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How Can Western Providers Adapt their Techniques when Working with the Hmong Population in a Mental Health Setting?

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How Can Western Providers Adapt Their Techniques When Working with the Hmong
Population in a Mental Health Setting?

Submitted by JoAnna Johnson

May, 2012

MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

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Abstract

Mental health is a common concern for Southeast Asian refugees who are struggling with acculturation. This study examined what therapeutic techniques Western clinicians use to assure cultural sensitivity during therapy. A qualitative study was conducted and nine clinicians were interviewed. The results of this study demonstrated it is imperative to include family, exhibit respect, and include traditional beliefs and values in an effort to be culturally sensitive. This maximizes optimal therapeutic interventions. The main diagnoses explored in this study were Post Traumatic Stress Disorder, Anxiety, and Depression. Both the study and the research displayed similar themes affecting clinicians when providing therapy to Southeast Asian refugees. This study is significant to clinicians working in the mental health field to ensure positive interactions with Southeast Asians. The idea of Western psychotherapy is foreign to Southeast Asians; it is crucial that clinicians have insight when providing care to this population.

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How Can Western Providers Adapt Their Techniques When Working with the Hmong Population in a Mental Health Setting?

Introduction

There are many Southeast Asian refugees who struggle with mental health issues as a result of their resettlement from Laos to the United States. According to the 2010 U.S. Census, 245,807 Hmong people reside in the U.S. with the largest population living in California (91,224). Minnesota's Hmong population is 66,181, reflecting a 46 percent increase since 2000. (Stratis Health, 2010). "An assessment by Minnesota's Ramsey County Mental Health Center found that more than 60 percent of Hmong refugees had clinical depression, but less than one percent received Western mental health care" (Karon, 2011, p. 2). "While research on the Hmong community and mental health is limited and outdated, available literature suggests that the Hmong community is at least twice as likely as the total United States population to experience any kind of mental health issue, particularly major depression, post-traumatic stress disorder, and other anxiety disorders" (Thao, Leite, & Atella, 2010, p.7). To effectively serve the Hmong population and meet their needs mental health providers must be sensitive to their culturally-specific needs. Hmong individuals can be faced with barriers to accessing Western medicine because Western practices conflict

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with many Hmong cultural beliefs. This literature review examines both Hmong and Southeast Asian populations. Following this, a qualitative study was done by interviewing mental health providers who work with Hmong clients. A series of thirteen questions were asked to determine how culturally sensitive Western providers are. The data was coded and the main themes are demonstrated in this paper.

Literature Review

History of the Hmong

The population referred to as Hmong are people who came from the mountains and were originally farmers from China (Grantham Cobb, 2010). Hmong people migrated to Southeast Asia in the 1700's and 1800's and primarily settled in Laos (Barrett, Shadick, Schilling, Spencer, Rosario, Moua, & Vang, 1998). The Hmong worked with the United States in the Vietnam War. In an effort to prevent the invasion of the Ho Chi Min Trail, the Central Intelligence Agency (CIA) recruited and trained the Hmong to help prevent the North Vietnamese from invading Laos and Vietnam (Grantham Cobb, 2010). When the troops withdrew in 1975, the United States acknowledged the important role the Hmong played however no protection was provided to them. Due to their partnership with the United States, the Hmong were then

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targeted for elimination by the new communist regime in Laos (Ugland-Cerhan, 1990). After the war, many fled to Thailand and lived in refugee camps (Barrett et al., 1998). A large number of Hmong immigrated to the United States in the early 1980's after being given preferred refugee status (Grantham Cobb, 2010). When the Hmong immigrated to the United States, they came with their own beliefs and rituals regarding health care (Grantham Cobb, 2010).

Psychopathology among Hmong People

There are many mental health diagnoses that Hmong refugees suffer from. Barrett et al. (1998) asserted the trauma from the war and disruption from their culture has affected the Hmong people. Post Traumatic Stress Disorder (PTSD) and depression are common results of the displacement of Hmong and the physical and emotional trauma they encountered. Southeast Asians have two components of psychological adjustment and adaptation: they are premigration trauma and resettlement (Chi Ying & Bemak, 2006). They have also experienced acculturative stress. According to Miranda and Matheny (2000), acculturative stress is often the result of problems specific to the immigrant which are worsened by the assimilation process and adapting to a new culture.

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Research has shown that Southeast Asians experience a high occurrence of somatic symptoms (Caspi, Poole, Mollica, Mar, & Frankel, 1998). Somatic symptoms are physical symptoms such as headaches, stomach aches, and chronic pain. Dhooper and Tran (1998) concluded with other researchers that Asians have reported physical symptoms when bothered by emotional issues. Hayes (1987) agreed with the other researchers indicating that many elders report somatic symptoms of depression such as poor appetite, sleeplessness, and agitation. Chi-Ying Chung and Kagawa-Singer (1995) stated “The Asian culture expresses symptoms including body aches and headaches when they are under psychological stress” (p. 640). Westermeyer (1987) stated that for refugees “the focus of psychological symptoms is transferred as a physical complaint due to their traditional background which discourages the direct expression of feelings, or their traditional holistic view of mind and body” (as cited in Thao, 2004, p. 20).

Depression and PTSD are common symptoms experienced by Southeast Asians. Several authors concluded this information. Dhooper and Tran (1998) indicated the most common diagnoses given to the refugees are PTSD, depression and anxiety. Kroll et al., (1989) found in their study that PTSD and major depression were the most common diagnoses found in the Hmong population.

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Ugland- Cerhan (1990) said the Hmong suffer from PTSD, depression, and chronic acculturation syndrome. This syndrome, he explained, resembles the more commonly used classification “Adjustment Disorder,” but is longer in duration and the symptoms are unremitting (p. 91). “PTSD has been described by the Hmong as having a “distressed and fearful mind, or frightened soul” (Culhane- Pera, Vawter, Xiong, Babbitt, & Solberg, 2003, p. 217).

Cultural Belief System

The Southeast Asians and Hmong have many cultural beliefs. Most Hmong will turn to Western medicine only after they have tried traditional methods because of their strong cultural beliefs and convictions. The Hmong have different views of what the definition of mental illness is compared to Western definitions. Literature indicates Hmong view someone with mental health issues as being “crazy” (Parker & Kiatoukaysy, 2008). The translation of Western mental health symptoms are not the same in the Hmong language. For example, the word “depression” translates to be “difficult, confused liver” (Goh, Dunnigan & McGraw-Schuchman, 2004 p. 120). The Hmong use the term “broken liver” to describe mental health issues (Culhane-Pera et al., 2003). Chi-Ying Chung and Ming Lin (1994) found that the Hmong population were the least likely to utilize Western medicine among Southeast Asian cultures. There is no direct

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interpretation in the Hmong language to describe PTSD and depression. They believe their feelings are the result of having too many worries, a fearful soul, or because they are “crazy” (Culhane-Pera et al., 2003). The Hmong believe if you are mentally disturbed it should not be discussed out of fear of bringing shame to the family (Tabora & Flaskerud, 1996). Researchers explained Asian Americans are reluctant to turn to Western medicine for help because their culture does not encourage disclosing their feelings or private matters (Sue & Kitano, 1973; Sue & Morishima, 1982 as cited in Gim et al., 1990). Root (1985) stated the belief is that they have no will power to control their thoughts and they need to solve problems independently. Chi-Ying Chung and Ming Lin (1994) stated many Southeast Asians do not embrace Western practices, but instead engage in traditional healing practices. The Hmong use herbs, medicine doctors and ritual healers such as shamans to help with their ailments (Culhane-Pera & Xiong, 2003). According to Helsel, Mochel, and Bauer (2004),

“A shaman is said to have been chosen by the spirits.

