seemed to contribute to the most psychological adjustment difficulties for the Hmong. For example, being less educated, being unemployed, and slow or low adaptability have been linked to somatization symptoms. Finally, Westermeyer and Uecker (1997) indicated that hostility symptoms were associated with those practicing animisms, living in large households, having limited occupational skills, holding non-leadership positions in their community, and being a woman. Early educational development in the U.S. has been related to less hostility behavior and symptoms (Westermeyer & Uecker, 1997).

Similarly, Danner et al. (2007) found that many Hmong individuals attributed their depressive symptoms to experiencing war trauma-related issues while living in Laos, a loss of role status, the enduring of physical ailments, and other stressors, such as unemployment and financial strain. Moreover, depression and anxiety symptoms presented in the Hmong were prevalent and have been found to be associated with having neuroticism, being unemployed and uneducated, and being older in age, according to Mouanoutoua and Brown (1995). Anxiety symptoms were also found to be associated with living near another Hmong household, having a large household, having a negative outlook, and having reported health issues (Westermeyer, Schaberg, & Nugent, 1995). According to Westermeyer, Neider, and Callies (1989), anxiety trends seemed to decrease over time, similar to depression, roughly about ten years after the initial resettlement (post immigration). Overall, it has been determined that those presenting with anxiety symptoms were related to having a negative outlook in life, while depressive symptoms have been due to a lack of education, unemployment and a poor ability to grasp English as a second language (e.g., reading, writing, and speaking). Comparatively, Lee and Green (2010) found that educational experience and abilities to use the English language have the largest

impact on positive adjustment in the U.S., including length of residency and age when immigrated. Acculturation has also been a buffer for decreasing depression overtime for those who resettled earlier in the U.S. (Westermeyer, Neider, & Callies (1989).

Collier, Munger, and Moua (2012) indicated that although most people endorsed having found some support for mental health and social problems by utilizing Hmong traditional herbal medicine, Shaman healing ceremonies, and Hmong religious congregations. Most Hmong continued to indicate a lack of basic knowledge of mental illness, including recognizing early signs. Further, despite the level of symptoms found in the research literature, there is evidence that Hmong might not seek professional psychological treatment. Chung and Lin (1994) revealed that the Hmong reported being less likely to seek Western treatment for mental health issues compared to other non-Hmong groups. Similarly, Westermeyer (1988) found that Hmong who presented with prolonged mental health symptoms were unlikely to seek Western treatment due to a lack of knowledge concerning mental health treatments; however, when Western treatment concepts (e.g., therapy and psychotropic medications) were introduced, Hmong clients seemed hopeful for such a Western treatment approach (Danner, Robinson, Striepe, & Rhodes, 2007). Therefore, it is important to understand if Hmong Americans can access mental health services despite having to face many barriers.

Given the Hmong's long history of accumulative war-related traumas, stressors relating to pre-post immigration, and adjustment difficulties, it is assumed that current mental health issues are manifested within acculturation and enculturation behavioral patterns of those currently residing in the U.S or new arrivals. Being that there is limited research conducted about the Hmong people's psychological well-being, this research attempts to uncover and address mental health issues as perceived by Hmong Americans that may impact the following:

acculturation, cultural identity, attitudes, beliefs and practices compared to Western behavior toward seeking professional psychological help and services. Factors such as age and gender are also investigated.

The current study will investigate the relationship between cultural identity, acculturation, and traditional beliefs and attitudes toward seeking services. It seems important to look at barriers toward seeking mental health services because of potential mental health incidence rates in the Hmong community and any relationship with the maintenance of traditional beliefs and practices. There are studies on general acculturation and mental health issues. It seems important to see whether there are associations between cultural identity and traditional beliefs and attitudes with seeking professional services. Therefore, the current study aims to see if acculturation, cultural identity, and traditional beliefs and attitudes are related. Although there are good scales to measure acculturation and cultural identity, there has not been much attempt to measure or study traditional beliefs and practices, such as working with a shaman. Therefore, a scale was created to measure the seeking of these services.

We hypothesized that the stronger the cultural identity and the less acculturation, the less likely Hmong Americans would endorse seeking professional services.

## **Method**

This study has been approved by the International Review Board (IRB) of a University of a Midwestern state located in the United States.

### **Participants**

The researcher provided adequate information regarding the general purpose of the study and informed the participants their rights to participate in the study. Participants were recruited for the study from a large Hmong American community in Southeastern Michigan. There were

60 participants in the study whose age ranged from 18 to 75 years with a mean of 36.23 (S.D.= 12.86). The gender break down of participants showed (N= 23 (38.3%) females; N= 37 (61.7%) males). A closer examination indicated that 26 (43.3%) participants were born in Laos or Thailand while 34 (56.7%) said they were born in the United States. With regard to the number of years they had been living in the U.S., there were a total of 34 (56.7%) participants who were born in the U.S. and 21 participants stating they have been living in the U.S. between 20 to 39 years; 5 (8.3%) participants indicating that they have been living in the States for 40 or more years. A little more than half (55%) of the participants indicated that they have been living in the U.S. for less than 20 years.

At the completion of the survey, most participants (43 (71.7%)) indicated that they were married and 14 (23.3%) were single or never been married. There were 2 (3.3%) participants who were in a domestic partnership, and 1 (1.7%) individual indicated having been separated. With regard to employment status, 45 (75%) participants reported having current employment; 4 (6.7%) participants were retired; 4 (6.7%) participants were students; 3 (5%) participants reported they were unable to work; 2 (3.3%) participants reported being a homemaker; one (1.7%) individual was self-employed; and one (1.7%) individual reported being out of work. In terms of household income and educational attainment level, 21 (35%) participants indicated having an income below 29,999 while another 21 (35%) participants indicated having an income between 30,000 and 69,000. A total of 18 (30%) participants reported having an income of 70,000 and above. Turning to educational attainment level, 7 (11.7%) participants had completed high school or equivalent (e.g., GED); 2 (3.3%) participants had earned a vocational training; 11 (18.3%) reported having earned an Associate degree; 15 (25%) participants indicated that they have completed some college credit, but no degree granted; 18 (30%) participants indicated

having earned a Bachelor's degree; and 6 (10%) participants had a Master's degree. One individual (1.7%) reported having a professional degree.

It was expected that most participants would be able to complete the research study between 10-20 minutes. There was no compensation given for participation in the study. Participants were not obligated to complete the questionnaires and could stop at any point during the study without penalty. There was no discomfort or risks reasonably expected in completing the survey.

