

**Does Acculturation and Stigma Affect Hmong Women's Attitudes  
Toward and Willingness to Seek Counseling Services?**

By

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**Abstract**

Although the Hmong have resided in the United States since the 1970s, there has been limited research exploring the effect of acculturation and stigma on the Hmong community and their perspective of mental health services. This study investigated the relationship between Hmong women's level of acculturation, perception of stigma, and the expression of attitudes toward professional psychological help and willingness to see a counselor. The 222 Hmong women completed a Demographic Questionnaire Form (DQF), the Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA), then the Stigma for Receiving Psychological Help (SSRPH), the Attitudes Toward Seeking Professional Psychological Help-Short Form (SSRPH-SF), and finally, the Willingness to See a Counselor questionnaire (WSC). Almost 86% of the Hmong women were between 18 and 35 years old, and 96.4% lived in the United States for 20 or more years and almost 53% practice Shamanism. Data analysis of the research hypotheses found that there was a weak positive significant correlation between acculturation and willingness to seek services. Additionally, the relationship between acculturation and attitudes toward counseling services, expression of attitudes and perception of stigma was statistically significant. However, the relationships between the other study variables: perception of stigma and acculturation, expression of attitudes and acculturation, and acculturation and willingness were not statistically significant. The findings of this study will enhance our understanding of Hmong women and their views of counseling.

**Keywords: Hmong women, mental health, counseling, acculturation**

## **Introduction**

There is existing literature describing how Asian Americans' acculturation status and view of stigma affect these individuals' willingness and attitudes towards seeking counseling services, but there is limited literature that focuses specifically on Hmong women's level of acculturation and views of stigma that may affect their willingness and attitudes towards seeking counseling services (Atkinson et al., 1989; Choi & Miller, 2014; Hamid et al., 2009; Nguyen et al., 2005). Most studies tend to focus on other Asian groups, including Chinese, Vietnamese, Japanese, and Indonesian individuals (Hamid, et al., 2009; Gim et al., 1990; Kim et al., 2003; Soorkia et al., 2011); additionally, the studies focus on Asian individuals' willingness and attitude towards seeking counseling services because of either their level of acculturation and/or level of stigma (Hamid, et al., 2009; Soorkia, et al., 2011; Vogel, et al., 2007).

According to the United States (U.S.) Census Bureau (2012), the Hmong population in 2010 was 260,073, which significantly increased from the Hmong population of 170,049 in 2000 (U.S. Census Bureau, 2004). As the Hmong population in the United States grows, it becomes more important to enhance our understanding of their perception and attitudes towards seeking counseling services. Providing mental health professionals a better understanding of Hmong women's perception and attitudes towards counseling services may improve their ability to work therapeutically with this population.

## **Hmong History**

Hmong history can be traced back to China (Quincy, 1995). The Hmong migrated into northern Vietnam because of the massacres at Chengkiang, when soldiers attacked Hmong villages, and slaughtered men, women and children even though the Hmong had already begun to leave the region. In the late 1740s, the Hmong settled in two locations, the Dong Quan and

Hoang-Su-Phi. Eventually, there was an influx of Hmong entering Vietnam as they began to move west of Dong Van into the northern tip of Fan Si Pan mountain range. As the Hmong resided in Vietnam, they built their lives in the mountainous areas, but once the United States entered into the Vietnam War, their lives took a different route (Quincy, 1995).

During the Vietnam War, the United States Central Intelligence Agency (CIA) recruited thousands of Hmong men to assist their military in opposing the Pathet Laos and Northern Communist Vietnamese (Cobb, 2010; Kaiser, 2003). When the United States withdrew from the Vietnam War, however, Hmong families were left to fend for themselves and the North Vietnamese and [the Pathet Lao] Lao Communities began to retaliate against the Hmong, and they became "targets of genocide" (Livo & Cha, 1991). Because of this, many Hmong families fled to Laos and Thailand where they were placed in refugee camps (Cha, 2010; Cobb, 2010; Kaiser, 2003; Quincy, 1995; Wang, 2005). Unfortunately, many family members died while trying to flee to Laos and Thailand (Meredith & Rowe, 1986). Although they escaped the genocide and had a place to live, the Hmong were attacked, victimized, and experienced mistreatment by the Thai (Quincy, 1995).

Because the Hmong supported the U.S. during the Vietnam War, the U.S. government sanctioned a "scattered policy" of resettlement for the Indochinese refugees from 1975-1980 (Miyares, 1998; Westermeyer, 1987). Hmong families were granted entry into the U.S., but these families were scattered to different parts of the U.S. as the United States' government wanted to stimulate acculturation for the Hmong community (Miyares, 1998). The policy limited the number of family members who could immigrate to the U.S. to eight and while sending them to various points around the country (Tatman, 2004). This policy affected Hmong individuals who valued and cherished the Hmong family and clan system (Tatman, 2004).

## **Hmong Generation and Acculturation**

Acculturation has been described as a process an individual experiences by giving up traditional cultural values and behaviors while taking on the values and cultures of the dominant social structure, in this case the American culture (Suinn, Rickard-Figueroa, Lew, & Vigil, 1987). Depending on the individual's level of acculturation, they will either hold onto their beliefs, values, and practices or they will discard them. Although the Hmong have resided in the United States for over 40 years, they still hold onto their traditional values, beliefs, and practices, which can prevent them from seeking mental health professionals' assistance (Pfeifer & Lee, 2005). Pfeifer and Lee (2005) estimated that 70% of Hmong Americans retained their traditional beliefs. Franzen-Castle and Smith (2013) reported that the process of "Americanization" for adolescents was associated with a decreased use and loss of the Hmong language.