Shamans healed their patients by covering their face with a black cloth and going into a trance so that they could communicate with the spirit world. While in a trance, he or she called out for specific animals to be sacrificed to appease the angry spirits who were responsible for the patient’s illness and battled with the forces of

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evil. An important part of the shaman's work was searching for wandering souls; when the shaman locates and retrieves a lost soul, health is restored" (p. 934).

The Hmong believe that illness is a result of spiritual components. They feel that if there is not a balance between body and spirit, they will become ill (Grantham Cobb, 2010). "Hmong believe that the symptoms of depression are connected to the loss of a person's spirit or soul; they are not related to the mind or body" (Lee, Lytle, Nhia Yang, & Lum, 2010 p. 334). This can make mental health interventions complicated. Hmong believe that a person is born with several souls and when one is lost they become sick (Fang, 1998). Symptoms of lost souls for people of this culture are equivalent to mental health symptoms in Western medicine (Fang, 1998). Those living with lost souls experience somatic symptoms such as tiredness, aches and pains (Fang, 1998). Tatman (2004) stated they also believe mental health symptoms may be evil spirits or a relative from the past whom they offended (p. 80).

Another belief held by some Hmong clients is the need to treat physical health before addressing their mental health issues. They often go see a medical doctor instead of a mental health specialist (Thao, 2004). This is difficult for Westerners to understand and this can be confusing for new immigrants.

Training Practitioners to be Culturally Responsive in Order to Implement Appropriate Interventions

To provide effective interventions, Western providers need to be culturally responsive. Gensheimer (2006) stated there needs to be a way to take Western mental health concepts and incorporate Hmong beliefs and practices in order to be effective in their practice.

The importance of family and traditional beliefs is held with high regard in the Hmong culture (Barrett et al., 1998). When a Western provider is treating a Hmong client, they need to be sure to involve the family and clan leaders (Barrett et al., 1998). Westermeyer and Her (2007) discuss the importance of family as individualism is seen as a weakness. Tatman (2004) suggested the importance of the family's involvement when a counselor is working with an individual. Uglan-Cerhan (1990) discusses the importance of involving shamans in the treatment process. Even though there is great importance placed on the family, it can also be a reason not to seek out treatment. Southeast Asians are very family focused. Most Western medicine approaches place value on the individual and not the family unit (Leong & Lau, 2001).

There are multiple approaches providers should use when working with the Southeast Asian population and certain beneficial

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ways to conduct an assessment. According to Her and Culhane-Pera (2004), Hmong patients favor healthcare providers who are happy and have a positive attitude. This shows them their practitioner is willing to accept their cultural beliefs which is necessary for effective treatment. “A culturally sensitive approach requires demonstrating respect for a patient’s cultural belief and reaching across cultures with human intentions” (p. 45). As an introduction to the client, the provider should acknowledge their Western training while communicating how it can be helpful in the client’s transition process. (Culhane- Pera et al., 2003). Kinzie (1989) stated the course of treatment when working with traumatized Southeast Asians should include building rapport, starting individual therapy and accounting for cultural factors. The next step is to get the family to participate and the client into group therapy (Kinzie, 1989). On the contrary, Hsu et al. (2004) reported that it may be challenging to engage Southeast Asians in group therapy because they are not comfortable with self-disclosure.

Culhane- Pera and colleagues (2003) discussed the Healing by Heart Model as a way to be culturally responsive.

- 1.) Be aware of the influence of culture on health status, beliefs, practices, and values.
- 2.) Increase self awareness about your own health beliefs, practices, and values.
- 3.) Learn about the prevailing health beliefs, practices, and values of the cultural

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groups you serve. 4.) Identify potential areas of congruity and difference between your own health beliefs, practices, and values and those of the cultural groups you serve. 5.) Increase self awareness about your own cross cultural health care ethics. 6.) Learn skills to identify, evaluate, and respond to cross-cultural ethical conflicts with special attention to challenges to professional integrity. 8.) Develop attitudes culturally responsive to the groups you serve. 9.) Learn communication skills culturally responsive to the groups you serve. 10.) Develop skills in applying culturally responsive knowledge, skills, and attitudes to particular clinical relationships (pp. 299-304).

Barriers to Accessing Mental Health Services

There are many barriers for Hmong to access mental health services. The first barrier addresses the Hmong's lack of exposure to Western medicine and lack of culturally sensitive providers. Research shows the Hmong were the least exposed to Western medicine upon their arrival in the United States compared to other immigrant groups (Wong, Kinzie, & Kinzie, 2009). Sue, Fujiino, Hu, and Takeuchi (1991) stated one of the main reasons the Southeast Asian refugee populations do not seek treatment is because of the lack of cultural responsiveness of providers. Sue et al. (1991) discussed ways providers can be culturally responsive: a.) training staff to work with clients of different cultures; b).

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employment of more bicultural mental health providers; c.) offer services that are culturally specific.

Hmong beliefs such as the believing in the supernatural are barriers to seeking help with emotional issues (Tung, 1983 as cited in Chi-Ying Chung & Bemak, 2006). However, Chi-Ying Chung and Meng Lin (1994) state that they used both traditional and Western approaches. Hmong seek Western treatment when traditional methods are not accessible.

Language is also a barrier to Hmong seeking mental health services. For optimal communication, a trained interpreter should be used (Chi- Ying Chung & Bemak, 2006). Chi-Ying Chung and Bemak (2006) stated inaccurate diagnosing is a risk when communication is translated incorrectly. Often, clinicians are not trained to work effectively with an interpreter, and therefore, inaccurate diagnostic assessments and interventions result (Gong-Guy, Cravens, & Patterson, 1991). Leong and Lau (2001) agreed with Gong-Guy and colleagues (1991) that misdiagnosis is a common barrier to accessing mental health services.

Hmong place great emphasis on family structure. They believe that all relatives are components within the nuclear family. Family plays a very important role in Southeast Asians choosing not to access Western medicine. The family is the main support for

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dealing with mental health in the Southeast Asian culture (Hayes, 1987). With this, they are often reluctant to seek out the assistance of Western providers. Western culture generally does not believe in involving the family to the extent that the Hmong culture does.

Another barrier to accessing mental health services is that refugee clients place greater priority on solving issues in their day-to-day activities. These issues include housing, financial stressors, and employment. They do not often prioritize mental health concerns (Chi- Ying Chung & Bemak, 2006).

Stigma also greatly impacts Southeast Asian's willingness to access Western medicine. Asian-Americans may not report symptoms due to shame and stigma (Root, 1985). Lee et al. (2010) stated seeking treatment from someone outside of their family can cause negative attention in their community. Because mental health disturbance carries a stigma in this culture, many Southeast Asians seek medical professionals or traditional healers rather than mental health providers (Wen Ying, 2001).

There are several reasons why Southeast Asians don't access Western mental health treatment. The Hmong are traditionally skeptical of Western providers. Elders in the Hmong population express mistrust of the Western mental health professionals because they explain depression as a biological factor

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and that explanation is not enough for elders to understand (Lee et al., 2010). Mental health services are the last option for Southeast Asian refugees after traditional healers, family, and community have been tried (Kinzie, 1985; Mollica, Wyshak & Lavelle 1987; Nguyen & Anderson, 2005 as cited in Wong et al., 2009). Also, lack of knowledge of Western culture, which often includes communicating personal issues, has been cited as a barrier to accessing Western services (Kinzie, Leung, Bui, Ben, Keoprasertuth et al., 1988). It has been reported that another reason for not accessing Western medicine is that the Hmong have been reluctant to move toward acculturation and want to maintain their culture (Arax, 1993).