Finally, out of 100 surveys distributed, a total 50% response rate was estimated which included the online and the paper format questionnaires. For the on-line survey, a total of 51 participants attempted to fill it out with 44 participants actually completing it. Moreover, one participant was excluded from the study because he marked down that his ethnicity was "White". Of the paper format survey, 68 surveys were distributed but 19 were returned. Of the 19 surveys returned, 2 surveys were partially completed; therefore, they were excluded from the analysis. Overall, there were a total of 49 paper format surveys that had not been accounted for from the 68 paper format surveys distributed.

#### Measures

***Hmong Traditional Beliefs and Practices (HTBP) scale.*** Hmong attitudes toward beliefs and practices was measured using the HTBP scale, which was developed by the researcher for the current study. It included a total of 18 items; however, only 13 of the items were on a 4-point Likert scale ranging from Disagreement to Agreement and were used to generate the total score in this study. The scale range was from 13 to 52. Items 14, 15, and 16 were categorical while items 17 and 18 were narratives, and they asked participants if they would be willing to provide statements regarding the improvement of the scale itself. An example of a question from the



HTBP was, “I go to see a Hmong shaman regularly” (Item 2). A Cronbach’s alpha was calculated, and it was .6. See Appendix A for scale.

***General Ethnicity Questionnaire- Hmong (GEQ-H) scale.*** Participants’ ethnic identity status was measured using GEQ-H (Tsai, 2001) which included 39 items on a 5-point Likert scale ranging from Strongly Disagree to Strongly Agree. This was relevant to their language usage and proficiency and their social affiliation. The GEQ-H asked participant questions such as, “I am familiar with Hmong cultural practices and customs” (Item 11). The Cronbach’s alpha for the scale was .87 with internal reliability of .78 for negative affect, and .89 for positive affect (Tsai, 2001).

***Attitudes Toward Seeking Professional Psychological Help (ATSPPH) scale.*** A measure for attitude toward seeking professional mental health services was conducted using Fischer and Turner (1970)’s scale (ATSPPH) which included 29 items on a 4-point Likert scale ranging from Disagreement to Agreement. Due to the nature of the scale, lower scores are consistent with interest in seeking professional psychological services while higher scores are reflective of less interest. An example of a question was, “There are a few times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem” (Item 5). Fisher and Turner’s analysis showed internal consistency results for the full scale ranging between .83 to .86. A two-week test-retest reliability analysis yielded .89 (Fisher & Turner, 1970).

***Hmong General Cultural and Behavioral Attitudes (HGCBA) scale.*** Finally, general Hmong cultural orientation (acculturation) was measured using a remodified version of the American and Hmong Acculturation Scale developed by Susan Bosher (1985, 1997). A measure of reliability using Cronbach’s alpha was run on each of the five American and Hmong

dimensions of acculturation (e.g., language use, social contact, behavior, attitudes, and values) and the internal consistency statistic scores ranged from .47 to .80 (Bosher, 1985, 1997). The tailored instrument (HGCBA) for this study consisted of 10 questions that assessed degree of cultural and behavioral attitudes affiliated with Hmong culture. The measurement was conducted using a 5-point Likert scale which asked participants to rate how they feel ranging from Strongly Disagree to Strongly Agree. A sample question from the HGCBA scale was, “Personal needs should come before the needs of the family” (Item 5).

### Procedure

The researchers recruited participants for the study through two Hmong churches located in Southeastern Michigan. The researcher first went to discuss his research study with both church leaders to gain permission prior to the direct recruitment. Then once permission was granted, the researcher was given an opportunity to announce his research study to the church goers which was followed by a distribution of the surveys via a paper and pencil format. In addition, a notebook was also distributed among the church goers to collect their email address if they chose to fill out the survey on-line instead of using the paper and pencil format. Participants were later emailed a link to the survey to complete and submit at their leisure. The researcher utilized an English only survey and it required approximately 10 to 20 minutes to complete. Based on the results, it was estimated that the participants (N = 44) who took the online survey took approximately an average of 35 minutes to complete it (between 8 minutes to 7:47 hours). However, when three of the longest time spans (1:46; 1:52; & 7: 47) were taken out, participants took an average of 20 minutes to complete the survey. The online format was administered using Survey Gizmo, an online survey tool. For both survey format types, participants were provided an option to give consent to participate by marking/clicking on either “Yes” or “No” on a radio

button to indicate their level of agreement or disagreement to take part in the research study. Participants who opted not to participate on the consent form were redirected to a Thank You page appeared at the end of the survey, and these participants were unable to participate in the survey. The data collected were analyzed using statistical analysis procedure conducted through SPSS. All data were handled appropriately according to ethical standards and issues with respect to confidentiality.

## Results

A Pearson product-moment correlation coefficient was used to assess all scales in the study with a total of 60 participants. Due to some missing data on scales GEQ-H (responses to 3 items) and ATSPPH (responses to 4 items), a mean substitution was used to calculate the average for the missing items.

As a test of hypothesis one, the results demonstrated Hmong acculturation (HGCBA) was negatively correlated and significant with attitudes and beliefs toward seeking professional mental health services (ATSPPH),  $r = -.288$ ,  $N = 60$ ,  $p < .05$ . As Hmong acculturation (HGCBA) increases, attitudes and beliefs toward seeking professional mental health services (ATSPPH) decreases. A higher score on ATSPPH reflects less interest in seeking professional services. The findings were consistent with hypothesis one. As stated previously, items on the ATSPPH scales reflected skepticism toward seeking professional psychological help. All information regarding intercorrelations are contained in Table 1.

Hmong acculturation (HGCBA) was not significantly correlated with general attitudes toward seeking Hmong traditional beliefs and practices (HTBP),  $r = -.079$ ,  $N = 60$ ,  $p = n.s.$  The findings were not consistent with hypothesis one. This indicated that acculturation is not associated with attitudes toward seeking Hmong traditional beliefs and practices though it was

expected that high acculturation was associated with less investments toward seeking Hmong traditional beliefs and practices. High acculturation was thought to be associated with increased attitudes toward seeking professional mental health services.

Hypothesis two revealed that cultural identity (GEQ-H) was not significantly correlated with general attitudes and beliefs toward seeking professional psychological services (ATSPPH),  $r = -.143$ ,  $N = 60$ ,  $p < n.s.$  The findings were not consistent with hypothesis two. However, this finding does show that the variables were associated in the predicted direction. There was no correlation between cultural identity (GEQ-H) and general attitudes toward seeking Hmong traditional beliefs and practices (HTBP),  $r = .021$ ,  $N = 60$ ,  $p < n.s.$  The findings were also not consistent with hypothesis two. Hmong cultural identity (GEQ-H) was not associated with general attitudes toward seeking Hmong traditional beliefs and practices (HTBP).

