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Hmong, mental health, and Acculturation

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Mental Health and Hmong Americans: A comparison of two generations

by

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Abstract

Early studies of Hmong refugees in the U.S. indicated high rates of mental distress related to post-migration stressors such as grief and loss, poverty, and social adversity. This study explores the mental health status of two generations of Hmong Americans 38 years after their first migration. The relationship between acculturation and mental health of 191 1st and 2nd generation Hmong are reported. Results indicated relatively low reports of depressive symptoms and medium to high rates of acculturation to American society. The results are unrelated to demographic factors indicating resilience and adaptation to Western society despite age and generational status and maintenance of culture of origin.

Key Words: Hmong, acculturation, mental health, generational status, refugee

Hmong in the U.S.: Acculturation and Mental Health

Introduction

War and immigration have profound effects on the mental health of immigrants resulting in higher reports of mental health distress upon arrival to the host country (Weine, 2011). In early studies, Hmong reported high rates of anxiety, depression, and PTSD soon after their arrival to the U.S. (Westermeyer, Vang, & Neider, 1984; Westermeyer, 1988). However, little research has been conducted on the mental health status of Hmong refugees since Westermeyer's seminal study.

The adjustment of refugees is often examined through the lens of acculturation (Lee & Green 2010; Weine, 2011). Acculturation is the process whereby immigrants acquire the characteristics of the dominant culture as they adjust to their new home. Through acculturation, immigrants integrate into their host society through learned norms, values, and practices of the host culture. As refugees adjust to their new environments, the initial culture shock along with the grief and loss experienced by refugees may decline due to an increased sense of self efficacy in their new homes, leading to increased feelings of well-being and reduction of anxious and depressed feelings. On the other hand, continued barriers to acculturation may prolong mental health distress (Weine, 2011). The major life transitions such as loss of loved ones, loss of home, belongings, and social networks involved in abrupt migration may contribute to higher mental distress among refugees, while at the same time, those who arrive with pre-existing mental health conditions may find it harder to adjust to their new homeland than those refugees who may possess characteristics that act as buffering factors. These characteristics include having been

educated in the home country, connections to members of one's own ethnic group, and vocational skills (Westermeyer Vang, & Neider, 1984 ; Pipher, 2003). Pre-existing mental health conditions may act as barriers to adaptation. These are different from situational mental health conditions. Therefore, refugees who experience mental distress as a result of their abrupt migration may report improvement once the situational stressors are no longer present. However, few studies have looked at mental health among Hmong who have been in the U.S. for a prolonged period. This paper examines the mental health status of a small group of Hmong Americans almost 40 years after their arrival to the United States.

The mental health and acculturation status of Hmong Americans across two generations is examined in this paper; first generation refugees who were born outside the U.S., and second generation Hmong born in the U.S. Refugees, upon arrival to their host country, may experience mental health distress such as anxiety and depression as a result of pre and post migration factors (Weine, 2011). Refugees suffer from grief and loss after leaving behind home, family, and social networks as well as having to face adjustment challenges due to the abrupt changes involved in migration. As stated earlier, the mental distress of new Hmong refugees is well documented by earlier studies (Westermeyer, Vang, & Neider, 1984; Westermeyer, 1988). However, as refugees adjust to their new environment, the mental health of many may improve depending on a variety of factors such as educational attainment, increasing familiarity with the societal norms and practices of the host culture, and employment which leads to enhanced economic well-being and feelings of self-efficacy. However, the mental health status of some refugees and immigrants may fail to show dramatic improvement even after several years in the host country. This may be due to factors such as difficulty in learning the new language, barriers to educational attainment which result in barriers to economic improvement, maintenance of cultural practices that may clash with those of the mainstream society, and unaddressed pre-existing mental health conditions.

Demographics of Hmong Americans

The U.S. Census 2010 reported almost 252,000 Hmong in the United States. Although there are many first generation Hmong immigrants and refugees, the current Hmong population is also comprisd of second and third generation Hmong, the children and grandchildren of first generation immigrants. Low levels of educational attainment and income are reported among Hmong in the U.S. Of Hmong Americans over the age of 25, only 14.5% reported having obtained a four year college degree (Xiong, 2012) as compared to 31% in the general U.S. population (U.S. Census, 2010). 29% of Hmong are employed in manufacturing jobs which are often the lowest earning jobs in blue collar industry (HND, 2013). Hmong men earn a median annual income almost $16,000 less than men in the general U.S. population. Hmong females earn a median annual income of $3,000 less than Hmong men (HND, 2013). Compared to 11.3% of all U.S. families who live in poverty, more than twice the number of Hmong families (27.4%) live under the Federal Poverty level which is $39,630 for a family of eight and $23,550 for a family of four (SEARAC, 2011; DHHS, 2013). Hmong households report an average household size of 6.89 while the overall U.S. population reported an average household size of 2.70 (SEARAC, 2011). The

Southeast Asia Resource and Action Center [SEARAC] reported in 2011 that 13% of Hmong families were receiving county cash assistance and 32.7% were receiving assistance through the Supplemental Nutrition Assistance Program (SNAP) (SEARAC, 2011) compared to 15% of the general U.S. population who receive SNAP benefits (Izzo, 2013). Hmong have remained impoverished at a rate that far exceeds that of the general American population (27.4% and 11.3% respectively) (SEARAC, 2011; DHHS, 2013).