Providing Culturally Sensitive Counseling to Southeast Asian Refugees

When working with Southeast Asians, clinicians need to be aware of the cultural norms. Clinicians must understand how the Hmong place significant importance in male family figures; they make all the major decisions. When a health issue is identified or suspected, the clan leader is contacted (Grantham Cobb, 2010). Tatman (2004) discussed the need for counselors to recognize the important role the family plays. Tatman (2004) defines family as the most important part of their culture.

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Clinicians can ask Southeast Asian clients to share their thoughts and feelings about their symptoms to gain understanding of the culture as it relates to depression. Mental health professionals must remember the shame mental illness has in the Hmong culture (Lee et al., 2010). Researchers discussed several options in working with this population. Bemak and Chung (2006) designed a multi-level model for working with refugees. “The four levels are: mental health education, individual, group and/or family psychotherapy, cultural empowerment, and indigenous healing” (pp. 161-163). All four levels may be used together and in any order. In level one, the focus is on the mental health provider to provide information regarding mental health treatment options. Level two focuses on the worker completing an assessment in order to develop appropriate treatment options. Level three stresses cultural empowerment and personal recognition of their environment. In level four, the counselor integrates Western and traditional modalities.

Another approach for treatment is medication. However, non-compliance is a risk that can occur because Southeast Asians do not like the side effects (Hsu, Davies, & Hansen, 2004). An additional reason for non-compliance with medications is that once they feel some relief they discontinue their use (Hsu et al., 2004). Western perspective has allowed us to be patient with the effects of

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medications. Providers need to ensure side effects and long-term effects be discussed with the patient.

Cognitive behavioral interventions have been considered valuable when working with Southeast Asian refugees (Bemak & Greenberg, 1994). Cognitive behavioral interventions can assist in teaching coping skills (Bemak & Greenberg, 1994). Use of cognitive behavioral therapy (CBT) can help the refugees learn behaviors to assist with managing symptoms and adjusting cultural beliefs (Bemak & Greenberg, 1994). The goal in this treatment modality is to provide direction, structure, and be an influence as a change agent (Bemak & Greenberg, 1994). De Silva (1985) stated this could be because cognitive interventions are similar to Buddhist beliefs. An example would be the performance of certain rituals as a means of coping with despair and unhappiness (Kinzie, 1988).

Research done has shown group therapy to be effective when working with this population. This may be more culturally effective than individual counseling because there is so much emphasis on family (Bemak & Chi-Ying Chung, 2006). McClead (2009) indicated group therapy has been effective in working with refugees who have experienced trauma. Tucker and Price (2007) stated group therapy provides an avenue to deal with their losses. While participating in a group setting the client may not feel so

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alone and may even have a sense of belonging, therefore, their fears and thoughts may be normalized.

For maximum outcomes, clinicians need to be willing to incorporate traditional beliefs into Western treatment. Kinzie and colleagues (1988) stated the therapist needs to watch for countertransference issues that arise from listening to past traumatic experiences which may trigger conflicts and profound emotions for health care providers. Lesser and Pope (2007) define countertransference as the “therapist’s unrealistic and inappropriate reactions to the client as a result of his or her own unconscious conflicts or developmental arrests” (p. 50). The feelings countertransference bring up can cause the therapist to become overwhelmed. This can lead to not being fully mindful in session and, therefore, not effective in treating the individual (Kinzie et al., 1988).

Several researchers have developed effective methods of treatment for working with Asian Americans. Leong and Lau (2001) note the following: “Practicing psychotherapy with a medical model (Hong, 1988; Murase, 1982); the clinician adopting an authoritative stance (Lorenzo & Adler, 1984; Murase, 1982); the clinician establishing credibility in the eyes of the client (Kinzie, 1985; Zane & Sue, 1991); enlisting family support in treatment (Shon & Ja, 1982; Sue & Morishima, 1982); exercising

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patience in gathering information and exploring the client's more vulnerable feelings (Lorenzo & Adler, 1984; Nishio & Blimes, 1978); incorporating the clients interpretation and meaning of his or her symptoms in the assessment and treatment process (Tanaka-Matsumi, Sieden, & Lam, 1996); and using directive, concrete, problem-focused techniques" (Kim, 1985; Lee, 1982 p. 211).

It is imperative that a clinician attempt to be multi-culturally competent. Clinicians need to be culturally sensitive and attuned with the culture of their client. Multicultural counseling requires having the knowledge of the client's beliefs and values and has been proven to be effective (Cooper & Lesser, 2011). Multicultural competence is defined as appreciating the history and strengths of a population that has been underserved (Pope-Davis, Reynolds, Dings & Ottavi, 1994). Sue, Arredondo, and McDavis (1992) stated "counselors need to understand their client's worldviews, beliefs and culture, as well as use intervention strategies that are sensitive to the cultural and contextual factors of the clients; such as their spiritual beliefs and traditions" (p. 481). Patterson (2004) felt understanding the cultural background is important. The author believed the best way to attain this information is to live in the culture and experience direct practice with that population.

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The role of gender is significant when working with this population. When it comes to individual therapy it is best to assign the individual and therapist by gender (Tatman, 2004). This will result in a stronger therapeutic relationship. For instance, a female client will feel more comfortable discussing her issues with a female practitioner. However, for family counseling it is suggested to use both a female and male practitioner (Tatman, 2004). The intervention and suggestions are best received when the male practitioner gives the information to the eldest male or parent in the family. This coincides with the importance of their patriarchal beliefs. Additional interventions have been found to be effective when working with this population. Westermeyer and Her (2007) discussed the use of behavior modifications as a form of psychotherapy. It does not require that clients believe or embrace Western concepts. While attempting to identify the most effective interventions, the providers should take into consideration the value of medication, therapy and education (Wong et al., 2009). Counselors should ask clients if they want to involve shamans or traditional methods in their treatment (Chi-Ying Chung & Bemak, 2006). Parker and Kiatoukaysy (1999) give the following recommendations when working with Hmong-Americans: “use trained interpreters, use same gender providers, support the idea of allowing the family and clan to be involved in decision making, be

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neutral or supportive of patients working with a shaman...”(p. 82).

Grantham Cobb (2010) stated every effort should be made to maintain the client’s dignity by being respectful of their culture.

It is important for clinicians to engage their client in the first session. This is achieved by addressing the client’s hierarchy of concerns. Lee et al. (2010) stated the client often needs assistance with other basic needs such as transportation, finances, housing, and employment. Wen Ying (2001) discussed the importance that needs to be given to these basic needs before mental health interventions can begin. It can be beneficial to begin sessions with a client by addressing every day stressors rather than immediately addressing the mental health issues. If basic needs are too much of an obstacle and are not addressed in the beginning stages of interventions, the client may not continue with therapy.

Deep breathing and muscle relaxation may be seen as beneficial coping skills (Wen Ying, 2001). The task of therapy is to work through past traumas. Clinicians need to constantly work to keep the client focused on the present. This can be accomplished by working on strengthening the person-in-environment. (Wen Ying, 2001). Lesser and Pope (2007) define the person-in-environment to be “the person-in-situation, bio-psycho-social and psychosocial perspectives the central organizing

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focus of the social work profession's approach to the helping process" (p. 2).

It has been identified that Hmong individuals have expectations of professionals with whom they work. Hmong stated that they want their professionals to interact with them and to be kind and have a good attitude (Barrett et al., 1998).