General attitudes toward seeking Hmong traditional beliefs and practices (HTBP) were significantly correlated with general attitudes and beliefs toward seeking professional psychological services (ATSPPH),  $r = .277$ ,  $N = 60$ ,  $p < .05$ . Namely, higher level of beliefs in traditional practice was associated with less interest in seeking professional services.

In term of age differences, and as a test of hypothesis three, Age was negatively correlated but not significantly with willingness to seek professional mental health services (ATSPPH), ( $r = -.144$ ,  $N = 60$ ,  $p < n.s.$ ). Age was also negatively correlated but not significantly associated with help-seeking behavior toward Hmong traditional beliefs and practices (HTBP), ( $r = -.019$ ,  $N = 60$ ,  $p < n.s.$ ). The results for hypothesis three indicated that age and help-seeking behaviors toward professional psychological help were associated in the expected direction but not significantly; however, age and seeking Hmong traditional beliefs and practices were not associated in the predicted direction.

Finally, the findings for hypothesis four revealed that there were no significant relationships between Gender and willingness to seek professional mental health services (ATSPPH), ( $r = .029, N = 60, p < n.s.$ ) and no significant associations with seeking Hmong traditional beliefs and practices (HTBP), ( $r = -.094, N = 60, p < n.s.$ ). The findings were consistent with hypothesis four.

In addition to the results from the hypotheses, the researchers noted that there were other significant findings. With regards to age and Hmong cultural identity (GEQ-H), the study found that Age was significantly correlated with Hmong cultural identity (GEQ-H),  $r = .389, N = 60, p < .001$ . This suggested that the older the participant the more likely they were to endorse Hmong cultural identity. Age was also found to correlate with Gender,  $r = .429, N = 60, p < .001$ . In this sample, there were not just more male than female participants, but the males were also older than females. This appears to be an artifact of this sample.

Subsequent analyses were run between age and the measures controlling for gender since Age was found to correlate with Gender. The results were essentially ineffective. However, Age continued to be significantly correlated with GEQ-H,  $r = .381, N = 60, p < .003$ .

Table 1a

	GENDER	AGE	HGCBA	HTBP	GEQ-H	ATSPPH
GENDER	1	.429**	-.026	-.094	.110	.029
AGE	.429*	1	.073	-.019	.389**	-.144
HGCBA	-.026	.073	1	-.079	.173	-.288*
HTBP	-.094	-.019	-.079	1	.021	.277*
GEQ-H	.110	.389**	.173	.021	1	-.143
ATSPPH	.029	-.144	-.288*	.277*	-.143	1

Note: \*  $p < 0.01$  significant level (2-tailed) and \*\* $p < 0.001$  significant level (2-tailed).

Table 1b

Control Variables		ATSPPH	GEQ-H	HTBP	HGCBA	GENDER
AGE	ATSPPH	1.000	-.095	.277*	-.281	.101
	GEQ-H	-.095	1.000	.031	.158	-.068
	HTBP	.277*	.031	1.000	-.078	-.095
	HGCBA	-.281	.158	-.078	1.000	-.064
	GENDER	.101	-.068	-.095	-.064	1.000

Note: \*  $p < 0.01$  significant level (2-tailed) and \*\* $p < 0.001$  significant level (2-tailed).

Table 1c

Control Variables		ATSPPH	GEQ-H	HTBP	HGCBA	AGE
GENDER	ATSPPH	1.000	-.147	.281	-.288*	-.173
	GEQ-H	-.147	1.000	.032	.177	.381**
	HTBP	.281	.032	1.000	-.082	.024
	HGCBA	-.288*	.177	-.082	1.000	.093
	AGE	-.173	.381**	.024	.093	1.000

Note: \*  $p < 0.01$  significant level (2-tailed) and \*\* $p < 0.001$  significant level (2-tailed).

With regard to the level of psychological health issues in the sample, 1 (1.7%) individuals reported having experienced anxiety, and 3 (5.0%) participants indicated they have had experienced both anxiety and depression. All of the other 56 (93.3%) participants reported having no mental health problems; however, a closer examination indicated that 49 (81.7%) reported “No” while 11 (18.3%) participants reported “Yes” to having sought professional mental health services. In terms of preferences for seeking support for mental health services, 39 (65.0%) participants indicated they relied on God for healing; 5 (8.3%) had sought counseling; 4 (6.7%) had sought a medical doctor; 1 (1.7%) had sought a psychiatrist; 2 (3.3%) had sought a psychologist; 1 (1.7%) had sought a spiritual being; and 1 (1.7%) had sought both God and medical doctor for treatment at some point. There was 1 (1.7%) participant who indicated a preference for turning to family for support; 1 (1.7%) participant preferred to seek a mentor and or a pastor, respectively for support; and 2 (3.3%) participants indicated they prefer to seek no one for support. One participant (1.7%) endorsed seeking a combination of God, medical doctor, counselor, and family for support. When compared to Hmong traditional beliefs and practices (Shamanism), the majority of participants indicated they have not or do not participate/seek the services of a shaman for support and healing (98.3%). There was 1 (1.7%) participant who indicated as practicing Atheism.

The current study showed that both HGCBA and HTBP were correlated with ATSPPH but not with each other. Therefore, we performed an exploratory analysis using a step-wise multiple regression to see if each contributes unique variance to seeking professional services. HGCBA was entered into Step 1 and significantly explained .083 (8%) of the variance in predicting seeking services. After entry of HGCBA and HTBP at Step 2, the model showed that HTBP significantly adds .065 (.7%) variance to account for seeking professional services,  $\beta$

= .256,  $t(57) = 2.087$ ,  $p < .041$ , with an  $R^2$  change of .065. The overall regression model was significant,  $F(2, 57) = 4.957$ ,  $p = .010$ , with an  $R^2$  of .148. The total variance explained by the model was .148 (15%). Because this is the first time the HTBP scale is being used, the Cronbach's alpha was calculated for internal consistency for 10 of the 18 items. These item numbers consisted of questions 1, 2, 3, 6, 7, 8, 9, 10, 11, and 12 of the scale. Item numbers 4, 5, 13, 14, 15, 16, 17, and 18 were not included because they were either not related to Hmong Shamanism or were narrative questions. The findings revealed a questionable reliability statistic score of Cronbach's  $\alpha = .6$  ( $M = 21.667$ ,  $SD = 3.2$ ).

