MENTAL HEALTH: IDENTIFYING BARRIERS TO HMONG STUDENTS’ USE OF MENTAL HEALTH SERVICES

Impoverished and minority children have the highest chances of not receiving mental health care. In particular, approximately 50% of the Hmong are at increased risks for mental illness. This study investigated acculturation and perceived stigmatization effects on 89 Hmong high school students' attitudes toward seeking mental health services and perceived barriers. There were five main hypotheses: 1) Perceived family stigmatization would be related to self perceived stigmatization. Results indicated that perceived stigmatization of the community, family, and self were all significantly intercorrelated. 2) Stigmatization would be related to attitudes toward mental health services. No support was found for this hypothesis. 3) Acculturation would be related to stigmatization and 4) Attitudes toward mental health. No support was found for these two hypotheses. 5) Knowledge and embarrassment barriers would be related to mental health use. Difficulties in making appointments was the only significantly related barrier. The discussion explored these findings in relation to prior research and directions for future research.

Kong Meng Vang
May 2010
MENTAL HEALTH: IDENTIFYING BARRIERS TO Hmong Students’
USE OF MENTAL HEALTH SERVICES

by
Kong Meng Vang

A thesis
submitted in partial
fulfillment of the requirements for the degree of
Educational Specialist in School Psychology
in the College of Science and Mathematics
California State University, Fresno
May 2010
APPROVED

For the Department of Psychology:

We, the undersigned, certify that the thesis of the following student meets the required standards of scholarship, format, and style of the university and the student's graduate degree program for the awarding of the master's degree.

__________________________
Kong Meng Vang
Thesis Author

__________________________
Marilyn Wilson (Chair) Psychology

__________________________
Robert Levine Psychology

__________________________
Paul Price Psychology

For the University Graduate Committee:

__________________________
Dean, Division of Graduate Studies
AUTHORIZATION FOR REPRODUCTION
OF MASTER’S THESIS

I grant permission for the reproduction of this thesis in part or in its entirety without further authorization from me, on the condition that the person or agency requesting reproduction absorbs the cost and provides proper acknowledgment of authorship.

Permission to reproduce this thesis in part or in its entirety must be obtained from me.

Signature of thesis author: ________________________________
ACKNOWLEDGMENTS

First and foremost, I would like to offer my sincerest gratitude to my committee chair, Dr. Marilyn Wilson, who has guided me through this process with her patience and knowledge. I will forever be grateful for your encouragement, efforts, and candor.

I would also like to express my deepest appreciation to my committee members, Dr. Robert Levine and Dr. Paul C. Price. Thank you Dr. Levine for your wisdom, guidance, and encouragement throughout this process. I would also like to acknowledge the mentorship and guidance of one of the most influential individuals I have met in my life, Dr. Paul C. Price. It is with your support that this accomplishment was possible. One simply could not wish for wiser, friendlier, and more passionate mentors.

Thank you to my parents for their unconditional love and support.

To my daughter, thank you for keeping me sane through this journey. To my wife, thank you for your patience and understanding when I simply could not tend to family matters due to school obligations.

Lastly, I would like to thank my cohorts. One day, many years down the road, we will look back and laugh about the experiences we had.
TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>LIST OF TABLES</th>
<th>viii</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter</td>
<td></td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Diversity Among Asian Americans</td>
<td>3</td>
</tr>
<tr>
<td>2. REVIEW OF THE LITERATURE</td>
<td>5</td>
</tr>
<tr>
<td>Importance of Mental Health Care for Children</td>
<td>5</td>
</tr>
<tr>
<td>What Is Mental Health?</td>
<td>6</td>
</tr>
<tr>
<td>Unmet Mental Health Care Services for Youth</td>
<td>7</td>
</tr>
<tr>
<td>Asian American Mental Health</td>
<td>9</td>
</tr>
<tr>
<td>Southeast Asian Americans</td>
<td>12</td>
</tr>
<tr>
<td>Who Are the Hmong?</td>
<td>13</td>
</tr>
<tr>
<td>Hmong Culture</td>
<td>15</td>
</tr>
<tr>
<td>Religion</td>
<td>16</td>
</tr>
<tr>
<td>Health</td>
<td>16</td>
</tr>
<tr>
<td>Education</td>
<td>17</td>
</tr>
<tr>
<td>Mental Health</td>
<td>19</td>
</tr>
<tr>
<td>Barriers to Mental Health Services Use</td>
<td>24</td>
</tr>
<tr>
<td>The Present Research</td>
<td>33</td>
</tr>
<tr>
<td>3. METHOD</td>
<td>35</td>
</tr>
<tr>
<td>Participants</td>
<td>35</td>
</tr>
<tr>
<td>Instruments</td>
<td>35</td>
</tr>
<tr>
<td>Pilot Study</td>
<td>40</td>
</tr>
<tr>
<td>Design and Procedure</td>
<td>41</td>
</tr>
</tbody>
</table>
Appendix

E. ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP SCALE (ATSPPH-SF) . . . . . 94
F. MENTAL HEALTH BARRIERS QUESTIONNAIRE . . . . . . 96
G. PARENT CONSENT FORM (IN ENGLISH AND HMONG). . . . 99
H. STUDENT CONSENT FORM . . . . . . . . . . . .104
<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Frequency and Percents of Parent/Guardian Demographics</td>
<td>36</td>
</tr>
<tr>
<td>2. Ranges, Means, and Standard Deviations for Acculturation, Perceived Stigmatization, and Attitudes Towards Seeking Professional Psychological Help</td>
<td>47</td>
</tr>
<tr>
<td>3. Correlations Between Attitudes Towards Seeking Professional Psychological Help (ATSPPH-SF) Score and Perceived Barriers With Means and Standard Deviations of Perceived Barriers</td>
<td>48</td>
</tr>
<tr>
<td>4. Correlations Among Perceived Community Stigmatization, Perceived Family Stigmatization, and Self Stigmatization</td>
<td>48</td>
</tr>
<tr>
<td>5. Correlations Between Stigmatization (ATMHP), Acculturation (SL-ASIA), and Attitudes Towards Seeking Professional Psychological Help (ATSPPH-SF)</td>
<td>50</td>
</tr>
</tbody>
</table>
Chapter 1

INTRODUCTION

Research in mental health continues to support the finding that children and adolescents lack adequate mental health care in the United States. Children from impoverished and minority families have substantially higher risks for mental illness due to increased financial, family, and social adversity (Massi & Cooper, 2006; Rosenkranz, 2006; Snowden, Masland, Libby, Wallace, & Fawley, 2008). These risks are further complicated as they also receive significantly lower amounts of mental health care (Kataoka, Zhang, & Wells, 2002). Many factors contribute to the discrepancy in mental health utilization; however, acculturation and stigmatization, in the form of shame, have been repeatedly identified as significant factors influencing the use of mental health services independent of socioeconomic status, English proficiency, and medical insurance (Gilbert et al., 2007; Shea & Yeh, 2008).

Providing adequate mental health care to youth is imperative to their success. Treated youth experience significantly more positive home, school, and social lives (Massi & Cooper, 2006). Youth with unmet mental health needs face increased risks of low academic achievement,
school dropout, delinquency, and health problems (Dryfoos & Barkin, 2006; Kataoka et al., 2002; Massi & Cooper, 2006).

Increasing attention towards minority mental health care has shed new light on Asian American mental health needs and risks. Although past research documented Asian Americans as having comparable mental illness rates to European Americans, current research is suggesting otherwise. Recent data show that Asian Americans have the highest rates of suicide in youth ages 15 to 24 and people over the age of 65. Yet, Asian Americans have the lowest rates of mental health utilization in the United States (Chung & Yamey, 2002; Sherer, 2008).

Despite data suggesting Asian Americans are at risk for mental illness, representative research among all Asian Americans subgroups is limited. As a result, the majority of studies on Asian American mental health have concentrated on more established Asian subgroups such as the Filipino Americans, Chinese Americans, and the Japanese Americans. The U.S. Department of Health and Human Services (USDHHS, 1999) identified language barriers as a primary factor that negatively impacted representative studies on Asian American subgroups. These results are not generalizable to all Asian groups as acculturation levels, education accomplishments, and financial stability range considerably.
Diversity Among Asian Americans

A major contributor to the diversity of Asian Americans in the U.S. has been the influx of Southeast Asian immigration since the 1970s. Southeast Asians differ greatly from other Asian subgroups because of their means for relocation into the U.S. The majority of them were forced to flee their homelands to escape persecution, war, and often times, certain death.

Since then, over 100,000 Hmong refugees from Laos have settled in the United States (Ida & Yang, 2003). Many studies have documented their insurmountable difficulties adjusting to the American culture. Their transition from a primitive lifestyle in a third world country to the most technologically advanced country in the world, the United States, is equivalent to being advanced 200 years into the future. As a result, many first generation Hmong immigrants suffered clinically diagnosable amounts of posttraumatic stress disorder, anxiety disorder, and depression upon arrival into the U.S. and continue to endure these disorders several decades later (Cerhan, 1990; Nicholson, 1997; Westermeyer, 1988).

With a vast body of research suggesting that traumas experienced by immigrants have lingering psychologically harmful effects on their children, Hmong youth may be in grave danger for mental illness. This peril was demonstrated in Fresno, California as eight Hmong youth
committed suicide from 1998 to 2002 (Administration for Children & Families [ACF], 2007). All cases were identified as uncharacteristic of teenage suicide risk profiles. As a result, in 2002, the Refugee Mental Health Program, Substance Abuse and Health Services Administration’s Youth Violence and Suicide Prevention Programs, and Hmong mental health professionals at California State University, Sacramento convened and identified major risks factors as intergenerational and family conflicts; traditional Hmong practices that differ from the dominant culture; Hmong community beliefs and attitudes towards as gays, lesbians, and bisexuals; Hmong stigmatization towards mental illness; and the lack of culturally appropriate mental health care.

In light of the tragedies and need for mental health research in the Hmong, this study extended the research by identifying the influence of acculturation and stigmatization or shame on Hmong students’ attitudes towards use of mental health services and perception of barriers in utilizing mental health services. Results may be used to aid school districts and mental health organizations in providing appropriate mental health care to Hmong students and students of similar backgrounds.
Chapter 2

REVIEW OF THE LITERATURE

The following literature review first presents data on the prevalence of children with mental illness in the United States and the discrepancy in mental health care for minority and disadvantaged children. Next, Asian American mental health will be reviewed with specific attention to Southeast Asian Americans. Then, an introduction to the Hmong will be provided along with mental health data on Hmong adults and Hmong youth. Finally, an examination of acculturation and stigmatization as potential barriers to the utilization of mental health services will be discussed.

Importance of Mental Health Care for Children

In the United States, mental health illnesses in children and adolescents are at an all time high. It is estimated that 1 out of 5 youth, 7.8 to 12.2 million, can be clinically diagnosed with a mental illness (Massi & Cooper, 2006; National Mental Health Association, n.d.; Substance Abuse and Mental Health Services Administration [SAMSHA], 2003; USDHHS, 1999). Approximately 11% of these children have serious impairing illnesses that affect their family, school, and social lives (USDHHS, 1999). Among
youth between the ages of 5 to 24 years, mental illness is the number one cause of suicides (American Association of Suicidology, 2005; Garlow et al., 2008). Mental illness knows no barriers as it transcends financial wealth, social status, and race.

What Is Mental Health?

The USDHHS (1999) defines youth mental health as “the achievement of expected developmental cognitive, social, and emotional milestones and by secure attachments, satisfying social relationships, and effective coping skills” (p. 123). Healthy youth progress through development, periods of change and restructuring, without significant long-lasting impairments in their abilities to function (USDHHS, 1999). Along this process, achieving higher education, having normal levels of self-esteem, acquiring social relationships, and developing a sense of safety all contribute to normal youth development (Dryfoos & Barkin, 2006). On the other hand, youth with mental illnesses have distorted cognitions and varied behaviors that are related to their inabilities to cope with change and the difficulties of maturation. As a result, they develop high levels of distress, demonstrate impaired functioning, and have difficulties developing meaningful relationships (Knopf, Park, & Mulye, 2008; SAMSHA, 2003). The most pervasive disorders found in youth are anxiety
disorders, attention disorders, eating disorders, substance use disorders, and mood disorders (Knopf et al., 2008). Fifty percent of mental illnesses with onset at ages 14 years or younger will develop into life-long chronic diseases (Dryfoos & Barkin, 2006). In North America, mental illnesses are the number one cause of disability in people ages 15 to 44 years (National Institute of Mental Health [NIMH], 2008).

**Unmet Mental Health Care Services for Youth**

Despite a large body of research supporting the pervasiveness of mental illness among youth, current data show that youth are underserved. According to data from Mental Health America (2006), only 21% of children who require mental health care receive the services they need. Astonishingly, even among school-aged children with debilitating disabilities that necessitate mental health care, only 40% obtained the essential services (Witt, Kasper, & Riley, 2003). In a study by Kataoka et al. (2002), the researchers examined results from the National Health Interview survey, the National Survey of American Families, and the Community Tracking Survey using a validated symptoms checklist made of selected questions from the Child Behavior Checklist. They revealed that 80% of children between the ages of 6 to 17, who were classified as at risk for mental illnesses, failed to
receive any basic mental health care. Moreover, the researchers found that Latino American children and uninsured children had an 87-88% chance of not receiving adequate mental health care. Among youth at-risk, Yeh, McCabe, Hough, Dupius, and Hazen (as cited in Ho, Yeh, McCabe, & Hough, 2007) found that 48% of African Americans, 72% of Asian Americans, and 47% of Latino Americans lacked proper mental health care.