The above literature reiterates the importance of adapting Western practitioners to be culturally sensitive when working with Southeast Asians. In an effort to meet the needs of this population, literature suggests adapting Western medicine to encompass cultural beliefs. It is important to understand the mental health symptoms, traditions and beliefs as well as barriers Southeast Asians encounter when dealing with Western medicine.

Conceptual Framework

This section will discuss the use of the Multicultural Counseling and Therapy theory (MCT). Lesser and Pope (2007) define multicultural theory to be "a conceptual framework that guides the practitioner in selecting and using the theoretical approach most consistent with the life experiences and cultural perspective of the client. It emphasizes the importance of viewing the individual "in context" and including relevant family or community members in treatment whenever possible and

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appropriate” (pp. 46-47). Sue, Ivey and Pedersen (1996) have developed six propositions to explain this theory.

The first proposition states theories used in counseling and psychotherapy in the Western world to help those of other cultures are not considered to be effective or ineffective. Each theory signifies different views. The first proposition emphasizes incorporation of the cultural background of the client along with incorporating group and family members in treatment. It recognizes the significance of the environment around the client and not identifying the client as the sole owner of the problem. The client is seen as having shared input in developing their goals.

The second proposition states the counselor’s and the client’s identities come from a variety of experiences. Consideration of all experiences is the priority of treatment modalities. The second proposition discusses using the person-in-environment model. It is necessary to understand the client’s role in his or her family and how the family is influenced by their non-traditional surroundings.

The third proposition states the influence of cultural identity affects the definition of the problem and a mutually agreed upon approach for both client and counselor. This leads to a more balanced power in the therapeutic relationship. A key to the third

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proposition is that workers need to continually explore and give credence to the impact of cultural identity for both client and worker.

Proposition four states the MCT theory is most effective when the counselor uses approaches and chooses goals that are in line with the values and experiences of the client. If counselors use a variety of multicultural skills, the relationship may actually be improved. Consideration must always be given to matching skill to the individual client need.

Proposition five of MCT theory discusses the importance of incorporating outside social supports in addition to individual therapy. Another component of proposition five indicates having a multicultural stance in counseling will lead to correct assessments and interventions.

Lastly, proposition six states, “The process of *conscientizacao* or critical consciousness is a constant dimension of the helping process which continuously considers the client’s entire context” (p. 22). An ongoing adaptation of techniques and theories may be exercised by clinicians throughout their career. Cultural awareness is also seen as important in this proposition.

The MCT theory implies the importance of integrating the client’s culture/beliefs into therapy. The six propositions coincide

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with the literature reiterating the importance and benefits of working with this population to meet client's where they are at, while at the same time taking into account his/her culture.

Methodology

Research Design

This researcher explored ways in which Western providers should be culturally sensitive in working effectively with the Hmong population. In order to discover how effective Western providers are a qualitative study was conducted. According to Berg (2009), qualitative research looks for answers to questions by exploring different settings and the individuals who comprise them.

Using a qualitative design, this researcher explored how Western providers are culturally sensitive when working with the Hmong population. Interview questions aided in obtaining this information. The interview questions were composed of thirteen questions that looked at cultural competence of the interviewee and symptomology of Hmong clients (appendix A). The data was collected from nine individuals and then reviewed, coded, and compared to other participants.

Sampled and Recruited

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In this project, this researcher interviewed nine mental health professionals who work with the Hmong population. This researcher interviewed participants from an agency in the Midwest. In order to locate these participants, this researcher contacted a member of her research committee who approached colleagues to inquire if they would be willing to participate. This writer composed an agency approval letter. Once the participants were identified, this researcher contacted them to schedule a time to conduct the interview. A phone call was placed by this researcher to the participants at least two weeks in advance of the initial interview. This researcher used a recruitment script (see Appendix C). This researcher asked the participant to relay back to this researcher what was being asked of him/her to check for assurance of his/her understanding regarding their involvement in the study. The mental health professionals were chosen based on their experience with the Hmong population and working with refugees. The participants are both male and female. There were no exclusions for this study. All providers working with Hmong clients in the mental health setting were considered.

Protection of Human Subjects

The participants were protected under confidentiality. This researcher explains below how the participants will be protected. Based on the consent form template provided by the University of

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St. Thomas and St. Catherine's University, the consent form addressed the following: background information, procedures, risks and benefits, confidentiality, voluntary nature of the study, contacts, and questions (see appendix B). The participants were notified of their right to confidentiality. The participants were informed that the information collected from the interview would be recorded and they would receive a copy of the consent form for their records. Institutional Review Board (IRB) approval was granted for this study as required. The interview was tape recorded to allow this writer the opportunity to transcribe it at a later date and to have record of the interview. Prior to the interview, the participants were reminded the interview would be recorded. The transcriptions, recordings, and consent forms were locked in this researcher's computer and desk for security. All information, including the tapes and transcriptions will be destroyed in May of 2012. Prior to destruction, the information will be accessible only to the researcher and the researcher's supervisor. Confidentiality will be maintained as no names will be used. The researcher will describe each participant by labeling each with a number.

Data Collection/Data Analysis

The data analysis used in this study was content analysis. Berg (2008) stated, "Content analysis is a careful, detailed, systematic examination and interpretation of a particular body of

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material in an effort to identify patterns, themes, biases, and meanings” (p. 338). This researcher identified common codes and themes through transcribing the interviews. The researcher played back the tape recordings to compose transcriptions which led the researcher to find codes and themes.

Strengths and Limitations

Strengths of this study are evidenced by the sample that was interviewed. This researcher interviewed both female and male participants. All participants are mental health professionals who work with Hmong clients. No preference was given to the age or ethnicity of the participants.

This study does have some limitations. First, the literature consistently expressed the importance of being culturally sensitive and competent but did not elaborate with examples. Another limitation of this study is that there were more female providers than male providers who participated. Third, this researcher only chose to ask the participants about the Hmong population and not the Southeast Asian population in general.

Findings

Demographics

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This study was conducted with participants who were employed by an outpatient clinic in the Midwest. Of the total participants, six were female and three were male. Eight were Caucasian and one was Hmong. The average age of the participants was forty years old. The average years of experience the participants had worked at the agency was six. The credentials of the participants included: three Licensed Psychologists, three earned Doctorate degrees in Psychology, two Master's degrees in Psychology, two Licensed and Marriage Family Therapists, and one Art Therapist working toward licensure to become a Psychologist Clinical Counselor. Four of the participants had dual degrees.

The purpose of this research study was to explore what methods Western providers use in an attempt to achieve cultural competency when working with the Hmong population. A total of nine interviews were completed, analyzed, and coded to identify the following emerging themes: (a.) diagnoses, (b.) recognition of mental health symptoms, (c.) obstacles/barriers to treatment, (d.) cultural sensitivity, (e.) spirituality, (f.) treatment modalities, (g.) effectiveness of treatment, (h.) barriers to recovery, (i.) family.

Diagnoses

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All of the participants indicated depression as one of the main diagnoses they had treated. All but two of the participants mentioned anxiety as another mental health diagnosis. All but one participant identified PTSD as a main mental health diagnosis.

The second participant stated, *“Um...I would say, there is certainly a good deal of depression, both Dysthymia and major depression...recurrent episodes. Um, certainly anxiety, too...generalized anxiety. Um, I don’t see a ton of phobias or social anxiety. It’s usually more generalized. Um...post traumatic stress disorder...PTSD. Um, and so understandably you have the intrusive thoughts, flashbacks...and then, um, there also tends to be a lot of pain.”*

Participant three stated, *“Major Depression, anxiety, and PTSD.”*

Participant six stated, *“I’d say probably depression, usually pretty severe to moderate severe; Post Traumatic Stress, definitely; Pain Disorder; anxiety.”*

The above diagnoses are the main mental health diagnoses that are prevalent in the Hmong population. It is important for the providers to have insight into the main diagnoses so they can provide the best therapeutic interventions.