### **Discussion**

The findings in this study appear to show that the small sample of Hmong participants' willingness to seek professional services is related to both acculturation and traditional beliefs and practices. Each of these domains adds uniquely to the level of seeking professional services. The more acculturated a Hmong individual the more they are likely to seek professional mental health services. This finding is consistent with previous research study on Asian Americans, in general, that suggested more highly acculturated Asian Americans displayed greater positive attitudes toward seeking professional support (Atkinson & Gim, 1989; Tata & Leong 1994; Ying & Miller, 1992) and demonstrated greater levels of actual help-seeking behaviors (Ying & Miller, 1992). This suggests that low levels of acculturation could be a barrier to seeking professional mental health services, while high acculturation indicates being more likely to seek professional services.

A participant's willingness to seek professional psychological help was significantly negatively associated with their willingness to seek Hmong traditional beliefs and practices (Shamanism). This finding was to be expected, and it is consistent with previous findings that



many Southeast Asians have a tendency to operate from a cultural context that ideally does not connect mental disorder with emotional difficulties or negative feelings (Tung, 1985). Western scientific conceptualization about mental health may conflict with traditional beliefs and practices due to a lack of mental health literacy. This has been seen as a major barrier for Southeast Asian refugee communities in the U.S. (Collier, Munger, & Moua, 2012; Lee, Lytle, Yang, & Lum, 2010). Like many Southeast Asian languages that lack words to adequately characterize mental health symptoms or concepts, the Hmong also face similar struggles (Lee et al., 2010). For example, many Hmong often use the word “mental” as a derogatory term to describe mental illness which had been carried over from severe cultural sanctions in their homeland (e.g., Thailand or Laos) for any public display of unacceptable behaviors (Collier, Munger, & Moua, 2012). The lack of common words or phrases to describe psychiatric disorders, compounded with a lack of knowledge of symptomatology, may amount to failure of communication problems between patient and health professionals (Regier et al., 1988). As such, cultural minorities are often seen as less willing to seek services from mental health professionals because of a lack of knowledge about mental illness and available treatments, including limited ability to recognize early signs and available resources when looking for professional services (Collier, Munger, & Moua, 2012; Lee et al., 2010). Additionally, what Westerners understand as symptoms that result from mental illness, most traditional Hmong speakers see as an act of *raug dab* or *dab tshoov*, which means a result from an evil or unhappy spirit. For the Hmong, mental health disorders are often seen as the work of evil spirits, bad karma, or curse causing the individual to feel powerlessness or to engage in non-evidence-based actions (Lee et al., 2010). As such, a mental health professional is not relevant; instead, a shaman is sought after to cleanse out the spirit (Collier, Munger, & Moua, 2012). In the current sample, the level of traditional

beliefs and practices is low; thus, future study needs a greater represented level that also includes church-goers as well. A larger representative sample could show stronger findings of barriers to seeking professional services.

Desan (1983) suggested that only 1/3 of Hmong in the U.S. practice Christianity. The current sample might over represent Hmong Christians. It is not clear if the result would show the same with non-Christians. However, having a larger representative sample of Hmong church-goers could show stronger findings of barriers to seeking professional services. Since all the participants were drawn from a church-goer sample, it is possible that they may have knowledge of Hmong traditional beliefs and practices, but they are unwilling to seek the services of a shaman because of their Christian beliefs. It was only assumed that all Hmong should have some degree of knowledge of the traditional beliefs and practices, especially the older Hmong; however, having knowledge of shaman practice does not mean using shaman practice.

It was surprising to see cultural identity not have a strong association with attitudes toward seeking professional psychological services though the finding is in the predicted direction. Studies have shown that there is a relationship between acculturation and enculturation which suggests that high enculturation is associated with less help-seeking behaviors (Kim & Omizo, 2005) and high acculturation with low enculturation were associated with better mental health (Miller, 2010). Acculturation involves a process of learning and incorporating values, beliefs, and customs of the host country for becoming acclimated to the new country, whereas cultural identity is a part of an individual's self-concept or psychological state, including feeling of belonging to a group. Acculturation is the portrayal of changes in cultural identity (Schwartz, Montgomery, & Briones, 2006). The current findings indicated that having a higher cultural identity was not as relevant as being adaptive; thus, acculturation may be more important than

cultural identity with respect to attitudes for seeking professional mental health services. However, cultural identity has no associations with help seeking behavior toward Hmong traditional beliefs and practices in the current sample. Perhaps this may be because of the level of cultural identity reported in the sample overall. The observable mean of cultural identity was at the low range in this sample and that may be why cultural identity did not have a strong association with seeking professional services.

There were no significant relationships between age and the likelihood of help-seeking behaviors for both seeking professional psychological services and Hmong traditional beliefs and practices in contrast to the hypothesis. Age was initially thought to be an important factor in seeking Hmong traditional beliefs and practices because traditionally, age is an important factor in the Hmong culture, and it serves as a pillar for a hierarchical and patriarchal social structure (Duffy et al., 2004; Lee, 1990). It seemed reasonable to suggest that the older the Hmong the more they would be likely to seek the services of a shaman which is historically rooted in their culture of origin. This tendency may indicate that older Hmong have lower level of acculturation when compared to younger Hmong, and younger Hmong have less knowledge of Hmong traditional beliefs and practices (e.g., Shamanism and the animistic belief system). Moreover, it is speculated that older and more acculturated participants may seek professional services more often than older and less acculturated participants, but evidence was not found in this study that suggested age was related to seeking professional services. However, acculturation and traditional beliefs were significant regardless of age. It may be relevant for future research to include a larger and more geographically diverse sample to demonstrate significant differences between age and help-seeking behaviors or that age might be less relevant than presumed.

Finally, the study did not find significant associations for gender and willingness to seek professional psychological services compared to Hmong traditional beliefs and practices.

Although the findings are in the direction with the hypothesis, it is important to acknowledge that the small sample size may not detect relationships between gender and help-seeking behaviors. It would be imperative for future research to include greater sampling size of both genders of non-church-goers. In general, it is possible that married males may be more likely to assert their patriarchal status because of the Hmong tradition, culture, and customs. This trend could play a role in sampling, as more men participated in the study than women. Often in psychological research, female participants outnumbered male participants (Kwak & Radler, 2002; Moore & Tarnai, 2002; Porter & Whitcomb, 2005; Underwood, Kim, & Matier, 2000). The response rates in this sample showed a significant gender difference in which Hmong males (62%) contributed disproportionately to the self-reported data set compared to Hmong females (38%). Thus, it may be customary for the husband to complete the survey because the husband carries the family name, and he has more authority than that of his wife (Duffy et al., 2004; Livo & Cha, 1991). It may be possible that gender is not a relevant factor in seeking professional psychological services or Hmong traditional beliefs and practices, but acculturation is a more important factor in predicting help-seeking behaviors.

