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We hereby approve the Dissertation

of

Sarah Palasciano-Barton

Candidate for the Degree:

DOCTOR OF PHILOSOPHY

_____
Advisor
Virginia (Ginger) Wickline

_____
Reader
Vaishali Raval

_____
Reader
Dawna-Cricket-Martita Meehan

_____
Graduate School Representative
Ann Fuehrer

ABSTRACT

NARRATIVE ANALYSIS OF HMONG REFUGEE HEALTH EXPERIENCES AND THE IMPACT OF A LOCAL COMMUNITY CENTER

by

Sarah Palasciano-Barton

Refugees who relocate to developed countries, such as the U.S., often experience the largest adjustments due to cultural and linguistic differences, and disparities between their skill sets and work opportunities available. Despite the majority of refugees originating from non-Western, developing countries, the theories and interventions proposed to work with these populations have been predominantly developed with Western frameworks. These discrepancies are especially relevant to the Hmong refugee community, as their culture, skills, and experiences differ vastly from those of the U.S., and the limited availability of research on this population has led to gaps between the community's needs and resources available. Thus, the current study used semi-structured interviews to examine the lived experiences of 12 Hmong refugees living in Madison, WI who accessed services at a culturally-specific, community mental health center (Kajsiab House). Interviews focused on participants' overall health after relocating to the U.S. and how services offered through Kajsiab House impacted their health over time. Qualitative thematic analyses of participants' narratives identified three major themes and five subthemes including: 1) factors impacting health before and outside of Kajsiab House, 1a) loss, 1b) barriers to adjusting to the U.S., 1c) impact of the existing Hmong community, 2) impact of Kajsiab House services on health, 2a) increased connection to community and family, 2b) reduction of stress on self and family, and 3) hopes and fears for Kajsiab House. Participants' narratives in the current study challenged universal, Western notions of health and healing and provided support for the development of collaborative, community-based interventions that honor and integrate traditional cultural and healing practices. Findings also highlighted the strength and resilience of the Hmong refugee community and pointed to the importance of including family and community members in the development and implementation of services. Implications for the development of future research and mental health interventions for refugees, as well as recommendations for the Kajsiab House program, are discussed.

NARRATIVE ANALYSIS OF HMONG REFUGEE HEALTH EXPERIENCES AND THE IMPACT OF A LOCAL COMMUNITY CENTER

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Sarah Palasciano-Barton

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Dissertation Advisor: Virginia (Ginger) Wickline

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In the last 50 years, more than half of the world's nations have experienced violent conflict (Buvinic, Gupta, Casabonne, & Verwimp, 2013). As of 2014, it is estimated that 59.5 million individuals have been forcibly displaced worldwide due to persecution, conflict, generalized violence, or human rights violations. Of those 59.5 million, 19.5 million have relocated outside of their home country and have been classified as refugees (United Nations Higher Commissioner for Refugees [UNHCR], 2015). Although the majority of refugees remain within their first country of asylum – typically within the developing world – or are repatriated to the country from which they fled, approximately one percent are resettled in a third country in the industrialized world (Goodkind, 2006). Refugees who resettle in a third, developed country such as the United States often face the largest adjustments in terms of cultural and linguistic differences, as well as disparities in opportunities for employment and ways of life (Goodkind, 2005). This is especially true for the Hmong refugee community who experience vast differences between their own culture, skills, and experiences and the predominant culture, language, and work opportunities within the U.S. (Culhane-Pera & Xiong, 2003; Goodkind, 2006). Further, their cultural practices and traditions differ significantly from other Asian subgroups in the United States. As such, it is critical to understand the socio-cultural, political, and historical context in which the Hmong have existed to develop culturally appropriate treatment interventions for this socially underrepresented and marginalized population.

Understanding Refugee Communities

Between 2010 and 2014, refugees seeking asylum in industrialized countries originated from 200 different countries. Of the 44 industrialized countries worldwide, the United States has ranked second, behind Germany, over the past several years for the number of refugees accepted (UNHCR, 2014). Further, over 2.5 million refugees have resettled within the United States since the inception of the its humanitarian program (Murray, Davidson, & Schweitzer, 2010). Refugee communities are diverse in cultural background, pre-flight trauma, flight experiences, and post-migration daily stressors they experience in exile. These experiences often cause a significant amount of emotional and psychological distress, resulting in a reduced ability to adapt to their new surroundings and create meaningful lives (Goodkind, 2006; Murray et al., 2010). Although some distress is caused by past traumatic experiences, recent research suggests that daily

stressors refugees face in exile – such as lack of meaningful social roles, loss of community and social support, poverty, economic concerns about survival, discrimination, lack of environmental mastery, undesired changes to their way of life, and social isolation – also play a large role in their overall distress (Goodkind, 2006). Further, working with refugee communities is particularly challenging as the majority of these populations originate from non-Western, developing countries who hold vastly different cultural values and beliefs from the dominant culture within the United States (Hwang, 2013; UNHCR, 2015). These differences raise concerns about the cultural appropriateness of psychological techniques, theories, and conceptualizations developed within Western contexts; the cultural competence of personnel who conduct assessments; cultural barriers which may impede access to resources; linguistic demands of communities; and the utilization and effectiveness of services provided (Paniagua, 2013; Sue, Zane, Nagayama Hall, & Berger, 2009). These concerns are especially relevant to the Hmong refugee community as the limited availability of research about this particular population may result in mental health professionals being uninformed about how Hmong cultural traditions and practices impact expression, understanding, and treatment choices when Hmong refugees experience distress (Tatman, 2004).

Hmong Culture and History in Southeast Asia

Over the last 40 years, one of the largest refugee groups to resettle within the United States has been Southeast Asian communities. These vastly diverse communities began arriving in the 1970s and 1980s as a result of the Vietnam Conflict and Pol Pot regime in Cambodia. One community in particular, the Hmong community, composed a significant part of the refugee groups who resettled during this time period (Goodkind, 2005). Although Hmong history has primarily been passed on through oral traditions such as storytelling, the Hmong are thought to have lived in Central Asia, now present-day Mongolia, since 2300 B.C.E. Over the centuries, Hmong people migrated south into Tibet and China and finally settled in Southeast Asia in the 1800s, primarily to Laos where they lived geographically, socially, and culturally separate from native Lao people. It is believed that the Hmong left China after violent conflict erupted between the Hmong and Chinese due to the Hmong community's desire for independence and refusal to conform to traditional Chinese culture (Culhane-Pera & Xiong, 2003; Quincy, 2000). Despite periods of tyranny that the Hmong were subjected to while living in Laos, during colonization by

the French and Japanese, the Hmong were mostly able to maintain an independent way of life for many decades in the highlands of Laos (Xiong, 2015).

Traditionally, Hmong people built their villages just below mountain summits and practiced slash-and-burn agriculture, which involved cutting and burning trees and/or vegetation to prepare and fertilize plots of land for farming. Hmong communities would farm these fields for relatively short periods of time and then either rotate to a nearby field or move the entire village to a new location in order to repeat the process (Cerhan, 1990; Culhane-Pera & Xiong, 2003). Hmong society is patrilineal, patrilocal, and patriarchal based on family clan membership. Family lineage is traced through the father, and all individuals with the same family clan name are related to one another. This patrilineal system is important socially and spiritually to the Hmong. People within the same clan refer to each other using an elaborate system of kinship terms in order to address one another, and men turn to their extended families for help when social, political, financial, or health problems arise (Culhane-Pera & Xiong, 2003). Further, husbands' family members have more social obligations to each other than they do to wives' family members. Animist spiritual rituals are passed from fathers to sons, and households' ancestral spirits have special relationships with household members. Male heads of household are responsible for maintaining relationships between household members and their ancestral and house spirits. This role is particularly important as the physical and spiritual world are thought to co-exist, and all aspects of life including marriages, births, illnesses, deaths, funerals, harvests, disputes, kinship relationships, and appropriate relationships between people are intertwined with these animistic beliefs and values (Culhane-Pera & Xiong, 2003). In addition to animistic spiritual beliefs, some Hmong converted to Christianity after coming into contact with Catholic missionaries in the early 1900s and Protestant missionaries in the 1940s. Many conversions occurred in large groups of hundreds or thousands of people in short periods of time, as whole villages followed their leaders' decisions to become Christian. Other explanations of mass conversions include a belief that foreigners would return their lost book to them, which was lost during conflicts with the Chinese, and the belief that the messiah would free them from their difficult life situations (Capps, 1994; Tapp, 1989).

In addition to family lineage divisions, there are societal distinctions between two major types of Hmong (i.e., White Hmong and Green Hmong). These two distinct groups have different language dialects, housing structures, and animistic rituals, and are identified by the

types of clothing that women wear in each community (Culhane-Pera & Xiong, 2003). Traditionally, Hmong men have more status and power than women in society as they are responsible for performing the ancestral and spiritual rituals for their families, arranging marriage contracts between clans, conducting funerals, and settling disputes either formally (in court proceedings) or informally (within their families or between clans). As they progress into middle age, men gain power; however, this power declines as they progress into old age (Culhane-Pera & Xiong, 2003). Traditionally, Hmong people are also patrilocal, meaning that they live with their father's side of the family. Thus, when a woman marries, she leaves her father's household and joins her husband's household. Hmong women have more private power than public power, influencing events within their households directly and events outside their households indirectly through their husbands. Similar to men, women gain power as they age, exercising considerable control over their households by middle-age through their roles as mother-in-laws. During this time period, women have influence over decisions involving money, farming, cooking, animals, children, marriages, and responses to sick family members. As women decline into old age, they are respected; however, once their husbands die, they relinquish household leadership to their married sons and daughters-in-law (Culhane-Pera & Xiong, 2003).

Prior to coming to the United States, members of a patrilocal household shared living space and fields where they grew crops. It was not uncommon for a husband to have more than one wife, and families often lived together under one large building that expanded as the family grew. Some families shared food and ate together in groups of up to one hundred people, and adult household members took collective responsibility of raising children (Culhane-Pera & Xiong, 2003; Cooper 1976). Children of both genders learned many of the same life skills and social values including agricultural, horticultural, and culinary abilities, as well as respect for their elders. They were also taught gender-differentiated skills such as weaving cloth and raising animals for the girls and playing musical instruments and hunting for the boys. Children often took on household responsibilities and obtained life skills, so they could function as adults and marry in their mid-teens. Storytellers, who were often grandparents, taught children about Hmong culture through family stories, folktales, and myths (Johnson & Yang, 1992). Hmong society was traditionally non-literate; however, in the past one hundred years, several writing systems have been developed using Chinese Characters, Lao, Thai, and Roman alphabets, as

well as Polar and Hmong script. Few children were able to attend primary schools in Laos until the 1960s when the United States Agency for International Development (USAID) set up primary schools in Hmong villages. At that time some students were able to continue secondary school in the only high school in Vientiane, Laos; however, others left to study in Australia, Canada, France, and the United States (Bliatout, Downing, Lewis, & Yang, 1988).

Secret War in Laos. In the 1960s the United States Central Intelligence Agency (CIA) began recruiting Hmong soldiers to stop the spread of communism in Laos during the Vietnam War. During recruitment efforts, the CIA promised that the United States would "take care of" the Hmong and that they would be provided with better political and educational opportunities in Laos (Pfaff, 1995). Due to Laos being established as a neutral, sovereign state during the 1954 Geneva Conference, the operations of the CIA and recruitment of Hmong soldiers became known as the Secret War (Xiong, 2015). The Hmong were particularly skilled in navigating the jungles of Laos and took part in some of the most dangerous missions during the war. As such, Hmong soldiers died at much higher rates than their American counterparts (Hamilton-Merrit, 1999). During this time period, Hmong communities were greatly disrupted. Between 1961 and 1975, northeast Laos was the most heavily bombed area in the world with more than two million tons of bombs dropped by U.S. airplanes (Warner, 1995). By 1967, almost forty thousand Hmong were serving as troops, guerrilla fighters, support personnel, navigators, and pilots in the fight against communist forces (Robinson, 1998). The fighting, bombing, and shelling from U.S. planes disrupted village life to the point that families including older men, women, and children fled to the jungle, resulting in approximately one million people being displaced from their homes (Culhane-Pera & Xiong, 2003).

In 1973, U.S. President Richard Nixon pulled all U.S. troops out of the region and discontinued all U.S. involvement with the Vietnam War, including the Secret War in Laos, due to being under pressure with the unpopularity of the war. Hmong troops were suddenly left without support and were now targets of the communist regime, as they had fought to support the U.S. (Xiong, 2015). After Laos came under communist control, the Hmong were viewed as wartime enemies, resulting in the mass murder of soldiers who participated in the war, as well as innocent men, women, and children. Unable to live in Laos any longer, many Hmong fled to Thailand for refuge (Hamilton-Merrit, 1999). During the trek to Thailand, many Hmong died of starvation and disease, and many of the sick and elderly had to be left behind in the jungle as the

Hmong were being hunted by communist forces (Miyares, 1998). Mothers were forced to drug their babies and small children with opium, which at times resulted in overdose and death, in order to avoid revealing their location to the communist soldiers. Communist forces also utilized a number of chemical weapons and biological toxins in order to disable the Hmong who attempted to flee, and many Hmong were killed by communist forces or drowned while trying to cross the Mekong River that borders Thailand (Hamilton-Merrit, 1999). Throughout the Secret War and subsequent genocide, which spanned between 1973 and 1997, it is estimated that about half of the Hmong population was killed (estimations range between 200,000 to 250,000; Hamilton-Merrit, 1999; Tobin & Friedman, 1983).

Life in refugee camps. Initially, the majority of Hmong who were able to escape Laos and survive the dangerous trek to Thailand were placed in refugee camps. Some Hmong never entered the camps but instead attempted to settle in existing Hmong villages in northern Thailand. However, those that were discovered were sent to official refugee camps (Robinson, 1998). Additionally, between 1985 and 1989, several thousand Hmong were sent back to Laos, and about 45 percent of Hmong refugees were denied refugee status in 1989 after stricter screening processes were put into place (Robinson, 1998). Despite being victims of massive human rights violations, the Hmong who were admitted to Thailand were treated like prisoners in the refugee camps (Xiong, 2015). This was primarily due to a previous tumultuous relationship between the 60,000 indigenous Hmong who lived in the highlands of Thailand and the Thai government. The Thai government was displeased with the Hmong's slash-and-burn-farming practices and worried that providing asylum to Hmong refugees from Laos would recreate an economic burden on the government. Nevertheless, the Hmong were allowed to seek refuge in Thailand due to the U.S.'s relationship with Thailand and the Hmong's service to the CIA (Xiong, 2015). The refugee camps were documented to be more similar to concentration camps than places of asylum (Hamilton-Merrit, 1999). The Hmong were crammed into overcrowded camps behind barbed wires where they were continuously monitored by Thai border guards (Hamilton-Merrit, 1999). The border guards frequently tortured the Hmong and beat and or murdered them at the slightest instance of wrongdoing (Quincy, 2000). Additionally, the amount of space provided to each family was small, the water supplies and sanitation facilities were limited, and food allowances were less than the international standard (Long, 1993; Robinson, 1998). Although some Western medical care was provided, death rates and birth

rates were high, and religious proselytizing was connected with services provided. These practices led Hmong refugees to become suspicious of physician's motives and methods and generated beliefs that Western medicine was connected to illness, death, and medical complications (Wright, 1986).

Hmong History in the United States

Resettlement experiences and life in the U.S. Despite the terrible conditions in the refugee camps, many Hmong were reluctant to volunteer for resettlement for a number of reasons. Many Hmong hoped that they could someday return to their villages in Laos with a noncommunist Lao government, while others wished that the Thai government would allow them to settle with their relatives in the Thai mountain communities. Furthermore, many people were waiting to hear back from their relatives who had yet to arrive from Laos, were in other refugee camps, did not have refugee status, or had already resettled in other countries so that they could be reunited. Families who resettled in other countries sent back reports of difficulties related to language, jobs, housing, and adjusting to the dominant culture (Culhane-Pera & Xiong, 2003). By the end of 1999, most of the refugees from Laos had left Thailand and were resettled in a third country or were repatriated to Laos. A small amount of Hmong remained in Thailand and lived in Buddhist wats (temples), unbeknownst to the Thai government. Most Hmong who resettled in a third country were sent to Australia, France, and the United States; however, others went to Argentina, Canada, French Guyana, and New Zealand. In total, 108,000 Hmong were resettled in the United States (Culhane-Pera & Xiong, 2003).

In order to be resettled in the United States, Hmong were subjected to many health and family stipulations, which caused further separations of family members and communities. Men with multiple wives were forced to choose which wives and children they would claim and which they would renounce. People had to be cured of tuberculosis, venereal disease, and leprosy. They were rejected if they were found to be mentally impaired; had mental health issues; were addicted to opium; were identified as communists, criminals, or polygamists; or were thought to have lied on their applications (Robinson, 1998). In order to lessen the impact on any one community, the United States intentionally dispersed the Hmong across the United States. However, this spreading policy lead to further disruption of communities and clans, resulting in a secondary migration during which many Hmong left their original resettlement sites and moved closer to family clan members (Goodkind & Foster-Fishman, 2002).

Furthermore, Hmong refugees who arrived in 1980 were provided with 36 months of federal funds to adjust to their new life. However, cash assistance was reduced to 18 months in 1982, and later all federal funds to support states' refugee assistance programs were rescinded (Culhane-Pera & Xiong, 2003).

Life changed drastically for the Hmong who resettled in the United States. The Hmong were used to being a self-sufficient people who lived in small agricultural villages without electricity, toilets, or vehicles. Their transition to modern cities in the United States has been described as "a hundred-year leap in a twenty-four-hour plane ride" (Culhane-Pera & Xiong, 2015, pg. 27). Many Hmong were suddenly unable to maintain self-sufficiency and lacked the necessary skills to care for themselves, their families, and their communities. Significant differences in culture between the Hmong and dominant U.S. culture led to the development of negative stereotypes about Hmong, which viewed them as defiant and or difficult to work with in neighborhoods, hospitals, and schools (Xiong, 2015). Neighbors complained of "barbaric animal slaughtering" that occurred in backyards during Hmong ceremonies. Schools were unprepared to help Hmong children who spoke English as a second language and went home to parents who were unfamiliar with the concept of homework (Cerhan, 1990; Xiong, 2015). Some Hmong converted to Christianity after arrival due to difficulty with finding traditional healers and ritual specialists or to please church resettlement sponsors. Over time, other Hmong chose to convert to receive scholarships to private Christian schools and find unity with nonrelated Hmong community members. This conversion did not always happen, though, as some Hmong rejected Christian beliefs and returned to their traditional spirituality, especially when prayer was not effective for treating chronic, recurrent, life-threatening illnesses. In general, both religious communities encouraged Hmong to choose one path and not switch back and forth repeatedly out of protection of either God or animist spirits (Culhane-Pera & Xiong, 2003).