How Mental Health Symptoms are Recognized

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A sub-theme that emerged under diagnoses was how providers recognize mental health symptoms in the clients. Four of the nine participants referenced somatic complaints as one way in which mental health symptoms were recognized. The majority stated they obtained their information through interview questions referencing their daily living skills.

Mental health providers often determine a mental health diagnosis through the client's somatic complaints. Somatic complaints are reported during the provider's interview with the client.

Participant three stated, *“Pain.... Isolation, very withdrawn. Fearfulness about their environment, um, and that has a lot do with the acculturation piece. Um...but probably the number one thing is pain, poor sleep, they have back pain, numbness in their arms and fingers. Um, but how they describe it then after that is, you know, I hurt all the time. You know, I have so much pain in my back. And then, I'm trying to think how they typically describe the depression...you know, they talk so much about the sadness and just being, um, tearful and can't concentrate, poor memory, forgetfulness. I have a lot of clients that perseverate because they feel like they are losing their minds. Because with depression comes poor memory and forgetfulness...”*

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Participant five stated, *“We will ask behavioral questions, you know, so...are they isolating? Are they, um...are they taking care of themselves? Are they helping out with daily activity, you know, daily chores around the house?”*

Participant seven stated, *“Well, I ask them about, you know, their daily living, their daily living skills, what they do, um, you know, how they function in this society... how they functioned, for example, in Thailand. If they were a refugee and, um, kind of what their parents did and how they grew up ... But, um, they’ll say their stomach hurts, they have headaches; they feel dizzy, um...yeah. They will have a lot of somatic symptoms usually, too.”*

Participant nine stated, *“Um...I find that I have to ask them about like mood or how they’re feeling in maybe several different ways. Because many of them will say often, they’ll say like, I have a heartache. You know and then try to figure out or talk with them about what that really means for them. You know is it really depression or is it more of like a physical, physical that is going on so yeah and asking in lots different ways.”*

Hmong clients do not define their symptoms in Western terms so it is imperative that providers recognize somatic symptoms in Hmong individuals with mental illness as mental illness.

Barriers/Obstacles to Treatment

One theme that emerged from interviewing the participants was barriers and obstacles to treatment. Four of the participants made reference to the language difference and issues with interpreters. The issues with interpreters varied from unprofessionalism to difficulty locating trained interpreters. Three of the participants mentioned therapy moves at a slower pace for immigrants and three of the participants discussed the client's lack of insight into Western medicine treatment modalities. Illiteracy and lack of education were discussed by three of the participants.

Participant six stated, *“Um, I think another barrier, or another concern, is, um, interpreters. Not all interpreters are great. Some are fantastic, some not so much. So we can't always know if they're interpreting adequately or accurately what they're actually saying and sometimes we do have a concern that interpreters may be kind of grooming them. Maybe they never went to school. A lot of them have never gone to school, never learned to read, never, um...you name it. They don't have the education of a third-grader or a second-grader in America. So there can be a little bit of a learned helplessness that can happen...They don't want to unlock the past. And...and that's, for me, I know that's a part of our therapy—my therapeutic process—is helping people go back to their past and reconciling it with their*

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present, and I think a lot of them don't want to do that. Or they don't have the insight to be able to make the connection."

Participant seven stated, *"Like some of the other people have said, you know, obviously the language barrier."*

Participant nine stated, *"Um...yes. I mean, sometimes I feel that is, um, difficult or I would say the most frustrating things sometimes is feeling like, um, therapy doesn't move as quickly as it does maybe with a more traditional client."*

As exhibited by the majority of participants, language was the biggest barrier in providing psychotherapy to Hmong individuals. Complicating the language barrier is the fact that some of the interpreters are not effectively trained or readily available. Having a trained interpreter can be a key factor in assuring a proper diagnosis is made. Lack of education related to the client often interferes with the ability to provide effective treatment modalities.

Cultural Considerations

Cultural considerations were another emerging theme. Cultural considerations are identified as providers explore the culture and beliefs. The participants stated the following were necessary to increase cultural sensitivity: continued learning about the culture by means of continuing education, reading, listening,

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asking questions, respecting, and showing compassion for the culture.

Participant one stated, *“Um...well, to me it'd mean heading...ah...with just basic respect for their culture and that they're immigrants. And being...having the commitment that you'll learn enough about that so that you can...um...kind of be connected to them and spend their time necessary to really learn what their story is. Ah...because...ah...well I think that the just traditional mental health providers kind of miss the point. So, you have to kind of have a...the sensitivity to one of those beyond, ah, what you just learned in school, so to speak, today. Learning about what it is to be a new immigrant....Well, I think a lot of its kind of on-the-job training.”*

Participant two stated, *“I think to be culturally competent and you said culturally sensitive, um, I think you have to do, um, continuing education....You know, learning more about Hmong history, learning more about being culturally sensitive and incorporating those practices into your therapy, Um, being open to working with a shaman, for example. Not discouraging that, not scoffing at that. ...Respecting, um, you know, just respecting different, ah, cultural ideas and, um, and faith backgrounds. And I think a lot of it, too, just from a gender perspective, being able to recognize that this is kind of how their culture works.”*

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Participant three stated, *“So it’s just, um, being open and really understanding their spiritual beliefs, their, um, their fears about Westernized medicine. And, um, how their culture works... Being just knowledgeable about their culture is what I find the most helpful and if I’m not, I’ll ask.”*

Participant six stated, *“I enjoy them, I care about them, I respect them...So having compassion I think is a really important, important thing. But I also want to help to teach them how to have dignity so they don’t feel dependent on people like us.”*

Having cultural consideration for treatment is an underlying focus and is crucial for effective interactions with Hmong clients. This needs to be done for optimal outcomes.

Shamans

The importance of combining shamans with traditional methods was reflected as a sub-theme. Each participant referenced the importance of spiritual beliefs. The participants routinely ask about their client’s spiritual beliefs/use of a shaman and demonstrate respect for their culture. The majority of the participants had no problem referring the individual to a shaman in conjunction with therapy.

Participant two stated, *“Well, for shamanism, you know, I...I tend to encourage people to consult with a shaman. But I like*

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to let my clients know that, you know certainly if that is available to you and you think that would be helpful to you, go for it. And encourage that. I think by certainly encouraging or talking about going to the shaman or spiritual healer in their community..."

Participant five stated, *"So it really, I think, is on an individual basis, um, and up to them. I usually ask all my clients about their spiritual beliefs or religious beliefs, and if they want those as a part of this."*

Participant six stated, *"If they go to a Christian church, I like to have them plug in there, get the support they need there, um, but if its shaman, I'll definitely work with their existing belief system about sacrificial cows and pigs and things like that..."*

The ninth participant stated, *"So I often ask and try to learn from them like what some of their culture and traditions are, um, and then try to incorporate it as much as I can... Um, well, understanding first of all, their culture and where their beliefs and understanding of themselves are coming from."*

This study demonstrated the participants routinely involved spiritual interventions to enhance the therapeutic relationship. There did not appear to be a conflict between Western therapy and traditional methods. The traditional methods were encouraged as an important aspect of therapy.