Other notable correlations emerged between variables in this study that suggested cultural identity was found to significantly associate with age, which is not surprising, that older Hmong would have stronger cultural identity. Therefore, this sample is not atypical in that older Hmong identify more with their primary cultural identity than with Western cultural identity. The findings in this study are consistent with previous studies that suggested older Hmong hold onto their cultural identity more than younger Hmong (Bliatout et al., 1985; Lee & Green, 2010; Ng,

2008). Moreover, young Hmong are shedding or keeping up with their traditional Hmong identity while also developing their own identity and attitude that reflects the norm of the host country (Berry, 1980; Ghuman, 1997; Padilla, 1980; Phinney, 1990; Westermeyer, 1989). Due to the small sample size, further research is needed to determine whether there are any variables that might affect the relationship between cultural identity (e.g., subgroup attitudes, levels of social/cultural collectivism) and age.

With regards to treatment and knowledge in mental health issues and interests, the finding was consistent across the survey. There were 49 (81.7%) participants who have indicated they have not sought out psychological consultation for support and services; however, 11 (18.3%) have indicated that they have had at least sought out the support or services of a licensed mental health professional in the past, such as a psychiatrist, psychologist, or counselor. Of the people who reported that they have sought out psychological support and services, only 3 (5.0%) have indicated they have experienced both anxiety and depression while 1 (1.7%) has experienced anxiety. The rest of the participants have indicated no mental health issues or experience with a psychological disorder in the past or at the time of completing the survey. Compared to the public, the most popular reasons for Americans who sought therapy were mild depression followed by marriage problems, child rearing issues, and difficulty in interpersonal relationships (Murstein & Fontaine, 1993). Other researchers found that, typically, many Asian Americans will generally seek professional psychological services only for dangerous, disruptive, or psychotic behaviors (Moon & Tashima, 1982) but not because of typical personal issues or general emotional distress (Tracey, Leon, & Glidden, 1985). This small sample suggested that the Hmong in this study preferred God as a source of psychological support which reflects the general Hmong population's strong history related to the Christian belief system

(Duffy et al., 2004). This trend is followed by a preference toward seeking a counselor, a traditional medical doctor, and a psychologist, respectively for support. Compared to the general population, psychologists were viewed as clearly preferred for mental health problems over psychiatrists followed by being almost as comfortable with physicians. Clergy was seen as eliciting significantly less comfortableness compared to psychologists (Murstein & Fontaine, 1993).

There is no way to know whether the Hmong in this sample have adequate knowledge that would allow them to make an informed decision when answering the questions related to the differences between the three professions (e.g., psychiatry, psychologist, and counseling) because the professions often share similar therapeutic techniques and treatment modality. Possessing general knowledge in seeking professional services may prove to be less of a barrier and increase the likelihood of seeking professional services than those with less knowledge which may hinder their willingness to seek professional services. If people suffering from mental health illness are to receive available evidence-based health care treatments and benefits, they may need some knowledge about the extent of what is known to work, including having some agreement of beliefs with mental health professionals. Although the research sampling was from church-goers, the current finding seems to be consistent with previous study by Chung and Lin (1994) that the Hmong reported being less likely to seek Western treatment for mental health issues compared to other non-Hmong groups. Hmong who presented with prolonged mental health symptoms were unlikely to seek Western treatment due to lack of knowledge concerning mental health treatments (Westermeyer, 1988). A previous study found that very few Hmong respondents knew of any Hmong who had previously been treated by a mental health professional or a psychiatrist. Most indicated that Hmong, in general, would not seek the services of a mental health professional for

psychological treatment unless the symptoms were deemed extremely severe (Collier, Munger & Moua, 2012).

### **Limitations**

Although there are some implications present in the current study, there are limitations which should also be addressed. One of the more apparent limitations of the present study is that the participants were drawn from a small church-goer sample which indicated a strong bias toward seeking God's healing over seeking professional psychological services or in Hmong traditional beliefs and practices. Future studies seeking to understand barriers to seeking professional psychological services, while also comparing Hmong traditional beliefs and practices, should conduct research using participants from the general Hmong population to increase sampling size and generalizability of findings. The low rate of return and somewhat small number of participants also limits attempts at generalization. Moreover, the current study cannot be generalized to the general Hmong population because the study only sampled the Hmong who were born in the U.S., who have lived in the U.S. for at least 40 or more years, and who live in one geographic region. Future studies could investigate whether participants' length of stay in the U.S. has any link to mental health status, the presence of psychological disorders, their willingness to seek professional psychological services, and their willingness to seek Hmong traditional beliefs and practices.

A more salient limitation in the current study could be related to language as a barrier for many Hmong Americans because this study assessed for culturally-related information. The on-line and paper format questionnaires were both written in the English language and many Hmong, particularly older Hmong, may have difficulties with understanding and comprehension using basic English language proficiency. The issue would be that these individuals might refrain

from participation and affect the sample. Moreover, because the Hmong language has limited vocabularies to describe and express mental health concepts and concerns, it is speculated that language barriers may have played a role in the effectiveness of the participants' approach and response to the questionnaire in the current study. It may be important for future research to include additional questionnaires as options that have been translated into the Hmong written language for Hmong who demonstrate limited English reading proficiency.

Finally, the use of self-reporting questionnaires to collect scientific data may pose potential problems in this study because it presents some limitations, and is susceptible to biases, including self-deceptive answers that may prevent participants from accurately responding to a question. For example, a participant may be biased towards responding yes to personal experiences, which happened only once, or they may answer a question conservatively because the experience has happened regularly. Moreover, participants may have varying degrees of understanding or interpretation of some questions which may make it difficult to ensure that all participants who completed the survey interpreted the questions in the same way, including the rating of the scales. For example, two people with the same opinion may have rated the scale points differently (e.g., 8 instead of 10). Additionally, on-line questionnaire distribution sites, such as Survey Gizmo, may allow for greater data collection and with ease, but there are problems with controlling for multiple responses in the same questionnaire by the same person. Among this and other biases, it is worth bearing in mind that the issues with self-reporting may impact the validity of the findings, potentially causing a halo effect, and the conclusions that have been drawn.



Appendix A

**Hmong Traditional Beliefs and Practices (HTBP) scale**

**Please rate the following questions that best reflect your own attitudes regarding Hmong traditional beliefs and practices compared to mental health professionals. Choose the number which tells how much you agree or disagree.**

Scale of Responses:

(1) Disagreement	(2) Probable Disagreement
(3) Probable Agreement	(4) Agreement

1.) I attend church regularly (either Hmong or American).

1                      2                      3                      4

2.) I go to see a Hmong Shaman regularly.