Min and Kim (2002) postulated four generational categories of Hmong: (1) first generation immigrants and refugees were born and raised in Laos and immigrated to the United States after the age of 12; (2) one-and-one-half generation immigrants and refugees who were born in Laos and arrived in the United States between the ages of two and 12; (3) second generation immigrants were born and raised in the United States; and (4) a third generation were born to parents who are second generation immigrants. Pa Der Vang (2014) found a difference in perception and acceptance towards Western treatment modalities between first and second generations.

## **Hmong Shamanism**

A traditional Hmong belief is that when family members become physically or mentally ill, the reason the family member is ill is because of a wandering soul (Quincy, 1995). The family members ask a "txiv neeg," which is the Hmong word for shaman, a spiritual healer

within the Hmong community, to perform spiritual rituals. The “txiv neeg” consults his “dab neeb” or neng spirits, and food are offered to attract the spirits. The “txiv neeg” uses his tools to guide him in the process, and determines if the “dab neeg” is able to help effect a cure. If the “txiv neeg” needs to retrieve a soul, the process is physically demanding because the “txiv neeg” calls and assembles his helper spirits to retrieve the soul. The “txiv neeg” waits for his spirits to arrive before he begins the journey into the spirit world. Once they arrive, he places a black veil over his face, signaling to the outside support that the spirits have arrived for the journey. Once the “txiv neeg” enters the spirit world, he has assistants support him if he loses his physical balance or falls during the journey. The “txiv neeg” jumps on and off a bench as if riding a horse and once he finds the lost soul, the “txiv neeg” guides and brings the soul back home to the individual who is ill. Once the lost soul crosses over into the world of the man with the “txiv neeg,” the process of the “txiv neeg” is complete and the shaman emerges from the trance. The “txiv neeg” is often tired from the journey to retrieve a lost soul. Because the Hmong believe that a “txiv neeg” is able to cure illness, the Hmong have traditionally trusted this method of healing rather than seeking Western counseling methods.

### **The Clan System**

Another traditional belief in the Hmong community involves the clan system. Between 18 and 25 clans exist within the Hmong community, which is identified by last names (Vang & Flores, 1999). The clan is comprised of individuals from the same clan and their extended families, and the admission to a clan is by birth, marriage, or adoption (Vang & Flores, 1999; Yang, 1992). Furthermore, individuals with the same clan last name are considered to be brothers and sisters of the same family. The heads of the clan system are male elders who are respected representatives that are selected to serve this role to resolve conflicts and problems that

occur in the home and within the community. In resolving problems internally, the clan male elders avoid the involvement of the legal and social justice system. The clan elder has the power and authority to communicate with other clan elders when there is conflict between different clans (Vang & Flores, 1999). Because of their traditional culture beliefs to not involve outsiders, Hmong families are more likely to involve clan elders when there are problems, concerns, or disputes within the home and/or community. Since the Hmong believe that clan elders can resolve their concerns, they are less likely to seek professional assistance, including counseling.

### **Mental Health in the Hmong Community**

Many Hmong are unfamiliar with the counseling process. They view the expression of emotions as a form of weakness, which is one reason that they will not seek counseling services (Tatman, 2004). Although the Hmong have a higher rate of mental health disorders compared to the Western population, they do not identify mental health professionals as possible resources to aid in their problems (Tatman, 2004; Westermeyer, 1988). Furthermore, they believe that a “txiv neeg,” who is part of the clan, provides results that heals and treats a family member's illness; a counselor is an outsider, who is not part of the family or clan, and cannot be trusted (Tatman, 2004).

The first documented comprehensive study on the Hmong and their mental health status was conducted by Joseph Westermeyer in 1986. Joseph Westermeyer, a psychiatrist, lived and worked extensively with the Hmong in Laos (Westermeyer, 1987). He began his work with the Hmong and followed 102 individuals who were less than 16 years of age from refugee camps to the US from 1977 to 1985. After the refugees resettled in the US, only 97 of the subjects continued in the study. A second comparative sample was recruited that was comprised of 51 Hmong mental health patients from the University Hospital of Minneapolis, Minnesota, from

1977 to 1982. These two groups had issues that were related to “downheartedness,” which was defined as low spirits, crying spells, decreased libido, bouts of fatigue, and suicidal ideation (Westermeyer, 1986). Depression is the most prevalent mental health diagnosis in Hmong Americans (Lee, 2013). Hmong women who married as teenagers reported higher depression in their adulthood compared to Hmong Americans who adopted western views that emphasize nurturing, adolescent development and identity, and educational attainment over early marriage (Vang and Bogenschutz, 2011). Furthermore, Hmong women who married in their teenage years reported lower educational attainment, lower income, marital abuse, and depressive symptoms; therefore, Hmong women who practiced and engaged in traditional cultural values that clashed with the dominant culture experienced higher rates of depression because of the incongruence of the two cultures (Pa Der Vang, 2014). In another study by Kroll, Habenicht, Mackenzie, and Yang (1989), 225 Hmong patients were sampled: 80.4% were seen for depression, 11.8% for posttraumatic stress disorder (PTSD), 3.5% for anxiety and somatoform disorders, 2.7% for psychoactive substance use disorder, 2.0% for organic mental disorder, 0.8% for schizophrenia, 0.4% for personality disorder, and only 11.8% did not have a psychiatric diagnosis.

One recent study by Collier, Munger, and Moua (2012) involved 28 individual interviews (men, women, adolescents, and professionals of Hmong descent) and four focus groups (Hmong-American Professionals, Women's Focus Group, Men's Focus Groups, and Youth Group) with a sample of 36 Hmong people from Eau Claire, Wisconsin. The participants mentioned various problems that affected them such as intergenerational communication difficulties, marital discord, domestic violence, and child abuse. In regards to issues related to mental illness, the participants were confused about the definition of mental illness, stigma associated with mental illness, psychiatric symptoms, elder status with mental well-being, developmental disabilities

along with general medical concerns, and additional issues related to well-being. The researchers did not provide specific information about the issues related to mental illness. The most pertinent information in regards to mental illness were the psychiatric symptoms, as the elderly male and female focus groups described symptoms that were associated with depression, anxiety (especially PTSD) and emotional isolation (Collier, Munger, & Moua, 2012). Furthermore, the participants described “forgetfulness, sleep difficulties, impaired concentration and ability to learn (i.e., English language), irritability, nightmares, helplessness and loss of control, suicidality, somatic preoccupation and health concerns, pain, and social isolation,” which overlapped with lack of social contact (Collier et al., 2012, p. 80).