Impact of the secrecy of the Secret War. Many Americans were unaware of the Hmong's involvement in aiding the U.S. during the Secret War and often viewed them as "welfare-hungry immigrants" who were taking advantage of U.S. benefits. This was not surprising, as the U.S. denied any involvement with air or ground support in the Secret War throughout the Vietnam War and for several decades following it. In the 1980s, the U.S. government continued to minimize both their involvement in Laos during the Secret War and the experiences of the Hmong people, despite countless stories that surfaced of the atrocities that the

Hmong faced. It was not until 1997 that the U.S. government admitted to its involvement in the Secret War and the contributions of the Hmong community (Vang, 2010). This "culture of silence" left many Hmong feeling abandoned by the U.S. (Xiong, 2015) and created increased distrust between the Hmong community and U.S. agencies. Lack of awareness about the Hmong community's assistance in Vietnam and the promises made by the U.S. have caused significant tensions between the Hmong community and the U.S. dominant population, leading to stereotyping and discrimination of the Hmong.

The Hmong community today. The Hmong community now has a population of approximately 260,000 (U.S. Census, 2010), with the largest numbers residing in California, Minnesota, and Wisconsin (Xiong, 2015). Although the Hmong community has experienced many traumas related to war, genocide, refugee camps, separation of family during migration, and the loss of meaningful social roles, community, and social support upon resettlement, many Hmong families have overcome poverty, built their own businesses, and obtained professional degrees (Vang, 2010). Nevertheless, post-migration issues continue to be particularly burdensome for the Hmong community in the U.S. today due to vast differences between their own culture, skills, and experiences and the predominant culture, language, and work opportunities within the United States (Goodkind, 2006). As such, Hmong communities continue to show significant disparities as compared to the U.S. general population, including Latino and African American populations, in relation to educational attainment and rates of poverty (Cerhan, 1990; Xiong, 2015). For instance, families live in poverty at double the rate of the U.S. general population (i.e., 25% versus 11%; Lee & Chang, 2013). Further, since resettlement within the U.S., difficulties with alcoholism, domestic violence, and crime have increased within the Hmong community (Culhane-Pera & Xiong, 2003). These difficulties, in combination with intergenerational differences in belief structures, gender roles, and differences in education and language skills have caused a significant amount of disruption in the Hmong community (Culhane-Pera & Xiong, 2003). Lastly, previous interactions with Western healthcare providers in refugee camps and significant cultural differences in views about health, illness, and healing led to a number of serious misunderstandings and conflicts between Hmong families and U.S. healthcare professionals. Lack of awareness about the Hmong community's previous interactions - as well as contrasting worldviews about health, illness, and healing - left both the Hmong community and U.S. healthcare providers confused and frustrated. Many Hmong have reported

feeling "disrespected with the way they are treated and angry that providers can do harmful things to them and their children against their will" (Culhane-Pera & Xiong, 2003, p. 3). Concurrently, many health care professionals have reported feeling frustrated and view the Hmong as difficult to work with in large part due to a lack of education and training about the social, historical, and cultural practices of the Hmong (Culhane-Pera & Xiong, 2003). In light of these difficulties, an understanding of the Hmong community's experiences, especially related to healthcare systems, is essential to providing the community with culturally competent services.

Cultural Competency and Refugees' Mental Health Needs

Historically, research and interventions targeting refugee communities have relied on models of trauma based on the experiences of individuals within Western, educated, industrialized, rich, and democratic societies (WEIRD; Hwang, 2013). The strategy of developing conceptualizations and theories of psychological phenomena within WEIRD societies and purporting them to represent "universal" human experience dates back to the founders of psychology, such as Wilhelm Wundt. With the expansion of Western capitalism and colonialism over the last few centuries, these conceptualizations and theories have spread across the globe and led to the acceptance of "universal" constructs within mainstream psychology (Hwang, 2013). Interestingly, although WEIRD societies only house 12% of the world's population, 96% of the world's top published research between 2003 to 2007 in psychology was produced within WEIRD societies. In addition, the majority of work published within the psychological literature is produced by behavioral and cognitive psychologists in Western cultures (i.e., Western Europe, the United States, and Canada), who now hold a dominant role in the field (Hwang, 2013). Thus, for the remainder of this paper I will use the term "Western" to identify all psychological theories, conceptualizations, models, and interventions developed by dominant groups (i.e. European and European American) within WEIRD societies including those used within the fields of clinical, counseling, and community psychology.

In response to these universal claims, many scholars and practitioners over the past several decades in non-Western societies have noted that imported theories of Western psychology are irrelevant, incompatible, and or inappropriate within their culture due to theories and practices stemming from European and European American culture (Hwang, 2013). Interestingly, recent studies investigating whether constructs and phenomena developed within WEIRD societies could be applied universally found that subjects who ascribe to dominant

values within WEIRD societies are particularly unusual compared to the global population in a number of domains including visual perception, fairness, cooperation, spatial reasoning, moral reasoning, reasoning styles, and self-concepts and related motivations (Henrich, Heine, and Norenzayan, 2010a, 2010b). As such, these authors concluded that there is no a priori to claim that psychological phenomena established in WEIRD societies are universal based on the sampling of this single subpopulation (Henrich et al. 2010a).

Similar to other theories within mainstream psychology, models developed to explain the experiences of refugees have primarily focused on disorders consistent with dominant Western frameworks of mental health such as Posttraumatic Stress Disorder (PTSD) and other related psychiatric symptoms such as depression, somatization, anxiety, hostility, phobias, and paranoia (Goodkind, 2005). Importantly, rates of identified psychopathology within refugee communities have varied tremendously, with some studies showing rates at twice the general population and other with rates below the general population within the United States (Murray et al., 2010). Although differences in rates of psychopathology may in part be due to measurement and differences in trauma exposure, more recent research has also alluded to the inappropriate use of Western trauma-models with culturally divergent populations. These concerns have led to significant criticism of the medicalization of trauma and its impact on refugee communities' ability to remain resilient and successfully adapt to their new environments (Bracken, 2002; Gozdziak, 2004).

Western models of trauma are developed within specific social, political, and historical contexts, and thus cannot exist independently of the contexts in which they are created. As such, they reflect the dominant conceptualizations of the relationship between culture and the self that are held within these contexts. The relationship between culture and the self (i.e., self-construals) influences people's perceptions, cognitions, emotions, motivations, and relationships and intergroup behaviors; thus, shaping the way they experience and understand the world around them (Markus & Kitayama, 1991; 2010). Although contextual and individual differences exist within every society (Singelis, 1994), research has found that dominant models within Western societies predominantly ascribe to an independent or individualistic sense of self where the primary mode of reference is to the individual's own thoughts, feelings, and actions. Accordingly, current Western conceptualizations of trauma are based on cognitivist models which are a product of the positivist, Cartesian framework assuming the separation of mind and

body and an individualistic self-construal (Bracken, 2002). In contrast, individuals from non-Western societies, such as the Hmong, have been found to ascribe to an interdependent or collectivistic sense of self, where the primary mode of reference is to the thoughts, feelings, and actions of others with whom the person has a relationship (Markus & Kitayama, 2010). Thus, Western models of psychotherapy that focus on individualistic conceptualizations of trauma are insufficient in understanding traumatic reactions of more collectivistic cultures such as the Hmong, who experience trauma more collectively (Jenkins, 1996). Further, individualistic conceptualizations and interventions of trauma often fail to recognize refugee communities as valuable sources of strength, containing resources that may alleviate distress of individuals who experience trauma, which further contributes to the disempowerment of both the individual and community (Goodkind, 2006).

Secondly, PTSD was historically developed to address the distress of Vietnam War veterans and their experiences as patients in the Veterans Affairs Healthcare system (Moghimi, 2012; Summerfield, 1999; Tobin, 2014). Although the development of PTSD appears to adequately capture the experiences of U.S. Vietnam veterans, it seems questionable at best as to whether it is able to provide a conceptualization of refugee trauma. As previously stated, Western trauma models are based on the idea of trauma being expressed as individual psychological and behavioral reactions to past, discrete traumatic events (Moghimi, 2012). This conceptualization is consistent with the experiences of Vietnam War veterans and with many individuals in Western societies who experience single, discrete traumatic events. However, it does not adequately reflect the experiences of refugee populations such as the Hmong, who are exposed to long-term, chronic, traumatic experiences and daily stressors which may span years or even decades. This distinction is especially important as research has shown that exposure to single, traumatic events, which typically result in PTSD, are both quantitatively and qualitatively different than being exposed to long-term, chronic traumatic experiences (Herman, 1992; Resick et al. 2012). Further, for many refugees and displaced persons, daily stressors and cultural bereavement (i.e., disconnection from homelands and loss of a known way of life) - and not traumatic experiences as defined by Western psychiatry - have been found to be key issues which determine psychological and social outcomes (Bracken, 2003; Von Peter, 2008). Indeed, a recent study conducted by Danner and colleagues (2007) found that role loss, separation from

family, unemployment, lack of education, and inability to speak English were key factors that impacted mental health in a sample of Hmong women.

Utilizing theories and conceptualizations of trauma and mental health that do not match the experiences and self-world construals of refugee groups not only leads to inappropriate use of psychiatric diagnoses, it also results in over-pathologizing and the use of deficit-based models when working with these communities. In line with these criticisms, many researchers and clinicians have begun to shift away from focusing on trauma experiences and post-traumatic stress symptoms and more towards understanding refugee experiences holistically by acknowledging cultural and individual differences and fostering strength and resilience by identifying existing capacities within refugee communities. This shift has promoted increased use of qualitative, emic approaches with refugee communities that seek to understand cultural differences in meaning-making and distress and foster cultural-specific methods of coping with adversity. Rather than pathologizing the refugee experience, holistic approaches utilize culturally accepted ways of engaging with refugees by honoring their cultural systems and values in order to foster recovery and resilience (Gozdziak, 2004; Papadopoulos, 2007; von Peter, 2008).

Hmong Mental Health Status and Previous U.S. Interventions

Unfortunately, minimal research has been conducted on the mental health of Hmong refugee communities since their arrival to the United States in the 1980s. A recent report by Lee and Chang (2013) that compiled research findings from the last several decades and information from the 2010 U.S. Census stated that limited resources and viable data resulted in an unclear picture about the mental health status of Hmong communities in the U.S. Further, the authors recommended that research protocols be developed in order to provide additional insight and depth into the experiences and needs of this population (Lee & Chang, 2013). Although some data exist, the majority of this information has been conceptualized through a Western psychiatric lens and deficit-based model (Cerhan, 1990; Sue & Sue, 2008). This has frequently led to over-pathologizing Hmong refugee experiences (Xiong, 2015). According to these models, Hmong are thought to suffer primarily from anxiety, depression, PTSD and adjustment disorders, as well as a sense of alienation and powerlessness (Culhane-Pera & Xiong, 2003; Lee, 2013). Although the Hmong have been exposed to a number of difficult experiences, primarily focusing on individual and community deficits without acknowledging their social and historical context is akin to blaming the victim (Sue & Sue, 2008), leading to invalidation of their experiences and

disempowerment of the community (Xiong, 2015). Furthermore, failure to recognize individual and community strengths and resiliency perpetuates the narrative that the Hmong are a "drain" on society's resources and ignores the contributions that both individuals and the community have made and can make to the U.S. In contrast to Western, positivistic psychiatric models, models that recognize the critical impact of social, cultural, and historical factors on lived experiences shift the focus from individuals being the cause of their distress to recognition of the impact of broader systems on individuals' ability to work towards or maintain wellness. These alternative models legitimize a diversity of experiences based on a multitude of worldviews and intersecting social identities, rather than a singular, dominant narrative posited to explain "universal human experiences." In line with the latter model, a primary goal of the current project is to understand the experiences of a Hmong refugee community within the social, cultural, and political context in which they live.

In addition to limited data on Hmong mental health, very few studies have evaluated the effectiveness of interventions utilized with Hmong refugee communities. A recent meta-synthesis conducted by Lee (2013) only identified six studies evaluating the effectiveness of interventions with Hmong refugee communities. Of importance, the majority of studies 1) solely utilized quantitative approaches and Western conceptualizations of trauma and 2) found mixed results for the effectiveness of treatments. For instance, Westermeyer (1998) compared Hmong patients with high depression scores who received therapy and medication versus those in a control group. The author found decreased levels of depression for the treatment group versus the control group after one year. However, at a two year follow up, there was still a difference between the two groups, but it was not statistically significant. In a case study of Hmong woman who was a widow and suffered from pain and depression, only psychotropic medication was found to be effective in treating her symptoms (Frances & Knoll, 1989). In another case study, some survival stress symptoms were alleviated for a Hmong refugee with a Hmong Shaman ritual, "ua neeb" (Tobin & Friedman, 1983). In contrast to more positive outcomes, several studies found treatment to be ineffective. For example, one study concluded that most depressive symptoms worsened, especially those related to self-worth, after six months of psychiatric treatment (Mollica, Wyshak, Lavelle, & Truong, 1990). In a study conducted by Danner and colleagues (2007) with a Hmong treatment sample, depressive symptoms did not improve with support or counseling groups. Lastly, a study conducted by Westermeyer and colleagues (1989)

found that several treatments for delusions were ineffective for Hmong patients with psychotic depression. Taken together, it appears that more holistic assessment and intervention approaches are needed due to an incomplete picture of Hmong mental health and the use of Western psychiatric approaches which have been largely ineffective at providing the Hmong community with necessary resources. Thus, another primary goal of this project is to examine whether and how the collaborative development of a culturally specific community-based mental health center- with the Hmong community in Madison, Wisconsin (WI) - has allowed the community to voice their needs and utilize existing community strengths and resources to develop culturally-appropriate mental health programs.

Method

Project Development

Guiding frameworks. The data analyzed within the current project were collected as part of a larger mixed-methods study collaboratively developed between members of the Hmong community in Madison, WI, and me. Madison was chosen as a site of interest due to Wisconsin housing one of the largest concentrations of Hmong people within the United States (Goodkind, 2006). The intervention model, Kajsiab House, was chosen as it is the only program of its kind in the country. Kajsiab House was developed and is currently operated by members of the local Hmong community to provide services to Hmong refugees who are unable to obtain/maintain employment and/or who need others to care for them throughout the day. Further, the program sought to integrate Western resources with Hmong culture, values, and spirituality to provide the community with culturally appropriate mental health services. The larger study was guided by transformative and social constructivist frameworks and incorporated elements of an explanatory sequential mixed-methods model within a social-justice framework (Creswell, 2014). A transformative framework posits that research should be intricately connected to an agenda for political change that confronts social oppression of marginalized groups (Mertens, 2010). As such, the research contains an action agenda that addresses specific issues, such as empowerment and oppression, and works to reform the institutions in which individuals live. Projects with a *transformative framework* focus on the collaborative nature of interventions to provide a space for participants to give voice to their concerns and advance an agenda that improves their lives (Creswell, 2014). This philosophical worldview is often combined with other frameworks, such as feminist and social constructivist theories, which similarly focus on the needs of marginalized

or disenfranchised groups in society. The second framework, *social constructivism*, posits that individuals create subjective meaning out of their experiences, which are shaped through dynamic interactions within their social, cultural, and historical context (Creswell, 2014). In contrast to positivist views that seek to understand the "objective" reality in the world, social constructivism frameworks seek to understand the varied and multiple views of participants to explore the complexity of views and construct the participants' subjective realities. As such, the goal of the research is to rely on participants' views of the situation and how subjective meanings are formed through interactions with others and cultural and historical norms that actively operate in their lives. Questions are framed as broad and general so that participants can construct meaning through interactions or discussions with others (Creswell, 2007). Further, researchers position themselves within the research and recognize how their own social, cultural, and historical backgrounds shape how participants interact with them, as well as how they interpret participants' stories (Creswell, 2014).

Impact of positionality on project development. In line with transformative and social constructivist frameworks, I began reflecting on my own social, cultural, and historical background and how my personal biases and subjective understanding would influence the research process from initial identification of a topic to development of questions and interpretation of the data. Further, based on the experiences of marginalization and oppression the Hmong community had experienced in Laos, Thailand, and the United States, I sought to develop a collaborative project that would provide a space for participants to voice their experiences and identify an area of concern that could be addressed to improve their lives. In order to maintain the collaborative and empowerment focused nature of the project, I also reflected on several key questions throughout project development including: 1) For whom and what is the project being conducted? 2) Who owns the data and the process? 3) What data are sacred? 3a) In turn, how and what data should be shared? 3b) What data should be kept within the community)? 3c) Is it my place to share participant stories with others inside and/or outside of the community? 4) How do linguistic and cultural differences impact participants' ability to engage and provide consent for the research process? The next section provides more detail about how the above guiding framework impacted project development.

When starting the project, I recognized that my personal identities and experiences as a 30-year old, middle class, light-skinned, multiracial, bisexual, Latina woman who was born and

educated within the Southern and Midwestern United States significantly impacted the way I understood the world. For instance, I often "passed" in society as a member of the dominant European American culture and thus did not face many of the experiences of marginalization and oppression that other minoritized individuals, such those within the Hmong community, faced on a daily basis. Further, my upbringing within a European American (my father) and Argentinian (my mother) household had resulted in the integration of social and cultural norms from both cultures. As such, I recognized I held differing cultural norms and values – and thus assumptions and ideas – about religion/spirituality, gender roles, relationships, and family systems as compared to the Hmong community with whom I would be working. These differences would impact the way that I heard and interpreted the experiences of participants and the way that I organized and retold their lived experiences in my scholarly work. In addition, I had been exposed to two languages throughout my upbringing (Spanish and English), with my primary language being English. As a native English speaker, I recognized I could more easily navigate educational, political, and social systems that are often difficult for non-English speaking individuals and those that learn English as a second language. I had also been exposed to the dominant religion within the U.S. (Christianity) from a young age, having been raised in both Baptist and Catholic religions. In addition, my status as U.S. citizen provided me with a number of privileges and advantages I am often blind to in my daily life, such as the right to live without fear of being deported or losing refugee status, the ability to hold employment without limited barriers (e.g., work visas), and the right to vote. Lastly, I had been educated within Western school systems including the completion of several degrees within higher education. The education I had received greatly influenced the way that I understood trauma, which was limited to theories proposed within the scholarly literature and was primarily influenced by Western frameworks about the mind and body. Further, my education endowed me with a number of privileges including the ability to more easily navigate and understand social and political systems within the U.S. and increased economic mobility.