Providing adequate services to children is vital to children’s success. Children from underprivileged and minority families have greater mental health needs due to immense adversity (Rosenkranz, 2006; Snowden et al., 2008). Massi and Cooper (2006) indicated that 57% of children with mental illnesses come from families with cumulative household incomes below the federal poverty level. Common hardships in impoverished and rural communities include racial discrimination, having parents with low socioeconomic status, and acculturation issues. Despite a greater need for psychological assistance, the factors associated with increased mental health risks are directly associated with receiving treatment. Neglected youth with mental illnesses will have significantly elevated risks of low academic achievement, school dropout, participation in violent acts, drug use, adjudication, health impairments, and suicide (Dryfoos & Barkin, 2006; Kataoka et al., 2003; Massi & Cooper, 2006).
Asian American Mental Health

A minority group gaining marked attention in the realm of mental health is Asian Americans. Asian Americans make up over 4% of the population of the United States, are the fastest growing ethnic group, and are expected to double in the next two decades. Although grouped into one category, Asian Americans are extremely diverse. The category encompasses over 43 different subgroups and in excess of 100 distinct languages and dialects (USDHHS, 1999).

Current data on Asian mental health show that Asians’ mental health illnesses are higher than previously reported. The USDHHS (1999) stated that past reports on Asian Americans suggested comparable mental illness population ratios to Caucasian Americans. However, further analyses of symptoms revealed that Asian Americans are more likely to have increased depressive symptoms than Caucasian Americans and African Americans. These results are further highlighted by Akutsu and Chu (as cited in Hsu & Alden, 2008) finding that only 6% of all Asian Americans needing mental health care sought professional services. It now appears that among all ethnic groups in the U.S., Asian Americans have the lowest rate of mental health care utilization (Sherer, 2008). Moreover, Chung and Yamey (2002) reveal that Asian Americans had the highest rate of suicide among people between the ages of 15 and 24 and over the age of 65.
Although a vast amount of research supports a heightened awareness for mental illness in the United States, data on Asian American mental health is limited (Speller, 2005; USDHHS, 1999, 2001). The report identifies language barriers as the leading factor inhibiting representative studies on Asian Americans. Yip, Gee, and Takeuchi (2008) conducted the first national study of Asian American mental health and reported racial discrimination as the leading stressor impacting mental health. Though racial discrimination affects all Asian Americans, its degree of significance varies among Asian American subgroups. Higher recognized Asian subgroups such as the Chinese Americans, Japanese Americans, and Filipino Americans may perceive discrimination as the major stressor; however, less well-known and lower established Asian subgroups with fewer amounts of English speakers may perceive the inability to adjust to the American culture as a more significant factor towards their mental health (Ida & Yang, 2003; USDHHS, 1999; Yip et al., 2008). The more recognized and established Asian American groups have resided in the U.S. for a more extensive period and have a significantly higher percentage of English speakers. As a result, language barriers do not negatively affect their participation in research, whereas language barriers have been the most frequently cited problem in researching Southeast Asian mental health (USDHHS, 1999). The lack of
representative sampling in Southeast Asian and Pacific Islander subgroups creates skewed results that are not generalizable to all Asian Americans.

Furthermore, a primary factor contributing to the inadequate amount of mental health data in Asian Americans is the misrepresentation and stereotyping of Asian Americans as the model minority. Ida and Yang (2003) found that on average, of all ethnic groups in the U.S., Asian Americans had the lowest percentage of incomes below $15,000. However, when the individual Asian subgroups were examined, Filipinos, Asian Indians, and Japanese were considered to be financially secure. In comparison, Southeast Asian groups such as the Cambodians, Laotians, and Vietnamese were 2 to 3 times more likely to be below the poverty level of $15,000 and the Hmong having 4 to 5 times the likelihood with 53 to 64% of their population under the poverty level (Ida & Yang, 2003; USDHHS, 1999). Southeast Asians differ immensely from the more established Asian subgroups due their more recent resettlement dates, motives, and procedures of arrival into United States. Accordingly, Ida and Yang (2003) state that Southeast Asian Americans experience more stigmatization in the form of shame, language barriers, inadequate availability and accessibility of services, lack of transportation, and lack of culturally sensitive care when accessing mental health care.
Southeast Asian Americans

Over the past 30 years, approximately 1 million Southeast Asian immigrants have settled in the U.S. (Chung & Lin, 1994; Miyares, 1998, Nicholson, 1997). Their means of access into the U.S. varied considerably from the more dominant Asian groups. Whereas the Chinese and Japanese may have voluntarily left their native countries in search of wealth and a better life, Southeast Asians were forced out of their homelands as a result of war and turmoil (Ida & Yang, 2003).

Research indicates that the process of migration has contributed to large numbers of Southeast Asians suffering from depression, anxiety, and posttraumatic stress disorder (PTSD) (Cerhan, 1990; Gensheimer, 2006; Nicholson, 1997; Westermeyer, 1988). These traumatic experiences have been shown to have lingering effects, carrying on to children of refugees who were not directly exposed to the traumatic events (Fazel & Stein, 2002; Han, 2005). In an investigation of bicultural stress and its impact on mental health, Romero, Carvajal, Valle, and Orduna (2007) revealed that Asian children’s struggles to balance new cultures with traditional cultures was significantly related to depressive symptoms.

These findings support the need to concentrate research among individual Asian subgroups. This study will focus on the Hmong as they collectively harbor significant
mental health risk factors. Over 50% of Hmong youth may have increased risks for mental health problems (Ida & Yang, 2003; Massi & Cooper, 2006). This problem is further complicated by their rapid growth. Ida and Yang stated that while the general Asian American population doubled from 1980 to 1990, the Hmong population increased an astounding 1,631%. According to the University of Wisconsin-Eau Claire (2000), the 2000 U.S. Census estimated over 170,000 Hmong to be living in the U.S.

In the following sections, an introduction to Hmong, their culture, and a review of Hmong adult mental health will be provided. The literature review will then address Asian American youth mental health, Hmong youth mental health, and potential barriers to their use of mental health services, such as cultural factors, acculturation, and stigmatization.

Who Are the Hmong?

The Hmong are a distinct subgroup of Southeast Asians. They are an indigenous tribe that lived along the hillsides of Southern China stretching to Southeast Asia that includes Thailand, Laos, Vietnam, and Burma (Cerhan, 1990; Cha, 2003; Miyares, 1998). The self referenced name of “Hmong” translates to “being free” and represents their proud lifestyle of being independent and resistant to external conquests (Westermeyer & Her, 2007). For
centuries, they lived in Southeast Asia and used slash and burn agriculture to grow rice, corn, and other vegetables (Cerhan, 1990).

During the late 1960s, the U.S. Central Intelligence Agency (CIA) recruited thousands of Hmong men to aid them in their combat against the Pathet Lao and Northern Communist Vietnamese. The Hmong were sought out as valuable allies due to their vast knowledge of the Ho Chi Minh trail (Cerhan, 1990; Johnson, 2002; Miyares, 1998). In 1975, the United States withdrew from the Vietnam War due to a lack of support from the American public and a stern defense from the Communist armed forces. The communist regimes immediately shifted their attention towards the Hmong for their acts of betrayal. Over 300,000 Hmong were persecuted and murdered because of their involvement in the war (Cha, 2003). The remaining Hmong were forced to flee Laos and Vietnam or face certain death. Consequently, thousands of Hmong made their way to Thailand and were placed into cramped refugee camps. After several months to several years of waiting, Hmong refugees were resettled in countries such as France, Germany, Australia, Canada, and the United States (Cha, 2003). The majority of the Hmong, over 80,000 members, followed their leader, General Vang Pao, to the United States (Cerhan, 1990; Quincy, 1995). According to the 2000 U.S. Census, there are approximately
200,000 Hmong living in the U.S. (U.S. Census Bureau, 2002).

**Hmong Culture**

Like the majority of Asian groups, the Hmong are a collectivistic group. Both men and women worked together for the benefit of the family in maintaining their crops of vegetables and livestock. Males were viewed to be superior to females and expected to achieve higher education, knowledge of customs, and concepts of healing techniques. The females were required to prepare food such as vegetables and rice, attend to the families, and rear the children. The Hmong men took responsibility of community interactions and leadership of the families (Cha, 2003; Johnson, 2002).

In a social context, the clan system operated as the primary social structure. Clans were made up of family members and people living in the same village. They were identified with 15 to 21 different last names. These names represented a kinship between other similarly named clans regardless of familiarity. Operating under a patrilineal hierarchy, the wives converted into members of the husbands’ clans and the children assumed their fathers’ surnames (Cerhan, 1990; Cha, 2003).
Religion

The most common religion in the Hmong is Shamanism. This religion incorporates worshiping ancestors, animism, and the belief that souls reincarnate. Shamans, or spirit healers, are believed to be the medium between the physical and spiritual world. They communicate with spirits and souls offering money, animal sacrifices, and food in return for good health (Cha, 2003).

The Hmong believe the soul to be the center of health. The soul must coincide with the body in accord to sustain good health. Thus, should the soul be separated from the body, illness may ensue. Although the number of souls a person has is not definite, it is believed that longer departures of the soul from the body and the more souls lost equates to more serious illnesses (Cha, 2003; Johnson, 2002).

Health

Herbalists, acupuncturists, and masseuses are comprised of skilled and respected members of a tribe that allocate responsibilities in treating physical ailments. These healers use techniques developed in the course of hundreds of years of experimentation to treat symptoms of the common cold to wounds and broken limbs. Herbalists, traditionally women, have a vast knowledge of plants and their remedial powers. They were often the first line of health defense and were commonly seen for problems such as
colds, burns, and stomach aches. Herbs such as quinine and opium are commonly made into soups, teas, and pastes for topical use (Cerhan, 1990; Cha, 2003; Johnson, 2002).

Acupuncturists treat many types body aches and somatic complaints. The Hmong believe that puncturing specific parts of the human body, such as toes and foreheads, with needles releases toxins and eliminated illnesses.

Masseuses work on bodily ills by massaging, contorting, and using abrasive dermal techniques such as coining and spooning. Their services consist of massaging stomach aches to push out impurities, using various turning techniques for safe deliveries, and using a silver coin or spoon to abravively rub selected areas of skin to extricate illnesses. Skilled masseuses are believed to be an integral factor in successfully healing broken limbs as the healers hold the arduous task of placing the bones back into the correct healing positions (Cha, 2003).

**Education**

Historically, the Hmong had little to no education. The Hmong relied on each family member’s physical contributions to aid to its survival. As a result, children often labored at early ages and were refrained from going to school in order to help the family cultivate their crops and livestock. Distance also played a key role in the lack of Hmong education as Hmong villages were scores to
hundreds of miles away from civilizations. Further, the Hmong lacked an established writing system until the 1950s (Ida & Yang, 2003). Much of their history and knowledge has been passed down via oral communication (Cerhan, 1990; Ida & Yang, 2003).

The Hmong represent a distinct population due to many reasons. First, not only did they live in a third world country, they lived in mountainous ranges hundreds of miles away from civilization which further limited their exposure to modernization. Secondly, because of their independence of modern technology such as electricity and western medicine, they lived primitive and nomadic lifestyles that included growing and raising their own food and relying primarily on ritualistic and herbal health practices. Survival was dependent on the family and community structure. Third, educational attainment was considered a novel practice due to not having a written language until the 1950s. And lastly, their entrance into the U.S. was not based upon financial motives; it was for survival.

As many researchers have indicated, the Hmong represent a group that were virtually transported several generations into the future when they fled their homeland and settled into the U.S. Being one of the most recent groups and fastest growing groups in the U.S., research on the Hmong may provide important information on mental health adjustment in the U.S.
Mental Health

Hmong Mental Health in the United States

Upon their entrance into the United States, the Hmong experienced extreme amounts of adjustment problems and culture shock (Ida & Yang, 2003). In a review of Hmong mental health, Cerhan (1990) found that the Hmong suffered many mental health crises as a result of the hardships they experienced. As indicated, many Hmong adjusted poorly in the U.S. due to their lack of education and struggle to grasp the American culture. The long list of obstacles included unemployment, comprehension of the English language, and racial discrimination.

The traumatic events the Hmong endured en route to the U.S. also had many adverse affects. Meredith and Cramer (1982, as cited in Cerhan, 1990) stated that all 118 participants from a needs survey in Nebraska reported to have elevated levels of stress, a longing for their homeland, and symptoms of PTSD. In a survey of 97 Hmong adults, Westermeyer (1988) found that 30% had chronic maladjustment, 6% had major depression, 2% had paranoid psychosis, and 13% had other various clinical syndromes. Across the U.S., Hmong refugees suffered from depression, PTSD, anxiety problems, and other mental illnesses as a result of their mandatory resettlements (Gensheimer, 2006; Ida & Yang, 2003; Johnson, 2002).
Nearly 30 years after emigration, Nicholson (1997) reported that the Hmong, Cambodians, Laotians, and Vietnamese continued to suffer from clinical levels of depression (40%), anxiety (35%), and PTSD (14%) as a result of their experienced trauma and concurrent struggles to adjust to the American culture. These findings provide evidence that the difficulties the Hmong and other Southeast Asians faced in early stages of their resettlements remain unchanged. The radical transition in lifestyles, experience of hardships, and challenges associated with the American culture may be inhibiting a healthy existence in the U.S.

Asian American Youths’ Mental Health

Asian American youth have been shown to be at a significant disadvantage in achieving good mental health. Choi, Meininger, and Roberts (2006) found that among European American, Hispanic American, and African American middle school students, Asian Americans significantly reported the highest amounts of social anxiety, family conflict, and mental distress, while at the same time reporting the lowest scores in sense of worth and family unity. Regardless of age, sex, and SES, discrimination was found to be significant factor. Additionally, compared to the major ethnic groups, Asian Americans reportedly lacked both family support and social support.
Moreover, Southeast Asian children have faced many daunting challenges as a result of their parents’ struggles. Ying and Han (2007) found that when Southeast Asian parents maintained their traditional cultural values, valuing the family as a whole over the individual members and expecting their developing adolescent children to adopt more contributive roles in the family, acculturation conflicts intensified between parents and their children. These acculturation differences ultimately led to intergenerational conflicts which were found to be positively correlated to children’s levels of depression.