When the Hmong seek help, they consult their family or clan leaders first. Nishio and Bilmes (1987) conducted a study on numerous Asian refugees, which included Hmong refugees, who would seek help for mental, emotional, social, and familial problems. The study found that Asian refugees did not recognize that mental health providers were a source for assistance for these problems. In particular, the Hmong participants in the study identified that family was their primary source for assistance in mental, emotional, social, and familial problems (Nishio & Bilmes, 1987). As a result, mental health providers are typically not viewed as important resources for problem resolution in the Hmong community.

The prevalence of mental health diagnoses in the Hmong community is a factor that should be considered when working with this population. The research literature provided on the mental health in the Hmong community offers an understanding of possible mental health disorders that are likely to occur, and some possible factors associated with the development of mental health disorders.

## **Methods**

### **Research Design**

This project, using quantitative methods, investigated whether the level of acculturation and level of stigma affect Hmong women's attitudes toward and willingness to seek counseling services. The researcher examined demographic variables of the participant's age, place of birth and the parent's place of birth, religion, and length of stay in the United States. The independent variables were levels of acculturation and the levels of stigma. The dependent variables were attitudes towards counseling services and willingness to seek counseling services. The research method that was used to analyze the data was a Pearson correlation and a Multivariate Analysis of Variance (MANOVA). In addition, depending on the research hypothesis, the researcher examined the relationship between the variables, using a one-tailed or two-tailed test of significance, with an alpha-level of 0.05.

### **Hypotheses**

The following three hypotheses were tested in this study.

1. Hmong women will display a positive relationship between acculturation and the expression of attitudes toward and willingness to seek counseling services.
2. Hmong women who display higher levels of acculturation and lower levels of stigma will have more positive attitudes and a greater willingness to seek counseling services than Hmong women who have lower levels of acculturation and higher levels of stigma.
3. Hmong women who display lower levels of acculturation and higher levels of stigma will have more negative attitudes and less willingness to seek counseling services than Hmong women who have higher levels of acculturation and lower levels of stigma.

## Measures

**Demographic Questionnaire Form (DQF).** The DQF was administered to all participants to gather their age, place of birth and the parent's place of birth, religion, and length of stay in the United States.

**Suinn-Lew Self-Identity Acculturation Scale (SL-ASIA).** The SL-ASIA was developed and modeled after the Acculturation Rating Scale for Mexican Americans (Cuellar, Harris, & Jasso, 1980). The SL-ASIA consists of 21 multiple-choice items that measures an individual's language preference, identity, friendship choice, behaviors, generation and geographic history (Suinn et al., 1987). Additionally, each item is rated on a scale of 1 (low acculturation) to 5 (high acculturation), and when all items are calculated, the generated total scores range from 21 to 105 (Suinn et al., 1987). The scale views acculturation as a "multifaceted phenomenon [that is comprised] of numerous dimensions, factors, constructs, or subcomponents (Cuellar, Harris, & Jasso, 1980, p. 209). An individual's "values, ideologies, beliefs, and attitudes appear to be important components of acculturation, [and their] cognitive and behavioral characteristics such as language, cultural customs, and practices [are relevant]" (Cuellar, Harris, & Jasso, 1980, p. 209). The SL-ASIA is significantly associated with "generational level, place of upbringing, and self-rating" (Suinn et al., 1987, p. 405).

The SL-ASIA has reliability that "was calculated using the alpha coefficient, which led to a coefficient of 0.88 on the 21 items, indicating an acceptable level of stability for the instrument" (Suinn et al., 1987, 403-4).

**Stigma Scale for Receiving Psychological Help (SSRPH).** This is a self-report measure that assesses an "individuals' perceptions of how stigmatizing it is to receive psychological treatment" (Komiya et al., 2000, p.139). "The SSRPH consists of five questions; each question

is rated from 0 (strongly disagree) to 3 (strongly agree), with higher scores indicating greater perception of stigma associated with receiving psychological help” (Komiya et al., 2000, p. 139).

The coefficient alpha for the SSRPH was 0.72, which indicates an acceptable level of internal consistency (Komiya et al., 2000). Support for the construct validity was correlated negatively with ATTSPH-SF ( $r = -0.40, p < 0.0001$ ), which indicates that the “less social stigma individuals perceived, the more positively they felt about seeking psychological help” (Komiya et al., 2000, p. 140).

#### **Attitudes Toward Seeking Professional Psychological Help-Scale Short Form**

**(ATSPPH-SF).** This 10-item self-report questionnaire assesses an individual's “attitudes regarding seeking help from mental health professionals in times of emotional crisis or distress” (Choi & Miller, 2014, p. 344). The short form uses the same response style as the original form, a four-point Likert-type scale (0 = “disagree” to 3 = “Agree,”), yet there were several “rewordings to represent contemporary terminology” (Elhai et al., 2008, p. 322; Fischer & Farina, 1995). The overall total score ranges from 0 to 30, with higher scores indicating more favorable treatment attitudes (Elhai et al., 2008; Fischer & Farina, 1995).

The short version has an internal consistency ranging from 0.82 to 0.84 (Constantine, 2002; Fischer & Farina, 1995; Komiya et al., 2000). There was a test-retest reliability of 0.80, and a correlation of 0.87 with the longer scale (Elhai et al., 2008; Fischer & Farina, 1995).