Literature Review

Mental Health

The U.S. Surgeon General reported 20% of women and 13% of men in the general U.S. population were affected by depression, 9.7% of women and 3.6% of men suffered from PTSD, and 6% of women and 3.1% of men suffer some type of panic related disorder (Galson, 2009). There exists no large scale study of mental illness among the Hmong population in the U.S., however small clinical studies were published in the late 1970's through the 1990's regarding the mental health status of Hmong soon after their arrival. In these earlier studies, Hmong refugees reported higher rates of depression, anxiety, and PTSD among former soldiers, non-English speakers, those with low vocational skills, and those with no social support from either their own community or the host community (Westermeyer, Vang, & Neider, 1984; Westermeyer, 1988; Mounoutoua, Brown, Cappeletty, & Levine, 1991; Mouanoutoua & Brown, 1995). The mental health disturbances in these studies were attributed to the situational context of post-migration stressors such as PTSD as a result of war, and anxiety and depression as a result of abrupt lifestyle changes.

Later studies examined how Western mental health assessment tools could be adapted for Hmong clients suffering from depression including the Beck Depression Inventory and the Hopkins 25 Symptom Checklist (Mounoutoua, Brown, Cappeletty, & Levine, 1991; Mouanoutoua & Brown, 1995). The focus of these studies explored the impact of post-migration factors such as cultural, language, and vocational barriers on the mental health of Hmong refugees. Mouanoutoua and colleagues (1991) found that several factors were associated with higher depression in their sample of 123 Hmong clinical patients including being female, older in age, serving as soldiers in the war, having lower education levels, limited English speaking ability, and less social support. This is consistent with Westermeyer and colleagues' (1988) studies that found positive relationships between depression and factors such as language barriers and poor social supports. These early studies were conducted with first generation Hmong refugees who had recently arrived in the United States. Lee and Chang (2012) conducted a systematic review of the extant literature on Hmong and mental health from 1979 to 1997, which covered the mental health status of first generation Hmong. Studies about the mental health status of second generation Hmong could not be located. Lee and Chang (2012) reiterate the lack of current research about mental health among Hmong in the U.S.; since 2000, few articles about Hmong and mental health had been published. They found high mental health concerns among Hmong refugees such as adjustment disorders, depression, and anxiety in the 1990's (Lee & Chang, 2012), however, due to lack of data about 2nd generation Hmong,

one cannot make meaningful conclusions about the current mental health status of this group.

Acculturation

The term acculturation is used to describe the change in the cultural practices, views, and beliefs of immigrants as a result of contact with the host culture (Berry, 2001; Rudmin, 2003; Yoon, Langrehr, & Ong, 2011). The degree and type of changes to immigrants' culture and characteristics vary on many different levels in regards to how much of the original culture is retained or shed and how much of the host culture is adopted (Berry, 2001; Lopez-Class, Gonzalez Castro, & Ramirez, 2011; Schwartz, Unger, Zamboanga, & Szapocznik, 2010). Acculturation occurs gradually through successive generations. Eventually, later generations will largely take on the characteristics of the host culture. Not all immigrants experience the same acculturation trajectory (Berry, 2001; Lopez-Class et al., 2009; Schwartz, Unger, Zamboanga, & Szapocznik, 2010; Thomson & Hoffman-Goetz, 2009). Multiple factors are involved in the process of acculturation including individual factors, ties to a home country network or ties with a host country network, personality and personal choice, socioeconomic status upon arrival, and age at arrival, among others (Berry, 2001; Lopez-Class et al., 2011). These multiple factors result in the unique acculturation trajectories for each individual (Schwartz, Unger, Zamboanga, & Szapocznik, 2010).

Acculturation may be necessary for survival in the host country (Berry, 2001; Thomson & Hoffman-Goetz, 2009). Survival refers to many different dimensions of social life including financial survival, social acceptance, and mental well-being among others. Therefore, in the United States, being able to obtain education and employment often signifies acculturation which signifies adaptation to Western society. Similarly, acquisition of the language of the host culture implies acculturation (Cheung-Blunden & Juang, 2008). Lee and Greene (2010) found that Hmong who could speak, read, and write English well reported higher levels of acculturation while Hmong refugees who arrived in the U.S. as older adults reported difficulty learning English and lower levels of acculturation to U.S. culture. Being able to speak, read, and write English makes it easier for immigrants to seek employment, increases success in school, and leads to ease of communication with members of the dominant society. Gainful employment, self-efficacy resulting from language and cultural knowledge, and feeling accepted by members of the dominant society are factors that contribute to positive mental health among new immigrants (Romero, Carvajal, Valle, & Orduna., 2007; Westermeyer, Vang and Neider, 1984).