In a study of Asian American college students, Hovey, Kim, and Seligman (2006) found that Korean American college students’ attempts to preserve their cultural values were inversely associated to their self-esteem, anxiety levels, and depressive states. Hwang and Ting (2008) expanded on this research and revealed that although perceived differential cultural affiliation between two cultures were associated with elevated levels of psychological distress and clinical depression, acculturative stress in the form of language differences, social conflicts, prejudice, and intergenerational family conflicts was a higher significant risk factor for mental illness. The researchers found that when Asian Americans students identified with their traditional culture, there was no predictive significance with mental illness; however, not being associated with the
dominant Caucasian culture was found to have significant negative effects. Additionally, the researchers stated that the differences in cultural affiliations alone were not predictive of mental illness, whereas the difficulties associated with the acculturation process were predictive.

These results support the view that being affiliated with diverse cultures may be less important to one’s mental health than the perception of one’s abilities to productively live and be successful alongside the dominant culture. The difficulties associated in the process of balancing two cultures have been found to be underlying factors. Findings from these studies further demonstrate that a failure to properly adjust to a dominant culture is predictive of mental health illness. Asian American youth stuck between cultures may have an increased risk of mental health as they are forced to adopt a dominant culture for success in the professional arena; however, they may feel a need to not disappoint their parents and hold on to their minority culture.

Hmong Youths’ Mental Health

Although research on Hmong children and adolescent mental illness is limited, much of the available data suggest that acculturation and stigmatization issues are at the forefront of the problem (ACF, 2007). In a study of Hmong high school students, Xiong (2006) found that
perceptions of parental acculturation levels were directly correlated with oppositional defiant disorder and higher levels of anxiety disorders. Moreover, Ying and Han (2008) discovered that as Hmong children acquired further education, they reported feeling more comfortable with the English language, and enjoyed more mainstream mass media and activities as compared to their less educated counterparts. With more education, Hmong youths’ acculturation levels will increase and this may negatively affect their relationships with their parents.

Similar to most Asian American groups, unhealthy methods of addressing familial troubles have also been reported in the Hmong (ACF, 2007). Su, Lee, and Vang (2005) indicated that Hmong college students often blamed themselves in times of high family conflict as a result of their cultural values; in turn, this increased their own distress levels and feelings of despair. As a sign of respect for the elders, many Hmong youth attributed familial problems to themselves. This relation was found to be more harmful as it led to higher intergenerational conflicts between children and their parents.

In lieu of the lack of representative numbers in Hmong youth mental health, the rash of Hmong teen suicides in the last decade provides a discernible need for mental health intervention (ACF, 2007). Furthermore, Ida and Yang (2003) propose that the growing number of over 25,000 Southeast
Asian gang members provides an analogous representation of Southeast Asians youths’ needs for services. Massi and Cooper (2006) support this proposition and state that 67% to 70% of youth in the justice system have clinically diagnosable mental illnesses. As the data suggest, there is a necessity to provide adequate mental health care to the Hmong youth. Providing services, however, is not without difficulties. The factors associated with Hmong youths’ increased mental health risks are also linked to their failure to utilize mental health services. This section will provide data on potential barriers contributing to disproportionate use of services. Because data on Hmong mental health use are insufficient, research from Asian groups with similar backgrounds will be provided alongside available Hmong data.

**Barriers to Mental Health Services Use**

**Culture**

Culture is the basis of many ethnic groups’ attitudes, values, and beliefs. It affects countless aspects of people’s lives including perspectives on health problems. In an ethnographic study of the Hmong culture, Johnson (2002) found that the lack of experience with modern medicine and comprehension of how illnesses arise have significantly contributed to the Hmong’s struggle to use Western medicine. Prior to their entrance into the U.S.,
the Hmong did not have knowledge of many body organs and their functions. As a result, their language does not have a broad range of anatomical terms to aid medical professionals in explaining illnesses. The medical staffs’ frustrations have also contributed to Hmong’s pessimistic perceptions of Western medicine. The author reports that the Hmong felt disrespected by doctors’ and nurses’ body languages and facial expressions when they questioned advice from the medical professionals. In turn, these experiences have been shared to the community and may negatively impact the Hmong’s use of Western medicine.

Due to a strong preservation of cultural beliefs combined with unpleasant experiences with western medicine, Miyares (1998) stated that the majority of Hmong still relied on traditional healing practices such as the use of shamans to perform ritualistic treatments. Furthermore, because the Hmong viewed illnesses as syndrome-related and believed that each syndrome had specific methodological cultural healing practices, indigenous healing practices were often accepted as the primary means of treatment. Such actions further contributed to the decreased likelihood of utilizing Western healthcare (Cha, 2003). Similar reports have been found in other Asian groups. Sheikh and Furnham (2000) reported that Asians in Britain were more likely to seek treatment of mental illnesses by first talking to a higher authority in their own social
structure such as a senior member of the community or a religious figure.

Stigmatization

Past research consistently supports the assumption that Asian cultural values significantly influence their attitudes and behaviors towards acquiring mental health services (Hsu & Alden, 2008; Kim & Omizo, 2003). These values have an effect on stigmatization, or perceived shame, and contribute to behaviors of concealing mental illnesses as to not show signs of weakness, personal instability, and genetic flaws (Yeh, 2000, as cited in Shea & Yeh, 2008; USDHHS, 1999). Additionally, the majority of Asian groups hold the family unit above individual members. Consequently, Asian Americans restrain from accessing mental health care in fear of conveying stigmatization to their families.

Snowden (2007) investigated family participation in 4,038 severely mentally ill clients and its effects on mental health service utilization. The results showed that 72% of Asian American, 62% of Latino American, and 22% of Caucasian mentally ill clients lived with family members and depended on their assistance. Asian Americans and Latino Americans reported considerably higher rates of living with their immediate family and reception of supportive services. The researchers proposed that the
factor of active family involvement in the treatment of family members’ mental illnesses contributed to disparities of service use among collectivistic and individualistic cultures. The decisions not to seek mental health services in collectivist cultures were associated with unwanted negative perceptions from the community and pessimistic expectations of treatment outcomes. Though collectivistic families may be more willing to directly aid family members with mental illnesses, this very sense of valuing the family above an individual may hinder the proactive use of mental health care as to not convey negative perceptions of the family.

Gilbert et al. (2007) posited that stigmatization occurs across three distinct categories: external shame, the belief that others will demean a person with a mental illness; internal shame, negative self-evaluations of having a mental illness; and reflected shame, the belief that a person with a mental illness can bring shame to a family or community. Using the Attitudes Towards Mental Health Problems self-report scale to investigate stigmatization in the form of shame, the researchers found that Asian college students were significantly more concerned with external shame and reflected shame than Caucasian college students. This finding suggested that community and family views were more important than Asian college students’ own feelings and beliefs about mental
illness. Stigmatizations from family and community members as well as stigmatization associated with a family member having a mental illness were the most disconcerting factors.

In Shea and Yeh (2008), an examination of Asian American college students’ help-seeking behaviors toward mental health care revealed results consistent with prior research. An attachment to traditional Asian values and beliefs toward mental health care was found to be the primary influencing factor in seeking mental health services and was found to have a significant negative correlation with the use of mental health care clear of effects from stigmatization, gender, age, and relational self-construal. Additionally, the researchers found that help-seeking views and behaviors were directly related to perceptions of stigmatization. Students that had increased perceptions of stigmatization associated with receiving mental health care reported significantly lower probabilities in seeking psychological help. Despite the equal opportunity for mental health services at schools, differences between Asian American and Caucasian American concepts of mental illness continue to hinder Asian Americans’ use of mental health services.
Stigmatization in the Hmong

In an investigation of help-seeking behaviors in Southeast Asians, Chung and Lin (1994) found that amidst all Southeast Asian groups, the Hmong were the least likely to use Western medicine in their homelands and continue to be the least likely to use Western medicine in the United States independent of age, gender, educational accomplishment, and English proficiency. In their native countries, the Chinese-Vietnamese were 4 times, the Cambodians were 7 times, the Laotians were 8 times, and the Vietnamese were 10 times more likely to use Western healthcare in comparison to the Hmong. Although assimilation in the U.S. has since increased the Hmongs’ use of Western healthcare 500%, they still trailed behind with only 56% of its population using Western healthcare as compared to 88% of Cambodians, 86% of Laotians, 76% of Vietnamese, and 69% of Chinese-Vietnamese. These findings may be explained by a lack of exposure to Western healthcare in their native country. The Hmong typically lived hundreds of miles outside of the city, relied first and foremost on indigenous healing, and lived the most primitive lifestyle out of the other Southeast Asian groups. As a result, strong cultural values may be compounding their lack of mental health service use.
Acculturation

To date, much of the research points to acculturation, the process of blending two cultures’ attitudes, behaviors, morals, and characteristics, as a mediator of mental health service use. In an ethnographic study by Ho et al. (2007), a significant relationship was found between children’s use of mental health services and their parents’ “cultural affinities.” Using survey results from 1,364 African American, Asian American, and Latino American children ranging from 6 to 17 years old, the researchers found that when Asian American and Latino American parents categorized themselves in a culture outside of the Anglo-American culture, their children were less likely to utilize mental health services. Particularly, 33% of Latino and 66% of Asian children were less likely to use services regardless of age, youth and parent gender, annual household salaries, parent educational accomplishment, and youth psychological symptoms. Similarly, Gudino, Lau, and Hough (2008) found native U.S.-born parents had a higher likelihood of providing their child with specialized mental health services.

Further, Atkinson and Gim (1989) found that higher acculturated Asian Americans were more likely to utilize mental health services. Using a survey of 263 Chinese, 185 Japanese, and 109 Koreans, the researchers found that use of mental health services was directly correlated to levels
of acculturation. Specifically, higher acculturated Asian American students were more skilled at recognizing their need for mental health support, more open-minded about stigmatization linked with the use of mental health services, and more amenable in disclosing their personal problems with a mental health professional. In support, Hsu and Alden (2008) found that differences between 1st-year Chinese immigrants’ and U.S.-born Chinese Americans’ likelihood to seek mental health services for severe anxiety problems were significantly attributed to acculturation differences.

Communication barriers have also been shown to contribute to the disproportionate use of mental healthcare. Sentell, Shumway, and Snowden (2007) investigated the differences in mental health care utilization in California among Latino Americans, Asian Americans, European Americans, and African Americans in three distinct English proficiency groups: English-speaking only, bilingual, and non-English speaking. Using results from the California Health Interview Survey (CHIS) that generated 41,984 participants, the researchers found that among individuals requiring mental health services, 51% of individuals that spoke English only and 42% bilingual speakers received care. In comparison, only 8% of non-English speaking participants attained any services even when poverty, medical insurance, U.S. nativity, and
duration of time in the U.S were controlled. Further analyses indicated the largest discrepancy of services in Asian Americans. Specifically, 56% of the Asian English-speaking only group received mental health care when needed compared to only 11% of Asian non-English speaking group. These results signified that non-English speaking Asian Americans had an overwhelming 85% chance of not receiving mental health care.

Acculturation in the Hmong

In a direct study of acculturation levels and perceptions on mental healthcare with adult Hmong participants, Thao (2006) concluded that highly acculturated and younger Hmong reported more optimistic attitudes towards mental health care. Notably, 36% of the Hmong participants reported positive inclinations towards accessing mental health care if needed; however, only 12% of the participants had previously used psychological services. Increased acculturation levels may contribute to differing perceptions about use of services, but research suggests that perceived pessimistic views of mental health services still prevail over the benefits of appropriate care. Hmong clients may still overly emphasize stigmatization and cultural values and as a result, refuse treatment.
Communication barriers have also been identified as significant barriers to the Hmongs’ use of Western healthcare. In a study of Hmong Americans in Colorado, Miyares (1998) found that language barriers were the leading cause of underutilization of health services. The causes were noted to be a lack of competent interpreters in both English and Hmong, the lack of Hmong anatomical terminology, and the lack of sufficiently trained professionals in culturally appropriate forms of communication. Additionally, as provided by Johnson (2002), negative body language has negated the Hmongs’ reception of Western health care. Though the majority of the Hmong may require mental health attention, cultural limitations such as language barriers as well as professional quandaries such as a lack of culturally trained professionals further exacerbate the problem.

The Present Research

A review of current literature identifies Hmong youth as a group with severe risks for mental health illness (Ida & Yang, 2008, Massi & Cooper, 2006, Snowden et al., 2008). The factors identified consisted of intergenerational conflicts, acculturation differences, immigration traumas suffered by parents, high rates of poverty, and discrimination. The research also indicates that the factors associated with the elevated risks also contribute
to their disproportionate failure to utilize mental healthcare. Factors such as parent and child acculturation levels have been linked to children's depressive symptomology (Hovey et al., 2006; Hwang & Ting, 2008; Ying & Han, 2007). Accordingly, differences in acculturation levels have also been connected to use of mental healthcare (Atkinson & Gim, 1989; Gudino et al., 2008; Ho et al., 2007).

Although there have been various studies conducted on Asian American youth groups' mental health, few studies have examined perceived stigmatization and acculturation effects on Hmong youths' perceptions and use of mental health services. While there are many similarities in social structures and cultural values to the other Asian American subgroups, the Hmong youth differ greatly in regards to parental immigration experiences, parental education levels, socioeconomic status, and acculturation hardships (Cerhan, 1990; Gensheimer, 2006; Ida & Yang, 2003; Nicholson, 1997, Westermeyer, 1988).

The present study aims to answer the following questions regarding stigmatization and acculturation effects on Hmong youths' use of mental health services: 1) Will acculturation and perceived stigmatization affect attitudes toward seeking mental health services? 2) What factors will students identify as significant barriers toward the use of mental health services?
Participants
The participants in this study included 89 Hmong high school students and their guardians from the Central Valley of California. The high school students were 51 males and 38 females. Eight students were first generation Hmong American, 77 were second generation Hmong American, and 4 were third generation Hmong American. The students’ ages ranged from 14 to 19 years old ($M = 16.2, SD = 1.3$). Fifty-five of the student participants were recruited from a local high school and 34 students were recruited at a local Hmong church.