**Willingness to See a Counselor Measure (WSC).** This self-report questionnaire assesses an individual's willingness to see a counselor for 24 different problems. The individual rates the item from 1 (not willing) to 4 (willing) on how likely he or she would see a counselor for specific problems (Choi & Miller, 2014; Gim et al., 1990). Higher scores indicate a greater willingness to seek counseling services (Choi & Miller, 2014).

Kim and Omizo (2003) provided factor-analytic evidence for construct validity with, which they confirmed the hypothesized three-factor structure of personal, academic/career problems, and health problems of the WSC. There have been prior studies that involved the WSC that yielded internal consistency estimates that ranged from 0.92 to 0.93 among Asian American and Pacific Islander (AAPI) college students (Choi & Miller, 2014; Kim & Park, 2009; Kim & Omizo, 2003).

### **Sample Size Needed**

A moderate sample size for the four-group Multivariate of Analysis of (MANOVA) with an alpha level of 0.05 and confidence level of 0.80, was used which required a sample size of 200 for the two independent variables with four groups (i.e., level of acculturation: high and low; level of stigma: high and low) (Stevens, 2009). Thus, there were at least 100 in each group: acculturation and stigma. The total sample size that was needed to conduct this study was 200.

## **Results**

### **Participants**

Initially there were a total of 306 respondents living in the United States recruited for this study. Of the 306 participants, only 222 fully completed the survey that formed the basis for the data analysis. These 222 participants were categorized into one of three levels of the independent variable, acculturation: less acculturation, bicultural acculturation, and more acculturation based on how the participants responded to the SL-ASIA. This procedure resulted in 21 participants identified as less acculturation, 187 participants identified as bicultural acculturation, and 14 participants identified as more acculturation.

## Descriptive Statistics

The demographic data was collected using the 222 Hmong women. Almost 46% of the participants were between 18 and 25 years old and 41% were between 26 and 35 years old. The remaining 14% of the sample were 36 years and older. The vast majority of participants (96.4%) had lived in the United States for 20 or more years. The remaining 3.6% had lived in the U.S. for 6 to 15 years. Participants were asked about what religion they practiced. Over half (52.7%) of the participants practice Shamanism. Almost 24% reported they practiced Protestant Christian, 4.5% practice Catholicism and 5% practice some other unidentified religion. Interestingly, 14% reported that they did not practice a religion.

Table 1 shows the numbers (N) and percentages (%) of participant’s place of birth and parents’ place of birth. Almost two-thirds of the participants were born in the United States and both parents were not born in the United States (69.4%).

Table 1

*Participants’ Place of Birth and Participants’ Parents Place of Birth*

Participants Place of Birth and Parent’s Place of Birth	N	(%)
Born in Laos, Thailand, or Vietnam, and parents born in Laos, Thailand, or Vietnam	73	32.9
Born in the US, and both of parents not born in the US	144	64.9
Born in the US and both parents born in the US	2	0.90
Born in the US; one parent born in Laos, Thailand, or Vietnam, and other parent born in the US	3	1.4
Total	222	100

*Note:* There were a total of 222 female participants in this study.

## Hypothesis Testing.

**Hypothesis One.** Hypothesis 1 explored the relationship Hmong women displayed between acculturation and the expression of attitudes towards counseling services. Participants reported mean and standard deviation of acculturation scores ( $M = 2.95$ ,  $SD = 0.34$ ). The range of these scores were from 2 to 4. Higher scores indicate more acculturation to the dominant culture, the U.S. Participants also reported attitudes toward seeking psychological services ( $M = 18.14$ ,  $SD = 5.53$ ). These scores ranged from a 4 to 30 with a higher score indicated a more positive attitude towards receiving professional psychological help.

The hypothesis was tested using a one-tailed Pearson correlation with a test of significance set at  $p < .05$  to determine the statistical significance of the correlation. The results of the correlation between level of acculturation and attitudes  $r(220) = 0.09$ ,  $p > .05$ ,  $r^2 = 0.008$  was not statistically significant. Thus, Hmong women's level of acculturation was not related to their attitudes toward receiving professional psychological help.

To determine the mean and standard deviation, the participants' mean scores from acculturation and means of willingness to seek counseling services were used. For acculturation, participants' mean score was 2.95 ( $SD = 0.34$ ), with a range from 2 to 4. The higher the score indicated greater acculturation to the dominant culture, the U.S. In the willingness to see a counselor scale, the participants rated items from 1 (not willing) to 4 (willing), and higher scores indicated a greater willingness to seek counseling services. Hmong women's mean score was 2.58 ( $SD = 0.70$ ), with a range of scores from 24 to 96. The higher the score indicated more willingness to seek counseling services.

The hypothesis was tested using a one-tailed Pearson correlation with the test of significance set at  $p < .05$  to determine the statistical significance of the correlation. The results

of the correlation between acculturation and willingness are presented in Table 2. The analysis resulted in a statistically significant but weak positive correlation between level of acculturation and level of willingness  $r(220) = 0.11, p < .05, r^2 = 0.0121$ . In addition, approximately 1.2% of the variability in level of acculturation was accounted for by the individual’s level of willingness. Hence, Hmong women’s level of acculturation was related to their willingness to see a counselor as the higher their acculturation level, the more willing they were to seek counseling services.

Table 2  
*Correlation Matrix of Acculturation Levels and Level of Willingness*

Variable	1	2
1. Acculturation	---	
2. Willingness	0.04*	---

*Note:* Acculturation coded as: Less Acculturation = 2; Bicultural Acculturation = 3; More acculturation =4. Mean for Willingness was used.

\* $p < .05$

**Hypothesis two and three.** Hypothesis two explored whether Hmong women who display higher levels of acculturation and lower levels of stigma will have more positive attitudes and a greater willingness to seek counseling services than Hmong women who have lower levels of acculturation and higher levels of stigma. Hypothesis three examined if Hmong women who display lower levels of acculturation and higher levels of stigma will have more negative attitudes and less willingness to seek counseling services than Hmong women who have higher levels of acculturation and lower levels of stigma.