Treatment Modalities

In review of transcriptions, treatment modalities were another theme that emerged. Seven of the nine participants referenced they use CBT as a form of treatment. Three of the participants discussed the benefit of group therapy. Two participants spoke of the use of relaxation techniques as a form of treatment. Finally, two participants commented on the importance of encouraging clients to use exercise as a coping skill.

Participant two stated, *“I tend to find that if I can do kind of hands-on behavioral things like we’ll practice diaphragm breathing. You know we’ll talk about, okay, put your hand on the diaphragm, you know, and it should come out if you’re taking a big breath. Um, and then also imagery. I have a lot of luck using imagery techniques... I gave...I give some of my folks, um, like a little stress ball and so that kind of tends to work as something concrete and tangible. Um...what other techniques or interventions? Um, certainly recommending exercise. You know, getting out and being active.”*

Participant four stated, *“Group support, that’s one of the, ah...I would say group support is one of the best for Hmong clients...Because individual therapy is great, also, but you really...you know, individual therapy is more of a higher*

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functioning thing with clients. I find emotional support and empathy to be very popular. Um, just to really, um, to be with them, where they're at. And to be an active listener basically, without any agenda."

Participant five stated, *"Um, in terms of like cognitive behavioral techniques or, um, I use those a lot. And I use, um, some emotional focused therapy techniques and some interpersonal techniques. So, um, it's more kind of shaping those in a way that's appropriate for the client, or, um, a lot of times, um, maybe simplifying something or talking in a more concrete way."*

Participant six stated, *"Teaching them how to just kind of relax their body and then relax their mind along with that. Ways to distract themselves. Like I actually use some kind of CBT skills with very basic things like using some sensory calming. Um, just using small ways for them to improve the difficult moments that they have. So, but keeping it very, very simple, very basic, um...if you're thinking this, try thinking this. Or if you're feeling this way, try to do this to make yourself feel better."*

Participant eight stated, *"Okay. I do a lot of mind-body stuff. So we might do breathing exercises. We might do Tai-Chi. We might do, um, stretching."*

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The providers demonstrated Western techniques were also used on Hmong clients. Group therapy was found to be more effective in clients with a lack of education. Individual therapy has been found to benefit higher functioning clients.

Effectiveness of Treatment

Ways to measure the effectiveness of treatment was another theme that emerged. Five of the nine participants stated that clients exhibited a better affect after treatment. Three participants stated their clients expressed appreciation through gift giving. Three participants reported clients just stop coming to therapy. Other participants reported they evaluated the effectiveness through self-report from the client. Another theme that developed was that clients noted their basic needs were being met. This may have been the reason for the improvement.

Participant one stated, *“They thank you....And they bring you, ah...things... they’ll bring you things in appreciation for bettering their life.”*

Participant two stated, *“Um, you know, typically they tell me..... I mean, they’ll tell me symptom-wise...self-report. And you can see it in their affect, too. I mean, we’ll go from having a session that is, um, very tearful and kind of emotionally dysregulated to sessions where there you know, aren’t as many*

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tears. You can just tell in how they're presenting and communicating that it's not as emotional."

Participant three stated, "...Um...they report less pain, they...their affect. They're a little more smiley. Um, they're...my clients are, you know—and of course I'm speaking generally here—are really loving so when they feel better, many of them bring you, bring you something. They bring you a gift..."

Participant seven stated, "...Um, they're feeling better. You know, they're less worried. Um, they usually come back and say that things are much better, that they're doing well..."

Participant nine stated, "...Um, I think when they're able to like, um, identify changes that they've seen. Um, you know, when they are able to rate, um, like the depression or anxiety or stress, um, you know, and seeing that change."

Gift-giving, which is a cultural component in the Hmong culture, was identified by participants as a measure of the effectiveness of treatment. Self-report and observations from the provider were other ways to measure whether treatment had been effective. Hmong clients commonly express gratitude in the form of gift giving.

Barriers to Recovery

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In addition to the previous themes, barriers to recovery were identified. Four participants identified acculturation as a barrier. Three of the participants identified isolation as a barrier to recovery and two of them talked about poverty as a barrier. Two participants commented that clients' resist treatment in order to keep their disability checks and get their family's attention. It was reported there is safety in their community so many participants don't feel they need to change. One participant mentioned the lack of education and language as a barrier.

Participant one stated, "*Poverty. I mean, if they had stable housing, a stable income, and they had...ah...stable resources...ah...many of them would have, you know, their mental health symptoms would be diminished.*"

Participant three stated, "*Um, so to me, you know the poverty, the acculturation and then the children being — straddling two cultures.*"

Participant five stated, "*Um...probably socioeconomic and, um, acculturation level, I think. And being forced into a new culture and then trying to have to play by these rules when you don't understand, you know.*"

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Participant six stated, “...*I think many of them because they have the safety of the community, they don’t need to change... So there can be a little bit of a learned helplessness that can happen.*”

Participant seven stated, “*Um...just the ability, I think, to navigate this culture. Um, so many of them say to me, um, like I’ve come from Thailand, or even Laos...So, you know, the isolation, I think, is very hard... Really, really hard.*”

Participant eight stated, “...*Um, I would say, ah...okay, barrier one is, um, they get very attached to their wounds. They...a lot of them find that, um, because of...because of what’s happening in their lives, they get a lot more attention at home, and they get a lot, a lot more attention in general. Um, it’s very unusual for people in the Hmong population to have somebody paying so much attention to them.*”

Participant nine stated, “...*One just being able to adjust to the culture because of the lack of education and language barriers... Hmm mmm. I think sometimes. And getting them to, like, move forward. I...the clients that I feel sometimes have...I have the biggest struggle with are those that have a lot of pain or complain about a lot of pain. And feeling like...I think they have an understanding that medication should just make it all go away.*”

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The participants identified several barriers to recovery. The main barriers identified were isolation, poverty, lack of education, and the language barrier. It is important for clinicians to explore and give consideration to why clients may not engage in therapy. There may be motivating factors impeding their recovery. The basic needs of the client need to be met before he/she can recover.

Family

Family was a recurring theme discussed by the majority of the participants. Family was seen as an enhancement to therapy, as well as, a stress-producing component reported by the client. Four of the participants stated they invite family to participate in therapy. Six of the nine participants gave examples of family issues causing stress that the client divulged in therapy. Two participants spoke about family hierarchy. Other examples of this theme include having lost family members to war and starvation as well as a difference in acculturation in different generations.

Participant two stated, *“I find the families to be incredibly helpful. There’s such an attitude of, um, helping, in particular with the elders. ... Um, typically they’ll come in because like, you know, a family member might be worried about their functioning. Enlisting family members to help the member to take their pills.”*

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Participant five stated, *“Um, but a lot times there’s family stress or grief over lost family members or, um...with older or with adults with children, sometimes there can be frustration over the children kind of adopting the new culture versus the older culture sometimes...”*

Participant six stated, *“Um, well, family issues, definitely. That’s one of their primary things I see—complaints about spouses, complaints about children... Yeah it is. It is. So that’s, that’s one of the main things. Just family issues between in-laws, spouses, children, everything.”*

Overall, the indication is that family is an important factor to address in therapy. Family involvement was found to be helpful as well as a topic of conversation and area of stress identified by the client. The family system was viewed as an important factor because the Hmong population places high importance on the family as a part of their traditions and cultural beliefs.