The guardian participants included 51 fathers, 37 mothers, and 1 guardian. Their ages ranged from 30 to 65 years old ($M = 45.3, SD = 8.4$). The frequency and percent of parent demographics are presented in Table 1.

Instruments
Demographics
A parent demographic questionnaire was developed to obtain information regarding the caregivers’ relation to the student, age, marital status, highest educational attainment, employment status, and decade of entry into the
Table 1

*Frequency and Percentages of Parent/Guardian Demographics*

<table>
<thead>
<tr>
<th>Demographics</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>Married</td>
<td>79</td>
<td>88.8</td>
</tr>
<tr>
<td>Divorced</td>
<td>6</td>
<td>6.7</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Level of Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below Elementary</td>
<td>31</td>
<td>34.8</td>
</tr>
<tr>
<td>Some High School</td>
<td>16</td>
<td>18.0</td>
</tr>
<tr>
<td>High School Graduate</td>
<td>17</td>
<td>19.1</td>
</tr>
<tr>
<td>Some College</td>
<td>10</td>
<td>11.2</td>
</tr>
<tr>
<td>College Graduate</td>
<td>10</td>
<td>11.2</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>4</td>
<td>4.5</td>
</tr>
<tr>
<td>Doctoral Degree</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Currently Employed</td>
<td>41</td>
<td>46.1</td>
</tr>
<tr>
<td>Part-time Employment</td>
<td>4</td>
<td>4.5</td>
</tr>
<tr>
<td>Full-time Employment</td>
<td>38</td>
<td>42.7</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>6.7</td>
</tr>
<tr>
<td><strong>Entrance into the U.S.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1970s</td>
<td>25</td>
<td>28.1</td>
</tr>
<tr>
<td>1980s</td>
<td>52</td>
<td>58.4</td>
</tr>
<tr>
<td>1990s</td>
<td>11</td>
<td>12.4</td>
</tr>
<tr>
<td>2000s</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Household Yearly Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below $30,000</td>
<td>59</td>
<td>66.3</td>
</tr>
<tr>
<td>$30,000 - $60,000</td>
<td>13</td>
<td>14.6</td>
</tr>
<tr>
<td>$60,000 - $90,000</td>
<td>9</td>
<td>10.1</td>
</tr>
<tr>
<td>$90,000 - $120,000</td>
<td>4</td>
<td>4.5</td>
</tr>
<tr>
<td>$120,000 - Above</td>
<td>4</td>
<td>4.5</td>
</tr>
</tbody>
</table>

*Note.* There were 89 parent/guardian participants.
U.S. (see Appendix A). In addition, a student demographic questionnaire was developed to investigate students’ age, gender, and whether they were first, second, or third generation Hmong-American (see Appendix B). The parents completed the parent demographic questionnaire and the students completed the student demographic questionnaire.

**Acculturation**

The instrument used to measure levels of acculturation was the Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA) developed by Suinn, Ahuna, and Khoo (1992) (see Appendix C). This scale contained 21 questions that were designed to measure language selection (4 questions), friendship preference (4 questions), conduct (5 questions), generational and geographical history (3 questions), self-identity (4 questions), and viewpoints (1 question) (Suinn, Rickard-Figueroa, Lew, & Vigil, 1987). Because the term “Asian” encompasses a diverse population, Suinn et al. (1987) stated that it was appropriate to replace it with the ethnicity of interest which in this case was Hmong. The levels of acculturation were measured using a Likert scale of 1 to 5, with a score of 1 signifying low acculturation with Hmong identification and a score of 5 signifying high acculturation with a low Hmong identification. Scores were summed and divided by 21. Lower scores indicated lower levels of acculturation and higher scores indicate higher
levels of acculturation. Prior studies utilizing this measurement tool reported internal consistencies alpha coefficients ranging from 0.88 to 0.91.

**Perceived Stigmatization**

The instrument used to assess stigmatization was the *Attitudes Towards Mental Health Problems Scale (ATMHP)* (see Appendix D). Developed by Gilbert et al. (2007), the ATMHP used 35 questions to investigate various elements of perceived stigmatization associated with mental illness. Perceived stigmatization was measured in five sections. The first section looked at perceptions of community attitudes (questions 1-4) and perceptions of family attitudes (questions 5-8). The second section explored self-perceptions of how the community would view them if they had a mental illness (questions 9-13) and how their family would view them if they had a mental illness (questions 14-18). The third section probed self-perceptions of inner shame and unconstructive self-identities associated with having a mental illness (questions 19-23). The fourth section examined self-perceived shame and attitudes about how their families will be affected if a member had a mental illness (questions 24-30). Lastly, the fifth section addressed self-perceptions of disgrace and humility associated with having a close family member with a mental illness (questions 31-35). Questions were measured on a
Likert scale. Scores for each section were averaged, with a low score of 0 signifying “Do not agree at all” and high score of 3 signifying “Completely agree.” Low scores indicated lower stigmatization levels and high scores indicated higher stigmatization levels. Previous studies that used this instrument reported Cronbach’s coefficient alphas ranges from 0.85 to 0.97.

Seeking Mental Health Services

The instrument used to determine students’ positions about seeking mental health services was the Attitudes Toward Seeking Professional Psychological Help Scale: Short Form (ATSPPH-SF) developed by Fischer and Farina (1995) (see Appendix E). The ATSPPH-SF is an updated version of the original ATSPPH that was created in 1970 by Fischer and Turner. This new version utilized 10 questions to assess acknowledgment of need for mental health services, attitudes toward stigmatization, willingness to share personal information, and confidence in professionals in mental health. A Likert scale was used to rate responses that ranged from 1 (disagree) to 4 (agree). Half of the questions (2, 4, 8, 9, and 10) were scored in reverse. Scores were summed. Low scores indicated negative attitudes and high scores indicated positive attitudes towards mental health services. Coefficient alphas range from 0.77 to 0.88
in prior studies (Elhai, Schweinle, & Anderson, 2008; Kim, 2007).

**Perceived Barriers**

Questions from the Massachusetts Institute of Technology Mental Health Task Force Report (2001) were used to identify attitudes and barriers towards the use of mental health services (see Appendix F). As it was originally constructed for use with college students, the wording was modified to accommodate high school students. The researchers selected 13 questions that covered concerns and beliefs and identified factors why students may not use mental health services. Responses were rated on a Likert scale of 1 to 7, with 1 equaling “Does not happen much” to 7 equaling “Happens a lot.” These questions were originally developed to aid the university in providing assistance to college students and as a result, reliability and validity calculations were not performed. Similarly, results from these questions may be used to provide high schools with Hmong populations and students with similar ethnic backgrounds pertinent information on identifying barriers to the use of mental health services. Each question served as an individual variable.

**Pilot Study**

A pilot study was conducted to ensure readability of the questions due to adaptations made to the questionnaire
and to examine the length of time needed to complete the questionnaire. The youth pilot participants were high school students. Parental consent was obtained prior to administration of the questionnaire. Of the 5 students that participated, 2 students identified “Anglo” as unfamiliar term. As a result, the term “Anglo” was substituted for “Caucasian.” Test completion times ranged from 12 to 15 minutes. Due to the relatively short completion times, it was determined by the researchers that the questionnaire would be suitable for administration at school sites.

**Design and Procedure**

Prior to beginning this study, an application for the use of human subjects was submitted to the University’s Institutional Review Board. After approval was granted, details of the study and procedures were presented and discussed with a school administrator of a Central Valley school district and a principal of a Central Valley high school to gain approval. Following endorsement of the study, the administrator provided memos stating that the research study met their school district policies and procedures for using their schools, students, and parents in the proposed research.
Recruitment 1

The researcher recruited participants during morning breaks on the high school campus. Students were recruited by providing a synopsis of the study and the potential benefits of the study. Interested students were provided parental consent forms (see Appendix G) and parent demographic questionnaires contingent on whether the students’ parents preferred English or Hmong school letters. At the same time, students were also provided with student consent forms (see Appendix H).

Once completed, instructions on the bottom of the questionnaire directed the parents to attach the consent form to the parent questionnaire and give it to the child to deliver to his or her instructor. Consent forms and completed questionnaires were picked up on a weekly basis. Once 10 consent forms were turned in, the researcher used the school’s conference room for questionnaire administration and called in 5 to 10 students to complete the student questionnaires. There were six questionnaire administration sessions in a span of 3 weeks.

Recruitment 2

The researcher visited a Hmong church in the Central Valley and provided details of the study and procedures. Approval was granted by the pastor and youth group leader. The researcher recruited youth by providing a synopsis of the study. Interested youth were provided parental consent
forms and parental questionnaires in either Hmong or English along with student consent forms. Phone numbers were collected from the students. Follow-up phone calls were made if the youth did not return the consent forms on the subsequent day. Four attempts were made to recruit participants and the questionnaires were collected during a span of three weekends at the church.

**Additional Data Recording Procedures**

To check for accuracy in data coding and recording, an interrater reliability check was performed on 50% of the data. A second rater rescored and reviewed inputted data for all even numbers, from participant 2 to participant 88. The results revealed an interrater reliability accuracy rate of .91.
Chapter 4

RESULTS

This study investigated Central Valley Hmong high school students’ attitudes towards seeking mental health services and sought to identify possible barriers. It was hypothesized that Hmong students’ perceived family stigmatization would be positively related to their own views on mental health. Secondly, it was hypothesized that Hmong youths’ perceived stigmatization would predict negative attitudes toward seeking mental health services. In addition, it was hypothesized that acculturation levels would predict perceived levels of perceived stigmatization and also predict their attitudes towards mental health services. Lastly, Hmong students’ knowledge about mental health services available and feeling embarrassed and not being able to work up the courage to seek mental health services was hypothesized to be most related to their mental health service use. Pearson correlations were used to analyze the relationships.

Descriptive Statistics

There were 51 male and 38 female participants. Their ages ranged from 14 to 19 years old (M = 16.2, SD 1.3) Eight students were first generation Hmong American, 77 were second generation Hmong American, and 4 were third
generation Hmong American. Parents were asked to provide their age, relationship to the student, marital status, level of education, employment, and entrance into the U.S. The frequency and percentage of parent demographics are provided in Table 1 (p. 36).

The Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA) contained 21 questions using a Likert rating scale of 1 to 5. The scores were averaged. Low scores indicated “Hmong-Identified,” middle scores indicated “Bicultural,” and high scores indicated “Assimilated.” Most Hmong youth indicated themselves to be “Bicultural” (see Table 2).

The Attitudes Toward Seeking Professional Psychological Help Scale: Short Form (ATSPPH-SF) was comprised of 10 questions using a Likert rating scale. Scores were summed. Low scores indicated negative attitudes and high scores indicated positive attitudes towards professional psychological services. The results from the Hmong youth ratings revealed neutral attitudes towards seeking mental health care (see Table 2).

The Attitudes Towards Mental Health Problems Scale (ATMHP) included 35 questions using a Likert scale of 0 to 3. Scores were summed. Low scores indicated low levels of perceived stigmatization and high scores indicated high levels of perceived stigmatization. The ratings from the
Hmong youth indicated low to neutral perceptions of stigmatization (see Table 2).

The barrier questions from the Massachusetts Institute of Technology Mental Health Task Force Report were made up of 13 questions using a Likert rating scale. Each question served as an individual barrier. Table 3 lists mean and standard deviations for each barrier. Most items ratings were at least midway or higher on a scale of “Does not happen” to “Happens a lot” indicating several potential barriers. “Being afraid of their friends or housemates finding out” and “Being afraid of parents finding out” were rated to be the highest frequently perceived barriers. The barrier of “appointments being too long” was rated to be the least frequently perceived barrier.

Research Hypothesis I

It was hypothesized that high levels of perceived family stigmatization would be positively correlated with high levels of self-perceived stigmatization. A Pearson correlation was used to compute the relationships between the stigmatization variables. The results supported the first hypothesis. Perceived family stigmatization was found to significantly positively correlated with self stigmatization, \( r(87) = .51, p < .01\) (see Table 4).
Table 2

Ranges, Means, and Standard Deviations for Acculturation, Perceived Stigmatization, and Attitudes Towards Seeking Professional Psychological Help

<table>
<thead>
<tr>
<th>Variables</th>
<th>Range</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acculturation (SL-ASIA)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>2.24 – 3.86</td>
<td>3.04</td>
<td>.32</td>
</tr>
<tr>
<td>Attitudes (ATSPPH-SF)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>11 – 40</td>
<td>25.26</td>
<td>5.17</td>
</tr>
<tr>
<td>Stigma Total (ATMPH)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>2.00 – 95</td>
<td>32.98</td>
<td>20.79</td>
</tr>
<tr>
<td>Stigma - Community&lt;sup&gt;d&lt;/sup&gt;</td>
<td>0 – 25</td>
<td>9.57</td>
<td>5.85</td>
</tr>
<tr>
<td>Stigma - Family&lt;sup&gt;e&lt;/sup&gt;</td>
<td>0 – 22</td>
<td>5.48</td>
<td>5.67</td>
</tr>
<tr>
<td>Stigma - Self&lt;sup&gt;f&lt;/sup&gt;</td>
<td>0 – 15</td>
<td>5.52</td>
<td>4.12</td>
</tr>
</tbody>
</table>

Note. <sup>a</sup>Acculturation scores were obtained from the Suinn-Lew Asian Self-Identify Acculturation Scale (SL-ASIA). Possible scores ranged from 1 to 5. Low scores indicated “Hmong-identified,” medium scores indicated “Bicultural,” and high scores indicated “Assimilated.”