The mean and standard deviation of level of acculturation, perception of stigma, perception of attitudes toward, and perception of willingness to seek counseling services are shown in Table 3. Level of acculturation, perception of stigma, perception of attitudes toward, and perception of willingness were also correlated using bivariate Pearson correlation, as shown in Table 4. For the analysis, the less acculturation group was coded as 2, the bicultural acculturation group was coded as 3, and the more acculturation group was coded as 4. As for

stigma, less perception of stigma was coded as 1 and greater perception of stigma was coded as

2. For attitudes toward, negative attitudes were coded as 1 and positive attitudes were coded as

2. The mean of willingness was used.

Table 3

*Mean and Standard Deviation of Acculturation, Stigma, Attitudes Toward, and Willingness to Seek Counseling Services*

Variable	<i>M</i>	<i>SD</i>
Acculturation	2.97	0.40
Stigma	1.39	0.50
Attitudes	1.50	0.50
Willingness	2.58	0.70

*Note:* There were 222 female participants in the study. *M* = Means; *SD* = Standard Deviation

As can be seen in Table 4, the correlation between expression of attitudes and perception of stigma was statistically significant ( $p < .01$ ). In addition, there were significant negative relationships between perception of stigma for receiving psychological help and willingness to see a counselor ( $p < .05$ ), and the expression of attitudes and willingness to see a counselor ( $p < .05$ ). Hence, those who held less stigma toward counseling tended to have a greater willingness to see a counselor compared to those who had a greater perception of stigma for receiving psychological help. Additionally, those who had positive attitudes toward receiving psychological help tended to have greater willingness to see a counselor than those who had negative attitudes toward receiving psychological help.

Table 4

*Correlation Matrix of Acculturation, Stigma, Attitudes Toward, and Willingness to Seek Counseling Services*

Variable	1	2	3	4
1. Acculturation	—			
2. Stigma	-0.08	—		
3. Attitudes	0.08	-0.19**	—	
4. Willingness	0.05	-0.15*	0.37**	—

*Note:* Acculturation coded as: Less Acculturation = 2; Bicultural Acculturation = 3; More acculturation = 4. Stigma coded as: less perception of stigma = 1; greater perception of stigma = 2. Attitudes coded as: Negative Attitudes = 1; Positive Attitude = 2. Mean for Willingness was used.

\* $p < .05$ , two-tailed

\*\* $p < .01$ , two-tailed

To test hypotheses two and three, a multivariate analysis of variance (MANOVA) was used. The MANOVA tested whether the level of acculturation and level of stigma differed on their combined attitudes toward and willingness to seek counseling services. MANOVA was used instead of two univariate Analysis of Variance (ANOVA) to control for Type 1 error inflation. Level of acculturation and level of stigma were the between-subjects independent variable for this analysis. The levels of acculturation were: (a) less acculturation, (b) bicultural acculturation, and (c) more acculturation. The levels of stigma were: (a) lesser perception of stigma and (b) greater perception of stigma. The dependent variables were the participants' attitudes toward and willingness to seek counseling services. Wilks' Lambda and an alpha level of .05 were used to determine the statistical significance of the MANOVA.

If the multivariate analysis was statistically significant, it was planned to conduct Step Down analysis to test the specific hypothesis that (a) Hmong women who display higher levels of acculturation and lower levels of stigma will have more positive attitudes and a greater willingness to seek counseling services than Hmong women who have lower levels of acculturation and higher levels of stigma; and (b) Hmong women who display lower levels of acculturation and higher levels of stigma will have more negative attitudes and less willingness to seek counseling services than Hmong women who have higher levels of acculturation and lower levels of stigma. This was accomplished by first using univariate ANOVA of the primary dependent variable (attitudes toward and willingness), which was evaluated using a Bonferroni corrected alpha level of 0.025 (.05/2 outcome measures = 0.025). It was planned to continue the Step Down analysis by comparing attitudes toward and willingness (the secondary dependent variables) between the level of stigma after controlling for differences in participants' level of

acculturation. The purpose of this Step Down analysis was to determine whether those who had lesser perception of stigma or greater perception of stigma differed in their attitudes toward and willingness to seek counseling services, after removing level of acculturation.

### **Omnibus MANOVA**

The results of the MANOVA indicated acculturation level had no interaction on combined attitudes toward and willingness to seek counseling services, Wilks' Lambda = 0.98,  $F(4, 430) = 1.133, p = 0.341$ . In addition, there was no interaction between acculturation and the dependent variables (attitudes and willingness), Wilks' Lambda = 0.98,  $F(4, 430) = 0.97, p = 0.424$ . Also, there was no interaction between the independent variable, stigma, and the dependent variables (attitudes and willingness), Wilk's Lambda = 0.98,  $F(2, 215) = 1.39, p = 0.250$ . Based on the aforementioned information, there was no interaction or difference on the two independent variables: acculturation and stigma, and on the dependent variables: attitudes and willingness. Therefore, the next step was to conduct the planned Step Down Analysis.

### **Step Down Analysis**

The first step of the Step Down analysis was to determine if those whose level of acculturation differed on the primary dependent variables, attitudes toward and willingness to seek counseling services, using a two-way ANOVA. Results of this univariate ANOVA indicated that those who had lesser perception of stigma ( $M_{positiveattitudes} = 1.58$ ) had more positive attitudes than those who greater perception of stigma ( $M_{negativeattitudes} = 1.38$ ),  $F(1, 219) = 1.97, p < .05, \eta^2 = 0.04$ . In addition, the univariate ANOVA indicated that those with lesser perception of stigma ( $M_{greaterwillingness} = 2.6614$ ) had greater willingness to see a counselor than those who had greater perception of stigma ( $M_{lesserswillingness} = 2.4492$ ),  $F(1, 219) = 2.27, p < .05, \eta^2 = 0.02$ .