1                      2                      3                      4

3.) On average, I have a basic knowledge of what a Hmong Shaman does.

1                      2                      3                      4

4.) On average, I have a basic knowledge of what a psychologist or a mental health professional does.

1                      2                      3                      4

5.) On average, I have a basic knowledge of what a mental health problem or a psychological problem is.

1                      2                      3                      4

6.) I believe a Hmong Shaman would be better at helping me deal with my mental health or psychological problem(s) than a mental health professional.

1                      2                      3                      4



15.) I have consulted with or sought the services of a license mental health professional, such as a psychiatrist, psychologist, or counselor.

- 1.) No      2.) Yes

16.) I have consulted with or sought the services of a Hmong Shaman.

- 1.) No      2.) Yes

17.) When I have a mental health or psychological problem(s), I prefer to seek help from a  
(Choose ONE of the following options)

- 1.) Hmong Shaman      2.) God      3.) Spiritual being      4.) Psychologist  
5.) Psychiatrist      4.) Counselor      5.) Medical doctor  
6.) None of the above      7.) Other\_\_\_\_\_

## References Cited

- Atkinson, D. R., & Gim, R. H. (1989). Asian American cultural identity and attitudes toward mental health services. *Journal of Counseling Psychology, 36*(2), 209-212.
- Bahrassa, N. F., Juan, M. J. D., & Lee, R. M. (2012). Hmong American sons and daughters: Exploring mechanisms of parent-child acculturation conflicts. *Asian American Journal of Psychology, 4*(2), 100-108.
- Berry, J. W. (1980). Acculturation as varieties of adaptation. In A. Padilla (Ed.), *Acculturation: Theory, models, and some new findings*. Boulder, CO: Westview.
- Berry, J. W. (1988). Acculturation and adaptation: A conceptual review. In J. W. Berry & R. C. Annis (Eds.), *Ethnic psychology: Research and practice with immigrants, refugees, native people, ethnic groups, and sojourners. Selected papers from a North American Regional Conference of the International Association for Cross-Cultural Psychology* (pp. 41-52). Berwyn, PA: Swets & Zeitlinger Publishing Service.
- Berry, J. W. (2003). Advances in theory and measurement: Conceptual approaches to acculturation. In K. M. Chun, P. B. Organista, & G. Marin (Eds.), *Acculturation: Advances in theory, measurement, and applied research*. Washington, DC: APA.
- Bliatout, B. T., Bliatout, H. Y., & Schools, P. P. (1985). Mental health and prevention activities targeted to Southeast Asian refugees. *DOCUMENT RESUME ED 266 199 UD 024 683, 85*, 190.
- Bosher, S. (1995). Acculturation, ethnicity, and second language acquisition: A study of Hmong students at the postsecondary level. *Unpublished doctoral dissertation, University of Minnesota, Minneapolis*.
- Bosher, S. (1997). Language and cultural identity: A study of Hmong students at the

- postsecondary level. *Tesol Quarterly*, 31(3), 593-603.
- Cha, D. (2003). *Hmong American concepts of health, healing, and conventional medicine*. New York: Routledge Press.
- Chan, S. (1994). *Hmong means free: Life in Laos and America*. Philadelphia: Temple University Press.
- Chung, R. H. C.-Y., & Lin, K.-M. (1994). Help-seeking behavior among Southeast Asian refugees. *Journal of Community Psychology*, 22, 109-120.
- Collier, A. F., Munger, M., & Moua, Y. K. (2012). Hmong mental health needs assessment: A community-based partnership in a small mid-western community. *American Journal of Community Psychology*, 49(1-2), 73-86).
- Cooper, R. G. (1998). *The Hmong: A guide to traditional lifestyles (vanishing cultures of the world)*. Malaysia, Singapore: Times Editions.
- Culhane-Pera, K. A., Her, C., & Her, B. (2007). We are out of balance here: A Hmong cultural model of diabetes. *Journal of Immigrant and Minority Health*, 9(3), 179-190.
- Danner, C., Robinson, B., Striepe, M., & Rhodes, P. (2007). Running from the demon: Culturally specific group therapy for depressed Hmong women in a family medicine residency clinic. *Women and Therapy*, 30(1/2), 151-176.
- Desan, C. (1983). A change of faith for Hmong refugees. *Cultural Survival*, Cambridge, MA.
- Duffy, J. M. (2007). *Writing from these roots: Literacy in a Hmong-American community*. Honolulu: University of Hawaii Press.
- Duffy, J. M., Harmon, R., Ranard, D. A., Thao, B., & Yang, K. (2004). The Hmong: An introduction to their history and culture. *Culture Profile*, 18. Washington, DC: Center for Applied Linguistic.

- Fadiman, A. (1998). *The spirit catches you and you fall down: A Hmong child, her American doctors, and the collision of two cultures*. New York: Farrar, Straus and Giroux.
- Fang, B.K. (1998). Acculturation as a predictor of attitudes toward seeking professional psychological help in the Hmong community. Doctoral Dissertation, California School of Professional Psychology, Fresno, CA.
- Fisher, E. H., & Turner, J. LeB. (1970). Orientation to seeking professional help: Development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology*, 35(1), 79-90.
- Ghuman, P. A. S. (1997). Assimilation or integration? A study of Asian adolescents. *Educational Research*, 39, 23-36.
- Gordon, M. (1964). *Assimilation in American Life: The role of race, religion, and national origins*. New York, NY: Oxford University Press.
- Hamilton-Merritt, J. (1980). "Gas warfare in Laos: Communism's drive to annihilate a people." *Reader's Digest*, 81-88.
- Hamilton-Merritt, J. (1993). *Tragic Mountains: The Hmong, the Americans, and the Secret Wars for Laos, 1942-1992*. Indiana University Press.
- Herskovits, M. J. (1948). *Man and his works: The science of cultural anthropology*. New York: Knopf.
- Hirayama, K. K., & Hirayama, H. (1988). Stress, social supports, and adaptational patterns in Hmong refugee families. *Amerasia Journal*, 14(1), 93-108.
- Johnson, K. S. (2002). Hmong health beliefs and experiences in the western health care system. *Journal of Transcultural Nursing*, 13(2), 126-132.
- Kim, B. S. K. (2007). Acculturation and enculturation. In: Leong FTL, Inman AG, Ebreo A,