<sup>b</sup>Attitudes scores were obtained from the Attitudes Toward Seeking Professional Psychological Help – Short Version (ATSPPH-SF). Possible scores ranged from 0 to 40. Low scores indicated negative attitudes and high scores indicated positive attitudes towards mental health services.

<sup>c</sup>Stigmatization Total scores were obtained from the Attitudes Towards Mental Health Problems scale (ATMHP) total score. Possible scores ranged from 0 to 105.

<sup>d</sup>Community,

<sup>e</sup>Family, and

<sup>f</sup>Self stigmatization were obtained from the Attitudes Towards Mental Health Problems Scale (ATMHP). Possible scores for perceived Community and Family ranged from 0 to 27. Possible Self perceived stigmatization ranged from 0 to 15. For all stigmatization variables, low scores indicated lower stigmatization levels and high scores indicated higher stigmatization levels.
Table 3

Correlations Between Attitudes Towards Seeking Professional Psychological Help (ATSPPH-SF) Score and Perceived Barriers With Means and Standard Deviations of Perceived Barriers

<table>
<thead>
<tr>
<th>Barriers</th>
<th>ATSPPH-SF Score</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Need</td>
<td>.03</td>
<td>4.44</td>
<td>1.91</td>
</tr>
<tr>
<td>Lack of Knowledge</td>
<td>.03</td>
<td>4.43</td>
<td>1.83</td>
</tr>
<tr>
<td>Embarrassed/No Courage</td>
<td>.13</td>
<td>4.99</td>
<td>1.96</td>
</tr>
<tr>
<td>Confidentiality Issues</td>
<td>.15</td>
<td>4.91</td>
<td>1.81</td>
</tr>
<tr>
<td>Parents Finding Out</td>
<td>.05</td>
<td>5.08</td>
<td>1.74</td>
</tr>
<tr>
<td>Friends/Housemates Finding Out</td>
<td>.07</td>
<td>5.17</td>
<td>1.75</td>
</tr>
<tr>
<td>Hearing Bad Things</td>
<td>.08</td>
<td>3.76</td>
<td>1.90</td>
</tr>
<tr>
<td>Difficulty Making Appointments</td>
<td>.25*</td>
<td>3.36</td>
<td>1.77</td>
</tr>
<tr>
<td>Appointments Too Long</td>
<td>.12</td>
<td>3.30</td>
<td>1.72</td>
</tr>
<tr>
<td>No Time/Never Get Around To It</td>
<td>.13</td>
<td>4.02</td>
<td>1.67</td>
</tr>
<tr>
<td>Belief It Will Not Help</td>
<td>-.03</td>
<td>5.01</td>
<td>1.71</td>
</tr>
<tr>
<td>Do Not Think of It</td>
<td>.11</td>
<td>4.81</td>
<td>1.97</td>
</tr>
<tr>
<td>Other</td>
<td>.11</td>
<td>4.44</td>
<td>1.62</td>
</tr>
</tbody>
</table>

Note. *Correlations are significant at the 0.05 level. Barriers were obtained from questions adapted from the Massachusetts Institute of Technology Mental Health Task Force Report in 2001. Possible scores ranged from 1 to 7. Low scores indicated “Does not happen much” and higher scores “Happens a lot.”

Table 4

Correlations Among Perceived Community Stigmatization, Perceived Family Stigmatization, and Self Stigmatization

<table>
<thead>
<tr>
<th>Stigmatization</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>-</td>
<td>.66</td>
<td>.63</td>
</tr>
<tr>
<td>Family</td>
<td>.66</td>
<td>-</td>
<td>.51</td>
</tr>
<tr>
<td>Self</td>
<td>.63</td>
<td>.51</td>
<td>-</td>
</tr>
</tbody>
</table>

Note. All correlations were significant at the 0.01 level.
A closer examination revealed that the variables of stigmatization (community, family, self) were all significantly positively correlated with each other. Perceived community stigmatization and perceived family stigmatization were significantly positively correlated, $r(87) = .66, p < .01$. as well as perceived community stigmatization and self stigmatization, $r(87) = .63, p < .01$. It appears that Hmong youths’ perceptions of mental health stigmatization were significantly positively related to their perceptions of their communities’ and their families’ stigmatization.

**Research Hypothesis II**

It was hypothesized that high levels of perceived stigmatization in Hmong youth would significantly predict negative attitudes towards seeking professional mental health services. The degree to which high levels of perceived stigmatization (ATMHP) in Hmong youth predicted negative attitudes towards seeking professional mental health services (ATSPPH-SF) was examined using a Pearson correlation. No support was established for the second hypothesis, $r(87) = -.05, p > .05$ (see Table 5). The range, mean, and standard deviations are provided in Table 2. The results indicated that perceived stigmatization was not significantly related to attitudes towards seeking professional mental health services.
Table 5

**Correlations Between Stigmatization (ATMHP), Acculturation (SL-ASIA), and Attitudes Towards Seeking Professional Psychological Help (ATSPPH-SF)**

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stigmatization (ATMHP)</td>
<td>-</td>
<td>.01</td>
<td>-.05</td>
</tr>
<tr>
<td>Acculturation (SL-ASIA)</td>
<td>.01</td>
<td>-</td>
<td>.08</td>
</tr>
<tr>
<td>Attitudes (ATSPPH-SF)</td>
<td>-.05</td>
<td>.08</td>
<td>-</td>
</tr>
</tbody>
</table>

**Note.** No significant correlations were found.

**Research Hypothesis III**

It was hypothesized that more assimilated Hmong youth would report lower levels of perceived stigmatization or shame toward mental illness. Using a Pearson correlation, the results indicated that the third hypothesis was not supported, $r(87) = .005, p > .05$ (see Table 5). Hmong youth’s acculturation scores (SL-ASIA) were not significantly correlated with levels of perceived stigmatization (ATMHP).

**Research Hypothesis IV**

It was hypothesized that more assimilated Hmong youth would have more positive attitudes towards seeking professional mental health services than lower acculturated Hmong youth. The fourth hypothesis was not supported, $r(87) = .08, p > .05$ (see Table 5). The results from a Pearson correlation indicated that acculturation (SL-ASIA)
was not significantly related to attitudes towards seeking professional mental health services (ATSPPH-SF).

**Research Hypothesis V**

It was hypothesized that attitudes towards seeking professional mental health services would be correlated with knowledge about the services available and feeling embarrassed and not being able to work up the courage to seek the services. A Pearson correlation was used to compute the relationships and the results did not support the fifth hypothesis, \( r(87) = .034, p < .05 \) and \( r(87) = .13, p < .05 \). Knowledge and embarrassment were not significantly related to Hmong youths’ attitudes towards seeking mental health services. Only one barrier, perceived difficulty in making appointments, was identified with a significant relationship, \( r(87) = .25, p < .05 \) (see Table 3). It appears that Hmong youths’ perceptions of the difficulty level in making appointments were positively related to their attitudes towards seeking mental health services.
Chapter 5

DISCUSSION

Implications of Research Findings

Numerous studies have identified the Hmong as a group with heightened risks for mental health illnesses due to migration stressors, acculturation, language barriers, and low socioeconomic statuses (Cerhan, 1990; Ida & Yang, 2003; Nicholson, 1997; USDHHS, 1999; Westermeyer, 1988). In an effort to distinguish barriers and implement mental health services to Hmong students between the ages of 14 years old to 19 years old, this study examined whether acculturation and perceptions of self, family, and community stigmatization affected Hmong students’ attitudes toward seeking mental health services. This study also intended to identify barriers that were perceived to be inhibiting their use of mental health services. It was hypothesized Hmong youth’s self perceived stigmatization would be significantly positively related to their perceptions of their families’ stigmatization. Secondly, it was hypothesized Hmong youths’ perceived stigmatization was hypothesized to be correlated with their attitudes towards seeking mental health services. Additionally, higher acculturation levels were hypothesized to be related to lower levels of perceived stigmatization and positive
attitudes towards seeking mental health services. Moreover, it was hypothesized that lack of knowledge of mental health services and embarrassment would be identified as the primary barriers towards Hmong youths’ utilization of mental health services. These hypotheses were measured through the dissemination of a Mental Health Survey to Hmong high school students at a Central Valley high school and Hmong-based church.

Community, Family, and Self
Stigmatization on Mental Health

Over and over again, mental health research continues to validate psychological treatments as effective strategies in the prevention and treatment of mental health illnesses (Gilbert et al., 2007; Shea & Yeh, 2008; Vogel, Wade, & Haake, 2006). Despite this, fewer than 40% of people requiring these services seek out the necessary professional psychological care (Mental Health America, 2006; Witt et al., 2003; Vogel et al., 2006). Among the many identifiable factors contributing to this path of despair and avoidance, stigma is recurrently cited as the number one reason (Corrigan, 2004). Seeking psychological help is often perceived as a sign of weakness and a socially undesirable trait. These beliefs are particularly pronounced in collectivistic cultures due to effects on individuals being generalized onto entire familial
ancestries. Individuals from Asian backgrounds have been consistently found to refrain from mental health care based on their strong allegiance to their families and fear of conveying shame (Gilbert et al., 2007; Hsu & Alden, 2008; Kim & Omizo, 2003; Shea & Yeh, 2008).

In consideration of the research, the first hypothesis stated that high levels of perceived family stigmatization would be positively correlated with high levels of self perceived stigmatization. This hypothesis was supported by the results. When Hmong youths’ perceptions of family stigmatization increased, so did their own perceptions of stigmatization. Hmong youths’ perceptions of community stigmatization and family stigmatization had a strong positive relationship with their perceptions of community stigmatization and their self stigmatization was also positively correlated. These results were consistent with past research. Gilbert et al. (2007) found that Asian students were more concerned about external shame, such as community perceptions and family perceptions, as opposed to their own perceptions. Specifically, Asian students were more concerned about what outsiders may think. Their ratings of self stigmatization were not significantly different in comparison to how Caucasians students felt about self stigmatization (Gilbert et al., 2007).

The Hmong community in the Central Valley is a close-knit community accounting for the second-largest Hmong
population in the U.S. Within this structure, there is an abundance of avenues for communication such as numerous Hmong radio stations, television shows, Internet communities, and public events such as the National Hmong New Year. With increased connections to the community, Hmong youth in the Central Valley may view the community as having strong impact on their families. Furthermore, over 50% of the participants had parents that achieved a high school education or lower. Students from these families may view factors from the community, such as their schools, as more informative and influential.

Stigma and Mental Health Care
The second hypothesis stated that high levels of perceived stigmatization in Hmong youths would predict negative attitudes towards seeking professional mental health services. The results from this study did not support the second hypothesis. An examination of the attitude scores indicated that the majority of Hmong youth did not have negative or positive attitudes towards the use of mental health services, but instead held neutral attitudes. In addition, the majority of the Hmong youth had neutral levels of perceived stigmatization. The lack of a heterogeneous score limited the likelihood of finding statistically significant relationship. As previously noted, the Hmong youth in this sample were predominantly
bicultural and second generation Hmong American (87%). The balancing of two cultures may be impacting their perceptions of stigmatization and also positively affecting their attitudes towards seeking mental health services. These findings were consistent with results from a study looking at perceived stigma and seeking of mental health care in college students (58.5% Caucasian, 22.7% Asian, 6.2% African American, 3.7% Latino, 8.8% Other) at a Midwestern public university. Golberstein, Eisenberg, and Gollust (2008) found that stigmatization was not significantly associated with utilization of mental healthcare despite Asian and Others having significantly higher levels of perceived stigmatization in comparison to Caucasians and Latinos.

**Acculturation and Stigmatization**

Research repeatedly shows that the process of acculturation remains a critical issue in healthcare. Danner, Robinson, Striepe, and Rhodes (2007) stated that conflicts between Eastern and Western cultures generate significant problems for the treatment of mental health ailments. They postulated that while several Eastern cultures believe their sufferings may be the result of losing souls, Western cultures view mental health problems to be psychological in nature. These varied etiological perspectives create incongruent treatment practices and may
cause unwanted anxiety and misunderstandings that result in lower levels of Western medicine adoption and acceptance.

Thus, it would be foreseeable that adoption of the Western culture would equate to a higher likelihood of accepting Western views of illness. Therefore, the third hypothesis stated that assimilated Hmong youth would report lower levels of perceived stigmatization or shame toward mental illness. The results from the current study did not support the third hypothesis; Hmong youths’ acculturation did not affect reported levels of perceived stigmatization. An examination of the acculturation mean score indicated that the majority of Hmong youths rated themselves as “biculural” indicating that they were equally balancing both the American culture and the Hmong culture.

Stigmatization scores indicated that Hmong youth generally reported low levels of perceived stigmatizations regarding mental health. Hmong youth in the Central Valley may be effectively balancing the American culture with their more traditional Hmong cultures and this biculturalism is decreasing mental health stigmatization. Moreover, because most of the participants rated themselves as bicultural individuals, the findings may have been skewed due to a limited acculturation range and diversity. Nonetheless, these findings challenge the results of Chung and Lin (1994), in which the Hmong were the least likely Southeast Asian group to use Western Medicine in U.S., and
suggest that Hmong youth are adapting to the Western culture and changing from their previous ways. The majority of the participants were second generation Hmong American. As a result, the lengthened exposure to American life may have significantly affected levels of stigmatization and acceptance of Western healthcare.

Acculturation and Mental Healthcare

The concept of increased acculturation relating to higher acceptance and use of unfamiliar practices is a widely accepted phenomenon in field of medicine. Many studies confirm that Asian families with high acculturation levels use mental health services more than their less acculturated counterparts (Atkinson & Gim, 1989; Ho et al., 2007). Due to the prior research, the fourth hypothesis stated that assimilated Hmong youth would have more positive attitudes towards seeking mental health services than Hmong-identified Hmong youth. The results revealed that Hmong youths’ acculturation levels were not predictive of their attitudes towards mental health service utilization. However, examinations of means indicated that the majority of the Hmong youth were bicultural and had neutral attitudes towards using mental health services.