A comparison between previous research and this study demonstrated several themes identified in both the literature and the findings. In addition to similarities, there were areas in this study that were not identified by the participants, but that the literature discussed. The nine themes from the findings will be compared to the literature. This section of the paper will also

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discuss how the literature and the findings related to implications of the Social Work profession

Discussion

Mental Health Diagnoses

The themes that emerged from this researcher's findings were congruent with the literature in regards to mental health diagnoses in the Hmong population. Several researchers reported outcomes that were consistent with the responses of the participants in this study. Barrett et al. (1998) stated PTSD and depression are products of displacement of Hmong populations and physical and emotional trauma. Several participants also spoke of anxiety being prevalent in the Hmong population. This was consistent with Dhooper and Tran (1998) who indicated the most common diagnoses given to the refugees are PTSD, depression, and anxiety.

It is imperative providers understand the main mental health diagnoses in the Hmong population to effectively treat the symptoms. Both the literature and the findings of this study were consistent with the mental health diagnoses that were most commonly recognized.

How Mental Health Symptoms Are Recognized

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The findings and the literature discussed the sub-theme of how mental health symptoms are recognized. Somatic symptoms were the main point referenced by participants. Literature was similar to the findings of the participants.

Dhooper and Tran (1998) are consistent with other researchers in that Asians reported having physical symptoms when bothered by emotional issues. Chung and Kagawa-Singer (1995) stated, “the Asian cultures express symptoms including body aches and headaches when they are under psychological stress.” Westermeyer (1987) stated that for refugees “the focus of psychological symptoms is transferred as a physical complaint due to their traditional background, which discourages the direct expression of feelings, or their traditional holistic view of mind and body (as cited in Thao, 2004, p.20).

When working with Southeast Asian clients, clinicians need to focus on somatic complaints in order to effectively treat the diagnosis. This writer was not surprised by the reference of somatic symptoms in regards to mental illness. The literature discussed the hesitancy to openly express mental health issues. Recognizing mental health symptoms is important for providers to determine if somatic complaints are possibly a symptom of other physical ailments that need to be addressed.

Barriers/Obstacles to Treatment

Language was a theme discussed in the literature and in the findings of this study. Chi-Ying Chung and Bemak (2006) stated clinicians are not trained to work effectively with an interpreter and, therefore, inaccurate diagnostic assessment and interventions result (Gong–Guy, Cravens, & Patterson, 1999). Leong and Lau (2001) agreed that misdiagnosis is a common barrier to accessing mental health services. The participants in this study also identified the risk of untrained interpreters as a barrier to mental health services.

Fear of Western medicine was another theme mentioned in both the literature and findings as a barrier to treatment. Lee et al., (2010) stated the Hmong are traditionally skeptic of Western providers. Additionally, the elder populations express mistrust of the Western mental health professionals. Interestingly, participant number three was the only individual who referenced this in the interview.

Providers need to identify where the mistrust of Western providers originates. They also need to explore the reason why this population does not access mental health treatment as frequently as Western clients. It is very important Western providers take this into consideration when dealing with a client who appears to be

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resisting treatment. This knowledge can help providers develop more effective treatments with Hmong clients. Further research needs to be done to include obstacles to seeking treatment so providers can identify obstacles in their practice with individuals.

Cultural Considerations

Respect for the Hmong culture was a major theme discussed in the literature and in the findings of this study. The conceptual framework for this study was also congruent with the findings and the literature. The MCT theory discussed the importance of incorporation of cultural background including family and group members in treatment. The MCT theory also states therapy is most effective when the counselor uses approaches and chooses goals that are in line with values and experiences of the client. Use of a variety of multicultural skills may improve the relationship with the client. Thirdly, the MCT theory states cultural awareness is seen as important in this framework. The MCT theory emphasizes the importance of integrating the clients' culture and beliefs into therapy. According to Her and Culhane-Pera (2004), "a culturally sensitive approach requires demonstrating respect for a patient's cultural belief and reaching across culture with human intentions" (p. 45). Participant's one, two, and six also spoke of the importance of respecting their culture.

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Respecting a client's culture is imperative to the social work profession as a means of empowering clients and encouraging self-sufficiency. If the social work professional empowers the client and respects their culture this may assist with the acculturation process.

Shamans

Both the literature and findings in this study discuss the importance of using shamans in addition to therapy. Ugland-Cerhan (1990) discussed the importance of involving shamans in the treatment process. This is similar to participants two and three's response in this study.

The literature was congruent with findings of this study with regards to understanding traditional beliefs. Gensheimer (2010) stated there needs to be a way to take Western mental health concepts and incorporate Hmong beliefs and practices in order to be effective in therapy. Cooper and Lesser (2011) agreed with Gensheimer (2010) by stating that multicultural counseling requires having the knowledge of a client's beliefs and values has been proven to be effective. These statements coincide with participant two.

If providers can clearly communicate to the client that their spiritual beliefs are important and valued by the therapist, there

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may be less resistance to seeking help in the future for mental health issues. All clinicians interviewed for this study reported incorporating traditional beliefs of the client when working with them on mental health issues.

Treatment Modalities

Treatment modalities most commonly used and discussed in both the literature and by participants included relaxation, cognitive behavioral therapy, and group therapy.

Tucker and Price (2007) stated group therapy provides an avenue to deal with their losses. In participating in a group setting, the client may not feel so alone and may even have a sense of belonging; therefore, fears and thoughts may be normalized.

CBT was another area discussed in both the literature and findings of this study. Researchers stated cognitive behavioral interventions can assist in teaching coping skills (Bemak & Greenberg, 1994). CBT can help refugees learn behaviors to assist in managing symptoms and adjusting cultural beliefs (Bemak & Greenberg, 1994). This research was consistent with the response by participant six. Participant's one, three, five, six, seven, eight and nine also reference their use of CBT when providing individual therapy. On the contrary, one participant did not feel the

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use of CBT to be effective, however did not elaborate on the reason for this.

An additional area discussed in the literature and this study was the use of relaxation techniques and exercises as a treatment modality. The literature states deep breathing and muscle relaxation may be seen as beneficial coping skills (Wen Ying, 2001). Participant two reported relaxation and exercise to be an effective treatment modality to use when providing therapy.

It is imperative that clinicians be familiar with several treatment modalities. Each provider must know that not every intervention will be effective for every client. The findings discuss the importance of incorporating multiple methods.

Effectiveness of Treatment

The literature did not reveal any information on this subject. Participants stated clients have shown they have been helped in therapy through gift-giving (i.e.; home-made food, tapestries and trinkets), improved affect, drop out, and self-reporting. The effectiveness of treatment can be measured through previously stated actions. It is imperative providers know the means in which clients demonstrate this for providers to understand if therapy has been effective.

Evaluating effectiveness of treatment is an ongoing skill necessary for clinicians. Clinicians need to continue to monitor effectiveness so they can adapt the techniques they use in practice to assure positive outcomes.

Barriers to Recovery

The importance of meeting the basic needs of clients before addressing mental health needs was an area mentioned in both the literature and findings of this study. Wen Ying (2000) stated if basic needs were too big of an obstacle and were not addressed in the beginning stages of intervention, clients may not continue in therapy. Other researchers agreed with Wen Ying (2000) and stated another barrier to accessing mental health services is that refugee clients place greater priority on solving issues in their day-to-day activities. These include housing, financial stressors, and employment leading to not prioritizing their mental health concerns (Chi- Ying Chung & Bemak, 2006). The literature was consistent with participant one who stated if the client has stable income and housing their mental health symptoms would diminish.

Family

The literature was congruent with the findings of this study in reference to the importance family plays in therapy. Barrett et al. (1998) stated that when a Western provider is treating a Hmong

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client they need to be sure to involve the family and clan leaders. Westermeyer and Her (2007) discussed the importance of family as individualism is seen as a weakness. Tatman (2004) was also consistent with other researchers in suggesting the importance of the family's involvement when a counselor is working with an individual. Hayes (1987) observed the family is a main support in dealing with mental health in the Southeast Asian culture. This is different from Western culture which does not believe in involving family to the extent the Hmong culture does. The participants of this study discussed the importance of involving family; however, none of the literature discussed that family can also be the source of stress and problems which lead a client to seeking out therapy.