Adoption of the cultural values and behavioral habits of the host culture are considered signs of acculturation. Using the Suinn-Lew Asian Self-Identity Acculturation Scale (Suinn, Ahuna, & Khoo, 1992) to measure acculturation, Vang (2013) found that Hmong who reported higher acculturation reported a tendency to marry later in life and to birth fewer children compared to those who reported lower levels of acculturation. Marriage later in life and smaller family size are consistent with family values in an industrialized society such as the United States where education is prioritized in early adulthood rather than starting a family, and smaller families are more common. This is in

contrast to traditional Hmong values of marrying earlier in life and birthing several children in order to survive in the agrarian society of their homelands.

Generational Status

Generational status refers to the number of generations the immigrant's family has been in the United States. Min and Kim's (2002) generational categories provide a framework for understanding the relationship between nativity and acculturation. Generational status is divided into categories: 1st generation immigrants are those born outside the country, 2nd generation immigrants are born to 1st generation immigrants, and 3rd generation immigrants are born to parents who are 2nd generation immigrants and so forth (Min & Kim, 2002). Generational status is conceptualized as having a positive relationship with acculturation to the host society. For example, second and third generation immigrants appear to identify more with the host culture, graduate from high school at a higher rate than first generation immigrants, report a higher rate of fluency in English and lower fluency in Hmong than the first generation, and second generations tend to have smaller family sizes and marry later in their adulthood than first generation immigrants (Lee & Greene, 2010; Vang, 2013).

Although generational status is closely related to immigrants' level of acculturation to the culture of their host country, it is not a precise determinant. Age at arrival to the United States may indicate an immigrant's rate of acculturation. For example, a first generation immigrant who arrives to the U.S. in their late teens may not acculturate as quickly as an immigrant who arrived as a young child (Kim, 2004). However, the trend showing later generations of immigrants reporting higher levels of acculturation has been an accepted pattern and thus results in the use of the terms acculturation and generational status interchangeably. For example, second generation immigrants tend to be more acculturated while first generation immigrants tend to be less acculturated. In this study, acculturation will be compared with generational status.

Acculturation, Generational Status, and Mental Health

Researchers have suggested a relationship between acculturation status and mental health status among immigrants (Westermeyer, Vang, & Neider, 1984; Westermeyer, 1988; Weine, 2011). Immigrants experiencing anxiety, depression, or grief and loss may have a harder time finding employment, maintaining a job, or learning the host language due to post-migration factors such as poverty, discrimination, and social adversity (Weine, 2011). Factors that have been found to contribute to higher rates of mental well-being among refugees include having social support from those within one's own cultural community as well as social supports from the host community (Westermeyer, Vang & Neider, 1984). Immigrants who report a higher alliance with their culture of origin and who are geographically located near those of similar cultural background report lower rates of mental disturbance while language barriers and economic instability contributed to more depression and anxiety (Westermeyer, Vang & Neider, 1984). Vang and Bogenschutz (2011) found that Hmong women who married as teens reported higher rates of depression in adulthood. However, Hmong Americans who have adopted the western view that adolescent development should be nurtured may emphasize adolescent identity

development and education attainment over early marriage. In Vang and Bogenschutz's (2011) study, Hmong women who married in their teens tended to report lower educational attainment, lower income, marital abuse, as well as depressive symptoms. Therefore, women who engaged in traditional cultural practices that clashed with dominant society tended to report higher depression due to the incongruence of two cultures. In addition, immigrants who report difficulty navigating both cultures, also known as bicultural stress, report higher rates of mental health distress due to identity confusion, feelings of isolation and marginalization, and contradicting expectations from both cultures (Romero et al., 2007). Finally, pre-existing mental illness may also act as a barrier to adjustment if left untreated (Weine, 2011).

Methods

This study was approved by the Internal Review Board of a university of a Midwestern state in the United States. An English only survey was administered using Qualtrics, an online survey tool. The data was analyzed using SPSS 21 Version.

Participants were Hmong, 18 years of age or older, and resided in the United States. We had a total of 201 respondents however, 7 respondents did not answer all questions, and only 2 respondents self-reported 3rd generational status, therefore, only 191 cases were retained for data analysis. Respondents gave their consent to participate in the study by clicking on a radio button labeled "Yes", located on the Consent Form which took them to the first page of the survey. Using the skip logic mechanism in the survey, respondents who clicked "No" at the end of the consent form were redirected to the end of the survey where a Thank You page appeared and these participants were not able to complete the survey.