Kim (2007) investigated Asian and European cultural values and their effects on 146 Asian American college students’ (23.3% Chinese, 18.5% Asian Indians, 18.5%
Koreans, 9.6% Filipinos, 7.5% Japanese, 4.8% multiethnic, 5% Taiwanese, 2.7% Vietnamese, 2.1% Indonesian, 1% Cambodian, 1% Malaysian, 1% Pakistani, 1% Thai, and 6.8% others) attitudes toward seeking professional psychological help. The results from the study revealed that there was no association with acculturation and attitudes towards seeking mental health services. These recent studies suggest that Asian American youth may be becoming more acculturated and may be viewing mental healthcare as more acceptable. Also, both samples were students, indicating the level of educational attainment may be a factor influencing a less negative view of mental health care.

**Barriers to Mental Health Care**

In the fifth hypothesis, knowledge about mental health services and feeling embarrassed and not being able to work up the courage to seek the services were hypothesized to be significantly correlated with Hmong youths’ attitudes towards seeking professional mental health services. This hypothesis was not supported by the findings. Only one barrier was identified to be significantly related with attitudes towards seeking professional psychological help and that was Hmong students’ perceptions of the difficulties in making appointments and accessing such services. Research indicates most Asian youth do not utilize mental health services and as a result, may not
understand the processes to do so. Moreover, the average age for the participants was 16.2 years old. At this age, they may have minimal experience in making health service appointments or locating available mental health services. Additionally, 66% of the annual household incomes were under $30,000. As a result, the majority of this sample may be under the state’s low income family health plans such as Medi-Cal which restricts the usage of mental health services, further limiting the exposure and access to the services.

In a similar study on Cambodian refugees, Wong et al. (2006) found that structural barriers, as opposed to cultural barriers, were most cited in underutilization of mental health services. Eighty percent of the participants endorsed the cost of services as the number one reason for the disproportionate use. Other significant barriers were listed as language problems, transportation, and discrimination. It was reported that less than 6% of the participants identified cultural barriers such as stigma, lack of trust of western healthcare, and familial opposition. An increase in acceptance of mental healthcare indicates that Asian Americans may be progressing towards a more neutral stance. Possible explanations include acculturation progression as both the Cambodian and Hmong have lived in the U.S. for 30 years. The majority of this study’s sample consisted of second generation Hmong
American and it is conceivable that cultural barriers may no longer be the primary barriers.

Although only one barrier was significantly related to Hmong youths’ attitudes towards seeking mental health services, six barriers were rated to be frequently perceived barriers towards mental health care utilization. The barriers of (a) feeling embarrassed and not being able to work up the courage to seek services, (b) concerned about confidentiality issues, (c) parents finding out, (d) friends finding out, (e) thinking the services would not help, and (f) not thinking about the services were rated to be moderately high barriers. These six barriers can be classified into two categories: perceived stigmatization and lack of knowledge.

Hmong youths’ ratings of embarrassment, parents finding out, and friends finding out about receiving mental health services may be influenced by their perceptions of stigmatization. Despite the majority of Hmong youth rating themselves to be neutral in perceptions of stigmatization, Hmong youth may perceive their families’ and peers’ levels of stigmatization to be elevated. In Hypothesis I, it was found that Hmong youths’ stigmatizations were related to their perceptions of their families’ and communities’ mental health stigmatization. Hmong youth may feel that their friends and families have negative views regarding mental health. Lee et al. (2009) found that Asian American
youth did not share their mental health problems amongst their peers or families. The participants cited that discussing mental health was a "taboo" and as a result, elected to conceal, neglect, or deny their mental illness symptoms.

In a recent study by Lee et al. (2009), 17 Asian American young adults from eight different ethnic groups (Asian Indian, Cambodian, Chinese, Indonesian, Korean, Taiwanese, Thai, and Vietnamese) participated in focus groups to identify barriers to mental health use. This study yielded results similar to the current study and identified (a) costs of mental health care, (b) stigma, (c) lack of awareness, (d) worrying parents, (e) lack of linguistically and culturally trained professionals, and (f) parents’ lack of mental health knowledge to be the major barriers. Hmong youths’ perceptions of mental health care barriers were consistent with other Asian American subgroups in the areas of stigmatization and worrying about parents finding out.

It may be that regardless of acculturation levels, Asian families may continue to view mental health as a sign of weakness due to the potential repercussions on the entire family. These strong adherences to collectivistic viewpoints may continue to hinder mental health use.

Hmong youths’ lack of knowledge on mental health care was also identified as a frequently perceived barrier.
Although the majority of Hmong youths rated themselves to be bicultural, held neutral levels of stigmatization, and held neutral attitudes towards seeking mental health care, they still lacked appropriate facts about mental health services. Their concerns about confidentiality and thinking the services would not help are commonly mistaken assumptions about mental health care. Confidentiality in mental health practices are governed by strict laws and ethical guidelines and are often clearly explained at the onset of therapy. In addition, the effectiveness of mental health care has been continuously validated in research. Such misconceptions may lead to their tendency to not think about the services. It may be that Hmong youths’ views of mental healthcare have changed; however, they may have yet to experience the services. Thao (2006) found that while 36% of the Hmong participants reported positive attitudes towards mental healthcare, only 12% had used mental health services. A lack of mental healthcare education, opportunity for services, and appropriately trained mental health care professionals may be contributing to increased stigmatization and a lack of knowledge about mental health.

Lee et al. (2009) found that the lack of linguistically and culturally trained professionals was a major barrier for Asian American youth in seeking mental health services. Access to Hmong mental health care professionals may increase Hmong youth’s use of mental
health services by promoting a comfortable and familiar option as they can speak to someone from their own ethnic group and in their native language. Such options can ease any tension from the unnatural environments and practices of mental health care.

Efforts to decrease Hmong youths’ perceptions of stigmatization and increase their mental health awareness should focus on mental health education and facilitating mental health discussions among families and youth groups.

Limitations and Future Directions
There were several limitations in this study. One of the main limitations to this study was the unknown reading skills of the student participants. Although the option to request for clarification and help was explained at the beginning of the all questionnaire administrations, only five students requested help. Other students may not have used these services due to plausible reasons such as embarrassment or carelessness. Two students’ questionnaires were removed from the sample by the recommendation of assisting school staff member due to the students having limited reading skills. It is probable that other students with reading weaknesses may have been included in this sample. Future research should offer oral questionnaire administration sessions.
A second limitation to the study was the homogenous sample. The participants in this study consisted primarily of second generation bicultural Hmong American high school students. A more diverse Hmong student population may have benefitted the study by providing a larger acculturation range in which stronger tests of relationships could be made. In addition, the majority of the participants came from homes with annual incomes lower than $30,000, parents with less than high school educations, and unemployed parents. Hmong students from these families may have dissimilar perspectives from Hmong students with more educated parents and that come from higher income families. Future research may look into investigating mental health perceptions between Hmong youth with varying acculturation levels as well as whether higher socioeconomic statuses affect acculturation levels and mental health perceptions. Strategies to collect heterogeneous Hmong youth samples need to be examined.

A third limitation to the study was the adaptation of two questionnaires for the sample group. First, the SL-ASIA had the term “Asian” changed to “Hmong”. Although the SL-ASIA directions stated that this replacement was approved for Asian subgroup research, there are no data investigating its effects for this subgroup. The Hmong are a subgroup vastly differing from others due to their limited exposure to Western culture and interchanging the
group names in the questionnaire may not yield equivalent results. Additionally, the MIT Barriers Survey questions were adapted from college student use to high school student use. Although the content of the questions were modified to accommodate high school students, the types of barriers may be inconsistent. College aged students may encounter different types of problems in comparison to high school aged students. Future research in this area should consider proper adaptations to questionnaires in terms of ethnic group terminology substitution and relevance of mental health barriers per age group.

Summary

Children in the U.S. continue to receive inadequate mental health care. Minority children have even greater chances of not receiving the needed services due to increased structural and cultural barriers. This peril is of particular concern in a Southeast Asian subgroup known as the Hmong. The Hmong have been repeatedly identified as having increased risk for mental illnesses due to language barriers, financial limitations, stigmatization, and acculturative processes (Ida & Yang, 2003; Massi & Cooper, 2006; Snowden et al., 2008). This study focused on investigating the effects of Hmong students’ acculturation and perceptions of self, family, and community stigmatization on their attitudes toward seeking mental
health services. This study also focused on identifying barriers that were perceived to be inhibiting Hmong students' use of mental health services.

The current study demonstrated that Hmong youth, ages 14 to 19, were mainly bicultural and successfully balancing the American culture with the Hmong culture. The bicultural effect was shown to mediate stigmatization towards mental health and as well as foster neutral attitudes towards using mental health services. Additionally, the results indicated that Hmong students are incorporating both the community and family to develop their own judgments regarding mental health. Successful acculturation also mediated cultural barriers to mental health. A structural barrier, difficulty in making appointments, was significantly related to their attitudes towards seeking mental health care. In addition, Hmong youth identified barriers related to stigma and the lack of mental healthcare knowledge to be moderate barriers towards mental health care use.

Other important findings indicated that acculturation has progressed despite 66% of the participants coming from homes with annual incomes of $30,000 or less and over 50% of the students having parents with a high school education or lower. This is of significant importance because these factors that once led to increased mental illnesses are not negatively impacting Hmong youths' views on mental health.
Furthermore, though this study focused primarily on mental health, it is conceivable that Hmong youth are also adopting American ways of life such as individualism. Future research continues to be necessary in order to monitor Hmong youths’ well being and use of mental health services. This study provides preliminary evidence that the Hmong youth in the Central Valley of California are bicultural and adopting Western cultural views such as mental healthcare.
REFERENCES
REFERENCES


Chung, H., & Yamey, G. (2002). Improving the mental health of Asian Americans depends on training primary care clinicians and educating the community. Western Journal of Medicine, 2, 601-602.


APPENDIX A

PARENT DEMOGRAPHIC QUESTIONNAIRE
(IN ENGLISH AND HMONG)
Parent Demographic Questionnaire

Directions: please check the appropriate space:

1) Parent:
   ____ Father   ____Mother
   ____ Guardian   ________________ (relation)

2) Age: _______ years

3) Marital status:
   ____ single   ____married
   ____ divorced   ____widowed

4) The highest level of education you have attained:
   ____below elementary level   ____college graduate
   ____some high school   ____some graduate school
   ____high school graduate   ____Master’s degree
   ____some college   ____Doctoral degree

5) Employment:
   ____not currently employed   ____full-time employment
   ____part-time employment   ________________other

6) Which decade did you enter the United States?
   ____1970’s   ____1980’s   ____1990’s   ____2000’s

7) What is your household yearly income?
   ____below $30,000   ____$90,000- $120,000
   ____$30,000 - $60,000   ____$120,000 - above
   ____$60,000- $90,000

PLEASE ATTACH COMPLETED QUESTIONNAIRE TO SIGNED CONSENT FORMS AND HAVE YOUR CHILD RETURN IT TO THEIR INSTRUCTOR. THANK YOU.
Lus Noog Niam Txiv (Parent Demographic Questionnaire)

Khiv rau yam qhaub koj:

1) Niam Txiv:
   _____ Txiv         _____Niam
   _____ Tus Saib Xyuas Me Nyuam
   (txheeb zeb li cas)

2) Hnoob yug: _____ xyoo

3) Marital status:
   _____tsis tau sib yuav    _____ sib yuav
   _____sib nrauj       _____ tus txiv/poj niam xiam

4) Kawm ntawv siab npaum li cas:
   _____Kawm ntawv qib tshaj      _____Kawm college mi ntsis
   _____Kawm high school          _____Kawm tiav college
   _____Kawm tiav high school     _____tau Master’s degree
   _____Kawm college mi ntsis     _____tau Doctoral degree

5) Ua Hauj Lwm:
   _____Tsis ua hauj lwm
   _____Ua hauj lwm full-time
   _____Ua hauj lwm part-time
   ______________________Lwm yam

6) Tuaj rau teb chaws United States rau xyoo twg?
   _____1970’s   _____1980’s     _____1990’s     _____2000’s

7) Ib xyoo tau nyiaj ntau npaum li cas hauv tsev?
   _____ tsawg tshaj $30,000       _____$90,000-$120,000
   _____$30,000-$60,000         _____$120,000-rov sauv
   _____$60,000-$90,000

THOV MUAB DIAM NTAWW QUESTIONNAIRE NROG DAIM NTAWW TSO
CAI RAU KOJ TUS ME NYUAM NQA TUAJ RAU KOJ TUS ME NYUAM TUS
XIB HWB. UA TSAUG.
APPENDIX B

STUDENT DEMOGRAPHIC QUESTIONNAIRE
Student Demographic Questionnaire

Directions: please check the appropriate space.

1) Gender:
   ____ male
   ____ female

2) Age:
   ____ 14  ____ 16  ____ 18
   ____ 15  ____ 17  ____ 19

3) What generation Hmong-American are you?
   _____ 1\textsuperscript{st} Generation (you were born outside of the U.S.)
   _____ 2\textsuperscript{nd} Generation (parents were born outside the U.S. and you were born in the U.S.)
   _____ 3\textsuperscript{rd} Generation (at least one of your parents were born in the U.S. and you were born in the U.S.)
APPENDIX C

SUINN-LEW ASIAN SELF-IDENTITY ACCULTURATION SCALE (SL-ASIA)
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. Circle the one answer which best describes you.