In contrast, most of the Hmong participants with whom I would be working with at Kajsiab House were born in either Laos or Thailand, had little to no education within or outside of the United States, did not speak English, previously held or currently held refugee status, and had difficulty obtaining U.S. citizenship. In addition, their worldview and understanding of the mind, body, and spiritual connection greatly differed from mine. Considering the differences

between myself and the participants, I actively reflected on the project's focus, developmental of consent and data collection procedures, and interpretation and distribution of results. Additionally, I recognized the need to be mindful of significant linguistic differences between English and Hmong that would impact the consent and research process with participants. I anticipated that my experiences of being a member of a minoritized (Latino) community within the U.S. and the daughter of an immigrant would enable me to be more open and sensitive to non-dominant cultural values the Hmong community held. Further, my acceptance and respect for their subjective worldview could facilitate in establishing rapport during the research process and help me to maintain awareness of how marginalization of participants' minority views could result in further oppression and silencing of their voices.

To address some of these concerns, I initially met with key informants at Kajsiab House to begin identifying the scope of the project, to determine how to approach the research process in a collaborative and culturally respectful way, and to discuss what type of project would be most beneficial for the local Hmong community members who received services at Kajsiab House. The staff psychiatrist was a European American male physician who was well respected and had been adopted into one of the clans within the Hmong community. His familiarity with Western mental health systems and extensive experience and intimate relationships with members of the Hmong community greatly facilitated the development of connections and trust between myself and staff members, as well as myself and participants, and bridged gaps in my understanding of differences between Hmong and Western conceptualizations of health. This initial relationship allowed me to develop connections with other key informants, such as the program manager and several clinicians, all of whom were Hmong. These informants acted as cultural brokers between myself and the Hmong community by orienting me to the Kajsiab House program, assisting me in the development of the project focus, developing questions which were relevant to the population and culturally and linguistically appropriate, providing key insights into issues participants faced as refugees, and explaining important cultural norms related to age, gender, spirituality, and health.

During this initial development phase of the project, an archival dataset with both quantitative and qualitative data previously collected during a jointly run study conducted by Kajsiab House and the University of Wisconsin-Madison (UW-Madison), which aimed to understand the physical and mental health needs of three generations of Hmong residents (ages

15 to 70 years) living in Dane County, Wisconsin, was identified as a potential project focus. Both the staff psychiatrist and the program manager noted that since data collection for this project had occurred, none of the data had been utilized to complete a manuscript. Thus, they hoped this data would serve some use within the current project. After further review of the data set and multiple discussions with the original project staff and the staff at Kajsiab House involved with the study, it became apparent that the data collected for this project focused on mental health from a solely Western perspective on trauma and mental health. For example, the study utilized measures such as a culturally adapted version of the Harvard Trauma Questionnaire (Mollica, Caspi-Yavin, Bollini, Truong, Tor, & Lavelle, 1992) to measure trauma experiences and PTSD symptoms and the Brief Symptom Inventory (Derogatis & Spencer, 1993) to measure general psychiatric symptoms (e.g., anxiety, depression) consistent with those noted in the Diagnostic and Statistical Manual Fourth Edition Text Revision; (DSM-IV-TR; American Psychiatric Association, 2000). Further, several staff noted confusion many participants felt about questions asked during the data collection phase of this study due to significant differences in conceptualizations of health and worldviews. Interestingly, preliminary data analysis noted that although a large portion of the refugee population reported high rates of trauma, the majority did not meet criteria for Posttraumatic Stress Disorder as measured by the Harvard Trauma Questionnaire (Krahn, Vang, Vang, Coleman, & Yonker, 2012).

Considering the transformative and social constructivist frameworks guiding the current study, I suggested to the staff psychiatrist and other project stakeholders that we develop a two-phase, mixed-methods study that would integrate data from the archival project and new qualitative interviews with client's at Kajsiab House focused on understanding experiences and conceptualizations of health from a Hmong perspective. More specifically, I proposed that a subset of the quantitative and qualitative data from the joint project between Kajsiab House and UW-Madison for participants aged 18 to 70 years would be used to provide basic demographic information about the local Hmong community and highlight Western conceptualizations of the Hmong refugee experience (i.e., a focus on PTSD and Western psychiatric symptomatology). This set of data included quantitative demographic information regarding acculturation in terms of language, religion, medical care, and diet; current and past substance use; general psychiatric symptoms using the Brief Symptom Inventory (Derogatis & Spencer, 1993); and trauma experiences and PTSD symptoms according to the culturally adapted version of the Harvard

Trauma Questionnaire (Mollica, Caspi-Yavin, Bollini, Truong, Tor, & Lavelle, 1992). Additionally, supplemental qualitative data from the Harvard Trauma Questionnaire, which was collected to clarify whether participants were exposed to any additional trauma experiences not captured on the quantitative portion of the questionnaire, would also be utilized. The data would be de-identified and not be directly matched to any participants in the second phase of the study.

In contrast, phase two of the study would consist of qualitative data collected by Kajsiab House staff during intake interviews, which consisted of stories told by refugees about their pre-flight, flight, and exile experiences since arriving in the United States. This archival qualitative data would be examined in conjunction with new information I would collect during qualitative interviews, which would explore participants' narratives related to their refugee, exile, and health experiences (in both Non-Western and Western contexts). By analyzing these portions of the qualitative data together, it was proposed that I would be able to provide a complete and detailed history of each participant's experiences and develop a deeper understanding of their needs based upon their unique situations. In addition, interviews would also explore whether and how the collaborative development of the Kajsiab House had empowered the community by eliciting the needs of community members and building programs which utilized the community's strengths and resources. Qualitative interviews conducted by me would be semi-structured, using open-ended questions collaboratively developed with several of the key informants and cultural brokers at Kajsiab House. Collaborative development of interview questions was particularly important as the language chosen and framing of each question often predetermines the answers obtained and confines conceptualizations to preexisting theories and models (Reyes & Sonn, 2011). As such, collaboration with members of the community would provide an insider-perspective and allow for the development of questions and content most relevant to participants. Further, it would facilitate the co-construction of participant stories that were more congruent with their social, linguistic, and cultural contexts.

It was proposed that the mixed-methods approach of this model would serve as a juxtaposition between the mainstream Western conceptualizations of trauma and refugee experiences, as presented by the quantitative and qualitative archival data examining PTSD and other psychiatric symptomatology from phase one, and alternative conceptualizations of the refugee experience, as presented by qualitative data from archival intake stories and qualitative interviews from phase two. These two different approaches give rise to divergent types of

information and each hold their own sets of inherent values and belief systems. As Western psychiatry often posits universality, especially within trauma experiences, it was my intention that the contrast between the types of information garnered from these two approaches would challenge this very assumption and highlight the diversity within refugee experiences and thus refugee needs. Through the disruption of the dominant refugee story, I hoped that these narratives would serve as a platform for social change by creating space to acknowledge alternative perspectives and in turn intervention modalities. Further, explicit discussions about the impact of my own cultural, social, and historical context, as well as the possibility of multiple interpretations of each participant's experience, would highlight how researchers' beliefs and values influence interpretations of trauma and the refugee experience. Lastly, examination of themes related to whether and how the collaborative development of Kajsiab House had empowered the community by validating their cultural values and beliefs and utilizing their existing strengths and resources would provide researchers and clinicians with alternative ways of designing and implementing interventions with refugee groups. Although this particular model would not be applicable to all refugee communities, the *process* of constructing community-based interventions which honor the cultural histories and values of the communities could be recreated as an intervention strategy.

First six-week community visit. After key informants and stakeholders at Kajsiab House approved the project focus, the project was then reviewed and approved by Journey Mental Health, the umbrella agency for Kajsiab House, and Miami University's Institutional Review Board. After obtaining these approvals, I traveled to Madison, WI for a period of 6 weeks to gain access to the archival data described above; develop relationships with staff and community members; learn more about the social, cultural, and historical contexts of the community; and collaboratively develop questions and protocols for interviews. This part of the process was particularly important for project development, as engaging the community as co-researchers would enable the project to centralize the community's voices and provide a space to reflect and revise the project to ensure it directly benefited the community (Morrow, 2007).

During this phase of project development, the impact of linguistic differences, gender roles, age, collective orientation, immigration status, and spirituality were particularly salient. For instance, I worked with multiple male and female staff members to develop questions that would elicit participant narratives while also being linguistically and culturally meaningful and

take each participant's age and gender into consideration. This process was particularly challenging as I found that many words did not translate from English to Hmong. Meaning and intent of language varied between English and Hmong even when similar phrases were used. Also, appropriateness of questions depended not only on participants' identities, but on the identities of the researcher and translator (i.e., questions asked and answers given would be highly context dependent). Further, differences across generations significantly impacted colloquial use of language and, thus, how questions and answers were framed and understood.

Spiritual beliefs were also particularly salient and significantly impacted project development. For example, during my interactions with several groups of clients at Kajsiab House, it became apparent that members of the community did not distinguish between mind, body, and spiritual aspects of themselves. All parts were conceptualized as wholly integrated; thus, physical or mental ailments could be conceptualized as having spiritual origins and vice versa. As typical questions about mental health within the Western context held divergent assumptions about the origins of symptoms, their connection to the body, and their association (or lack thereof) with spirituality, recognition of these differences led to further discussions about question development and the importance of integrating spirituality when assessing for mental health with the Hmong community. Moreover, these differences in understanding of the connection between the mind, body, and spirit often resulted in divergent views of what interventions would be most effective to treat an individual's concerns. For instance, in Western/European cultures, the separation between mind, body, and spirit led to the assumption that mental health issues originated in the mind and should be addressed by a person(s) who specialized in mental health; any additional physical or spiritual ailments would need to be addressed by separate experts. In contrast, when I presented symptoms typically associated in Western contexts with the mind, clients at Kajsiab House often suggested their connection to spiritual origins and suggested a shaman would be most appropriate to address the issue. Shaman are the foremost healer in Hmong culture, providing a wide range of healing methods that extend far beyond the scope, capacity, and expertise of Western physicians. The shaman is thought to receive all knowledge and wisdom from his role in the spiritual dimension. He or she is chosen for the role by spiritual forces and is granted authority as a healer by the Hmong community. A shaman's role in health and healing includes the diagnosis and treatment of spiritual illnesses. As Hmong people view the mind, body, and spirit as intimately connected, symptoms of spiritual

illnesses may include stress, sadness, worry, seeing or hearing things that are not there, fainting, breathing problems, and infertility to name a few (Plotnikoff, Numrich, Wu, Yang, & Xiong, 2002). In line with this conceptualization of health, participants did not see the need to seek services from multiple treatment providers (e.g., one person to address spiritual problems and another to address mental health issues) because there was no disconnection between mind, body, and spirit. Consequently, I worked with staff to develop interview questions that integrated spirituality and allowed participants to provide explanations of their health and choices in treatment congruent with conceptualizations of themselves and their connection to the physical and spiritual world.

Cultural norms about generational roles and gender roles, as well as the collective nature of the community, were also identified as important factors during project development. For instance, staff noted how differences in age and gender between the researcher, translator, and participant could impact the interview process. More specifically, people's age and gender within the community impacted their status and thus provided information about how others should interact with them and what information would be appropriate to share with them. In line with these cultural norms, male participants would be more open and willing to engage with a male versus a female translator/researcher of a similar age. Similarly, female participants would be more open and willing to engage with a female versus a male translator/researcher of a similar age. The staff further noted how people's position within the Hmong community could impact how participants engaged with a staff translator. For instance, some community members, including staff, held more power than others due to their family connections within their clan and how closely they were affiliated with clan leadership. These differences in power also determined how and what was appropriate to say to each person with whom they interacted. Staff also noted that although the collective nature and close connection within the community was a strength, this closeness could make it difficult to elicit feedback about participants' negative experiences at Kajsiab House, as this information could be construed to mean staff were not doing their jobs. Moreover, clients reported worries about what information during the interviews would be shared and with whom, as sharing personal information or any negative feedback could cause disruptions within interpersonal relationships in the wider Hmong community.

Finally, clients and staff discussed the impact their immigration status and refugee experiences-within and outside of the U.S. had on interpersonal interactions, especially with individuals from outside of the community. For instance, staff noted that clients experienced fears related to loss of citizenship/refugee status, deportation, having resources taken away (i.e., loss of benefits), and being punished by U.S. government agencies if they discussed certain aspects of the Secret War in Laos. Additionally, fears within the Hmong community had increased over the last year during the 2016 presidential race, as heightened racist, xenophobic, and anti-immigrant rhetoric coincided with an increased number of hate crimes in the U.S. (Federal Bureau of Investigation, 2016; The Southern Poverty Law Center, 2017). Considering I was an outsider to the community who had physical features consistent with individuals in the dominant European American community, the staff discussed how participants may be hesitant to engage in the study and disclose information about any negative experiences they had while living in the U.S. These important conversations and community experiences with clients were pivotal in the decision-making process about how best to protect participant confidentiality within the research process and wider Hmong community, how data should be protected, what data should be shared academically and within the wider community, what questions to ask which participants, how questions should be framed, how to structure the interviews, and who should be conducting interviews. For more detailed information about how this impacted the current study, please see the method and, specifically, procedures section below.

Second six-week community visit. After completing the initial six-week community visit, I traveled back to Madison, WI for a second six-week period to recruit participants and conduct qualitative interviews for the second phase of the project. During this phase, collaboration with staff members at Kajsiab House continued to be critically important in developing a project that centralized the voices of community members and actively recognized the impact of participants' socio-cultural, political, and historical contexts. This process was iterative and resulted in changes to recruitment, consent, and interview protocols. For instance, after participants were identified by the staff psychiatrist and translators, we determined that recruitment and consent of the study should be conducted by the translators in a separate room without me present, rather than by me, the researcher. This change was proposed due to me having more perceived power than participants (e.g., education, citizenship, relationship to the staff psychiatrist, physical characteristics consistent with the dominant society) and how these

differences could result in participants feeling pressured to engage in and give consent for the project. Further, one of the translators suggested changes to the consent process that would provide more specific information about what information would be asked of participants (e.g., giving them example questions from the interview protocol) so that they could make a more informed decision of whether they would want to participate and disclose such information to the researcher. Both translators also suggested that I emphasize my relationship to the staff psychiatrist more than what was originally proposed as existing relationships within the community were key to developing trust with outsiders.

In addition to changes in recruitment and consent, changes to interview protocols were also suggested. Both translators suggested that appropriate self-disclosure by the researcher would create a more relational atmosphere and provide more context about why I was interested in their stories. This change to the research protocol was especially important considering the Hmong culture is highly relational and depends on contextual information about each person to determine how to address each other and what information should be shared. Further, self-disclosure by me as the researcher was identified as another process that could lower the power-differential in the room between the researcher and participant and result in a more collaborative research process (Marino, Child, & Campbell Krasinski, 2016). Additionally, several questions about religion and spirituality, relocation to the U.S., discrimination, and participants' experiences at Kajsiab House were adjusted to be more linguistically congruent. The translators and I collaboratively worked to alter these questions after it became apparent during initial interview sessions that some of the questions initially developed were too vague, worded in ways which were not linguistically compatible with Hmong, and/or did not provide enough contextual information for participants to answer them.

Changes to participant payment were also suggested by staff at Kajsiab House. Initially, I proposed to pay participants $20 in cash or with a Visa gift card. However, after a discussion with several staff, it became apparent that this form of payment would be inappropriate for participants due to many participants' disability status, difficulty with accessing banks and using electronic payment systems, and participants' reliance on staff and family members to complete daily tasks of living. Considering these barriers, staff suggested participants be paid with either a live chicken or a $20, 11-pound bag of rice frequently purchased by members of the Hmong community. Staff noted these types of gifts would be valued by participants as they could use

them immediately and understood their value. After further discussions with the university and Kajsiab House staff, it was agreed upon that participants would be paid with the 11-pound bag of rice. In addition, it was suggested I attach a personal note hand-written by me to each bag of rice, as not doing so would be considered rude.

Lastly, and one of the largest changes to the project, was a shift in the project's focus from the mixed-methods study noted above to a solely qualitative project examining clients' experiences at Kajsiab House and how changes made to the Kajsiab House program over the last several years had impacted the community center and clients. This shift in focus was the result of many conversations with Kajsiab House staff towards the end of my second six-week visit that revealed the current project focus only partially addressed the community's needs. Although I had openly recognized differences between myself (as a multiracial, light-skinned, second generation, Latina student of color who held U.S. citizenship) and members of the Hmong community, as well as the potential impact these differences would have on the research process (e.g., how community members might interact with me and the need to develop culturally sensitive protocols); I did not fully understand how my connection to the staff psychiatrist, differences in cultural norms about communication, and physical distance from the community center would impact the project development and implementation process. For instance, many of the project development conversations in between the first and second six-week visit were conducted via e-mail due to the distance between my location (Ohio) and the community center (Wisconsin). Although the program manager expressed some concerns about allocating staff resources for translation and interviews for the study via e-mail, it was not until my second six-week visit that I learned from staff that there were additional concerns about how I would interact with community members and how interview questions would impact participants. During these follow-up conversations with staff, it was brought to my attention that my connection to the staff psychiatrist (a European American male who was adopted into the Hmong community and held an important community position, as he provided all of the psychiatric services to the Hmong community at Kajsiab House), my status as a student from a Western university, and my light skin (a reflection of the wider dominant culture that actively worked to oppress the community) made it difficult for them to fully express concerns they had about the project.