- Yang L, Kinoshita L, Fu M. (Eds.) *Handbook of Asian American Psychology*, 2<sup>nd</sup> ed. Thousand Oaks, CA: Sage, pp. 141-158.
- Kim, B. S. K., & Omizo, M. M. (2005). Asian and European American cultural values, collective self-esteem, acculturative stress, cognitive flexibility, and general self-efficacy among Asian American college students. *Journal of Counseling Psychology*, 52(3), 412-419.
- Kim, S. C., Chu, K. H., & Lee, S. (1987). Focus on Korean-American teens. *COTESOL Newsletter*, 10, 3-4.
- Kroll, J., Habenicht, M., Mackenzie, T., Yang, M., Chan, S., Vang, T., Nguyen, T., Ly, M., Phommasouvanh, B., & Nguyen, H. (1989). Depression and posttraumatic stress disorder in Southeast Asian refugees. *American Journal of Psychiatry*, 146(12), 1592-1597.
- Kwak, N., & Radler, B. (2002). A comparison between mail and web surveys: response pattern, respondent profile, and Data quality. *Journal of Official Statistics*, 18(2), 257-273.
- Lee, G. Y. (1990). *Refugee from Laos: Historical Background and Causes*. Retrieved from <http://www.hmongnet.org/hmong-au/refugee.htm>.
- Lee, G. Y., Tapp, N. (2010). *Culture and customs of the Hmong*. Santa Barbara, California: Greenwood.
- Lee, H. Y., Lytel, K., Yang, P. N., & Lum, T. (2010). Mental health literacy in Hmong and Cambodian elderly refugees: A barrier to understanding, recognizing and responding to depression. *Int'l. J. Aging and Human Development*, 71(4), 323-344.
- Lee, J. K., & Green, K. (2010). Acculturation processes of Hmong in Eastern Wisconsin. *Hmong Studies Journal*, 11, 1-21.
- Lee, S. E. (2013). Mental health of Hmong Americans: A metesynthesis of academic journal article findings. *Hmong Studies Journal*, 14, 1-31.

- Lee, S., & Chang, J. (2012b). Revisiting 37 years later: A brief summary of existing sources related to Hmong and their mental health status. *Hmong Studies Journal*, 13(2), 1-13.
- Lindsey, J. (2002). *The Hmong People in the U.S.* Retrieved from [http://www.jefflindsay.com/Hmong\\_tragedy.html](http://www.jefflindsay.com/Hmong_tragedy.html).
- Livo, N. J., & Cha, D. (1991). *Folk stories of the Hmong: Peoples of Laos, Thailand, and Vietnam*. Westport, Connecticut: Libraries Unlimited.
- Lor, N. P. & Chu, M. M. (2002). Hmong parents' perceptions of their youths' delinquency. - *Journal of Social Work Research and Evaluation*, 3, 47-60.
- Miller, M. J. (2007). A bilinear multidimensional measurement model of Asian American acculturation and enculturation: Implications for counseling interventions. *Journal of Counseling Psychology*, 54(2), 118-131.
- Miller, M. J. (2010). Testing a bilinear domain-specific model of acculturation and enculturation across generational status. *Journal of Counseling Psychology*, 57(2), 179-186.
- Miller, M. J., Yang, M., Hui, K., Choi, N., & Lim, R. H. (2011). Acculturation, enculturation, and Asian American college students' mental health and attitudes toward seeking professional psychology help. *Journal of Counseling Psychology*, 58(3), 346-357.
- Moon, A., & Tashima, N. (1982). *Help-seeking behavior and attitudes of Southeast Asian refugees*. San Francisco: *Pacific Asian Mental Health Research Project*.
- Moore, D. L., & Tarnai, J. (2002). Evaluating nonresponse error in mail surveys. In R. M. Groves, D. A. Dillman, J. L. Eltinge, & R. J. A. Little (Eds.) *Survey nonresponse* (pp. 197-211). New York: John Wiley & Sons.
- Mouanoutoua, V., & Brown, L. G. (1995). Hopkins symptom checklist-25, Hmong version: A



- screening instrument for psychological distress. *Journal of Personality Assessment*, 64(2), 376-383.
- Mouanoutoua, V., Brown, L. G., Cappelletty, G. G., & Levine, R. V. (1991). A Hmong adaptation of the Beck Depression Inventory. *Journal of Personality Assessment*, 57(2), 309-322.
- Murstein, B. I., & Fontaine, P. A. (1993). The public's knowledge about psychologists and other mental health professionals. *American Psychologist*, 48(7), 839-845.
- Ng, F. (2008). *From Laos to America: The Hmong community in the United States*. In Huping Ling (Ed.), *Emerging Voices: Experiences of Underrepresented Asian Americans* (pp. 17-33). New Brunswick, NJ: Rutgers University.
- Padilla, A. M. (1980). The role of cultural awareness and ethnic loyalty in acculturation. In A. Padilla (Ed.), *Acculturation: Theory, models, and some new findings*. Boulder, CO: Westview.
- Pfeifer, M. (2008). Hmong Alone population or in any Combination: Estimates from the 2008 American Community Survey. Retrieved on January 7, 2010 from [www.hmongstudies.org/2008SEAAmericanCommunitySurvey.html](http://www.hmongstudies.org/2008SEAAmericanCommunitySurvey.html).
- Pfeifer, M., Sullivan, J., Yang, K., & Yang, W. (2012). Hmong population and demographic trends in the 2010 Census and 2010 American Community Survey. *Hmong Studies Journal* 13(2), 1-31.
- Phinney, J. S. (1990). Ethnic identity in adolescents and adults: Review of research. *Psychological Bulletin*, 108, 499-514.
- Porter, S. R., & Whitcomb, M. E. (2005). Non-response in student surveys: The role of

- demographics, engagement and personality. *Research in Higher Education*, 46(2), 127-152.
- Rairdan, B., & Higgs, Z. R. (1992). When your patient is a Hmong refugee. *American Journal of Nursing*, 52(3), 52-55.
- Redfield, R., Linton, R., & Herskovits, M. J. (1936). Memorandum for the study of acculturation. *American Anthropologist*, 56, 973-1002.
- Regier, D. A., Hirschfeld, R. M. A., Goodwin, F. K., et al. (1988). The NIMH depression awareness, recognition, and treatment program: Structure, aims, and scientific basis. *American Journal of Psychiatry*, 145, 1351-1357.
- Rick, K., & Forward, J. (1992). Acculturation and perceived intergenerational differences among Hmong youth. *Journal of Cross-Cultural Psychology*, 23, 85-94.
- Schwartz, S. J., Montgomery, M. J., & Briones, E. (2006). The role of identity in acculturation among immigrant people: Theoretical propositions, empirical questions, and applied recommendations. *Human Development*, 49, 1-30.
- Tata, S. P., & Leong, F. T. L. (1994). Individualism-collectivism, social-network orientation, and acculturation as predictors of attitudes toward seeking professional psychological help among Chinese-Americans. *Journal of Counseling Psychology*, 41(3), 280-287.
- Tatman, A. W. (2001). Hmong perceptions of disability: Implications for vocational rehabilitation counselors. *Journal of Applied Rehabilitation Counseling*, 32(3), 22-27.
- Tracey, T. J., Leong, F. T. L., & Glidden, C. (1985). Help-seeking and problem perception among Asian Americans. *Journal of Counseling Psychology*, 33(3), 331-336.
- Tsai, J. L., Ying, Y., & Lee, P. A. (2001). Cultural predictors of self-esteem: A study of Chinese