1. What language can you speak?
   1. Hmong only
   2. Mostly Hmong, some English
   3. Hmong and English about equally well (bilingual)
   4. Mostly English, some Hmong
   5. Only English

2. What language do you prefer?
   1. Hmong only
   2. Mostly Hmong, some English
   3. Hmong and English about equally well (bilingual)
   4. Mostly English, some Hmong
   5. Only English

3. How do you identify yourself?
   1. Oriental
   2. Hmong
   3. Asian-American
   4. Hmong-American
   5. American

4. Which identification does (did) your mother use?
   1. Oriental
   2. Hmong
   3. Asian-American
   4. Hmong-American
   5. American

5. Which identification does (did) your father use?
   1. Oriental
   2. Hmong
   3. Asian-American
   4. Hmong-American
   5. American
6. What was the ethnic origin of the friends and peers you had, as a child up to age 6?
   1. Almost exclusively Hmongs
   2. Mostly Hmongs, Hmong-Americans, Orientals
   3. About equally Hmong groups and Caucasian groups
   4. Mostly Caucasians, Blacks, Hispanics, or other non-Hmong ethnic groups
   5. Almost exclusively Caucasians, Blacks, Hispanics, or other non-Hmong ethnic groups

7. What was the ethnic origin of the friends and peers you had, as a child from 6 to 18?
   1. Almost exclusively Hmongs, Hmong-Americans, Orientals
   2. Mostly Hmongs, Hmong-Americans, Orientals
   3. About equally Hmong groups and Caucasian groups
   4. Mostly Caucasians, Blacks, Hispanics, or other non-Hmong ethnic groups
   5. Almost exclusively Caucasians, Blacks, Hispanics, or other non-Hmong ethnic groups

8. Whom do you now associate with in the community?
   1. Almost exclusively Hmongs, Hmong-Americans, Orientals
   2. Mostly Hmongs, Hmong-Americans, Orientals
   3. About equally Hmong groups and Caucasian groups
   4. Mostly Caucasians, Blacks, Hispanics, or other non-Hmong ethnic groups
   5. Almost exclusively Caucasians, Blacks, Hispanics, or other non-Hmong ethnic groups

9. If you could pick, whom would you prefer to associate with in the community?
   1. Almost exclusively Hmongs, Hmong-Americans, Orientals
   2. Mostly Hmongs, Hmong-Americans, Orientals
   3. About equally Hmong groups and Caucasian groups
   4. Mostly Caucasians, Blacks, Hispanics, or other non-Hmong ethnic groups
   5. Almost exclusively Caucasians, Blacks, Hispanics, or other non-Hmong ethnic groups

10. What is your music preference?
    1. Only Hmong music
    2. Mostly Hmong
    3. Equally Hmong and English
    4. Mostly English
    5. English only

11. What is your movie preference?
    1. Hmong-language movies only
    2. Hmong-language movies mostly
    3. Equally Hmong/English English-language movies
    4. Mostly English-language movies only
    5. English-language movies only
12. What generation are you? (Circle the generation that best applies to you.)
   1. 1st Generation = I was born in Asia or country other than U.S.
   2. 2nd Generation = I was born in U.S., either parent was born in Asia or country other than U.S.
   3. 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.
   4. 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.
   5. 5th Generation = I was born in U.S., both parents were born in U.S., and all grandparents also born in U.S.
   6. Don't know what generation best fits since I lack some information.

13. Where were you raised?
   1. In Asia only
   2. Mostly in Asia, some in U.S.
   3. Equally in Asia and U.S.
   4. Mostly in U.S., some in Asia
   5. In U.S. only

14. What contact have you had with Asia?
   1. Raised one year or more in Asia
   2. Lived for less than one year in Asia
   3. Occasional visits to Asia
   4. Occasional communications (letters, phone calls, etc.) with people in Asia
   5. No exposure or communications with people in Asia

15. What is your food preference at home?
   1. Exclusively Hmong food
   2. Mostly Hmong food, some American
   3. About equally Hmong and American
   4. Mostly American food
   5. Exclusively American food

16. What is your food preference in restaurants?
   1. Exclusively Hmong food
   2. Mostly Hmong food, some American
   3. About equally Hmong and American
   4. Mostly American food
   5. Exclusively American food
17. Do you
1. Read only a Hmong language?
2. Read a Hmong language better than English?
3. Read both Hmong and English equally well?
4. Read English better than a Hmong language?
5. Read only English?

18. Do you
1. Write only a Hmong language?
2. Write a Hmong language better than English?
3. Write both Hmong and English equally well?
4. Write English better than a Hmong language?
5. Write only English?

19. If you consider yourself a member of the Hmong group, how much pride do you have in this group?
1. Extremely proud
2. Moderately proud
3. Little pride
4. No pride but do not feel negative toward group
5. No pride but do feel negative toward group

20. How would you rate yourself?
1. Very Hmong
2. Mostly Hmong
3. Bicultural
4. Mostly Westernized
5. Very Westernized

21. Do you participate in Hmong occasions, holidays, traditions, etc.?
1. Nearly all
2. Most of them
3. Some of them
4. A few of them
5. None at all
APPENDIX D

ATTITUDES TOWARDS MENTAL HEALTH PROBLEMS SCALE
(ATMHP)
We are interested in people’s thoughts and feelings about mental health problems. As you may know, some people suffer from mental health problems such as depression and anxiety. These can make it difficult to cope with everyday life. Depressed people can feel tired, not enjoy life, want to hide away and may withdraw from family life. Below are a series of statements about how you, your community and your family may think about such problems. Read each statement carefully and circle the number that best describes how much you agree with each statement. Please use the following scale:

\[ 0 = \text{Do not agree at all}; \ 1 = \text{Agree a little}; \ 2 = \text{Mostly agree}; \ 3 = \text{Completely agree} \]

For this first set of questions please think about how your community and family view mental health problems such as depression and anxiety with a difficulty to cope in everyday life.

1. My community sees mental health problems as something to keep secret.
   \[0\text{ Do not agree} \quad 1\text{ Agree a little} \quad 2\text{ Mostly agree} \quad 3\text{ Completely agree}\]

2. My community sees mental health problems as a personal weakness.
   \[0\text{ Do not agree} \quad 1\text{ Agree a little} \quad 2\text{ Mostly agree} \quad 3\text{ Completely agree}\]

3. My community would tend to look down on somebody with mental health problems.
   \[0\text{ Do not agree} \quad 1\text{ Agree a little} \quad 2\text{ Mostly agree} \quad 3\text{ Completely agree}\]

4. My community would want to keep their distance from someone with mental health problems.
   \[0\text{ Do not agree} \quad 1\text{ Agree a little} \quad 2\text{ Mostly agree} \quad 3\text{ Completely agree}\]

5. My family sees mental health problems as something to keep secret.
   \[0\text{ Do not agree} \quad 1\text{ Agree a little} \quad 2\text{ Mostly agree} \quad 3\text{ Completely agree}\]

6. My family sees mental health problems as personal weakness.
   \[0\text{ Do not agree} \quad 1\text{ Agree a little} \quad 2\text{ Mostly agree} \quad 3\text{ Completely agree}\]

7. My family would tend to look down on somebody with mental health problems.
   \[0\text{ Do not agree} \quad 1\text{ Agree a little} \quad 2\text{ Mostly agree} \quad 3\text{ Completely agree}\]
8. My family would want to keep their distance from someone with mental health problems.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Do not agree</td>
</tr>
<tr>
<td>1</td>
<td>Agree a little</td>
</tr>
<tr>
<td>2</td>
<td>Mostly agree</td>
</tr>
<tr>
<td>3</td>
<td>Completely agree</td>
</tr>
</tbody>
</table>

For the next set of question please think about how you might feel if you suffered from mental health problems such as depression and anxiety with a difficulty to cope in everyday life.

9. I think my community would look down on me.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Do not agree</td>
</tr>
<tr>
<td>1</td>
<td>Agree a little</td>
</tr>
<tr>
<td>2</td>
<td>Mostly agree</td>
</tr>
<tr>
<td>3</td>
<td>Completely agree</td>
</tr>
</tbody>
</table>

10. I think my community would see me as inferior.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Do not agree</td>
</tr>
<tr>
<td>1</td>
<td>Agree a little</td>
</tr>
<tr>
<td>2</td>
<td>Mostly agree</td>
</tr>
<tr>
<td>3</td>
<td>Completely agree</td>
</tr>
</tbody>
</table>

11. I think my community would see me as inadequate.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Do not agree</td>
</tr>
<tr>
<td>1</td>
<td>Agree a little</td>
</tr>
<tr>
<td>2</td>
<td>Mostly agree</td>
</tr>
<tr>
<td>3</td>
<td>Completely agree</td>
</tr>
</tbody>
</table>

12. I think my community would see me as weak.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Do not agree</td>
</tr>
<tr>
<td>1</td>
<td>Agree a little</td>
</tr>
<tr>
<td>2</td>
<td>Mostly agree</td>
</tr>
<tr>
<td>3</td>
<td>Completely agree</td>
</tr>
</tbody>
</table>

13. I think my community would see me as not measuring up to their standards.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Do not agree</td>
</tr>
<tr>
<td>1</td>
<td>Agree a little</td>
</tr>
<tr>
<td>2</td>
<td>Mostly agree</td>
</tr>
<tr>
<td>3</td>
<td>Completely agree</td>
</tr>
</tbody>
</table>

14. I think my family would look down on me.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Do not agree</td>
</tr>
<tr>
<td>1</td>
<td>Agree a little</td>
</tr>
<tr>
<td>2</td>
<td>Mostly agree</td>
</tr>
<tr>
<td>3</td>
<td>Completely agree</td>
</tr>
</tbody>
</table>

15. I think my family would see me as inferior.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Do not agree</td>
</tr>
<tr>
<td>1</td>
<td>Agree a little</td>
</tr>
<tr>
<td>2</td>
<td>Mostly agree</td>
</tr>
<tr>
<td>3</td>
<td>Completely agree</td>
</tr>
</tbody>
</table>

16. I think my family would see me as inadequate.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Do not agree</td>
</tr>
<tr>
<td>1</td>
<td>Agree a little</td>
</tr>
<tr>
<td>2</td>
<td>Mostly agree</td>
</tr>
<tr>
<td>3</td>
<td>Completely agree</td>
</tr>
</tbody>
</table>

17. I think my family would see me as weak.

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Do not agree</td>
</tr>
<tr>
<td>1</td>
<td>Agree a little</td>
</tr>
<tr>
<td>2</td>
<td>Mostly agree</td>
</tr>
<tr>
<td>3</td>
<td>Completely agree</td>
</tr>
</tbody>
</table>
18. I think my family would see me as not measuring up to their standards.

0 Do not agree  1 Agree a little  2 Mostly agree  3 Completely agree

For the next set of questions please think about how you might feel about yourself if you suffered from mental health problems such as depression and anxiety with a difficulty to cope in everyday life.

19. I would see myself as inferior.

0 Do not agree  1 Agree a little  2 Mostly agree  3 Completely agree

20. I would see myself as inadequate.

0 Do not agree  1 Agree a little  2 Mostly agree  3 Completely agree

21. I would blame myself for my problems.

0 Do not agree  1 Agree a little  2 Mostly agree  3 Completely agree

22. I would see myself as a weak person.

0 Do not agree  1 Agree a little  2 Mostly agree  3 Completely agree

23. I would see myself as a failure.

0 Do not agree  1 Agree a little  2 Mostly agree  3 Completely agree

For the next set of questions we would like you to think about how you might feel if you suffered from mental health problems such as depression and anxiety with a difficulty to cope in everyday life. This time consider how worried or concerned you would be about the impact on your family.

24. My family would be seen as inferior.

0 Do not agree  1 Agree a little  2 Mostly agree  3 Completely agree

25. My family would be seen as inadequate.

0 Do not agree  1 Agree a little  2 Mostly agree  3 Completely agree

26. My family would be blamed for my problems.

0 Do not agree  1 Agree a little  2 Mostly agree  3 Completely agree
27. My family would lose status in the community.

0 Do not agree  1 Agree a little  2 Mostly agree  3 Completely agree

28. I would worry about the effect on my family.

0 Do not agree  1 Agree a little  2 Mostly agree  3 Completely agree

29. I would worry that I would be letting my family’s honor down.

0 Do not agree  1 Agree a little  2 Mostly agree  3 Completely agree

30. I would worry that my mental health problems could damage my family’s reputation.

0 Do not agree  1 Agree a little  2 Mostly agree  3 Completely agree

For the next set of questions we would like you to think about how you might feel if one of your close relatives suffers from mental health problems such as depression and anxiety with a difficulty to cope in everyday life. This time consider how worried or concerned you would be about the impact on you.

31. I would worry that others will look down on me.

0 Do not agree  1 Agree a little  2 Mostly agree  3 Completely agree

32. I would worry that others would not wish to be associated with me.

0 Do not agree  1 Agree a little  2 Mostly agree  3 Completely agree

33. I would worry that my own reputation and honor might be harmed.

0 Do not agree  1 Agree a little  2 Mostly agree  3 Completely agree

34. I would worry that if this were known I would lose status in the community.

0 Do not agree  1 Agree a little  2 Mostly agree  3 Completely agree

35. I would worry that others might think I might also have a mental health problem.

0 Do not agree  1 Agree a little  2 Mostly agree  3 Completely agree
APPENDIX E

ATTITUDES TOWARD SEEKING PROFESSIONAL
PSYCHOLOGICAL HELP SCALE (ATSPPH-SF)
For the next set of questions, please indicate to what extent you agree or disagree with the statements below:

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.
   1. Disagree  
   2. partly disagree  
   3. partly agree  
   4. Agree

2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.
   1. Disagree  
   2. partly disagree  
   3. partly agree  
   4. Agree

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.
   1. Disagree  
   2. partly disagree  
   3. partly agree  
   4. Agree

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.
   1. Disagree  
   2. partly disagree  
   3. partly agree  
   4. Agree

5. I would want to get psychological help if I were worried or upset for a long period of time.
   1. Disagree  
   2. partly disagree  
   3. partly agree  
   4. Agree

6. I might want to have psychological counseling in the future.
   1. Disagree  
   2. partly disagree  
   3. partly agree  
   4. Agree

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.
   1. Disagree  
   2. partly disagree  
   3. partly agree  
   4. Agree

8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
   1. Disagree  
   2. partly disagree  
   3. partly agree  
   4. Agree

9. A person should work out his or her own problems; getting psychological counseling would be a last resort.
   1. Disagree  
   2. partly disagree  
   3. partly agree  
   4. Agree

10. Personal and emotional troubles, like many things, tend to work out by themselves.
    1. Disagree  
    2. partly disagree  
    3. partly agree  
    4. Agree
APPENDIX F

MENTAL HEALTH BARRIERS QUESTIONNAIRE
For this first set of questions, please read the possible reason as to why students may not use mental health services and circle how much you feel it occurs.