Participants were surveyed across three variables: demographics, level of acculturation, and mental health status. The demographic questions included 16 items asking respondents to indicate generational status, age, gender, level of education, income, number of children, and marital status just to name a few.

Respondents' acculturation status was measured using Jeanne Tsai's General Ethnicity Questionnaire (GEQ) which included 38 questions on a 5 point Likert scale ranging from Strongly Agree to Strongly Disagree (Tsai, 2001). An example of a question from the GEQ is "I believe my children should have American names only" (Item 9 in the GEQ).

Finally, respondents answered 10 questions tailored after the DSM-IV criteria for depression (the DSM-V had not been published at the time of data collection) which include nine symptoms experienced for more than two weeks over the last 12 months and one question measuring severity.

Measures

Generational Status

Generational status measures respondents' location of birth; in or outside the U.S. in relation to parents' place of birth. This refers to cultural maintenance in the context of environmental and social factors that influence cultural maintenance. Respondents were asked to indicate their generational status across three values, 1st generation (your parents were born outside the United States, you were born outside the United States), 2nd generation (your parents were born outside the United States, you were born in the United States), and 3rd generation (your parents were born in the United States, you were born in the United States). 1st Generation, respondents were prompted to answer the question "What year did you arrive in the United States?" to indicate length of residence in the U.S.

General Ethnicity Questionnaire

The General Ethnicity Questionnaire (GEQ) measures acculturation to American society. This tool was created and tested by Jeanne Tsai (2001) as an acculturation measurement tool and includes items such as " I wish to be accepted by Americans", "The people I date are American" and "How much do you speak Hmong at home?". The GEQ consists of 38 questions on a 5 point Likert Scale. The mean score for each respondent was used in the analysis. A higher mean score indicated a higher level of acculturation towards American culture. The lowest mean score in this sample was 1.89 (I have a strong belief that my children should have American names only) and the highest mean score was 4.12 (Now I am exposed to American culture). The mean score for all 191 respondents was 2.46. This indicated that respondents were clustered in the middle to lower end of the acculturation continuum which was between 1 to 5.

Depressive Symptoms

The depression score measured depressive symptoms; it was not intended to measure depression but to reveal symptomology. We tailored this after the DSM criteria for Depressive Disorder NOS which consists of a 9 symptom criterion and 1 question measuring duration/severity. Respondents answered a total of 10 items on a 5 point likert scale. The items consisted of the following: little interest or pleasure in doing things; feeling down, depressed, or hopeless; trouble falling or staying asleep, or sleeping too much; feeling tired or having little energy; poor appetite or overeating; feeling bad about yourself--or that you are a failure or have let yourself or your family down; trouble concentrating on things, such as reading the newspaper or watching television; moving or speaking so slowly that other people could have noticed. Or the opposite--being so fidgety or restless that you have been moving around a lot more than usual; thoughts that you would be better off dead, or hurting yourself in some way; if you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people. The total score was used in the analysis. A higher score indicated more depressive symptoms. The lowest score was 10, the highest depression score was 38, and the mean score was 19 indicating an overall low depression symptomology.

Results

As stated above, a total of 191 cases were used in the analysis. 70.2% of respondents were female (n=134). This was a fairly young sample with the oldest respondent being 42 years of age and the youngest being 18 years of age (M=21.76, SD=4.353). This is consistent with the median age of Hmong at 20 years old in the 2010 U.S. Census. 64.9% of respondents were between the ages of 18-21 (n=124). 81.2% of respondents were single/not married (n=156). 16.2% of respondents reported having a Bachelor's degree or higher (n=31). A majority of respondents self-identified as second generation (n=142; 73.6%), meaning they were born in the United States to immigrant parents while 25.7% of respondents (n=49) self-identified as first generation immigrants, meaning they were born outside the United States. The lowest acculturation score was 2.18 and the highest acculturation score was 3.71 on a scale of 1 to 5 with 5 being the highest. Meanwhile, 80.1% of respondents (n= 153) reported an acculturation score of 2.5 or higher reflecting a middle range in their reported level of acculturation to American culture. See Table 1 at end of paper.

Chi-Square Results

Age, Year of Arrival, and Acculturation

Age at the time of the survey had a weak relationship with acculturation score ($\chi^2(6) = 4.277$, $p = .639$). Younger respondents (ages 18-27) comprised 92.7% (n=174) of the sample with 73% of this group concentrated in the medium to high end of the acculturation continuum (2.5-3.8 out of 5). Similarly, a majority of respondents ages 28-42 were also clustered on the medium to high end of the acculturation continuum (92.8%). 1st generation immigrants reported their year of arrival to the U.S. ranging from 1976-1997, which translated to the range of time spent in the U.S. from 16 years to 37 years at the time of the study. Year of arrival to the U.S. was not significant with the acculturation score ($\chi^2(28) = 35.263$, $p = .162$).