The next step of the Step Down analysis was to determine whether the level of stigma differed on attitudes toward and willingness to seek counseling services (the secondary outcome) after controlling for their differences in level of acculturation. This was accomplished by running a MANCOVA of level of stigma values with levels of acculturation values as the covariate. The between-subjects independent variable was again stigma with the following levels: (a) lesser perception of stigma and (b) greater perception of stigma. The dependent variables were attitudes toward and willingness to seek counseling services, and the covariate was acculturation. The results of the Step Down MANCOVA are shown in Table 5.

Acculturation was not found to account for a significant portion of the variability in the participants' attitudes toward and willingness to seek counseling services ( $p > .05$ ), as was suggested by the earlier not statistically significant bivariate correlation between negative and positive attitudes and lesser and greater willingness to seek counseling services. Hence, the covariate-adjusted for acculturation specific means ( $M_{positivattitudes} = 1.57$  and  $M_{negativeattitudes} = 1.38$ , respectively) were closer than were the raw acculturation means ( $M_{positiveattitudes} = 1.58$  and  $M_{negativeattitudes} = 1.38$ , respectively). Additionally, the covariate-adjusted for acculturation for specific means ( $M_{lesserwillingness} = 2.45$  and  $M_{greaterwillingness} = 2.66$ , respectively) were closer than were the raw acculturation means ( $M_{greaterwillingness} = 2.66$  and  $M_{lesserwillingness} = 2.44$ , respectively). The raw and covariate-adjusted stigma means are illustrated in Figure 1. After removing the variability in the levels of acculturation accounted for by stigma, those who had lesser perception or greater perception of stigma towards receiving psychological help were found to be significantly different in their attitudes toward receiving psychological help and their willingness to see a counselor ( $p < .05$ ). This finding supports the hypothesis that those Hmong women with lower levels of stigma will have more positive attitudes toward and a greater willingness to seek

counseling services. This finding also supports the third hypothesis that Hmong women with higher levels of stigma will have more negative attitudes toward and a less willingness to seek counseling services.

Table 5  
*Summary of Step Down MANCOVA Comparing Stigma for Attitudes Toward and Willingness to Seek Counseling Services after Adjusting for Participants’ Level of Acculturation*

Source of Variation	SS	Df	MS	F	$\eta^2$
Acculturation (covariate) (Attitudes)	0.24	1	0.24	0.97	
Acculturation (covariate) (Willingness)	0.17	1	0.17	0.35	
Stigma (IV) (Attitudes)	1.96	1	1.96	8.10*	0.04
Stigma (IV) (Willingness)	2.27	1	2.27	4.73*	0.02
Within Attitudes (error)	53.18	219	0.24		
Within Willingness (error)	105.26	219	0.48		
Total Attitudes (Corrected)	55.38	219			
Total Willingness (Corrected)	107.70	221			

\* $p < .05$

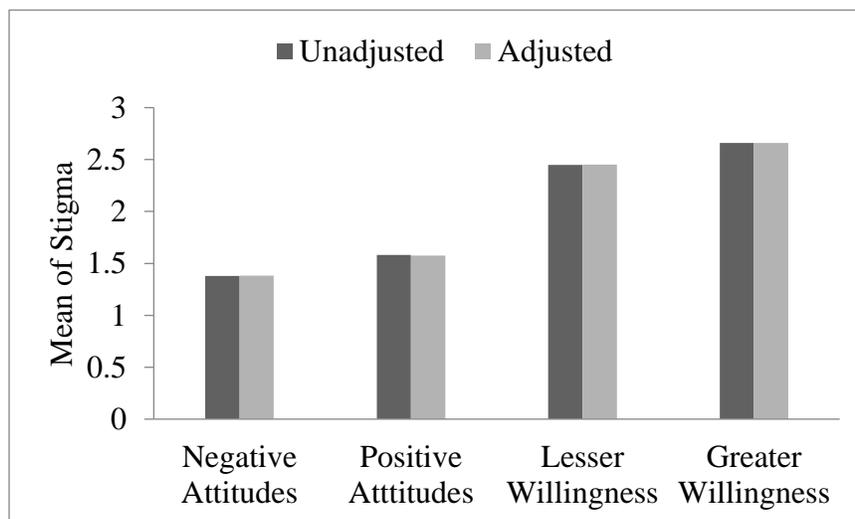


Figure 1. Raw and covariate-adjusted stigma means for those who have negative or positive attitudes and lesser or greater willingness.

## **Discussion**

As with all studies, this one had some limitations that require the results to be interpreted with caution. These limitations included years living in the U.S., the informants' place of birth and their parents' place of birth, relationships, the method to recruit participants as well as possible language barriers. The method of recruitment may have limited who was able to participate in this study. Because recruitment occurred over the internet, only those Hmong women who had access to and could effectively use a computer were able to. Thus perhaps Hmong women, who were older and more traditional and did not have computer skills, may not have had the ability to respond to the survey, thus there may have been a technological bias. It may be useful to develop a survey targeted for older Hmong women.

In addition, in order to participate in this study, Hmong women were required to read English. The questionnaires were not translated into the two Hmong dialects (White and Green). Thus, Hmong women who were more traditional or more recent immigrants to the U.S. and may not have learned to read English were not able to participate. These two factors may have influenced the results of this study by limiting who was able to participate.

In future research with Hmong women, it may be useful to provide the opportunity to translate the questionnaires from English to the two Hmong dialects. The fluency of the Hmong language is also an important consideration because there are varying levels of fluency in the Hmong community from none to native fluency in Hmong or English. In addition, if a potential respondent cannot read English or the Hmong language, then the questionnaires can be verbally

read to them. Thus, providing the questionnaires online and in person may enhance the breadth of Hmong women who can participate in a study examining their attitudes and behaviors.