1. They do not feel the need.
   Does not happen much 1 2 3 4 5 6 7 Happens a lot

2. They have a lack of knowledge about the services available.
   Does not happen much 1 2 3 4 5 6 7 Happens a lot

3. They are embarrassed and cannot work up the courage to seek the services.
   Does not happen much 1 2 3 4 5 6 7 Happens a lot

4. They are concerned about confidentiality issues.
   Does not happen much 1 2 3 4 5 6 7 Happens a lot

5. They are afraid of their parents finding out.
   Does not happen much 1 2 3 4 5 6 7 Happens a lot

6. They are afraid their friends or housemates would find out.
   Does not happen much 1 2 3 4 5 6 7 Happens a lot

7. They hear bad things about such services.
   Does not happen much 1 2 3 4 5 6 7 Happens a lot

8. It is difficult to make appointments.
   Does not happen much 1 2 3 4 5 6 7 Happens a lot

9. The waits for appointments are too long.
   Does not happen much 1 2 3 4 5 6 7 Happens a lot

10. They do not have time/ never get around to it.
    Does not happen much 1 2 3 4 5 6 7 Happens a lot

11. They do not think it would help.
    Does not happen much 1 2 3 4 5 6 7 Happens a lot
12. They do not think of it.

<table>
<thead>
<tr>
<th>Does not happen much</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Happens a lot</th>
</tr>
</thead>
</table>

13. Other:________________________

<table>
<thead>
<tr>
<th>Does not happen much</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Happens a lot</th>
</tr>
</thead>
</table>
Dear Parents:

My name is Kong Vang and I am a graduate student in School Psychology at Fresno State. I am writing to ask you and your child to participate in a research study. I am working with the Dr. Marilyn Wilson, a professor at Fresno State. We have asked you and your child to take part in our study because your child is a Hmong high school student at a school in the Central Valley.

The Study. If you choose to participate, please write your child’s name, sign this permission slip below, and complete the demographic questionnaire. After you have completed the questionnaire, put it in the envelope provided and send it back to school with your child to give to his or her instructor. Your child will then, within few days or weeks, complete a questionnaire about his or her acculturation levels, perceived stigmatizations associated with mental illness, attitudes towards seeking mental health services, and perceived barriers towards the use of mental health services which would be administered to your child during school hours. He or she would simply answer questions about himself or herself which will take no more than 30 minutes.

Analyzing and Reporting the Results. Our interest is not in the responses of specific students. Instead, we are interested in whether acculturation and stigmatization levels will have an effect on students’ attitudes towards seeking mental health services. Additionally, we aim to identify potential barriers students feel are inhibiting their use of mental health services. Because this information might be useful to educators and other researchers, we plan to write a minimum of one article about our results for these audiences. We will report the results, however, in terms of group averages. We will not report the results for individual students or parents.

Benefits and Risks. We are doing this study because we want to learn about the extent to which acculturation and stigmatization impact attitudes on mental health services and to identify mental health barriers. The results of this study can be beneficial in that it may provide useful information to aid educators in providing mental health services for Hmong youth. In addition, your consent for participation will also give your child an opportunity to think about his or her perception of mental illness. There may be some discomfort for you or your child when reflecting on mental illness. Nevertheless, we feel that this may provide an opportunity to reflect on this subject and to increase mental health awareness.

Your Responses are Confidential. If you choose to participate, any information provided by you and your child will remain confidential. We may share the general results, but will not report responses given by individual students and parents (see Analyzing and Reporting the Results above). It is also important for you to know that no participant’s responses will be made available to any other participant in the study. For example, we will not tell students about their peer’s relationship with their parent(s).
Participation is Voluntary. Your child’s participation in this study is completely voluntary. Your child is not required to participate, and there are no negative consequences for not participating. If you choose to participate, please write your child’s name below, sign your name in the provided area, and return this form back with your child to give to his or her teacher. If you choose not to participate, you need not do anything.

Contact Information. For more information, feel free to contact me at (559) 420-5793 or Dr. Wilson, at (559) 278-5129. Also, feel free to contact the Committee for the Protection of Human Subjects, at (559) 278-4468, for any further questions or comments.

*    *    *    *    *

I give my permission for _____________________ to participate in the research study.

_______________________________                    ______________________  
Parent Signature   Date

--------------------                    ---------------------  
Student Signature       Date
Nyob Zoo Txog Ib Tsoom Niam Txiv,

Kuv lub npe yog Koob Vaj. Kuv kawm ntawv tiav nyob rau pem Fresno State los ua ib tug School Psychology (tus kuaj me nyuam luj xiv seb lawm lub hlwb khiav zoo npaum li cas). Kuv sau tsab ntawv no los thov koj ua niam txiv thiab me nyuam kom koj pab koom nrog rau txoj kev kawm (research study) no. Kuv ua hauj lwm nrog Dr. Marilyn Wilson. Nws yog ib tug xib hwlb qhia ntawv nyob rau pem Fresno State. Peb tau noog koj ua niam txiv thiab koj tus me nyuam vim tias nws yog ib tug luj xiv kamw ntawv nyob rau hauv Central Valley.

Kev Kawm. Yog koj xav koom nrog rau peb txoj kev kawm no, thov sau rau daim ntawv tso cai thiab teb cov lus nyob rau daim ntawv nram qab. Thaum koj teb cov lus tas, thov muab daim ntawv ntsaws rau lu nbv ntawv peb muab nrog rau tsab ntawv no. Ces muab rau koj tus me nyuam qab cov qab tuj rau nws tus xib hwlb. Ob peb hnub los yog ob peb vas thiv tom qab, koj tus me nyuam yuav teb ib cov lus noog txog tuaj nyob teb chaws Mes Kas no kawm tau mes kas tej tuaj chi, nws xav li cas txog kev pab rau cov me nyuam xoob moom khiav tsis zoo. Tej zaum yam no ua rau nws (ashame) poob ntsej muag li cas rau txoj kev pab rau cov neeg xoob moom khiav tsis zoo. Nws yuav teb cov lus noog txog nws tus kheej. Qhov no, yuav siv sij hawm li 30 feeb xwb yuav tsis tshaj qhov ntawv.

Kev Kuaj Tau thiab Kev Qhia Txog Tej Yam Kawm Tau. Peb tsis yog kawm cov lus tej tug me nyuam luj xiv teb. Peb tsuas xav paub seb tuaj nyob teb chaws mes kas kawm tau lawv cov txuj ci no, puas muaj tej yam yuav ua rau me nyuam thiaj xav txawv txawv rau kev pab rau cov me nyuam xoob moom khiav tsis zoo. Yog tau kev pab rau cov me nyuam xoob moom khiav tsis zoo me nyuam yuav xav li cas. Peb xav nrhiav seb puas muaj tej yam yuav tiv thai me nyuam lawv thiaj tsis xav tau kev pab rau txoj kev xoob moom khiav tsis zoo. Vim tias tej zaum kawm nrhiav tau tej yam no, nws yuav pab tau cov neeg kawm (educator / researchers). Peb xav sau txog tej yam peb kawm los yog nrhiav tau rau cov neeg kawm txog yam no nyeem kom lawv paub ntxiv mus. Thaum peb qhia no, peb yuav tsis qhia tias tus no teb li no rau sawv daws. Peb yuav muab tag nrho cov lus cov me nyuam teb es poob rau lawv qib los saib, ces peb mam li qhia seb vim li cas lawv lus hlwb ho khiav zoo li ntawv.

Zoo Npaum Li Cas (Benefits) thiab Phem Npaum Li Cas (risks). Peb kawm txog yam no vim tias peb xav kawm seb Yam peb kawm tau no zoo rau qhov nws yuav pab peb nrhiav kev pab rau cov me nyuam luj xiv Hmoob es xoob moom khiav tsis tsuas zoo. Tsis tas li nov, koj txoj kev koom no yuav ua rau koj tus me nyuam xav txog kev xoob moom khiav tsis zoo. Tej zaum tham txog kev xiam xoob moom no yuav ua rau koj los yog koj tus me nyuam txaj muag (discomfort). Tsis tas li nov, peb xav tias kev kawm no
yuav muab sij hawm rau peb nrhiav kev pab los yog qhia txog kev xiam xoob moom no rau sawv daws.

**Cov Lus Koj Teb Yuav Tsis Qhia Rau Leej Twg.** Yog køj txaus siab koom, Tag nrho cov lus koj teb, peb yuav tsis muab los qhia rau ntiaj teb paub. Peb yuav tsis qhia tias tus no hais li no, los yog tus me nyuam no teb li no. Peb tsuas tshaj tawm rau sawv daws kom lawv paub xwb. Peb yuav tsis qhia rau cov niam txiv koom rau txoj kev kawm no thiab. Xw li, peb yuav tsis qhia rau lwm tus me nyuam seb tus me nyuam thiab lawv niam thiab txiv muaj teeb meem zoo li cas nyob rau hauv lawv tsev neeg.


**Kev Paub Ntxiv.** Yog køj xav paub ntxiv txog txoj kev kawm no los yog muaj lus noog txog tej yam køj txhawj, thov hu tuaj nrog kuv tham los kuj tau. Kuv tus xov tooj yog (559) 420-5793) los yog nrog Dr. Wilson, nws tus xov tooj yog (559) 278-5129. Koj kuj hu tau rau pem Committee for the Protection of Human Subjects. Lawv tus xov tooj yog (559) 278-4468.

**YOG KOJ SAU KOJ LUB NPE RAU NRAM QAB, QHIA TAU TIAS KOJ TSO CAI RAU KOJ TUS ME NYUAM KOOM NROG RAU TXOJ KEV KAWM.**

* * * * *

___________________________________    __________________
Niam Txiv Sau Npe             Hnub Vas Thib
Dear Students,

You are invited to participate in a study conducted by Dr. Marilyn Wilson, a Psychology professor at Fresno State, and Kong Vang, a Psychology graduate student. The purpose of this study is to investigate the relationships between levels of American or Hmong cultural adoption and views of mental illness in association with attitudes towards mental health services and perceptions of mental health service barriers. We think it will be beneficial to identify if varying levels of cultural adoption and views of mental health can negatively or positively affect attitudes towards mental health utilization and to identify potential barriers towards use of mental health services.

**The Study.** You were asked to participate in this study because you are a Hmong high school student in the Central Valley. Your parents will have to give permission for you to participate if desired. You will be asked to complete questionnaires about your American or Hmong cultural adoption level, your views of mental illness, your attitude towards seeking mental health services, and complete a questionnaire about what you perceive to be barriers towards accessing mental health services. In total, participation will take about 15 to 30 minutes.

**Benefits and Risks.** Benefits are good things that happen from being in the study. One good thing you might learn is how levels of culture adoption and views of mental illness are related to Hmong youths’ perceptions of mental health services. This may enable us to provide more interventions to increase Hmong youths’ use of mental health services. It might also provide you with an opportunity to think about your own level of cultural adoption, view of mental illness, and identify your own personal barriers towards the use of mental health services.

Risks are bad things that can happen from being in the study. The only thing we can think of is that you might feel unhappy to have to think about mental illnesses. But we also believe that you may think about these kinds of things anyway, so it is not out of the ordinary.

**Participation is Voluntary.** This means that you do not have to participate in this study if you do not want to. If you choose not to, we do not mind and it will not count against you in any way. Even if you start completing the questionnaire, you can stop at any time. You can skip any questions that you do not want to answer.

**Responses are Private.** All of the answers you give on the questionnaire will be kept private; nobody will know what answers you give.

**Contacting Us.** If you have any questions about this study, you can ask the research assistant. You or your parents are also welcome to talk to Dr. Wilson at Fresno State (559) 278-5129 or the Committee for the Protection of Human Subjects at Fresno State.
(559) 278-4468. This is the group that reviews studies done by Fresno State professor and students to assure they are safe.

AFTER READING THIS CAREFULLY, IF YOU AGREE TO PARTICIPATE IN THIS STUDY, PLEASE SIGN BELOW:
California State University, Fresno

Non-Exclusive Distribution License
(to make your thesis available electronically via the library’s eCollections database)

By submitting this license, you (the author or copyright holder) grant to CSU, Fresno Digital Scholar the non-exclusive right to reproduce, translate (as defined in the next paragraph), and/or distribute your submission (including the abstract) worldwide in print and electronic format and in any medium, including but not limited to audio or video.

You agree that CSU, Fresno may, without changing the content, translate the submission to any medium or format for the purpose of preservation.

You also agree that the submission is your original work, and that you have the right to grant the rights contained in this license. You also represent that your submission does not, to the best of your knowledge, infringe upon anyone’s copyright.

If the submission reproduces material for which you do not hold copyright and that would not be considered fair use outside the copyright law, you represent that you have obtained the unrestricted permission of the copyright owner to grant CSU, Fresno the rights required by this license, and that such third-party material is clearly identified and acknowledged within the text or content of the submission.

If the submission is based upon work that has been sponsored or supported by an agency or organization other than California State University, Fresno, you represent that you have fulfilled any right of review or other obligations required by such contract or agreement.

California State University, Fresno will clearly identify your name as the author or owner of the submission and will not make any alteration, other than as allowed by this license, to your submission. **By typing your name and date in the fields below, you indicate your agreement to the terms of this distribution license.**

Kong Meng Vang

Type full name as it appears on submission

4/9/2010

Date