Generational Status and Acculturation

Respondents' generational status was not significant with their acculturation score ($\chi^2(2) = .110$, $p = .947$). A high percentage of respondents in both the 1st and 2nd generation groups reported acculturation scores on the middle of the continuum ranging from 2.5 to 3.8. In other words, regardless of generational status, Hmong tended to report medium to high rates of acculturation status overall with 80.1% (n=153) of the sample reporting an acculturation score of 2.6 or higher out of 5. Of the 49 first generation immigrants, time spent in the U.S. was not significantly related to acculturation scores ($\chi^2(28) = 39.949$, $p = .067$). See Table 2 at end of paper.

Depression, Acculturation, and Generational Status

The depression items asked participants to respond to ten items on a 5 point Likert scale on items tailored after the DSM -IV criteria for depression (the data collection was

conducted before the publication of the DSM-V). These items measured symptomology, duration and severity. The depression score was tabulated by taking the sum of scores for the ten depression items. Depressive scores were low among the whole sample with the lowest score at 10 and the highest score at 38 out of a possible score of 50 with 91.8% of respondents (n=168) reporting a depression score of 10-29 and 7.9% of the sample reporting scores of 30 to 38.

The relationship between depressive symptoms and all other variables in this study were not significant. An insignificant trend was observed among respondents who reported higher acculturation scores along with slightly more depressive symptomology ($\chi^2(4) = 3.248$, $p = .517$). The relationship between depression and generational status was also not significant ($\chi^2(2) = 2.952$, $p = .401$); 15% of 2nd generation respondents and 16% of 1st generation respondents reported a depression score of 25 or higher reflecting similar depression scores across both generations. See Table 3 at end of paper.

Depression scores also had no significant relationship with marital status ($\chi^2(4) = 3.501$, $p = .645$), number of children ($\chi^2(8) = 7.763$, $p = .457$), education level ($\chi^2(12) = 11.405$, $p = .495$), and income ($\chi^2(6) = 8.440$, $p = .230$). Slight trends indicated all respondents who scored highest on the depression scale had received less than a college education and earned less than $33,000 a year. All participants with four or more children and all divorced respondents (1 male; 3 females) scored themselves lowest on the depression scale.

Discussion and Implications

This study found a medium score of acculturation (2.1-3.7) to U.S. culture among the Hmong American respondents in this sample regardless of generational status, age, or length of residence in the United States. Similarly medium levels of acculturation across all ages in this sample may indicate that Hmong Americans continue to maintain strong alliance with their culture of origin with parents successfully passing on and nurturing traditional Hmong cultural values, beliefs, and practices among their children birthed in the U.S. In addition, this sample reported insignificant depressive symptoms in relation to generational status, acculturation scores, or demographic variables, indicating that depressive symptoms may be a factor that is independent of factors included in this study. Higher depressive symptoms could be found evenly scattered throughout each generation, indicating that the presence of depressive symptoms may be unrelated to length of time in the U.S., the sample reported having either been born in the U.S. or having lived in the U.S. from 16 to 37 years. It was interesting to note that respondents with four or more children rated themselves lower on the depression score which may indicate that having large families caters to the collectivist and communal nature of Hmong society; those who have large families feel more fulfilled.

Acculturation, Generational status, and Age

While it is believed that 2nd generation immigrants tend to be more acculturated to their host culture than 1st generation immigrants, this study demonstrated that both 1st and 2nd generation Hmong refugees tended to report insignificant differences in their

acculturation to U.S. culture, which is consistent with Tsai's (2000) study which found similar acculturation levels between 1st and 2nd generation Hmong adults. A majority of respondents from all age groups reported acculturation scores on the medium to high end of the acculturation continuum with no respondent reporting higher than a 3.8 out of 5 in acculturation.

Length of time in the U.S. among 1st generation Hmong refugees was also not related to acculturation status; all 1st generation respondents in this study arrived in the U.S. as infants or young children, the oldest being 13 years of age at arrival. The sample size of 49 who reported year of arrival to the U.S. is not large enough to make a strong conclusion about the influence of time in the U.S. and level of acculturation among 1st generation immigrants alone. However, the insignificant difference in acculturation scores across both generations and all age groups suggests that Hmong, regardless of generation and age, acculturate at similar rates. That a majority of respondents were clustered in the middle of the acculturation continuum indicates that the respondents in this study seemed to retain their culture of origin and resist complete acculturation over the four decades of their lives in the United States. This suggests that Hmong Americans are successfully nurturing their cultural identities within their family systems and across all ages. Hmong are maintaining a large amount of their cultural identity while at the same time integrating into their society through education and income attainment. No trend was seen in the relationship between acculturation and education, nor acculturation and income. This may indicate that levels of education and income do not significantly impact how Hmong identify with their traditional culture in this sample. The Hmong in this sample were able to both articulate their identification with Hmong culture while at the same time maintain a relationship with the dominant society. This is a marker of biculturalism among Hmong Americans.