There are several explanations regarding the results of this study, which include but are not limited to Hmong cultural values and beliefs and their views that expression of emotion is a form of weakness. According to Tatman (2001), the Hmong community is opposed to seeking mental health services as they prefer the txiv neeg (shaman) to heal and treat their illnesses and view the counselor as an outsider who is not part of the family or clan and cannot be trusted. Furthermore, Nishio and Bilmes' (1987) reported that Hmong refugees did not utilize mental health services and did not believe they were a source to intervene in mental, emotional, social, or familial problems, as the Hmong preferred family to be the primary source to help with such issues. This Hmong belief system and style of family intervention raises the question of how can a mental health practitioner incorporate members of a family into the assessment and treatment of Hmong women. Mental health practitioners are encouraged to look systemically when conducting assessment and not only utilizing an individualist world view.

This study also found that Hmong women with lower levels of stigma will have more positive attitudes toward and a greater willingness to seek counseling services. Because Hmong women have a tendency to view mental health professionals as outsiders, it would be easy for these individuals to feel a sense of stigma regarding mental health services.

The California Department of Health Care Services (DHCS) (2007), reported that stigma and discrimination are reasons why minorities will not seek mental health services. Minority individuals also experience racism, poverty, language barriers, and clinician bias (DHCS, 2007) which inhibits their desire and ability to seek mental health services. In addition, Sue and Morishma (1982) found Asian cultures (including the Hmong community) view mental illness as

a poor reflection on the individual's entire family. As a result, it appears to be imperative that mental health practitioners work specifically to reduce the stigma and eliminate the cultural barriers that can be associated with seeking mental health services.

This study provides a snapshot Hmong women's views of mental health services as well as their willingness to seek treatment. The results of this study inform mental health professionals that stigma is a critical factor in Hmong women's attitudes toward and willingness to seek counseling services rather than their acculturation level to the U.S. culture. It is hoped that mental health practitioners will use the results of this study to better understand factors that influence Hmong women's views of counseling services and thus better prepare themselves to develop a safe and positive clinical environment as well as effective interventions in order to provide easier counseling access to Hmong women.

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## MATERIALS

### APPENDIX A

#### Demographic Questionnaire Form (DQF)

##### Demographic Questionnaire Form (DQF)

1. What is your age?
  - a. 17 and under
  - b. 18-25
  - c. 26-35
  - d. 36-45
  - e. 50 +
  
2. What is your religion?
  - a. Shamanism
  - b. Protestant Christian
  - c. Catholic
  - d. Other, please specify \_\_\_\_\_
  
3. How many years have you lived in the United States?
  - a. Less than 1 year
  - b. 1-5 years
  - c. 6-10 years
  - d. 11-15 years
  - e. 20+ years
  
4. Which statement best fits where you born, and where your parents were born?
  - a. I was born in Laos, Thailand, or Vietnam, and my parents were born in Laos, Thailand, or Vietnam.
  - b. I was born in the United States, and my parents were not born in the United States.
  - c. I was born in the United States and both of my parents were born in the United States.
  - d. I was born in the United States, and one of my parents was born in Laos, Thailand, or Vietnam, and my other parent was born in the United States.
  - e. I was not born in the United States, and one of my parents was born in Laos, Thailand, or Vietnam, and my other parent was born in the United States.

## APPENDIX B

### Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA)

#### SUINN-LEW ASIAN SELF-IDENTITY ACCULTURATION SCALE (SL-ASIA)

Richard M. Suinn, Ph.D.

INSTRUCTIONS: The questions which follow are for the purpose of collecting information about your historical background as well as more recent behaviors which may be related to your cultural identity. Choose the one answer which best describes you.

1. What language can you speak?
  - a. Asian only (for example, Chinese, Japanese, Korean, Vietnamese, etc.)
  - b. Mostly Asian, some English
  - c. Asian and English about equally well (bilingual)
  - d. Mostly English, some Asian
  - e. Only English
  
2. What language do you prefer?
  - a. Asian only (for example, Chinese, Japanese, Korean, Vietnamese, etc.)
  - b. Mostly Asian, some English
  - c. Asian and English about equally well (bilingual)
  - d. Mostly English, some Asian
  - e. Only English
  
3. How do you identify yourself?
  - a. Oriental
  - b. Asian
  - c. Asian-American
  - d. Chinese-American, Japanese-American, Korean-American, etc.
  - e. American
  
4. Which identification does (did) your mother use?
  - a. Oriental
  - b. Asian
  - c. Asian-American
  - d. Chinese-American, Japanese-American, Korean-American, etc.
  - e. American
  
5. Which identification does (did) your father use?
  - a. Oriental
  - b. Asian
  - c. Asian-American
  - d. Chinese-American, Japanese-American, Korean-American, etc.
  - e. American

6. What was the ethnic origin of the friends and peers you had, as a child up to age 6?
  - a. Almost exclusively Asians, Asian-Americans, Orientals
  - b. Mostly Asians, Asian-Americans, Orientals
  - c. About equally Asian groups and Anglo groups
  - d. Mostly Anglos, Blacks, Hispanics, or other non-Asian groups
  - e. Almost exclusively Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
7. What was the ethnic origins of the friends and peers you had, as a child from 6 to 18?
  - a. Almost exclusively Asians, Asian-Americans, Orientals
  - b. Mostly Asians, Asian-Americans, Orientals
  - c. About equally Asian groups and Anglo groups
  - d. Mostly Anglos, Blacks, Hispanics, or other non-Asian groups
  - e. Almost exclusively Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
8. Whom do you now associate with in the community?
  - a. Almost exclusively Asians, Asian-Americans, Orientals
  - b. Mostly Asians, Asian-Americans, Orientals
  - c. About equally Asian groups and Anglo groups
  - d. Mostly Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
  - e. Almost exclusively Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
9. If you could pick, whom would you prefer to associate with in the community?
  - a. Almost exclusively Asians, Asian-Americans, Orientals
  - b. Mostly Asians, Asian-Americans, Orientals
  - c. About equally Asian groups and Anglo groups
  - d. Mostly Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
  - e. Almost exclusively Anglos, Blacks, Hispanics, or other non-Asian ethnic groups
10. What is your music preference?
  - a. Only Asian music (for example, Chinese, Japanese, Korean, Vietnamese, etc.)
  - b. Mostly Asian
  - c. Equally Asian and English
  - d. Mostly English
  - e. English only
11. What is your movie preference?
  - a. Asian-language movies only
  - b. Asian-language movies mostly
  - c. Equally Asian/English-language movies
  - d. Mostly English-language movies only
  - e. English-language movies only
12. What generation are you?
  - a. 1st Generation = I was born in Asia or country other than U.S.
  - b. 2nd Generation = I was born in U.S., either parent was born in Asia or country other than U.S.