After learning about the oppressive nature of their experience, I deeply reflected on my experiences and realized how my own biases in communication and unchecked privileges (e.g., my light skin and position within academia) had resulted in lateral oppression of the Hmong community by not fully including their voices throughout the research process. Although I have been working to combat the processes of colonization and its impact on my work as a clinician and researcher over the past 5 years, I have nevertheless internalized colonized (i.e., positivist) views and thus utilized these colonized strategies (my research processes), as well as my position within the Western, patriarchal, academic system, to develop a project without fully understanding the needs and concerns of the community. As such, I immediately began to consult with the staff about what would make the process more collaborative and how we could develop a project which would truly benefit the community.

Further conversations with staff revealed the larger community mental health center (Journey), which housed Kajsiab House, had made a number of significant changes to the original Kajsiab House model over the past several years. These changes had shifted the program from one that provided community-focused mental health services which took into consideration the social, cultural, and historical context of its community members to more Western mental health services: "evidence based" crisis interventions and therapeutic modalities. Several staff expressed concern that these new services were frequently not useful for the majority of clients and, at times, harmful to their community. Although they recognized these changes were in part due to the need to find funding sources for the program, they also noted concerns that the wider agency encouraged this shift towards a more Western framework because they did not understand the socio-cultural, political, and historical context of the population they served.

In line with these concerns, staff noted that although they saw value in comparing Western and non-Western conceptualizations of refugee experiences, they did not see this issue as central to the immediate needs of their community. Instead, they would find more value in a project that focused on clients' experiences at Kajsiab House and how recent changes to the program's structure had impacted client care and overall wellbeing of the population they served. Upon reviewing all the data collected, I identified a portion of the original interviews collected during the second phase of the study which captured participants' experiences at Kajsiab House over time and how services offered impacted their well-being. After further consideration, the staff agreed that shifting the project focus to examining this portion of the data would be most

beneficial to their community, as findings could provide evidence of the importance of considering the populations' socio-cultural, political, and historical context when developing/implementing interventions and lead to less oppressive policies and practices by both Journey Mental Health Center and the larger dominant culture. Consistent with the needs of the community, the remainder of this paper will focus on the subset of data noted above. For more detailed information about specific methods and procedures for this set of data, please see below.

Narrative Research Methodology

According to Daiute and Lightfoot (2004), narrative research comes in many forms and uses a variety of analysis techniques. However, a common theme throughout narrative research is a focus on stories of events as told by individuals (Polkinghorne, 1995). The present study used narrative methodology similar to the one proposed by Chase (2005), as it was consistent with both the transformative and social constructivist frameworks which guided the larger, originally proposed project. In line with a transformative framework, Chase (2005) proposed that narrative methodology may be used for paradigmatic reasons such as examining how individuals are enabled or constrained by social resources. Similarly, this study utilized narrative methodology to examine how changes to interventions/services within Kajsiab House from more culturally-specific approaches that considered the clients' socio-cultural, historical, and political context to those based on Western conceptualizations of mental health and psychiatric illness have impacted community members' overall health and well-being.

Moreover, in line with the social constructivist framework, Creswell (2007) noted that narrative research may be viewed as a collaborative process where both participants and interviewers are actively involved in the telling and re-telling of stories. This process acknowledges both the participants' and researcher's social, cultural, and historical contexts and thus provides a unique perspective on how the researcher's personal biases and subjective understanding influence the data being gathered and interpreted (Chase, 2005; Creswell, 2007). As such, one of my primary concerns when analyzing participants' stories was to understand how individuals perceived and organized events in order to present each person's truth as situated within his or her own historical, social, and cultural context, rather than search for "true objective reality" in the world. Accordingly, I worked to honor each participant's story as her or his own subjective reality, rather than searching for the "object truth" in their accounts of events. In addition, I worked to recognize the impact of my own identities and social, cultural, and

historical context throughout the interview and analysis processes. Recognition of their impact allowed me to be aware of power imbalances between myself and participants while completing the project. Awareness of power differences is especially important when working with marginalized groups such as refugee groups, as unrecognized imbalances of power may lead to further exploitation and oppression of these groups. As such, I intentionally positioned myself and my perspectives throughout the research process to recognize my own biases; differences in power between myself, the translator, and participants; and the impact of my position on the co-construction of participant stories.

Participants

The initial sample of participants consisted of six men and six women recruited from Kajsiab House in Madison, WI. Two men and two women were recruited from each of the waves of refugees who relocated to the U.S. in the 1980s, 1990s, and 2000s, as I hoped this would increase the breadth of perspectives and provide a more complex picture of participant experiences. One male participant, who was approximately 50 years of age, was excluded from the final analyses after it was determined he did not meet criteria to participate in the study. For more information about inclusion criteria, please the see procedures section below. The remaining 11 participants included in the final analyses ranged in age from approximately 60 to 80 years of age. It is important to note that although participants could identify what harvest season they were born, none of them were able to identify their chronological age during the interview due to differences in cultural understandings of time. The ages presented above are an approximation based on documentation provided by Kajsiab House during their initial intake process. However, it is important to note that these dates were often provided to Kajsiab House via documentation from refugee camps or other agencies that often assigned the same birthdate to many refugees at one time or assigned birthdates to individuals based on their needs for services. All participants were born in Laos and fled to Thailand to live in refugee camps after the U.S. withdrew troops from Laos during the Vietnam War. Participants' relocation experiences varied widely, with some living in the jungle for extended periods of time before reaching a refugee camp in Thailand, while others experienced shorter treks through the jungle to reach the camps. Length of stay in the refugee camps and the number of refugee camps each participant lived in also varied widely among participants. Participants who relocated to the United States earlier (i.e., the 1980s) had much shorter stays and lived in fewer refugee camps as

compared to those who relocated later (i.e., 1990s and 2000s). All participants directly experienced and witnessed violence perpetrated against friends and family members. Two participants were soldiers in the Secret War, and one participant returned to Laos after relocating to Thailand to fight with guerilla groups who defended the Hmong after the U.S. pulled troops out of Laos. In addition, one of the participants was imprisoned for an extended period after speaking up about human rights abuses in the refugee camps.

Per participant reports, none of the participants received formal education or spoke English fluently. However, all participants noted they had engaged in classes to learn English as a second language after arriving in the U.S. One participant could read English well enough to drive and complete daily activities, but the remainder of participants could not read or write English and ranged in ability of speaking English from one or two words to a few phrases. Importantly, all participants noted they spoke Thai well enough to be able to complete activities of daily living and be active members of their communities while living in Thailand before relocating to the U.S. In addition, the length of time participants had been engaging in services varied from 1 year to 18 years (since the opening of Kajsiab House). Eight participants had been engaging in services at Kajsiab House for 11 or more years. Further, three of the eight participants were founding members of Kajsiab House and contributed to initial development and identification of services. The remaining three participants had been engaging in services for one to four years. Lastly, it is important to note that several of the participants were related to each other and staff. For instance, several of the male and female participants were couples, and one of the participants was directly related to one of the translators. These types of dual roles were expected as part of the study as the local Hmong community in Madison is closely connected and the type of sampling procedure (snowball) encouraged participants to invite others they knew in the community who would meet criteria for the study.

Procedures

After working with several staff members (e.g., the staff psychiatrist, both translators, and the program manager) to identify an initial list of 12 potential participants, translators spoke with participants of the same gender (i.e., female translators spoke with female participants and male translators spoke with male participants) about the study in a private setting while they received services at Kajsiab House. Translators were gender matched to participants due to traditional Hmong gender norms, which influenced how and what information individuals in the

community shared with each other. Further, the decision for translators to recruit participants without my presence was a result of several conversations with staff about how their existing relationships within the community were critical for establishing trust. Staff noted how this trust could help participants feel more comfortable with asking questions and decline participation if they did not feel comfortable with the study. To aid with recruitment, translators were provided with consent forms, the interview script and questions, and debriefing forms in both English and Hmong so they could provide detailed information about inclusion criteria for the study, example questions, and explain benefits and risks of engaging in the study. For more information about translation of these documents, please see the translation process section below. These documents were reviewed by each translator and me before they contacted participants in order to clarify any questions they had and explain the importance of providing a thorough explanation of the study, including risks and benefits of engaging in the study, prior to asking for consent.

To be included in the study participants had to be of Hmong descent, currently be 18 years of age or older, and have accessed services at Kajsiab House during the past year. Although all 12 participants initially identified agreed to participate in the study, one of the male participants became ill and was unable to participate. As such, the program manager identified a 12th participant for the study who spoke English well enough to read, write, and conversate with me. However, after I reviewed the consent form in English, it was determined that he did not meet criteria for the study as he had not received services at Kajsiab House within the past year.

Translation process. Translators for the interview process were identified by the staff psychiatrist and program manager based on their gender and the program's available resources. Due to the limited resources at Kajsiab House and work requirements of staff, the consent form, interview questions, and debriefing form were translated by a third-party translation company. All documents were forward translated by one transcriber then back translated into English by a second transcriber. Both the Hmong and English versions were then reviewed by both translators who would be conducting the interviews for semantic and linguistic equivalence. The final agreed upon documents can be viewed in Appendices A, B E, F, G, & H.

Prior to beginning the interviews, participants met with gender-matched translators in a private room to review the consent form in more detail. The same two translators conducted all 11 consent procedures and interviews. Due to most participants' limited proficiency in reading English and Hmong, consent was obtained verbally through a discussion with the translator.

Once participants consented to participating in the study, they signed the consent form in English (please see Appendix E) and a release of information (ROI) form for access to paper copies of their intake interview when they initially sought services at Kajsiab House. This form was provided by Journey Mental Health Center and currently meets the Health Insurance Portability and Accountability Act (HIPPA) requirements for releasing medical information (please see Appendix D). Participants were then offered copies of the consent form in English or Hmong to take home and review with family. A copy of the signed consent form and HIPPA form were also provided to Kajsiab House to be placed in their personal client files.

After participants consented to the study, I was asked to come into the room to begin the interview process. All interviews took place in Hmong with a gender-matched translator and me in the room. Prior to asking interview questions, the translator provided the client with more contextual information about me (please see introduction script on the interview questions form in Appendix A) and why I wished to interview the participant. During the interview, I referred to interview questions on the English interview question form, and the translator then asked the identified question to the participant in Hmong. The translator then translated the participants' answers to me into English. It is important to note that the list of questions provided in Appendix A contains a list of all possible questions that could have been asked. Depending on the answers provided by each participant, I asked more or fewer questions and frequently requested elaborations to participants' answers. Interviews took between two and a half to three hours and were audio recorded. After completing the interviews, the translator reviewed the debriefing form with each participant, and I provided them with an 11-pound bag of rice as compensation their participation, along with a personal note of thanks.

Interview Context and Approach

Narrative research may be viewed as a collaborative process where both participants and interviewers are actively involved in the telling and re-telling of stories (Creswell, 2007). This process acknowledges both the participant's and researcher's social, cultural, and historical contexts, and thus provides a unique perspective on how the researcher's personal biases and subjective understanding influence the data being gathered and interpreted (Chase, 2005; Creswell, 2007). As such, it is important that I recognize my own identities and current contexts that will influence the research process.

Positionality and anticipated impact on interview process. As previously stated, I approached this project from a transformative and social constructivist framework using narrative methodology. I anticipated that my personal identities and experiences as a multiracial, light-skinned, Latina woman who spoke English as her first language and was born and educated within the United States would impact interviews with participants. For instance, I anticipated that participants may perceive me as part of the dominant culture and be less likely to answer questions about negative experiences in the U.S. or difficulties within their community. Due to differences in cultural and gender norms, I anticipated that I may break "invisible cultural rules" through either verbal or nonverbal communication. However, I hoped that translators could buffer these interactions by informing me when questions would be considered rude or inappropriate to ask and provide me with information about how to communicate respectfully in a nonverbal way. I anticipated that differences in education and English proficiency between myself and participants might make it difficult to ask impromptu follow-up questions during the interview as they would not be checked for semantic or colloquial use. Further, I anticipated that my experiences being born, raised, and educated in the U.S. might create distance between myself and the participants and make it difficult for them to believe I could understand their lived experiences. I anticipated that my self-disclosures during the interview process about my experiences being raised by a first-generation, non-English speaking, immigrant family would reduce the distance between myself and participants and create a more relational experience. Lastly, I anticipated that the framework of the study and my own worldview about the importance of understanding people's subjective lived experiences would lower power differentials between myself and the participants and aid in establishing rapport.

Interview questions/statements. Narrative research methodologies encourage more open-ended formats to explore the participants' stories and allow flexibility in which parts of the stories researchers emphasize (Chase, 2005). Consistent with this spirit, the current study utilized open ended questions to explore participants' narratives related to their refugee, exile, and health experiences. In line with a transformative framework, I included questions that focused on key areas of inquiry, which allowed for the development of an argument for social change. Interviews would remain flexible to participants' narratives, as questions asked would vary according to participant experiences, and additional questions would be included when I needed to clarify experiences. It is important to note that the larger project included questions addressing

pre-flight, flight, and exile experiences, as well as experiences in the Kajsiab House program (please see Appendix A for questions). For the purposes of this paper, I will be specifically focusing on questions that addressed participants' overall health (e.g., physical, spiritual, emotional, and mental) after relocating to the U.S. and during their time at Kajsiab House (please see Appendix C for this subset of questions). As these experiences cannot be understood in isolation, I also included questions about participants' living situations, daily activities, and connection to their community and family.

Anticipated problems. Due to the personal and distressing nature of pre-flight, flight, and exile experiences, I anticipated that some participants may not want to answer every question or may experience distress during the interview. I recognized it could be difficult for participants to navigate these discussions, as it is considered incredibly rude in Hmong culture to not answer a question that is asked, especially by an outsider to the community. In order to be sensitive to this cultural difference in communication style, I worked with the local Hmong translator and Dr. Coleman, the resident psychiatrist, to learn how to identify signs that a participant may be distressed or not want to answer questions. For instance, during the interview I anticipated that participants may provide answers that do not exactly answer the question asked. I understood that these types of answers may be due to the participant not understanding the question or not feeling comfortable answering the question. As such, I could work with the translator during these instances to identify if the participant was distressed. One advantage of conducting interviews at Kajsiab House is that mental health professionals and psychiatry staff, who are sensitive to Hmong cultural values, would be present during interview times and could assist in connecting participants to additional services if needed. Thus, when participants became distressed and or did not want to answer questions, the interview could be stopped. Translators, who were also clinicians, could then assess whether the participant would like to discontinue the interview and or needed additional support.

In addition to possible distress that could occur, I anticipated that cultural differences related to non-verbal behaviors and social interactions may disrupt the interviewing process. As previously stated, the Hmong community has a complex social system that greatly influences who can/should say what depending on context, their placement within the clan, and their gender and age. I anticipated that this could be further complicated by my own gender and status as an outsider and may influence what participants felt comfortable saying to the translator while I was

in the room. I hoped that by stating my relations to Dr. Coleman and Dr. Garms (a psychologist at Kajsiab House), as well as my personal interest in the Hmong community (please see my introduction in Appendix A) prior to beginning the interview, I could provide context for participants about my place and purpose within the community and develop initial rapport.

In addition to my interactions with participants, I anticipated that the relationship between each translator and participant would also impact what was said and how participants shared their stories. This was due to the fact that the translators who helped with this study were established members within the local Hmong community and had daily contact with participants for more than 6 months prior to interviews. Further, due to the collectivistic nature of the community and social norms around greetings, participants either knew the translators' family or knew a family member or close friend who were familiar with the translator and their family. Lastly, I anticipated that differences in age, social status, dialect (White and Green Hmong), and generational use of language between the translator and participant would impact interpretation and translation of participants' stories during the interview process. Although I was able to match participants with translators based on gender, it was not possible to match each participant with a translator who was of a similar age, dialect, and social status. As such, I recognized the importance of considering the impact of the research context on the co-creation of participant narratives and their subsequent interpretation.

Approach to Data Analyses

"Analysis of narratives" techniques consistent with the approach described by Polkinghorne (1995) and Chase (2005) were used to analyze and interpret the interview data. In comparison to "narrative analysis" techniques in which researchers collect descriptions of events and configure them into chronological stories using a plot line, analysis of narrative techniques create descriptions of themes that hold across stories or taxonomies of types of stories (Creswell, 2007). To accomplish this, researchers first *listen* to the voices within each narrative and draw connections between the multiple stories told by each person. Each narrative is understood as being constructed within the context created by the research process and the participants' broader socio-cultural and historical context. As such, researchers recognize that each narrative can have multiple interpretations and are impacted by the lived experiences of the individual interpreting them (i.e., the researcher; Josselson, 2011; Riessman, 2002). Further, each person is viewed as having his or her own narrative strategy (i.e., how [s]he tells his or her story), which contributes

to complexity within each person's voice, the various subject positions each person takes, and the diversity among people's experiences within the same group (Chase, 2005). Only after examining the voices within each narrative are connections drawn between stories told by different individuals. In this way the complexity of views and the common themes across the individuals interviewed tells a story of both unique and shared experiences. This approach is an iterative process that may include multiple readings and re-readings of stories to identify and draw connections between the multiple stories within each narrative and between narratives of participants.

Data analytic process. During the interview process, I wrote down my impressions after each interview to note my immediate understanding of participants' experiences and their engagement in the interview process. After completing all interviews, I transcribed and coded the English portions of the interviews that addressed participants' overall health after arriving in the U.S. and during their time at Kajsiab House in MAXQDA Standard 2018 data analytic software (VERBI GmbH, 2018). During this process, I consulted with Kajsiab House staff about whether it would be beneficial to have translators transcribe the Hmong portions of the interviews. Although they acknowledge this process could be beneficial, it was determined by senior staff that involving translators in this process would not be feasible due to needing the translators to provide necessary services to the community and concern about their ability to transcribe for the project, while also generating enough billable hours for the center. MAXQDA is a software specifically designed to analyze qualitative data with tools for transcription, coding, and visualization. After transcribing all interviews, I read through each interview, developed an initial coding structure, and noted down potential themes and subthemes, as well as individual codes within each theme. After the initial coding phase, I repeated this process several times for each interview to consolidate coding, note emerging patterns, and further solidify themes and subthemes. In line with the project focus and framework, I paid particular attention to contextual factors that impacted participants' health, both before and while engaging in services at Kajsiab House, such as their exile experiences (e.g., when they relocated to the U.S.), their connection to family and the broader community, and the impact of broader systems on participants' ability to engage in society. In addition, themes related specifically to participants' views of Kajsiab house services were also noted. For more specific information about themes, please see Table 1.