- American female and male young adults. *Cultural Diversity & Ethnic Minority Psychology*, 7(3), 284-297.
- Tung, T. M. (1985). Psychiatric care for Southeast Asians: How different is different? In T. Owan (ed.), *Southeast Asian mental health: Treatment, prevention, services, training, and research* (pp. 5-40). Washington, D.C: U.S. Department of Health and Human Services.
- Underwood, D., Kim, H., & Matier, M. (2000). To mail or to Web: Comparisons of survey response rates and respondent characteristics. Paper presented at the 40th Annual Forum of the Association for Institutional Research, Cincinnati, OH, May 21–24, 2000.
- U.S. Census Bureau (2010). 2017 American Community Survey 1-Year Estimates. Category of Hmong Alone or in any Combination. Retrieved October 28, 2018 from <http://factfinder.census.gov>.
- Westermeyer, J. (1986). Two self-rating scales for depression in Hmong refugees: Assessment in clinical and non-clinical samples. *Journal of Psychiatric Research*, 20(2), 103–113.
- Westermeyer, J. (1987). Prevention of mental disorder among Hmong refugees in the U.S.: Lessons from the period 1976-1986. *Social Science and Medicine*, 25, 941-947.
- Westermeyer, J. (1988). A matched pairs study of depression among Hmong refugees with particular reference to predisposing factors and treatment outcome. *Social Psychiatry and Psychiatry Epidemiology*, 23, 64-71.
- Westermeyer, J. (1988). DSM-III psychiatric disorders among Hmong refugees in the United States: A point prevalence study. *American Journal of Psychiatry*, 145, 197-202.
- Westermeyer, J. (1989). Paranoid symptoms and disorders among 100 Hmong refugees: A longitudinal study. *Acta Psychiatrica Scandinavica*, 80, 47-59.
- Westermeyer, J., Neider, J., & Callies, A. (1989). Psychosocial adjustment of Hmong

- refugees during their first decade in the United States: A longitudinal study. *Journal of Nervous and Mental Disease*, 177, 132-139.
- Westermeyer, J., Bouafuely, M., Neider, J., & Callies, A. (1989). Somatization among refugees: An epidemiologic study. *Psychosomatics: Journal of Consultation Liaison Psychiatry*, 30(1), 34-43.
- Westermeyer, J., Schaberg, L., & Nugent, S. (1995). Anxiety symptoms in Hmong refugees 1.5 years after migration. *Journal of Nervous and Mental Disease*, 183(5), 342-344.
- Westermeyer, J., & Uecker, J. (1997). Predictors of hostility in a group of relocated refugees. *Cultural Diversity and Ethnic Minority Psychology*, 3(1), 53-60.
- Williams, C. L., & Westermeyer, J. (1983). Psychiatric problems among SEA refugees: A descriptive study. *The Journal of Nervous and Mental Disease*, 171, 79-85.
- Xiong, M., & Jesilow, P. (2007). Constructing a social problem: Suicide, acculturation, and the Hmong. *Hmong Studies Journal*, 8, 1-34.
- Xiong, Z. B., Detzner, D. F., & Rettig, K. D. (2001). Southeast Asian immigrants' perceptions of good adolescents and good parents. *Journal of Psychology*, 139(2), 159-175.
- Xiong, Z. B., Rettig, K. D., & Tuicomepee, A. (2008). Differences in nonshared individual, school, and family variables between delinquent and nondelinquent Hmong adolescents. *The Journal of Psychology*, 142(4), 337-55. Retrieved from <https://search.proquest.com/docview/213825542?accountid=28018>.
- Ying, Y. W., & Akutsu, P. D. (1997). Psychological adjustment of Southeast Asian refugees: The contribution of sense of coherence. *Journal of Community Psychology*, 25(2), 125-139.
- Ying, Y. W., Akutsu, P. D., Zhang, X., & Huang, L. N. (1997). Psychological dysfunction in

Southeast Asian refugees as mediated by sense of coherence. *American Journal of Community Psychology*, 25(6), 839–859.

Ying, Y. W., & Miller, L. S. (1992). Help-seeking behavior and attitudes of Chinese Americans regarding psychological problems. *American Journal of Community Psychology*, 20(4), 549-556.

### **Author Bios**

**Ethan Teng Xiong** is currently a clinical psychology doctoral student at the University of Detroit-Mercy located in Michigan. He hopes to advocate for and shape mental healthcare and service policy that pertains to the Hmong Americans at all levels of government in the future. Among many mental health research interests, he is especially interested in understanding the current mental health status of the Hmong people, particularly those residing in the United States. He hopes to continue to conduct research that focuses on barriers to mental health utilization, mental health disparities, and attitudes and behaviors toward seeking mental healthcare and services that may benefit the Hmong community and community at large. Aside from interest in research, Ethan also hopes to teach at a university level as well as to provide public and private mental health care and services upon completing doctorate and post-doctorate work in clinical psychology.

**Dr. Carol Cronin Weisfeld** is Professor of Psychology at the University of Detroit Mercy, in Detroit, Michigan, U.S.A., where she has taught for 40 years. Her courses for undergrads and graduate students have covered several areas: Developmental Psychology, Cross-cultural Psychology, Human Sexuality, Sex Differences and Sex Roles, and Health Psychology. Her research interests include sex differences across the lifespan, and mate selection and retention, particularly as seen through an evolutionary and ethological lens. She is co-editor of the book, *The Psychology of Marriage: An Evolutionary and Cross-cultural View*.

**Barry Dauphin, PhD, ABPP** is a Professor of Psychology and Director of Clinical Training at the University of Detroit Mercy PhD Clinical Psychology Program. He is president of the Society for Psychoanalysis and Psychoanalytic Psychology (Division 39/APA). Dr. Dauphin has a variety of research interests including information processing, cognition and personality, affect, attachment and object relations, video-gaming and personality, psychological assessment, professional education, psychoanalytic theory, American culture, therapy work with under-served populations, and clinical judgment. He is the author of *Tantalizing Times: Excitements, Disconnects and Discontents in Contemporary American Society* (2006; Peter Lang Publishing).