Acculturation, Depression, and Generational Status

Acculturation scores were not significantly related to depression scores in this sample. This was an important part of this research in order to examine how refugees would fare in regards to mental health after having spent time in the United States. Recently arrived Hmong refugees tended to report high rates of mental illness as seen in previous studies (Westermeyer, Vang, & Neider, 1984; Westermeyer, 1988; Mounoutoua, Brown, Cappeletty, & Levine, 1991; Mouanoutoua & Brown, 1995). This study demonstrated that the depressive symptoms of the 49 1st generation immigrants in this study tended to mirror that of 2nd generation Hmong Americans who were born in the United States, demonstrating that that the mental health of early refugees improved as they become acclimated to their new home country. The 49 1st generation respondents are fairly young (age 42 and under) and may report less depressive symptoms than expected of first generation refugees due to their youth at arrival, participation in compulsory education, and propensity to learn the language and culture of U.S. society with much more ease than older refugees. This study has failed to gather data from older refugees who may reflect a much higher rate of depressive symptoms than the younger 1st generation immigrants in this study.

Implications

This study shows that depressive symptomology appears similar among Hmong Americans, regardless of age, socioeconomic status, acculturation and generational status. Therefore, it is important to view the mental health of Hmong Americans as any other population; that mental health complications may surface among Hmong regardless of demographic status. This is important because current research about refugees often portray refugees as a monolithic group suffering from post-migration stressors. As Hmong integrate into American society, issues of war related trauma, grief and loss, and adjustment disorders may not be as relevant among Hmong who were born in the U.S. or who arrived as children. Stressful immigration factors soon become memories to those who came to the U.S. as children. These memories are passed on as stories to younger children born in the U.S. who are far removed from the war. This is not to say that the dire effects of the war era are not passed onto children through the intergenerational transmission process; rather, although younger Hmong may continue to be affected by their parents' memories of the war and migration, the effect is not felt with the same sense of immediacy as experienced by older Hmong who experienced the war themselves. Mental health disorders that may surface among younger Hmong may be unrelated to the situational factors of post-migration stress.

Many Hmong in this sample reported medium to higher acculturation to American society, however, acculturation was not related to participation in American institutions such as education and employment. The fact that Hmong in this sample did not report extremely high acculturation indicates that Hmong continue to hold onto their culture of origin regardless of education and income status; this goes against the notion that higher education and economic status leads to higher acculturation. Therefore, in treating Hmong for mental health concerns, it is important to note that Hmong may continue to hold onto the values and practices of their culture of origin. This calls for continued efforts to include traditional mental health treatments for Hmong consumers. In addition, the efforts to adapt Western treatment modalities and prioritize traditional treatments should continue to be improved.

Although the mental health of Hmong in this sample appears to be unrelated to acculturation status, Hmong, including other minorities in American society, continue to experience social adversity with harmful effects to their mental health. This study does not measure social adversity factors such as racism and discrimination that continues to have dire effects on the functioning of Hmong; this study does not negate these very important factors.

Next, this study demonstrates that first generation immigrants tend to be resilient and able to adapt to the host culture; eventually mirroring their counterparts who were born in the United States. As a whole, the sample tended to report acculturation scores at the middle to high end of the continuum. This provides valuable insight into our understanding of acculturation trajectories among new immigrants. Early in their arrival to the United States, Hmong, a tribal people, were unaccustomed to American ways and suffered several structural barriers such as language barriers, cultural barriers, and xenophobia, however, over time, Hmong have adjusted to life in the United States while

also taking on an American identity. Rather than outsiders, Hmong have become insiders in the American community.

Although refugees come to the United States with higher rates of depression, anxiety, and PTSD from their pre-migration experience as well as their immediate post migration experience, this sample has shown that first generation refugees are able to eventually adapt to their new home. No significant difference in mental health status was detected among 1st and 2nd generation Hmong immigrants and refugees in this study indicating that as new immigrants adjust to life in the U.S., their mental health status begins to reflect that of those immigrants born in the U.S ($t(56.119) = .236$, $p < .05$).

Limitations

The sample for this study consisted of younger Hmong Americans with a majority of the respondents between the ages of 18 to 27. A majority of respondents were single, and a majority was born in the United States. This study failed to collect data from older Hmong Americans who may not have access to a computer, who may not read, write or speak English, and whose life situations may prohibit them from responding to online surveys. Older Hmong Americans who came to the United States as adults may report more mental health distress due to continued language barriers, cultural barriers, unemployment and marginalization as a result of racism, and PTSD as a result of the trauma they experience in the war. This study is not intended to ignore or negate the challenges faced by older Hmong Americans. In order to include this population, future studies must be conducted using in-person surveys or interviews that use interpreters or are translated into Hmong.

Finally, future studies are needed to explore the reported depressive symptoms across the sample in this study that appeared to be unrelated to demographic factors. The use of surveys in this study limited the researchers' ability to gather descriptive information regarding mental health.