Throughout this process, I consulted with colleagues who have experience working with Southeast Asian refugee communities, including a mental health clinician who had several years of experiences working clinically with various Southeast Asian refugee populations and clinical staff working in refugee agencies that served the Hmong refugee population in Minnesota. Consultations centered around whether and how something was a theme, how to label themes in ways which were congruent with participants' language, and how best to organize subthemes. Once again, Kajsiab House staff were consulted about whether it would be beneficial to include translators during the analysis process to aid in the identification of themes and subthemes, and if member checks with participants about identified themes would helpful in improving the validity of findings. After further consideration, Kajsiab House management determined translators could not be involved in the analysis process due to previously noted concerns about translators' abilities to provide services to the community and generate billable hours for the center, while working on the project. Further staff suggested that member checks with participants would be inappropriate, as participants may interpret my clarification questions as a sign that they did not provide information I needed for the study or that I did not believe the stories they provided.

After finalizing themes and subthemes, I went back through the coded data to identify direct quotes from the interviews that illustrated each theme and subtheme and paraphrased them. The decision to paraphrase participants' direct quotes was based on several factors including: 1) The community center has been developed, run, and attended by a very tight knit community where many people are related or know other clients or staff members quite intimately; 2) Individuals in the community were aware of who participated in the study because they spoke with one another after each interview to discuss whether another participant would be safe participating in the study; and 3) The results of this study will be presented back to the community center staff and clients. Many of the clients expressed concerns about other clients and staff members finding out what they said, as it would be easy to identify them based on their narrative. Many of the concerns participants expressed were related to how comments about improving Kajsiab House services would be interpreted by friends, family, or community members who worked at the center (e.g., they may interpret them as staff not doing their jobs properly). Thus, to gain consent for participation in the study, I informed participants that I would be using themes and paraphrases instead of direct quotes in order to protect their identity. Although paraphrasing direct quotes adds an additional layer of interpretation between

participants' voices and the results, the concerns about participants' confidentiality and safety were prioritized over the need to provide direct quotes as supporting evidence in this study.

Reliability and validity. Definitions of reliability and validity differ in quantitative versus qualitative research (Golafshani, 2003). In qualitative research, Brinkmann and Kvale (2015) describe validity as a process that evaluates the quality of craftmanship of a study. As such, validation is not a separate stage of a study, but rather permeates the entire research process through continuous evaluation of: 1) whether the project is adhering to the overarching theoretical framework, 2) whether the study's design and methods produce knowledge beneficial to the community while minimizing harm, 3) the quality of the interview process including clarification to understand the meaning of narratives, 4) whether interpretations of narratives are logical and make sense given the context, 5) decisions about what forms of validity make sense given the project and community, and 6) whether the final report provides a valid account of the findings (Brinkmann & Kvale, 2015). Throughout this project I have sought to adhere to this model of validity by evaluating adherence of the project to the overarching theoretical frameworks and working collaboratively with the community to develop a project that is most beneficial to them and minimizes harm (as noted in the project development section). In addition, I asked additional questions during interviews and consulted with staff to clarify the meaning of narratives and consulted with colleagues who have experience working with similar communities about identified themes and their meaning. More recently, I have been in contact with Kajsiab House staff to set up a meeting with participants so that I can review the findings of this study with participants and ensure it matches their understanding of their narratives.

Although some qualitative researchers assert that reliability is irrelevant in qualitative research due to paradigmatic differences between quantitative and qualitative research approaches, others have noted how the concept of reliability can be altered for qualitative research to focus more on issues such as dependability (findings are consistent with the raw data collected) and transferability (generalizability of results; Golafshani, 2003). It is important to note that differences in conceptualizations of reliability and validity at times overlap due to differences in researchers' understanding of what constitutes reliability and validity in qualitative work. For instance, the above noted concept of dependability noted by Golafshani (2003) is similar to Brinkmann and Kvale (2015)'s sixth tenet of what constitutes validity. Thus, reviewing narratives with participants to verify adherence to their narratives may address issues

of both validity and reliability. Regarding transferability, I anticipated that depending on the extent of common themes across participants' narratives, I may be able to draw broader conclusions about refugee health experiences within the local Hmong community. For instance, I could provide information related to what types of services have been most helpful at Kajsiab House and what approaches to health treatment have been most valued by participants. However, these conclusions would be tempered by when and where other Hmong refugees relocated to in the U.S., which period (or wave) they relocated, and to what resources they had access. Considering the focus of the study and that Kajsiab House is the only known treatment model of its kind in the U.S. for Hmong refugees, I anticipated that access to the services at Kajsiab House would significantly influence participant narratives and reduce generalizability of findings to other Hmong refugees without access to such a program.

Saturation. Data saturation is another important criterion to evaluate the quality of a qualitative study (Saunders et al., 2017). Although there are varying definitions and opinions on what areas to focus on when considering saturation in qualitative research (e.g., saturation in sampling, theoretical saturation, saturation in coding), I chose to evaluate saturation in terms of data collected. This perspective on saturation focuses on "informational redundancy" or the point at which new data tends to be redundant of data already collected (e.g., the researcher begins to hear the same/similar comments again and again while conducting interviews). Once redundant information begins to emerge, data saturation is proposed to be reached, and no new interviews are needed (Saunders et al., 2017). Within the current study, several important factors impacted determination of data saturation. For instance, limited time was available to conduct interviews for the project due to translators needing to provide services to Kajsiab House participants and generate billable hours for the center. As such, the number of interviews conducted was negotiated by myself and Kajsiab House staff based on time constraints and availability of staff. Throughout the interview process, translators were consulted to discuss commonalities and differences among participant narratives to determine whether additional interviews could aid in the identification of themes, and whether adding interviews would be feasible considering the constraints of the center. After conducting 11 interviews, it appeared that there were enough commonalities between participant experiences to construct themes and subthemes for the current study, while also highlighting participants' unique personal experiences in terms of health, relocation, and services at Kajsiab House. This number of interviews also allowed

translators to be fully involved in the interview process, while also fulfilling their obligations to Kajsiab House.

Results

Research Context

The narratives participants shared during this study were influenced by their multiple intersecting identities, as well as the current political and socio-cultural context in which they exist. As such, it is important to understand the region of the U.S. where they currently reside and the history of the Kajsiab House program prior to delving into the findings of this study. Wisconsin houses the third largest Hmong population in the U.S. behind California and Minnesota. In 2010, it was estimated that 5.8 million people (87.5% White/European American) lived in the state of Wisconsin, 47,127 (0.8%) of which identified as Hmong (University of Wisconsin-Madison Applied Population Laboratory, October 2015; U.S. Census Bureau, 2010a). Madison is a city in the southern portion of Wisconsin with a total estimated population of 233,209 (78.7% White/European American), 2,637 (1%) of which identify as Hmong (U.S. Census Bureau, 2010b). Madison houses the state capital, several smaller community and liberal arts colleges, and the University of Wisconsin-Madison with a student population of 43,820 (69% White/European American), 2,502 (5%) of which identify as Asian (University of Wisconsin-Madison, March 2018). Politically, although the state of Wisconsin tends to be more conservative, Dane County, the county which houses Madison, has a strong democratic base and tends to vote more liberally (71% voted democratic in the 2016 presidential election; Politico LLC., November 22, 2016).

Kajsiab House. Kajsiab House was opened in January of 2000 on the premise that providing services to Hmong elders in the community who were having difficulty adjusting to life in the U.S. and suffered from chronic health conditions (e.g., mental, physical, and spiritual) would enable younger generations to obtain and maintain employment and more effectively care for themselves and their families. Prior to the development of Kajsiab House, members of the local Hmong refugee community had access to some needed services at various community-based centers and the United Refugee Services of Wisconsin. However, members of the community often did not access services at local community mental health centers due to linguistic differences and meaning associated with the words mental health (i.e., mental health meaning someone who is “crazy”). Further, necessary services such as cultural brokering,

translation, and citizenship services were often not available, and the need to drive to multiple locations for services made it difficult for younger generations to maintain employment and care for their families. Although there were several local nursing home agencies available in the area, members of the community did not view this type of service as a viable option due to vast differences in cultural and spiritual values between the nursing facility and the community, Hmong cultural norms about caring for the elderly, and linguistic barriers.

As such, members of the local Hmong community began to advocate for a day-treatment center where their family members could access a wide range of services including outreach, transportation, cultural brokering, and health services (mental, physical, and spiritual) and could have opportunities for socialization and connection with other community members. Further, community members advocated for a program similar to a recently developed program for Cambodian refugees in Madison that would be sensitive to their cultural and spiritual values and collaboratively work *with* community members to develop, evaluate, and implement services.

Considering that Hmong culture greatly values elders and frequently seeks their opinions as part of group decision-making processes, founding members of Kajsiab House worked collectively with community members (including the elders they sought to serve) to understand their needs and develop a culturally-informed treatment model. The agreed upon treatment model for Kajsiab House integrated concepts from the Hmong extended family and Hmong villages, as well as aspects from Assertive Community Treatment and Modified Clubhouse models (Kajsiab House, 2005). This unique treatment model provided comprehensive services that addressed the diverse needs of the community, integrated clients into decision making processes, encouraged clients' active participation in the maintenance of the program to address role loss, and provided opportunities for clients to connect with the wider community. Program components included the participant advisory board (chosen by staff and program participants), cultural brokering, assistance with citizenship and accessing benefits, modified group therapy, Tai Chi, community outreach and events, trips and outings in the community, transportation services, and psychiatry services.

During my second six-week visit at Kajsiab House, I spoke with a variety of staff about their experiences at Kajsiab House and changes that have been made to the program over the last 13 years. Staff noted positive changes that occurred including the development of a Hmong house and exhibit, development of an internship program for Hmong students interested in

mental health, English as a Second Language (ESL) courses, and sharing the Kajsiab House model with other national and international agencies. However, a number of staff also noted changes to the program within the last three to four years that they felt were detrimental to their clients. For instance, staff noted that many programs were no longer being offered or did not run on a regular basis including ESL classes, Tai Chi, modified group therapy, trips and outings, and community engagement (with both the local Hmong and wider community). Although many of the staff recognized these changes were due to financial issues and changes in billing structure, they also felt reductions in these services were negatively impacting clients' well-being. Further, several staff expressed concerns about staff morale due to budget constraints and whether new administration at Journey Mental Health Center understood the importance of maintaining community-focused aspects of the program, rather than pushing Kajsiab House towards more Western crisis management and therapy services.

Linguistic Differences. The narratives participants shared were also heavily influenced by the language they used. In fact, recent research indicates the language people speak heavily influences the way they think, perceive, and understand the world (Boroditsky, 2011). For instance, within Western cultures emotions are associated with the heart, whereas emotions within the Hmong culture are associated with the liver. Therefore, within the Hmong culture people may say they have a difficult liver, meaning they are stressed or are having a hard time with life. Other examples include a broken liver (grieving, sad, or feeling bad), an unsettled liver (lonely, sad, or missing a loved one), a long liver (happy, patient, tolerable), a drop liver (distress or worry), and a rotten liver (heart repeatedly broken or no hope/desire to live). In addition, how each of these phrases are interpreted also depends on the context in which they are used (Vue & Lee, 2014). The Hmong language also does not have a term for mental health. The closest word to mental health in the Hmong language is nyuab siab, which typically implies a sense of sadness combined with hardship. Thus, instead of asking about mental health concerns a Hmong translator may ask, "Are you having a hard time with life?" or "Is there anything bothering or stressing you?" These questions imply a focus more on overall wellness as opposed to illness commonly associated with Western medical models (Vue & Lee, 2014). Hmong language also places an emphasis on how a person is *doing* rather than how a person is *feeling*. As such, the language does not allow a translator to ask each person, "How are you feeling?" Instead, the translator would ask, "How are you doing (living)?" Finally, Hmong people's beliefs in the

connection between the physical and spiritual world influences how they may express difficulties they are experiencing. The spiritual realm is highly influential in determining what happens within the physical world. Therefore, if a person is experiencing a physical or mental health issue, it could be due to something in the physical or spiritual world. For instance, if someone expresses having a broken liver (sad, feeling bad, or grieving), (s)he may explain the reason behind it as, "When I lost my job, I was scared/startled, and it caused my soul to leave" (Vue & Lee, 2014). As is evident, there are significant linguistic and cultural differences between the Hmong and English language. As such, these differences significantly shaped the narrative process by influencing how I framed interview questions, how questions were translated, and how participants responded to the questions asked.

Reflexivity During and After Interviews

During the interview process, I continued to reflect on how my identities and the contexts within which I exist impacted my own views and biases, as well as my interactions with translators and participants. For instance, my identities and experiences as a light-skinned, multiracial, Latina woman who was born and raised in the U.S. and spoke English as my first language led me to hold certain biases about how I should interact with participants and my ability to respond to nonverbal body language. During the first few interviews, I quickly realized that the beliefs and expectations I held about such interactions did not match participants' worldviews or experiences, and I felt unable to accurately read nonverbal language or tell if participants were distressed while we spoke. These experiences resulted in some of my own anxiety about whether I could tell if the interviews needed to be discontinued and a greater reliance on translators to determine when participants were distressed and if we should stop the interviewing process. In addition, although I initially anticipated how differences in gender and gender norms might impact the interview process, I did not fully understand how my own biases and expectations would impact my interactions with participants and translators. For example, interviews with female participants felt more organic and comfortable as compared to my interviews with male participants. I often felt more awkward and unsure of how to relate to the male participants and had to rely on the male translator more than I expected to know if a question might be inappropriate for a woman my age to ask a male participant. Further, when consulting with translators about how to appropriately interact with participants, I received different – and at times contrasting – feedback about how to appropriately interact with male

versus female participants. I also recognized how linguistic and educational differences between myself, translators, and participants significantly impacted the interview process. For instance, I often struggled to word follow-up questions in ways that did not use academic jargon and would translate more easily from English to Hmong. Moreover, linguistic and educational differences between the translators and myself impacted how and what changes could be made to the interview process. Due to the female translator's experience of being born, raised, and educated within the U.S., I found it less difficult to explain the purpose and guiding framework of the study and to make changes to the interview process as issues arose. In contrast to the female translator, the male translator was born and raised in Laos and Thailand and had a stronger mastery of the Hmong language. As such, when speaking with the male translator I often found it more difficult to translate Western academic concepts related to research processes and explore how changes to the interview protocols could potentially impact the interview process with participants. During the interviews, the male and female translators also appeared to differ in how they mediated the conversation between myself and participants. Although both translators took time during the interviews to clarify the meanings of participants' answers, the female translator more openly discussed how she was clarifying participants' answers and what topics participants clarified with her. These conversations were usually brief and focused on the interview question presented. In contrast, the male participant engaged in longer discussions with male participants and would subsequently provide brief yes or no answers to me. During these instances, I often had to inquire about what was being discussed, instead of the male translator openly offering a brief explanation of their conversation. The male translator also informed me that he frequently clarified more relational aspects of the conversation (e.g., if he knew a participant's family member or if he knew a participant when they were younger). These differences in how translators interpreted conversations significantly impacted the co-creation of narratives during the interview process by mediating the relationship between myself and participants.

How participants responded to me. As previously stated, my goal during the interviews was to centralize participants' voices by honoring their stories as their own subjective realities rather than searching for some "objective truth." Thus, throughout the interview process I attempted to present and position myself with participants as someone who was interested in learning about experiences from their point of view. Participants' responses to me varied and

appeared to be impacted by differences in gender. For instance, all six women responded to me by expressing they felt valued and heard during the interviews. One woman even cried and informed me she viewed me like a daughter, and another woman made me a handmade gift so that I could remember her. Women also showed more emotion than men during interviews and often cried while discussing difficult experiences. Moreover, when asked about what the interview process was like, women openly shared how differences between the interviewer and themselves (e.g., language, skin color, education) impacted the interview process. In contrast, only two of the five men noted they felt heard and validated during the interview process. Further, only two men openly showed anger while discussing their experiences, but later apologized to me for possibly upsetting me by their display of emotion. Lastly, when men were asked about what the interview process was like for them, most them focused on how there were no differences between me and them, especially as it related to their status or how they spoke to me.

Participants' responses to me during the interview also appeared to vary by their status within the Hmong community. For example, one of the male participants that I interviewed held a high position within the Hmong community. He openly shared his experiences of racism in the U.S., his mistrust of outsiders like me (e.g., how important it was for me to know the staff psychiatrist), and changes he wished to see at Kajsiab House. He and another male participant – who was also well respected – also spent much of the interview trying to teach me about Hmong cultural and spiritual practices and "assist me with my schooling." In contrast, none of the other participants were willing to directly share experiences of racism with me, and many tried to convince me how grateful they were for the help they received from the U.S. In addition, one woman informed me she had thoughts about how to improve Kajsiab House but did not feel comfortable disclosing it to me. Finally, there were shared reactions participants had to me during the interview process. For instance, all participants noted how my self-disclosures during the interview process helped them understand why I was interested in their lives, and each of them noted the impact the language barrier had on the interview process (e.g., the need for a translator).

Major Themes and Subthemes

The findings of this study were organized into three major themes and five sub-themes including: 1) factors impacting health before and outside of Kajsiab House, 1a) loss, 1b) barriers

to adjusting to the U.S., 1c) impact of the existing Hmong community, 2) impact of Kajsiab House services on health, 2a) increased connection to community and family, 2b) reduction of stress on self and family, and 3) hopes and fears for Kajsiab House. For a visual representation of themes and subthemes, please see Table 1. Although these themes are subdivided into distinct categories, it is important to recognize that participants' experiences often overlap between themes. For instance, the impact of gender was interwoven throughout each of the themes and appeared to influence what types of services participants engaged in, how they understood their experiences, and how they conveyed their experiences to me. This overlapping of experiences is a testament to the complexity of participants' narratives and highlights the challenge of reducing narratives into categorical "boxes." Nevertheless, the categories identified above attempt to capture meaningful commonalities between participant experiences to provide a broader understanding of refugee health experiences within the local Hmong community.