- c. 3rd Generation = I was born in U.S., both parents were born in U.S, and all grandparents born in Asia or country other than U.S.
  - d. 4th Generation = I was born in U.S., both parents were born in U.S, and at least one grandparent born in Asia or country other than U.S. and one grandparent born in U.S.
  - e. 5th Generation = I was born in U.S., both parents were born in U.S., and all grandparents also born in U.S.
  - f. Don't know what generation best fits since I lack some information.
13. Where were you raised?
- a. In Asia only
  - b. Mostly in Asia, some in U.S.
  - c. Equally in Asia and U.S.
  - d. Mostly in U.S., some in Asia
  - e. In U.S. only
14. What contact have you had with Asia?
- a. Raised one year or more in Asia
  - b. Lived for less than one year in Asia
  - c. Occasional visits to Asia
  - d. Occasional communications (letters, phone calls, etc.) with people in Asia
  - e. No exposure or communications with people in Asia
15. What is your food preference at home?
- a. Exclusively Asian food
  - b. Mostly Asian food, some American
  - c. About equally Asian and American
  - d. Mostly American food
  - e. Exclusively American food
16. What is your food preference in restaurants?
- a. Exclusively Asian food
  - b. Mostly Asian food, some American
  - c. About equally Asian and American
  - d. Mostly American food
  - e. Exclusively American food
17. Do you
- a. read only an Asian language
  - b. read an Asian language better than English
  - c. read both Asian and English equally well
  - d. read English better than an Asian language
  - e. read only English
18. Do you
- a. write only an Asian language

- b. write an Asian language better than English
  - c. write both Asian and English equally well
  - d. write English better than an Asian language
  - e. write only English
19. If you consider yourself a member of the Asian group (Oriental, Asian, Asian-American, Chinese-American, etc., whatever term you prefer), how much pride do you have in this group?
- a. Extremely proud
  - b. Moderately proud
  - c. Little pride
  - d. No pride but do not feel negative toward group
  - e. No pride but do feel negative toward group
20. How would you rate yourself?
- a. Very Asian
  - b. Mostly Asian
  - c. Bicultural
  - d. Mostly Westernized
  - e. Very Westernized
21. Do you participate in Asian occasions, holidays, traditions, etc.?
- a. Nearly all
  - b. Most of them
  - c. Some of them
  - d. A few of them
  - e. None at all

## **APPENDIX C**

### **Stigma for Receiving Psychological Help (SSRPH)**

#### **STIGMA FOR RECEIVING PSYCHOLOGICAL HELP (SSRPH)**

**INSTRUCTIONS:** Read each statement carefully and indicate your degree of agreement using the scale below. In responding, please be completely honest.

1 = Strongly Disagree      2 = Disagree      3 = Agree      4 = Strongly Agree

1. Seeing a psychologist for emotional or interpersonal problems carries social stigma.
2. It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems.
3. People will see a person in a less favorable way if they come to know that he/she has seen a psychologist.
4. It is advisable for a person to hide from people that he/she has seen a psychologist.
5. People tend to like less those who are receiving professional psychological help.

## APPENDIX D

### Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF)

#### ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP-SHORT FORM (SSRPH-SF)

INSTRUCTIONS: Read each statement carefully and indicate your degree of agreement using the scale below. In responding, please be completely honest.

0 = Disagree            1 = Partly Disagree            2 = Partly Agree            3 = Strongly Agree

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.
2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.
3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.
4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.
5. I would want to get psychological help if I were worried or upset for a long period of time.
6. I might want to have psychological counseling in the future.
7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.
8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
9. A person should work out his or her own problems; getting psychological counseling would be a last resort.
10. Personal and emotional troubles, like many things, tend to work out by themselves.

## APPENDIX E

### Willingness to See a Counselor (WSC)

#### WILLIGNESS TO SEE A COUNSELOR (WSC)

INSTRUCTIONS: The following items present problems that some Hmong women may have. Please assume that you have these issues and rate your willingness to seek counseling for each of the problems listed below. We are not asking whether you have these issues; rather, we are interested in your willingness to see a counselor IF YOU HAD these issues. Please use the rating scale provided to indicate your willingness for each item.

1 = Not Willing to See a Counselor                      2 = Probably Not Willing to See a Counselor  
3 = Probably Willing to See a Counselor              4 = Willing to See a Counselor

1. General Anxiety
2. Alcohol Problems
3. Shyness
4. College Adjustment Problems
5. Sexual Functioning Problems
6. Depression
7. Conflicts with Parents
8. Academic Performance Problems
9. Speech Anxiety
10. Dating or Relationship Problems
11. Financial Concerns
12. Career Choice Problems
13. Insomnia
14. Drug Addiction
15. Loneliness or Isolation

16. Inferiority Feelings
17. Test Anxiety
18. Alienation
19. Problems Making Friends
20. Trouble Studying
21. Ethnic or Racial Discrimination
22. Roommate Problems
23. Ethnic Identity Confusion
24. General Health Problems