Conclusion

This study showed positive signs of acclimation to their home country among Hmong Americans with 1st generation Hmong mirroring their 2nd generation counterparts in relation to reported acculturation status and depressive symptoms. Earlier studies of Hmong immigrants and refugees who recently arrived to the United States showed high rates of mental distress related to post-migration stressors. This study suggests that as refugees and immigrants adjust to their homeland, post-migration factors may cease and mental health may increase as immigrants become accustomed to the ways of their host culture. The medium to high acculturation scores in this sample also suggest that Hmong are able to maintain their traditional culture while participating in the dominant culture through work and education. Mental health treatment modalities must balance two things: the notion that Hmong have become acculturated to Western society, while Hmong also continue to maintain strong elements of their original culture in identity and lifestyle.

References Cited

Berry, J.W. (2001). A psychology of immigration. *Journal of Social Issues*, *57 (3)*, 615-631.

Cheung-Blunden, V.L., & Juang, L.D. (2008). Expanding acculturation theory: Are acculturation models and the adaptiveness of acculturation strategies generalizable in a colonial context? *International Journal of Behavioral Development,* 32 (1), 21-33.

U.S. Department of Health and Human Services [DHHS] (2013). *2013 Poverty Guidelines.* Washington, DC: U.S. Department of Health and Human Services. Retrieved on August 12, 2013 from http://aspe.hhs.gov/poverty/13poverty.cfm#guidelines.

Galson, S. K. (2009). Surgeon General's Perspectives. *Public Health Reports,* 124, 189-191. Retrieved on July 12, 2013 from http://www.surgeongeneral.gov/library/publichealthreports/sgp124-2.pdf

Hmong National Development [HND]. (2013). *2010 U.S. Census Hmong Populations.* Washington, DC: HND. Retrieved on September 2, 2013 from http://www.hndinc.org/cmsAdmin/uploads/dlc/Research-Center-Data-Tables.pdf.

Izzo, P. (2013). "Food-Stamp Use Rises; Some 15% Get Benefits". *Wall Street Journal.* Retrieved on August 12, 2013 from http://blogs.wsj.com/economics/2013/08/09/food-stamp-use-rises-some-15-of-u-s-gets-benefits/

Kim, S. (2004). The Experiences of Young Korean Immigrants: A Grounded Theory of Negotiating Social, Cultural, and Generational Boundaries. *Issues in Mental Health Nursing,* 25(5), 517-537. doi:10.1080/01612840490443464

Lee, G. Y. (2007). Diaspora and the Predicament of Origins: Interrogating Hmong Postcolonial History and Identity. *Hmong Studies Journal*, 8, 1-25.

Lee, S. & Chang, J. (2012). Mental health status of the Hmong Americans in 2011: Three decades revisited. *Journal of Social Work Disability & Rehabilitation,* 11(1), 55-70.

Lee, J.K., & Green, K. (2010). Acculturation Processes in Hmong in Eastern Wisconsin. *Hmong Studies Journal,* 11, 1-21.

Lopez-Class, M., Castro, F.G., & Ramirez, A.G. (2011). Conceptions of acculturation: A review and statement of critical issues. *Social Sciences and Medicine, 72*, 1555-1562.

Min, P.G. & Kim, R. (2002). Formation of ethnic and racial identities: Narrative by Asian American professionals. In P.G. Min (Ed.). *The second generation: Ethnic identity among Asian Americans (pp. 153-180).* Walnut Creek, CA: Alta Mira Press.

Mounoutoua, V.L., Brown, L.G., Cappeletty, G.G., & Levine, R.V. (1991). A Hmong Adaptation of the Beck Depression Inventory. *Journal of Personality Assessment,* 57(2), 309-322.

Mouanoutoua V.L. & Brown L.G. (1995). Hopkins Symptom Checklist-25, Hmong version: a screening instrument for psychological distress. *Journal of Personality Assessment,* 64(2), 376-83.

Pipher, M. (2004). *The middle of everywhere.* New York, NY: Mariner Books.

Romero, A., Carvajal, S., Valle, F., & Orduña, M. (2007). Adolescent bicultural stress and its impact on mental well-being among Latinos, Asian Americans, and European Americans. *Journal of Community Psychology, 35,* 519-534.

Rudmin, F.W. (2003). Critical history of the acculturation psychology of assimilation, separation, integration, and marginalization. *Review of General Psychology, 7,* 3-37.

Schwartz, S.J., Unger, J.B., Zamboanga, B.L., & Szapocznik, J. (2010). Rethinking the concept of Acculturation, Implications for theory and Research. *American Psychologist, 65 (4),* 237-251.

Suinn, R.M., Ahuna, C., & Khoo, G. (1992). The Suinn-Lew Asian self-identity acculturation scale: Concurrent and factorial validation. *Educational & Psychological Measurement, 52(4),* 1041-1046.