The following section provides more detailed information about themes and subthemes and paraphrased excerpts from interviews to support the findings. To protect the privacy of participants, I will be identifying participants by pseudonyms and noting their gender but will not be providing other identifying information.

Factors impacting health before and outside of Kajsiab House. Participants described a range of factors impacting their health before they had access to services at Kajsiab House in the U.S. including loss, barriers to adjusting to the U.S., and the existing Hmong community. Further, they noted many of these issues continued to impact their daily lives when they were not present at Kajsiab House (e.g., on the weekends or when Kajsiab House was closed for holidays), as other systems frequently did not provide necessary services to support their daily functioning outside of Kajsiab House.

Loss. All 11 participants described how the impact of loss affected their physical, mental, and spiritual health after moving to the U.S. Experiences of loss varied widely and included role loss, loss of familiar objects or food, restricted access to non-Western treatments for health, disconnection from their homeland, and disconnection from their families and community. The most common experiences of loss of across participants were restricted access to non-Western health treatments (8 out of 11 participants) and disconnection from their families and community (10 out of 11 participants). Women discussed a wider range of losses they experienced as compared to men, who primarily focused on the impact of restricted access to non-Western

treatment modalities and disconnection from their families and community on their health. The following narrative co-created by Diav (a female participant) and me illustrates the impact multiple losses have on her health.

Diav was born in Laos and fled to Thai refugee camps during the Secret War. She lived in the camps for a period of time with family but became disconnected from one of her children and siblings in Thailand when she relocated to the U.S. After moving to the U.S., Diav relocated to Madison, WI with another one of her children. She noted that although she had family who had already relocated to the U.S., she continued to miss her child and siblings, as well as familiar places in Thailand and Laos. She also noted how it was quite difficult when she moved to the U.S. because she was used to Thai medications and did not know what medications to use when she became ill. Fortunately, she had another sibling who had already relocated to the U.S. who helped her identify Western medications and connected her with Shaman to treat her ailments. Diav also noted how there was nothing to do in the U.S. Even though she recognized how poor she had been in Laos and Thailand, she stated there was a lot of labor to do during the day. While living in Madison, WI, Diav cared for her grandchildren; however, she noted how her relationships with her family, including her grandchildren, were different once she moved to the U.S. After moving to the U.S., Diav noted how she would prepare meals, but the children would not eat with her when she called. Although her grandchildren lived in her home, she stated she often ate, completed chores, and sat alone as the children were busy doing other tasks. Prior to coming to Kajsiab House, Diav stated she was very sad and stressed because she no longer knew what to do at home once the children grew older and moved away. She noted that although services at Kajsiab House have reduced her sadness and stress because she can socialize with others, learn new things, and engage in activities such as gardening, she continues to struggle with loneliness and boredom at home.

Another female participant, Cua, elaborated on how disconnection from her family members, as well as familiar objects and food, intersected with her health. Similar to Diav, Cua was also born in Laos and fled to Thai refugee camps after the war began. When she relocated to the U.S., she stated it was really difficult for her because there were things she could not find (e.g., objects or food) and others that were completely unavailable. With the help of her family, Cua described how she slowly began to learn how to recognize things she needed and how to buy them. She described how this process was very difficult for her and her family and increased

their stress. In addition, when Cua relocated to the U.S., she was forced to leave one of her children behind in Thailand. Cua noted that although she is thankful to live in the U.S., the disconnection from her child continues to cause her a significant amount of worry, stress, and sadness. Cua stated she believes she could have had a better life and been less sad and stressed if her child had been able to move to the U.S. with her. She reported she and her husband often worry about their child's well-being and feel guilty they have so much while their child has so little. She and her husband also experience sadness due to not being able to share their life experiences with their child. Cua noted how she and her husband both struggle with various health concerns such as diabetes, cholesterol, and hypertension, and she often worries about what will happen to their child after they die. Although Kajsiab House has helped Cua with the immigration process for their child, Cua continues to worry and experience sadness because she has not heard back from the immigration agency who is processing their application.

Zaj, a male participant, described how disconnection from his family and members of the community impacted his health and led to increased isolation after moving to the U.S. Zaj grew up in Laos and fled to Thailand after the war broke out where he lived in several refugee camps before relocating to the U.S. Although Zaj relocated with his children, he felt unhappy because he could not speak English, work, or complete basic tasks such as going to the store. He explained that in Laos and Thailand he had a better life with less stress because he could visit his family members and friends daily whenever he wished. In contrast, Zaj noted he was only able to visit with family in the U.S. every few months or sometimes even once a year. He noted how difficult this change was for him and how he was often alone when he was at home without anyone to talk to. Zaj stated he first sought services at Kajsiab House so that he could meet people, see close friends, and socialize with others. He did not view staying at home as an option, as he often felt sad and stressed due not being able to communicate with anyone in his neighborhood and spending most of the day alone.

Barriers to adjusting to the U.S. All 11 participants described barriers to adjusting to the U.S. including language barriers, difficulties with accessing benefits or resources, immigration issues, difficulties with caring for their families, difficulties with completing tasks of daily living, transportation issues, and health concerns. Both men and women described facing similar barriers, the most common of which were language barriers (11 participants), immigration issues (seven participants), difficulties completing tasks of daily living (six participants), health

concerns (six participants), and transportation issues (five participants). Men tended to focus primarily on the impact of the language barrier and immigration issues, whereas women discussed a broader range of issues including the impact of the language barrier, health concerns, difficulties with completing tasks of daily living, and transportation issues. Most participants reported experiencing multiple barriers that compounded and led to increased social isolation, reduced ability to engage in society, and reduced ability to care for themselves and their family members. The following narrative co-created by Mim (a female participant) and me highlights how these multiple barriers such as language, difficulties with accessing benefits, and health concerns impacted her ability to care for herself and her children after moving to the U.S.

Mim was born in Laos and fled to Thailand after the war began. When Mim relocated to the U.S., she had limited contact with her family and community members who continued to live in Thailand and Laos. Due to the Hmong community not being well established in the area to which she relocated, she was often unable to locate Shaman or use other traditional treatments to address her multiple physical ailments. Although she sought services through local hospitals and social agencies, she often had to travel to multiple places to access resources, and the language barrier made it more difficult to interact with providers and staff. Mim described how she tried to learn English but was unable to do so due to difficulties with learning. She had several children to care for and was unable to drive due to the language barrier she experienced. Mim described how she often felt sad and stressed because there was no one to take her to the doctor when she needed treatment. Some hospitals provided translators, but as time progressed, Mim stated she relied on her children to translate for her at hospitals and other agencies. She also had difficulties with obtaining health insurance coverage. For a period of time she was allowed to be placed on her children's insurance coverage, but she no longer had access to these benefits once her children became adults. Prior to coming to Kajsiab House, Mim described how she did not have anyone to talk to or rely on for support when she became very sad or stressed. Although she stated she relieves stress through socializing at Kajsiab House today, Mim stated she is still only able to sit quietly and watch television when she is sad and stressed at home.

Similar to Mim, Cua described the impact of compounding barriers on her health and ability to engage in society. Shortly after moving to the U.S., Cua's distress increased when social agencies began pressuring her to find work. Cua noted how she did not know the language, could not drive, and was unfamiliar with the country and city in which she lived. She

often worried how she and her family would survive if they could not understand the language and did not understand the country they lived in. Cua stated that despite living in such a wealthy country, she became lonely and stressed due to her inability to drive, speak English, or complete daily activities such as withdrawing money from the bank. She was especially sad and stressed about her inability to speak with people in her neighborhood or community, as none of them spoke Hmong. Like Mim, Cua tried to learn English but was unable to even though she took classes. Although Cua stated she wished to speak with others, she described how she frequently sat at home and stared out of her window in silence. She described how she felt especially lonely when she was outside because she saw other people talking to each other, but she could not speak to them. Even though Cua stated she feels happier and less stressed when she talks with others at Kajsiab House, she continues to feel sad, lonely, and stressed at home because she has no one to speak to and often sits alone.

Another participant, Pov, discussed how his experiences of facing multiple barriers impacted his ability to care for himself and his family, increased social isolation, and impacted his overall well-being. Similar to other participants, Pov was born in Laos and fled to Thailand after the Secret War began where he lived in several refugee camps. When Pov relocated to the U.S., he was accompanied by his wife and several children. He stated his children had difficulties learning in school, but he and his wife were unable to assist them with schooling due to not ever attending school and their inability to speak English. As such, Pov and his wife eventually moved to Madison in search of more assistance with schooling for their children. Pov described how he also had difficulties with immigration issues and accessing benefits before coming to Kajsiab House. Pov had been unable to obtain assistance with Section 8 housing and supplemental security income even though he had applied through various agencies. In addition, he had applied for citizenship several times but had been denied. Pov described how both his children and the local Hmong community provided him with support which reduced some of the stress he and his wife experienced. However, he stated that his inability to speak English continues to prevent him from doing many things such as speaking with others, driving, and completing tasks such as shopping for his family. On the days he is not at Kajsiab House, Pov noted he feels lonely and bored because cannot go places or communicate with others. Further, he described how his inability to speak English has led him to compare himself and his worth to his younger grandchildren, as they know the same amount of English as he does.

Impact of the existing Hmong community. Seven out of the 11 participants discussed how the existing Hmong community impacted their health and ability to care for themselves and their families. Most of the conversations about the existing Hmong community centered around participants' abilities to find Non-Western treatments such as Shaman, herbal medicines, rituals, and magic healers when they had health concerns. A few participants discussed how their family and the existing Hmong community assisted them with necessities such as food after their arrival in the U.S. when they were unable to access refugee benefits. Participants who arrived in earlier waves tended to have less familial support and relocated to areas where an established Hmong community was small or non-existent. In contrast, those that relocated in later waves typically had family in the U.S. and relocated to places where a Hmong community was already established. As such, these participants had less difficulty with adjusting to the U.S. and had access to more familiar non-Western treatments upon arrival.

For instance, Diav and Cua noted they were both able to find Shaman and other traditional healers after their arrival in the U.S. due to them moving with family to an area that had many Hmong people. Cua also noted how her transition to living in the U.S. was easier than others before her because she had family living in the area she relocated to who helped her with translation and finding things she needed. In contrast, when Mim relocated, most of her family was living in Laos or Thailand, and the area she relocated to did not have many Hmong people living there. Because she was unable to find a Shaman or other traditional healers, Mim sent messages back and forth to family members in Laos or Thailand to ask them to speak with Shaman and traditional healers about health issues she was experiencing. Mim stated that after the healer figured out what the issue was they would complete a ceremony with her family in Laos or Thailand. She explained that because she was connected to her family in Thailand or Laos, a ritual that was performed within her family would still heal her in the U.S. because her soul was connected to theirs. However, Mim stated this process could take anywhere from 20 to 30 days to complete.

Another participant, Keej, described how his existing family in the U.S. was one of the key factors that helped him transition to living in the U.S. after he relocated from Thailand. Keej was born in Laos and relocated to Thailand after the war began. He lived in several refugee camps before relocating to the U.S. with his wife and several children. When Keej relocated to the U.S., he noted there were not many services available for refugees like himself in the area to

which he moved. Although he was eventually able to access benefits from a local refugee agency, the cash and food assistance they provided was not enough to support his family. Keej noted how lucky he was to have a large, close family already living in the U.S. who were able to supplement his food and income when he was unable to support his family. He also discussed how difficult it was for his other family members who came before him, as there were not many Hmong already living in the area who could help them and services from the government were limited. Keej also noted how important his family and the local Hmong community were for keeping him and his children healthy after moving to the U.S. Several of Keej's family members who relocated earlier to the U.S. were Shaman and could perform rituals when he or his family members became ill. He noted his family was also well-connected to the local Hmong community and could introduce him with other types of traditional healers.

Impact of Kajsiab House services on health. Participants described how services provided at Kajsiab House impacted their health and the well-being of themselves and their families. Identified subthemes included 1) increased connection to community and family and 2) reduction of individual and familial stress.

Increased connection to community and family. All 11 participants described a variety of services provided through Kajsiab House that increased their connection to others by providing a space to develop and maintain relationships with family members and others in the Hmong community. Identified services included the food program, walking in groups, gardening, sewing, creating art/music, playing Bingo, and socializing in large groups. It is important to note that the types and amount of time participants engaged in services were not only impacted by their needs but also by factors such as gender roles, physical health conditions, and the commitments they had to their families and the wider community. Although participants stated they needed a range of services when they first came to Kajsiab House, many participants noted the increased connection they felt to others was the most important service Kajsiab House provided, as it reduced social isolation and increased their social support networks. Further, several participants noted that services focused on connecting them to the wider community in Madison and the U.S. resulted in them feeling more connected to the local community and country as a whole. The following narrative co-created by Lis (a male participant) and me illustrates the impact community-based activities provided by Kajsiab House had on his health.

Lis was born in Laos and fled to Thailand after the war began. He lived in several refugee camps in Thailand before relocating to the U.S. with his wife and several children. After moving to the U.S., many of Lis' family members died. He described how he began to experience intense sadness and had difficulty sleeping. Lis also frequently worried about his family's future and felt he could not have a good life. He noted he and his wife lived alone and cared for several children with limited social support and financial resources. After learning about Kajsiab House, Lis decided to engage in services because he had heard positive things about the center from the local Hmong community. Lis described how he had many needs when he first arrived at Kajsiab House such as citizenship, physical health issues, and assistance with accessing benefits. However, he noted his most important need was socialization. Lis stated he viewed the ability to talk and spend time with friends and family as a form of medicine. When he spoke with others about his stress and engaged in group-based activities such as gardening and traditional crafts at Kajsiab House, he found his stress significantly reduced, and the day went by faster. When I asked Lis how he reduced stress before coming to Kajsiab House, Lis could not identify anything that effectively decreased his stress or social isolation. Even today, he stated he feels sad and lonely when he is not at Kajsiab House due to not having other spaces where he can access adequate social support.

Similar to Lis, Mim explained how connection to the staff and community played a large role in improving her health and well-being. Prior to seeking services at Kajsiab House, Mim stated she did not have a place where she could relieve stress or anyone she could talk to when she was lonely or sad. She stated she had little to look forward to as she could not communicate with others in her community and often sat at home alone. Mim stated that since starting services at Kajsiab House, she looks forward to each morning and is excited to talk to others, learn new things, and share her experiences. When I asked her what services were most helpful, she stated that having a companion, whether it be staff or friends, and socializing with others was what was most important for her health. Mim noted she enjoyed group activities such as the lunch program and Bingo. She described how she enjoyed talking about what life was like when she lived in Laos and Thailand and how each person's journey was different. Mim stated that talking to others and sharing her experiences made her feel less lonely, sad, and stressed. Finally, Mim noted how important learning was for her at Kajsiab House. She stated she especially enjoys learning about things such as current events, how advanced technology is, and how to surf the

internet. Mim stated there are times when something "hits home for her," and it makes her feel happy and more connected to others.

In line with Lis' and Mim's experiences, Zaj began coming to Kajsiab House so that he could see friends and family and talk to them when he was lonely. Zaj described how the language barrier made it difficult to do anything in the U.S. He stated he could not ask for help when he needed it, buy food when he was hungry, drive to see family when he was lonely, or work to provide for his family. When asked about what services were most helpful at Kajsiab House, Zaj replied that the respect between members and staff, the ability to share traditional art forms, and the ability to talk with others were the most important things. He described how the ground rules created by the community members helped everyone be respectful of each other by not allowing people to call each other names, talk down to one another, or ignore people when they were speaking. Because of these rules, Zaj felt more comfortable asking for help and felt other people would support him when he needed it. In addition to socializing with others and engaging in group activities such as gardening and Bingo, Zaj stated one of his favorite things to do at Kajsiab House was to create and share traditional art forms. He noted how he enjoyed the process of creating them, just as much as he enjoyed sharing them. Zaj stated he was able to communicate through his art forms to someone else, even if they did not speak the same language. So, even though he could not communicate with others through language, he could use the art forms to talk to others. Zaj stated he looked forward to making art and sharing it with his friends and staff. He stated he also worked on art at home to make the day go by faster.

Reduction of stress on self and family. Nine out of 11 participants described how services provided at Kajsiab House reduced their stress and stress on their families. Women focused on how services impacted both themselves and their families, whereas men focused on how services reduced their stress. Services that participants identified as helping reduce stress included group activities (e.g., trips, gardening, sewing, & walking), assistance with immigration issues and accessing benefits, transportation, assistance with tasks of daily living, physical health concerns, and translation services. The following narrative co-created by Kiab (a female participant) and me illustrates how group activities, assistance with tasks of daily living, transportation, and translation services reduced Kiab's and her family's stress.

Kiab was born in Laos and fled to Thailand after the Secret War began. After living in several refugee camps, Kiab relocated to the U.S. with her husband and several children. Kiab

described how it was difficult for her and her family after they moved to the U.S. because they could not speak English, drive, or work. She stated she was very sad and stressed and did not know who to turn to for help. Kiab stated she tried to learn English, but she was so stressed she became physically ill and had to stop studying. After living in several places throughout the U.S., she and her husband decided to move to Madison, WI to live with relatives. When Kiab first arrived at Kajsiab House, she stated she needed help with daily tasks such as reading mail, transportation, and making doctor's appointments. As she spent more time at Kajsiab House, she stated she began to join group activities such as sewing, gardening, and the women's group. When I asked what she found most helpful at Kajsiab House, Kiab replied that the trips she took to visit places such as Yellowstone National Park, The White House, and Mount Rushmore have been the most helpful. She also stated that gardening was very important to her because she enjoyed caring for the plants and watching them grow. She described how nature made her feel happy and reduced her stress. Kiab stated Kajsiab House changed her life for the better because even if her children are unable to help her with paperwork or other things she needs, she can call Kajsiab House and they will help her. Because of this support, Kiab stated she and her family worry less and are less stressed.