The provider's understanding of the role the family plays in therapy will lead to a better therapeutic relationship and rapport with the client. It is important clinicians recognize families are a major part of their culture so the client feels the provider is culturally sensitive.

Implications for the Social Work Profession

The findings of this study offer several implications for the social work profession. There needs to be more research done on Hmong and mental health on the macro-level so social workers can advocate for effective therapeutic interventions with Hmong

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clients who experience mental health issues. One way to explore this on a macro-level would be to mandate that social workers and other professionals be required to obtain continuing education on cultural sensitivity.

This study demonstrated the use of person-in-environment by discussing the importance of taking into account the traditional beliefs of Hmong clients. The MCT theory also discussed the use of the person-in-environment model stating it is necessary to understand the client's role in his or her family and how the family is influenced by their non-traditional surroundings. This study acknowledges that trauma and the difficulty with acculturation are areas of concern for this population.

The MCT theory places importance on understanding the client in the context of their culture. This theory is valuable to the social work profession because it places value on understanding the client's culture to enhance the relationship between therapist and client. The clinician needs to explore approaches to use that are consistent with the client's values and experiences. This will lead to a more balanced therapeutic relationship.

It is the responsibility of the social worker or other provider to advocate for immigrants in general. Recognition and value must

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be given to the immigrant's different beliefs regarding Western medicine in order to effectively serve their needs.

Mental health funding has been affected by budget cuts which result in a lack of available and experienced practitioners. Social workers need to advocate for mental health policies for immigrant populations.

Strengths and Limitations

In assessing the findings, consideration must be given to limitations as well as strengths of this study. One strength was that the importance of cultural sensitivity was mentioned in the literature and by participants in this study. Additionally, having participants that had worked with this population for a minimum of two years and were highly qualified was strength. The questions asked provided the opportunity for the clinicians to be detailed in their answers. This study acknowledged the importance of incorporating Southeast Asians traditional beliefs into therapy.

There were many limitations of this study. The main limitation was that not one of the participants interviewed is a social work professional. Due to this, none of the participants spoke of referenced social work theories. When this researcher contacted the participants their credentials were not disclosed until the interview was in process. The literature did not address how to

judge if the therapeutic interventions with Hmong clients were effective. Implications for social work practice were not mentioned in the literature. All of the professionals interviewed practiced in an outpatient clinic and no other setting. Some of the participants interviewed for this study veered off topic and started story telling which may have affected the spontaneity of their answer and which at times resulted in them not answering the question completely.

Conclusion

This paper explored how Western providers should be culturally competent when working with Hmong clients. This study interviewed nine participants in a clinic setting. Several themes were identified and explored in this study. The main theme that emerged is the importance of embracing the client's traditional beliefs as a way to be culturally sensitive and competent. The results of this study imply practitioners respect the Hmong culture and have a basic knowledge of how to provide mental health treatment, however literature is out-dated. There appears to be limited clinicians interested in working with immigrant populations. Another aspect this study discussed is the importance of incorporating family in the treatment of Southeast Asians experiencing mental health issues. It must be acknowledged that family can assist in treating mental health or hinder their progress.

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In conclusion, knowledge and skill continues to lack in the treatment of immigrant populations.

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Appendix A

How Western providers can adapt techniques to be effective when working with the Hmong population.

- 1.) How many years of experience do you have providing direct care (therapy) to the Hmong population? What is your license/degree? How long have you been with this agency? What is your age?**
- 2.) As a practitioner what are the main mental health diagnoses you treat in the Hmong population?**
- 3.) How do you recognize mental health symptoms in Hmong clients?**
- 4.) How do you incorporate traditional methods into your work with Hmong clients IE; including the family, shamanism, etc?**
- 5.) What is the main reason clients are referred to you?**
- 6.) Do you observe cultural barriers when providing therapy to Hmong individuals and if so, how do you address this?**
- 7.) What is the biggest barrier to recovery for the Hmong population related to their mental health symptoms?**
- 8.) What treatment modalities do you find to be most effective when working with this population?**
- 9.) What is the average length of time you see a Hmong client with mental health issues?**
- 10.) What do Hmong clients speak about in session other than their mental health symptoms?**
- 11.) What does it mean to be culturally sensitive/competent in working with the Hmong population?**
- 12.) Are there any areas you can improve on regarding being culturally competent when working with this population?**
- 13.) How do you know when mental health treatment has worked with a Hmong patient?**

Appendix B**How Western providers can adapt their techniques to
effectively work with the Hmong population****RESEARCH INFORMATION AND CONSENT FORM****Introduction:**

You are invited to participate in a research study investigating how Western providers can adapt their techniques to effectively work with the Hmong population. This study is being conducted by JoAnna Johnson, student at St. Catherine University. You were selected as a possible participant in this research because you work in the mental health field and work with Hmong clients. Please read this form and ask questions before you decide whether to participate in the study.

Background Information:

The purpose of this study is to figure out how Western providers can be culturally competent to effectively work with the Hmong population. Approximately 9 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked ten to twelve questions in an interview setting of your choosing. This study will take approximately sixty to ninety minutes.

Risks and Benefits:

The study has one minimal risk. A risk may be that disclosing information on working with this clientele may cause you some personal distress

There are no direct benefits to you for participating in this research.

Confidentiality:

Any information obtained in connection with this research study that could identify you will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented.

I will keep the research results in a password protected computer in my home and only I and my advisor will have access to the records while I work on this project. I will finish analyzing the data by April 29, 2012. I will then destroy all original reports and identifying information that can be linked back to you. They will be destroyed by May 31, 2012

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University in any way. You may refuse to answer any questions if you choose. If you decide to participate, you are free to stop at any time without affecting these relationships, and no further data will be collected.

New Information:

If during course of this research study I learn about new findings that might influence your willingness to continue participating in the study, I will inform you of these findings.

Contacts and questions:

If you have any questions, please feel free to contact me, JoAnna Johnson at 612-558-4200. You may ask questions now, or if you have any additional questions later, the faculty advisor, Dr. Pa Der Vang, will be happy to answer them at 651-690-8647. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact John Schmitt, PhD, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739.

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You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time and no further data will be collected.

I consent to participate in the study. (If you are video- or audio-taping your subjects, include a statement such as "and I agree to be videotaped.")

Signature of Participant

Date

Signature of Parent, Legal Guardian, or Witness

Date

(if applicable, otherwise delete this line)

JoAnna Johnson

11/27/11 _____

Signature of Researcher

Date

Appendix C

Recruitment Script

Hello, my name is JoAnna Johnson and I am a graduate student at St. Thomas and St. Catherine's University. I am conducting a research project in partial fulfillment of my MSW program. My research project is on how Western providers can adapt their techniques to be culturally responsive when working with the Hmong population.

The reason I have chose to interview you is because you are a mental health provider and you work with Hmong clients.

I will be asking you 10-13 questions about cultural sensitivity in working with Hmong clients.

I will also be asking you different techniques and treatment modalities that you find to be effective when working with the population.

If you agree to be in this study I will ask you to complete an audio-taped interview that will last between one hour and ninety minutes.

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future

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relations with St. Catherine University in any way. You may refuse to answer any questions if you choose. If you decide to participate, you are free to stop at any time without affecting these relationships, and no further data will be collected