Thomson, M.D. & Hoffman-Goetz, L. (2009). Defining and measuring acculturation: A systemic review of public health studies with Hispanic populations in the United States. *Social Science & Medicine, 69,* 983-991.

Tsai, J.L. (2000). Cultural orientation of Hmong young adults. *Journal of Human Behavior in the Social Environment,* 3 (3/4), 99-114.

Tsai, J. L. (2001) Instruments: General ethnicity questionnaire. Retrieved from http://www-psych.stanford.edu/~tsailab/GEQ.htm

U.S. Census. (2010). *Educational attainment.* Retrieved September 15, 2013 from http://www.census.gov/hhes/socdemo/education/data/cps/2010/tables.html.

Vang, C.Y. (2008). *Hmong in Minnesota.* St. Paul, MN: Minnesota Historical Society Press.

Vang, P.D. (2013). Generational Differences among a Small group of Hmong Americans. *Journal of Cultural and Ethnic Diversity in Social Work,* 22(1), 76-92.

Vang, P.D. & Bogenschutz, M. (2013). Early marriage and mental health among Hmong Women. *Journal of Social Work.* 13, 164-183. doi: 10.1177/1468017311409135

Yoon, E., Langrehr, K., & Ong, L.Z. (2011). Content analysis of acculturation research in counseling and counseling psychology: A 22-year review. *Journal of Counseling Psychology,* 58(1), 83-96.

Weine, S.M. (2011). Developing preventative mental health interventions for refugee families in resettlement. *Family Process,* 50(3), 410-430.

Westermeyer, J., Vang, T.F., & Neider, J. (1984). Refugees who do and do not seek psychiatric care: an analysis of premigratory and postmigratory characteristics. *The Journal of Nervous and Mental Disease,* 171(2), 86-91.

Westermeyer, J. (1988). DSM-III Psychiatric Disorders Among Hmong Refugees in the United States: a point prevalence study. *American Journal of Psychiatry,* 145(2), 197-202.

Xiong, Y.S. (2012). Hmong Americans educational attainment: Recent changes and remaining challenges. *Hmong Studies Journal,* 13(2), 1-18.

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Table 1. Demographics

Gender	**n**	**%**
Male	57	29.8
Female	134	70.2
Age		
18-21	124	64.9
22-27	53	27.7
28-35	6	3.1
36-42	8	4.2
36-42	8	4.2
Education Level		
Some high school or less	9	4.7
High school/GED	43	22.4
Some college/Associates	109	56.8
Bachelors Degree	23	11.9
Masters Degree	4	2.1
Post Graduate/Ph.D.	4	2.1
Marital Status		
Single	156	81.2
Married	32	16.7
Divorce	4	2.1
Generational Status		
1st Generation	49	25.4
2nd Generation	142	73.6
Acculturation Score		
< 2.49	38	19.9
2.5-2.99	128	67.0
3.0 <	25	13.1

Table 2: Chi-Square Tables of Acculturation Score, Age, and Generational Status Variables (N=191)

	Acculturation Score									
	2.0-2.49		2.5-2.99		3.0-3.8		Total			
	N	%	*N*	%	*N*	%	*N*	%	*df*	X^2
Age										
									6	4.277
18-21	24	19.3	85	68.5	15	12.1	124	64.9		
22-27	13	24.5	33	62.3	7	13.2	53	27.7		
28-35	0	0	4	66.7	2	33.7	6	3.1		
36-42	1	1.3	6	7.5	1	1.3	8	4.1		
Generational Status									2	.110
1st	10	20.4	32	65.3	7	14	49	25.6		
2nd	28	19.7	96	67.6	18	12.7	142	74.3		
Time in the U.S.										
16 – 20 years	5	10.2	8	16.3	2	4	14	28.6	28	39.949
21-25 years	7	14.2	12	2	1	2	20	40.8		
26-30 years	0	0	4	8.1	0	0	4	8		
31-37 years	1	2	7	14.3	1	2	9	18.4		

Table 3: Chi-Square Table of Depression Score, Acculturation and Generation Variables

	Depression Score									
	10-20		21-30		31-40		Total			
	N	%	*N*	%	*N*	%	*N*	%	*df*	X^2
Acculturation Score										
2.0-2.49	26	20.6	87	69	13	10.3	126		4	3.248
2.5-2.99	10	18.1	34	61.8	11	2	55			
3.0-3.8	2	20	7	7	1	1	10			
Generational Status									2	2.952
1st	30	61.2	18	36.7	1	3	49	25.7		
2nd	96	67.6	37	26.1	9	6.3	142	74.3		
Year of Arrival									4	3.356
1975-1979	6	4.7	1	1.8	0	0	7	14.3		
1982-1989	11	8.7	6	10.9	0	0	17	34.7		
1990-2000	13	10	11	20.0	1	10	25	51		