Neeb, a male participant, discussed how general socialization, group activities, and physical health services provided through Kajsiab House helped reduce his stress. Neeb was born in Laos and fled to Thai refugee camps during the Secret War. Eventually, he relocated to the U.S. with his wife and several children. Neeb described how it was very difficult when he first moved to the U.S. because he could not find Shaman in several of the cities in which they lived. Initially, Neeb stated he was able to work, but as he grew older, he began to have health difficulties that prevented him from working. After Neeb discontinued working, he stated his children and eventually his grandchildren cared for him and his wife. Neeb stated he and his wife decided to move to Madison, WI with one of his children, and soon after, he started coming to Kajsiab House. When Neeb first arrived at Kajsiab House, he stated he was lonely, sad, and very bored at home. He described how he could not stay at home alone because he began to have too many thoughts about his past. Neeb stated he met many people he did not know and began to make friends. He also started taking group walks and enjoying other group activities. Neeb described how he also began to be able to depend on Kajsiab House for his medical care. He stated he can now tell staff about any medical needs or doctor appointments he has, and they will

help him. When I asked Neeb what he likes most about Kajsiab House, he informed me that Kajsiab House is a very good place to come and have socialization. He stated at home he is so lonely and bored, but when he comes to Kajsiab House he can talk to staff, talk to his friends, and talk to people he does not know about the past. Neeb also noted there are so many activities to do that the day goes by very fast, so he feels happier and less stressed.

Another female participant, Yeev, explained how assistance with immigration issues, the food program, medical care, and general socialization help reduce stress for her and her family. Yeev was born in Laos and fled to Thailand after the war began, where she lived in several refugee camps. Although Yeev stated she did not have any difficulty finding things she needed when she moved to the U.S. because she had family members here, she stated she was sad and very lonely. Yeev described how she would often wake up, eat breakfast, and go outside to cry for most of the day. When asked by family members why she was so sad, Yeev stated this was not her country, this was not her place, and she was so lonely. She described how she left all her immediate family members behind in Laos and Thailand, and how she missed them every day. After a period of time, Yeev moved to Madison, WI to live with her other children; shortly thereafter, she began services at Kajsiab House. When I asked why Yeev came to Kajsiab House, she stated because she was bored and lonely, and she needed help with getting her citizenship and passport. Yeev stated she began attending citizenship classes each week and made friends by socializing with other members. When I asked if there was anything that made Yeev happy at Kajsiab House, she stated she was very happy that she was able to get her citizenship and passport so that she could go back to Laos and visit her family. Yeev also noted how important the medical care and food program were for her. She stated she was thankful that Kajsiab House monitored her physical health issues and that they are able to help her if she falls or becomes ill. In addition, Yeev stated that the breakfast, lunch, and snack Kajsiab House provided reduced her stress a lot. She described how when she is at home she cannot drive, has difficulty seeing, and often cannot access food unless others help her. Yeev described how there have been times when she has gone for long periods without eating at home because there was no one to help her. However, on the days she comes to Kajsiab House, she knows she has three meals and that someone will help her if she needs something. Lastly, Yeev noted how services at Kajsiab House improved her relationship between her and her husband. She described how she and her husband

often argue at home because they are stressed. However, she stated this does not happen when they come to Kajsiab House.

Hopes and fears for Kajsiab House. Questions such as, "What services do you wish Kajsiab House provided that are not currently available?" and "Is there anything else important you would like me to know that I have not asked you about your experiences at Kajsiab House?" elicited responses from participants about their hopes and fears for Kajsiab House. When asked these questions, eight out of the 11 participants described how they were satisfied with the current services available through Kajsiab House. However, several of those same participants also noted things they wished they could change or feared might happen to Kajsiab House in the future. For instance, Kiab described how many of the younger people who came to Kajsiab House would get help with their citizenship and then leave. She stated she hoped that these younger members would stay and help Kajsiab House grow. Kiab also described how she was worried about Kajsiab House disappearing if Journey Mental Health Services decided to close the current facility and could not find a new one to house the program. She stated she was worried that if one day Kajsiab House disappeared, she would not know what to do. Another participant, Keej, noted that although the services Kajsiab House currently provided met his needs, he needed more assistance with childcare. He described how difficult it was to get back home on time from Kajsiab House when he needed to care for small children after they came home from school. However, Keej stated this issue has not made him feel unwell even though Kajsiab House cannot provide him this service right now. Two other participants, Cua and Lis, described how they hoped Kajsiab House would provide more exciting activities in which everyone could participate. Although Cua could not identify a specific activity, Lis noted he would like more events for people to do crafts and create art. Lastly, Diav noted she wanted something that Kajsiab House did not offer, but she did not feel comfortable telling me during the interview.

Discussion

The current study sought to understand the experiences of Hmong refugees in Madison, WI who engaged in services at a local, culturally-specific community center (Kajsiab House). More specifically, the study sought to understand how services offered through Kajsiab House impacted participants' health and well-being over time. Narrative methodology was utilized to centralize and prioritize participants' voices by recognizing and valuing each person's subjective

truth as being situated within her or his own historical, socio-cultural, and political context and increasing awareness of how power differentials between myself and participants influenced the interview and analysis process. Thematic analysis of participant narratives resulted in the identification of three larger themes and five subthemes. Participants' narratives provided both unique and overlapping experiences within and between themes, resulting in a broader, coherent narrative reflecting the lived experiences of Hmong refugees living in Madison, WI who engage in services at Kajsiab House.

The narratives within this study were co-constructed within the context created by the research process and were influenced by participants' multiple intersecting identities and broader historical, socio-cultural, and political contexts. More specifically, narratives were impacted by generational influences (including language), educational background, health status, spirituality, gender, and wave during which they relocated to the U.S., to name a few. Further, participants' geographical location within the U.S. and their access to the Kajsiab House program also significantly impacted their narratives. Although the state of Wisconsin is predominantly European American and tends to be politically conservative, it also houses the third largest Hmong population in the U.S. In addition, residents within the city of Madison tend to vote more liberally and be openly supportive of immigrant and refugee communities. Kajsiab House, which is known to be the only program of its kind, has actively worked to integrate the Hmong community, and more specifically the elders, into group decision making processes to develop a culturally-specific treatment model that addresses the needs of the community. However, over the past several years, new administration and difficulties with finances have resulted in significant changes to this program from primarily focusing on culturally specific community-based treatments (e.g., traditional arts and crafts, gardening, and trips) to more Western crisis management and individual therapy services. These changes resulted in concerns from the staff about the applicability of services for their client population and the impact these changes may have on clients' health and well-being.

Factors Impacting Health

Participants discussed a range of factors that impacted their health before they had access to services at Kajsiab House, as well as when they were not present at Kajsiab House. These factors fell into three broad categories including loss, barriers to adjusting to the U.S., and the impact of the existing Hmong community. In general, women tended to focus on a broader

range of issues impacting their health, whereas most men tended to focus on a few issues that were common to most participants. One of the most prominent barriers that appeared to impact most areas of participants' lives was the language barrier. Although most of the participants spoke multiple languages (i.e., Lao and Thai), they only spoke and wrote a minimal amount of English (e.g., spoke a few words or a phrase and could write their name). Further, the language barrier persisted throughout their time living in the U.S., despite many of them taking formal classes or trying to learn with the help of younger family members. Participants described how their inability to speak English impacted their ability to obtain employment, drive, open bank accounts, shop, read mail, and form relationships with individuals outside of the Hmong community. These findings are consistent with previous research examining the needs of older refugees, such as the population included in this study, who relocated to Western countries such as the U.S., United Kingdom, Australia, and Europe. Despite individual and cultural differences between refugee groups, research has found that older refugees face common challenges such as language difficulties, social isolation and loneliness, loss of traditional roles, stress, culture shock, lack of access to appropriate services, and physical and mental health challenges (European Council on Refugees and Exiles, 2002; Gozdziak, 1988; Hugman, Bartolomei, & Pittaway, 2004; Connelly, Forsythe, Njike, & Rudiger, 2006). Language difficulties are particularly salient for older refugee populations as difficulties with acquiring the new host country's language can prevent older refugees from accessing important information and services, using public transportation, socializing, and fostering a sense of belonging in their new home (Slade & Borovnik, 2018).

As a result of these barriers, participants reported being unable to engage in society or provide and care for themselves and their families in the way they had before they moved to the U.S. This role loss was sudden and happened almost immediately after participants relocated to the U.S. Participants also described how younger generations were able to learn English quickly, which resulted in changes in their relationships with their children and grandchildren. Instead of participants being able to teach and guide the younger generations, they often had to rely on their children and grandchildren to translate for them and help with other daily tasks (e.g., reading mail, driving, etc.). These role reversals significantly changed family dynamics, as traditionally parents and grandparents in Hmong culture were responsible for teaching life skills and social values and passing on Hmong culture through storytelling (Johnson & Yang, 1992). As such,

participants described how role loss and role reversal resulted in increased sadness, stress, and worry, and led some participants to question their value as members of the family. Research indicates that the social roles people occupy help shape identity and significantly impact a person's sense of well-being by providing meaning and structure to their daily lives and a sense of competence and self-esteem (Heller, 1993; Kivela, 1997; Lavik, Hauff, Skrondal, & Solberg, 1996). Thus, the loss of such roles may significantly impact people's health and well-being, their identity, and their sense of competence and self-esteem. In line with this research, the refugee population in this study described how the loss of previously held social roles led to decreases in their overall health, self-esteem, and environmental mastery. Further, these findings are consistent with other studies examining exile-related stressors in refugee populations, which found that role loss and role reversal were some of the primary stressors impacting health and adjustment for refugees who relocated from second and third world countries to the U.S. and Canada (Hugman et al., 2004; Kanu, 2008; Miller, Worthington, Muzurovic, Tipping, & Goldman, 2002). Role loss and role reversal are compounding issues, especially for elder refugee populations (Gozdziak, 1989) such as the one in the present study. Although some elders try to maintain their traditional roles as transmitters of their native language and culture, they may find that more acculturated grandchildren are less interested in their family's cultural heritage and teachings (Yee, 1992). These types of situations can result in intergenerational conflict among grandparents, parents, and grandchildren, and cause a significant amount of distress and worry for elder refugee populations (Chenoweth & Burdick, 2001).

In addition to role loss and role reversals, participants described how their inability to communicate with others outside of the Hmong community led to increased social isolation and, in turn, increased stress, loneliness, and sadness, and lower overall quality of life. Although participants' living situations varied, many participants lived in areas which were most affordable to them (e.g., Section 8 housing), rather than locations which were closest to their communities and families. Additionally, even though some participants lived with younger generations (e.g., children and/or grandchildren), these family members were often in school or at work and were unable to provide social support or companionship during the day. As such, most participants spent the majority of their time at home with no one to talk to, despite wanting to build relationships within their new communities. Lack of connection to their new community was compounded by the disconnection they experienced from their homeland, as well as from

family members who remained in Laos or Thailand and those who were now regularly inaccessible in the U.S. due to geographical distance. In addition to the impact of social isolation on their immediate context, participants also described how these disconnections increased worry about their future (e.g., will there be anyone here when I am sick? or what will happen when I die?). The impacts of social isolation (e.g., low social support and loneliness) have been documented across refugee populations as one of the most salient experiences of exile- related distress (Miller et al., 2002). Numerous studies have documented how indicators of social isolation such as living alone, having a small social network, low participation in social activities, perceived lack of social support, and feelings of loneliness have been associated with worse health (Berkman & Syme, 1979; Dean et al., 1992; Hawkley et al., 2006; Krause, 1987; Thoits & Hewitt, 2001). For instance, individuals who lack social connections or report feeling frequently lonely tend to experience higher rates of morbidity and mortality, as well as physical and mental health issues. Although social isolation has been associated with worse health across all age groups, the health risks posed by social isolation are thought to be particularly severe for older adults (Cornwell & Waite, 2009). Thus, consideration of the impacts of social isolation on the current community is particularly important as they have experienced social isolation over an extended period of time and now face additional challenges related to aging and end of life concerns.

Mediating Factors. Participants discussed the impact of the existing Hmong community as one of the primary mediating factors of their health and the health of their families after they relocated to the U.S. Participants who relocated in earlier waves reported having more stress due to having little or no family support and living in regions where established Hmong communities were not present. In contrast, those that relocated in later waves typically moved to areas with an established Hmong community and had family who already relocated to the U.S. nearby. These participants described experiencing less personal and familial stress and having less difficulty transitioning to the U.S. due to having additional family and community support. Most narratives related to the impact of the existing Hmong community were centered around participants' abilities to access traditional healers such as Shaman, people familiar with herbal medicines and rituals, and magic healers. Of note, most participants stated they saw benefit in both Western and traditional treatments, as they understood each to serve a specific purpose based on the presenting issue. As such, not having access to traditional healers and treatments was highly

stressful, as they felt they could not effectively treat specific issues for themselves and their families. In addition to accessing traditional healers, participants also discussed how the local Hmong community (including family members) assisted them with their transition to the U.S. by supplementing food and income, helping them find basic necessities, connecting them with resources such as Kajsiab House, and providing translation when needed. Participants noted how resources provided through government agencies and non-profit organizations were often not enough to support their families. As such, the existing Hmong community helped fill in the gaps between services, connected participants to trusted sources, and provided necessary support to reduce stress and assist participants with transitioning to the U.S. Participants described how this support has continued over time and positively impacts their health even today. These findings are consistent with previous research that has found social networks to be a significant resource for refugees, especially when they first relocate to a new country (Williams, 2006). Access to such networks not only provides emotional support, but also enables newly arrived refugees to connect with resources such as trusted health providers, social service agencies, and community-based organizations.

Impact of Kajsiab House Services

Participants described how services offered through Kajsiab House improved their health by increasing social connection to family and community members and reducing stress on themselves and their families. Importantly, women tended to focus more on how services reduced stress on themselves and their families, whereas men primarily focused on how services reduced their own stress. All the services participants identified as increasing connection to others were group-based such as the food program, gardening, walking, taking trips, sewing, creating art/music, playing Bingo, and socializing in large groups. However, services identified as reducing stress included both group-based activities, such as the ones listed above, and those that addressed practical and logistical issues such as assistance with immigration paperwork, accessing benefits, transportation, assistance with tasks of daily living, monitoring physical health concerns, and translation services. Although participants reported needing a range of services when they first arrived at Kajsiab House, most reported the increased connection to others and the land was the most important service Kajsiab House provided, as it improved their social support networks and decreased social isolation and disconnection. One participant discussed how he viewed socializing and spending time with friends and family as a form of

medicine. Further, another participant discussed how she viewed assistance with immigration issues (i.e., citizenship and passport) as a tool she could use to reconnect with family members who remained in Laos and Thailand. Still another participant noted how he used music and art to connect with others when he could not communicate with them in English or when he wished to connect with friends and family members.

Importantly, although participants noted how staff provided socialization and companionship through Kajsiab House programs, none of the participants identified individual therapy or crisis stabilization services as a key factor in improving their health. Further, of the participants who noted they had difficult thoughts about the past, each of them stated that their ability to share these experiences with others in group activities and settings was most helpful in alleviating their distress. These finding run contrary to the beliefs of many Western mental health agencies and professionals who prioritize the processing of trauma by providing individual therapy services or other crisis-based interventions over social and geographical disconnection or logistical needs (Ai, Peterson, & Ubelhor, 2002; Kinzie, Boehnlein, Leung, Moore, Riley, & Smith, 1990; Neuner, Schauer, Karunakara, Klaschik, Robert, & Elbert, 2004). This is not to say that the impacts of war-related trauma, such as those experienced by this population, are not important to address. However, in line with more recent shifts in research, these findings highlight that the services and types of interventions used when working with refugee populations such as this one need to take a more holistic approach to understanding refugee experiences and prioritize the needs of the community (Miller & Rasmussen, 2010) rather than prioritizing services and modalities based on Western assumptions of trauma.

In addition to socialization, participants described how services at Kajsiab House improved their health by providing them with a sense of purpose, restoring lost social roles, and enabling them to maintain important cultural practices. Prior to accessing services at Kajsiab House, many participants described how they had little to look forward to and were often bored and lonely at home. However, after coming to Kajsiab House, participants described how they looked forward to each day and felt they had a safe space where they could connect with others and learn new things. In addition, services such as gardening and creating traditional arts and crafts provided participants with a sense of purpose and reconnected them with previous roles they once held in Laos and Thailand. Prior to the war, many of the participants lived in villages where they helped support their families by farming plants and animals. Thus, the gardening

program at Kajsiab House restored lost social roles by enabling participants to utilize existing skill sets and contribute to their communities and families by sharing plants they grew. Moreover, the creation and sharing of traditional art forms and crafts at Kajsiab House provided participants with additional ways to fulfill important social roles as adults - and especially elders - are responsible in Hmong culture for maintaining cultural practices and passing them on to younger generations (Johnson & Yang, 1992). During the resettlement process, refugee elders often lose personal power through the processes of role loss and role reversal. As such, it is important that their power is restored through engagement in familiar cultural activities and socialization with friends and family members (Chenoweth & Burdick, 2001). These activities and opportunities for social engagement provide elders with a sense of continuity during their transition to a new country and provide them with the opportunity to demonstrate competence and share their wisdom, while also learning information about their new home and country (Chenoweth & Burdick, 2001). Thus, programs such as gardening and traditional arts and crafts at Kajsiab House help alleviate some of the impacts of role loss and role reversal in participants' lives by providing a space where they can regain a sense of environmental mastery and fulfill important cultural roles that contribute to their families and communities. In addition, it appears that opportunities for learning and connection with their new home, such as the ones illustrated below, assist with alleviating some of the effects of role loss and role reversal, and increase refugee elders' sense of belonging.

As stated above, another important factor that impacted participants' health was the sense of belonging they found through Kajsiab House services. Although participants did not explicitly state they felt services increased their sense of belonging, they described various ways the Kajsiab House program promoted the development of connection to friends and family members, their community, and the wider country. For instance, a few participants discussed how the ground rules developed by participants helped develop an environment where they felt safe to connect with others and ask for support when needed. Other participants described how programs centered on teaching new skills, such as how to use technology, increased their sense of competence, and helped them feel more connected to the younger generation. Further, one of the participants described how the trips she took with Kajsiab House to important historical locations helped her feel more connected to the U.S. For displaced persons such as this refugee population, the experience of separating and moving away from family and homeland can result

in the feeling of being torn between belonging to two or more places, or not belonging anywhere at all (Rapport & Dawson, 1998). Displacement from one's home and emplacement in a new unknown environment disrupts a person's sense of belonging and challenge a person's sense of self and place in the world (Fozdar & Hartley, 2014). Thus, re-establishing a sense of belonging is an important part of re-establishing ontological security (one's sense of self and place in the world; Fozdar, 2012), as a diminished sense of self and belonging have been linked with worse mental health outcomes and diminished social and functional ability to create a healthy and meaningful life (Vandermark, 2007).

Lastly, participants noted how Kajsiab House services reduced stress on their families and improved family relations by providing assistance with practical and logistical barriers. For instance, many of the participants noted how they and their families worried less about their physical health conditions because they trusted that Kajsiab House staff would care for them and connect them with outside resources, if necessary. A few of the participants also noted how Kajsiab House alleviated stress on their family members by assisting with daily tasks such as reading the mail, providing meals, making doctors' appointments, and providing transportation and translation services. Further, one of the participants noted how she and her spouse fought less when they attended services at Kajsiab House due to feeling less lonely, isolated, and stressed than they did when they were home alone. Findings from this population are consistent with other research examining the needs of refugee elders who have resettled in Western countries. Previous studies have found that refugee elders are a unique population with specific needs and challenges (Chenoweth & Burdick, 2001; Hugman et al., 2004; Slewa-Younan, Santalucia, McDonald, & Salem, 2016). In contrast to younger family members who experience greater independence over time, many refugee elders remain dependent on family members over time and need help with daily tasks such as paying bills, depositing money, and transportation (Chenoweth & Burdick, 2001). In line with cultural norms, many refugees from non-Western countries tend to rely on informal, familial support for most of their needs, which can, at times, result in extreme stress within the family system when issues such as severe health problems arise (Slewa-Younan et al., 2016). Thus, best practices in caring for this population include consideration of the needs of elders individually and holistically within the family unit to elicit family strengths and identify existing needs. It is not only important to address the logistical and practical needs of both elders and caregivers (e.g., housing, health, education, transportation) but

also to provide elders with community activities and services that are accessible and of interest to them. This combined approach works to reduce familial stress of caregivers and social isolation often reported in elder refugee populations and improve family functioning to provide elders with a higher quality of life (Chenoweth & Burdick, 2001). These recommendations appear to be in alignment with the services provided through the Kajsiab House program and support the approach taken by this Hmong community to address the needs of their elder population.

Hopes and Fears for Kajsiab House

When participants were asked about services they wished Kajsiab House had or if there was anything else they would like to share with me about Kajsiab House, most responded by saying they were satisfied with current services. However, some of these same participants then shared current unmet needs they had such as assistance with childcare, wanting more exciting activities with which everyone could be involved, and integration of more traditional crafts and art. One of the participants expressed hopes and concerns she had for Kajsiab House such as wishing younger members would stay to help it grow and fearing that Kajsiab House may close if Journey could not find new facilities for the program. Like most other participants, this participant noted how many of the presenting issues she experienced when she first came to Kajsiab House continued to persist during times when she was at home and did not attend services. Thus, she worried about how she would cope if Kajsiab House closed because other agencies were not providing necessary services for participants like herself to maintain a fulfilling and healthy life. Overall, it appears that many of the services Kajsiab House provides fulfill the needs of their participants. However, the recent shift to focusing on individual therapy and crisis intervention services is very concerning, as it appears the most impactful services Kajsiab House provides, as reported by participants, are group-based and culturally specific treatment interventions such as trips and outings, the food program, activities that encourage new learning, gardening, walking, sewing, creating art/music, playing Bingo, and socializing in large groups. Further discussion of these findings, including recommendations for the Kajsiab House program, will be discussed below.

Limitations

Although the present study sought to provide insight into the health experiences of Hmong refugees in Madison, WI, it is important to note several limitations. First, participants in this study were predominantly older, ages 60 to 80 years, and relocated during one of the three

major waves (1980s, 1990s, and 2000s). As Hmong refugees began arriving in the U.S. as early as the mid-1970s and continued to relocate to U.S. in larger numbers until 2006 (Vue & Lee, 2014), the experiences of this particular sample may not reflect the experiences of all Hmong refugees who relocated to this area of the U.S. In addition, as various demographics, including the age at which refugees relocate, significantly impact the types of experiences they have, the challenges they face, and the resources available to them upon arrival (Yakushko, Watson, & Thompson, 2008), the experiences of this particular population may differ from other Hmong refugees who relocated to the U.S. at younger or older ages. Second, the small sample size and narrow geographic focus on Hmong refugee men and women in the Midwest may limit the generalizability to all Hmong refugees within the U.S. In addition, the participants that were sampled for this study were required to be clients who received services at Kajsiab House within the past year. This requirement limits the generalizability of the findings of this study and may not represent refugees in the local community who have not accessed services at this agency or for those who previously engaged in services, but chose not to within the last year. In light of these limitations, it would be important for future research to further examine the health experiences of Hmong refugees across the various areas of the U.S., as well as those who chose not to engage in services at Kajsiab House or who live in other areas where access to a similar type of program is not available.

A third limitation of this study was an exclusive focus on conducting interviews with participants themselves. Future researcher including interviews with participants' family members, friends, and other individuals familiar with them in the community could provide a richer understanding of participant experiences and further elucidate strengths and resources available to such populations. Fourth, my experiences as a biracial (Argentinian and European American) U.S. born citizen, with a Western educational background, and an inability to speak Hmong limited the extent to which I could understand and interpret participant experiences from their personal worldviews. For instance, as a native English speaker and outsider of the community, I had a limited amount of cultural and linguistic knowledge about Hmong culture and health with which to develop questions and required the assistance of translators during the interview process. Future research conducted by native speakers from the community would have more first-hand cultural and linguistic knowledge, and thus may be able to develop questions more in line with cultural understandings of health and reduce added layers of

interpretation that accompany the use of translators. Additionally, my experiences as a U.S. born citizen limited my understanding of the lived experiences of refugees as I had never been dislocated from my country or community and never faced the challenges of obtaining citizenship. Thus, other Hmong researchers with personal refugee experiences may be able to develop questions and co-create narratives during the interview process that better highlight difficulties refugees face after relocating to Western countries. Finally, my training within U.S. academic settings has shaped the way I understand health and trauma from a predominantly Western perspective. As such, future research conducted by scholars trained in non-Western academic settings, closer to that of the Hmong population, may be able to provide a more in-depth analysis and understanding of Hmong refugee health experiences.

Implications and Future Directions

The findings of this study allude to important implications for work with Hmong refugee communities in the U.S., as well as the community that was specifically sampled for this study. Historically, mental health intervention models and services provided to refugee communities have primarily been based on dominant, Western cultural views of trauma that emphasize an individualistic, cognitive approach to healing (Bracken, 2002; Goodkind, 2005). Although there has been a recent push in the field of psychology to increase cultural sensitivity of interventions through the use of evidence-based practices (EBP; APA Presidential Task Force on Evidence-Based Practice, 2006), many of these treatments continue to prioritize Western theories of health and healing and fail to recognize the value of indigenous knowledge and healing practices in communities such as the Hmong (McCabe, 2008). The voices of participants within this study provide evidence that challenges universal, Western notions of mental health and healing and further supports the development of collaborative, community-based intervention models that honor and integrate traditional cultural and healing practices (Gozdziak, 2004; Papadopoulos, 2007; von Peter, 2008), such as Kajsiab House. More specifically, the findings of this study provide evidence of a broader understanding of what constitutes health and healing in the Hmong community. For instance, considering the interdependent and collective nature of the Hmong community, it is no surprise that collective, community-based interventions (e.g., gardening, sewing, creating art/music, and socializing in large groups) are viewed as more impactful than traditional Western individual or group psychotherapy within the community, as these types of

approaches are more in line with their view of the world and connection between themselves and others.

In addition, the findings of this study suggest that health providers should recognize and respect the existing strengths and knowledge that exist within indigenous communities, such as the Hmong, and have been used to heal community members for thousands of years (e.g., Shaman and other traditional healing practices; Robbins & Dewar, 2011). As the Hmong view health from a more holistic standpoint (i.e. the intricate connection between mind, body, and spirit), participants in this study viewed the integration of spiritual healing (e.g., utilizing a Shaman) as a vital part of improving and maintaining their health. Thus, when working with Hmong refugee communities, providing access to traditional healing practices such as Shaman, herbal medicines, and magic healers, in conjunction with Western approaches, may improve the health of clients. These findings are consistent with more recent research stating that many Hmong patients find traditional healing methods such as Shaman to be effective, irrespective of their age, gender, or degree of acculturation. As such, building relationships with traditional healers and integrating traditional healing methods such as Shamanism into the care of Hmong clients can serve as a powerful compliment to Western treatments and increase trust between health care providers and the clients they serve (Plotnikoff et al., 2002).

In addition, the strength, resilience, and support of the Hmong community reported by participants in this study challenges the narrative that refugees are helpless victims who depend on agents of compassion to keep them alive (Ghorashi, 2005). In fact, findings of this study highlight how the existing Hmong community was a powerful mediating factor in supporting participants' health after they relocated to the U.S., even when other social agencies were providing financial, logistical, and health services (e.g., hospitals). These findings point to the importance of including family members and the wider Hmong community into the identification, development, and implementation of interventions for Hmong refugees. Family and community members should be viewed as valuable assets with strengths, knowledge and resources that can facilitate the development of community-based services that directly address the specific needs of their communities. Interventions developed should address the needs of both family members and individual clients, as refugees typically rely on family to support and supplement their needs after relocation (Slewa-Younan et al., 2016). Inclusion of the family and community would not only work to address the collective trauma often experienced by more

collectivist cultures such as the Hmong (Jenkins, 1996), but would also bolster the clients' existing support system by reducing familial stress and increasing the family system's ability to support clients who present for services (Chenoweth & Burdick, 2001; Norris, Friedman, Watson, Byrne, Diaz, & Kaniasty, 2002).

Future research with this population should also collaboratively work with the community to develop projects that are inclusive and reflect the perspectives and needs of the community. Community participation should be elicited from identification of the project idea to development of study materials to interpretation of results. Models such as participatory action research, as well as critical and feminist theories, would be particularly useful in the development of research projects with refugee communities, as these approaches actively work to share decision making power and recognize community members as holding sets of expertise that can facilitate project development and implementation (Hill & Kral, 2003; Kidd & Kral, 2005). In line with the above research approaches, I will be presenting the findings of the current study to both participants and staff at Kajsiab House to elicit feedback about the findings, interpretation, and recommendations. Prior to publication, the feedback from participants and staff will then be integrated into the paper to ensure that the results and interpretation accurately reflect participant narratives and that recommendations are useful to the staff and community for future development of the Kajsiab House program.

The findings of this study also highlight the importance of developing programs that address a wide range of needs when working with refugee communities such as translation, immigration, accessing benefits, assistance with tasks of daily living, transportation, health (i.e., mental, physical, and spiritual), and social and geographical disconnection. For this particular population, it appears that addressing daily stressors, including social and geographical disconnection, would be most beneficial in improving health and well-being. These findings are consistent with recent research evaluating proposed models for working with war-exposed individuals conflict and post-conflict, such as refugees. Researchers found that an integrated approach that prioritized localized salient daily stressors before development of mental health and psychosocial interventions was most beneficial to these populations (Barenbaum, Ruchkin, & Schwab-Stone, 2004; Betancourt & Williams, 2008; Bolton & Betancourt, 2004; Miller & Rasmussen, 2010). These recommendations were based on findings from recent studies indicating that daily stressors significantly impacted mental health above and beyond the impacts

of war-related exposure (Betancourt, 2008; Fernando, Miller, & Berger, 2010; Rasmussen, Nguyen, Wilkinson, Vundla, Raghavan, Miller, & Keller, 2010). Further, researchers cautioned against professionals prioritizing trauma-related health symptoms, such as PTSD, as it most likely reflected the interest of mental health professionals rather than the actual needs of communities they served (Miller & Rasmussen, 2010). In line with the above research and the voiced needs of participants in this study, it is my recommendation that Kajsiab House maintain and expand group-based, culturally specific treatment interventions that integrate the local Hmong community and provide opportunities to learn about and connect with regional and national contexts (e.g., trips and outings, creating art/music, and activities that encourage new learning). Shifting the program to a focus on individual therapy and crisis intervention services would not only run counter to recent research findings related to best practices for this type of population, it would also prioritize Western conceptualizations of mental health over the voiced needs of the community.

Personal Reflections

Finally, my experiences within this Hmong refugee community have further shaped how I view both clinical work and research with refugee populations. Whether it be conducting research or developing intervention models, I firmly believe that emic approaches, which seek to understand the lived experiences and needs of refugee communities from their worldview, are essential to developing culturally competent and ethical models of treatment. Emic approaches that seek to understand the experiences and needs of these populations from their worldview provide valuable information about the community and their needs that are often overlooked by etic, top-down approaches. Information gathered through these emic research approaches can then be used to develop intervention models from the ground up that address each refugee community's unique needs and cultural values. In contrast to more top-down models, this type of approach values and prioritizes the voices of the community and allows for the identification of both needs and strengths.

In addition to influencing my views on research, my experiences working with this refugee community have further highlighted limitations I have as a native English speaking, Western educated mental health professional. Due to the vast differences between my identities and lived experiences (e.g. language, spirituality, cultural values) and those of the Hmong community, I have come to understand that much of the skills and knowledge I hold as a

professional do not match, and many times are inapplicable, when working with the Hmong refugee community. As such, I firmly believe that referring individuals who identify as Hmong to professionals or treatment centers which specialize in providing services to this population is not only important, but ethically necessary. Although there are limitations to referrals in some contexts (e.g. specialized services may not be available in rural areas), every effort should be made to connect clients with services that provide the best possible care, considering their cultural background and specific needs.

Conclusion

In conclusion, this study contributes to the anthropological, sociological, and psychological studies on refugee health experiences by providing a space for Hmong refugees to give voice to their needs and experiences rather than imposing a predetermined theoretical framework of trauma and health. In particular, the narratives within this study highlight the diversity of refugee experiences and challenge concepts of universal, Western notions of mental health and healing. These findings also highlight the strength and resilience of refugee communities and their important role in improving the health and well-being of community members. Finally, the success of the Kajsiab House model and the narratives of participants in this study provide further evidence for the use of more holistic treatment interventions that are collaboratively developed *with* the community and provide wraparound services, while also honoring and integrating traditional and cultural healing practices.

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Table 1. *Themes and Subthemes of Narratives*

Factors impacting health before and outside of Kajsiab House
Loss
Barriers to adjusting to U.S.
Impact of existing Hmong community
Impact of Kajsiab House services on health
Increased connection to community and family
Reduction of stress on self and family
Hopes and fears for Kajsiab House

Appendix A: Questions for Semi-Structured Interviews in English

"I am a student studying to be a doctor, like Dr. Garms, and will be working with Dr. Coleman. Part of my family is from another country and came as immigrants here and have learned to live differently here than the ways they lived in the country they came from. This has made me interested in how people manage the changes when life is America is different than life from where they came from. I am interested in learning about experiences about your past, in your current daily life, and the experiences you have had at Kajsiab House. I will be talking with you about your life and asking you some questions. I realize that it might be strange talking about your life with someone like me whom you don't know and is not from your community. You can tell me as much as you feel comfortable and you don't have to answer any question that you don't want to. Remember if you become distressed at any point during the interview please let the translator and researcher know."

<u>Personal information and daily activities:</u>

- Tell me about yourself (e.g., how old are you?, where do you live?, whom do you live with?)
- Do you have a job? If so, do you know how much money you make? If not, how do you receive money to live?
- If you have a job:
    - What do you think about your work?
    - What are some benefits of this work?
    - What are some drawbacks of this work?
- How easy or hard is it to find work?
- What is your role in the community?
- What do you think about your role in the community?
- What do you think about your community?
- Are you religious? What religion do you follow? What kinds of religious activities do you engage in?
- What kinds of things make you happy, fine, or satisfied?
- What kinds of things make you feel bad/stressed/upset? What do you do when you feel bad/stressed/ upset?

<u>Past experiences</u>

- Tell me about your experiences while growing up.
    - Where were you born?
    - Where did you grow up?
    - Whom did you live with?
    - What were your experiences like in childhood and adolescence?
    - What were your experiences like in adulthood?
- Before moving to the United States what were your experiences?
    - Where did you live? (e.g., country?, local community?, refugee camp?)
    - If you lived in a refugee camp before moving, what services were provided?
        - What services did you/your family find most helpful?
        - What services did you need in the refugee camp that were not provided?
    - Were there positive experiences in the country where you lived before moving to the United States? Can you tell me about them?
    - Were there negative experiences in the country where you lived before moving to the United States? Can you tell me about them?
    - What were your primary concerns before moving to the United States?
    - What was your community like before you moved to the United States?
    - What was your role in the community?
- When did you move to the United States? How old were you?
- Why did you move to the United States?
- Whom did you move with to the United States? Were there people in your family/community whom you left behind?
- What were your experiences while moving to the United States?
    - What were your primary concerns when relocating to the United States?
    - What did you find most difficult while moving?
- Where did you first move to in the United States?
- What were your experiences after you moved to the United States?
    - Were there positive experiences after you moved to the United States? Can you tell me about them?
    - Were there negative experiences after you moved to the United States? Can you tell me about them?

        - What did you find most difficult after you moved?
    - What were your primary concerns after you moved to the United States?
    - Did you feel capable of taking care of yourself/family when you first moved to the United States?
    - What was your role in the community after you moved to the United States? How was this role the same or different from your role in your community before you moved?
    - What was your community like after you moved to the United States?
- Did you relocate a second time after moving to the United States? If so, why did you move?
- When did you move to Wisconsin? Why did you move to Wisconsin?
- How did you learn about Kajsiab House?
- How/when did you first come into contact with Kajsiab House?
- Why did you come to Kajsiab House?
- What were your needs when you first came to Kajsiab House? (e.g., physical, logistical, economic, mental, spiritual, emotional)
- What services were available that addressed your needs when you first came to Kajsiab House?
- Was there anything that you needed that Kajsiab House did not offer?
- Did anyone at Kajsiab House ask you about your needs when you first came to Kajsiab House?
- Has anyone at Kajsiab House asked for your opinion about the services being offered at Kajsiab House?
- Were you/have you ever been involved in any individual or community meetings about what services would be important for you or the local Hmong community?
    - If so, could you please describe this experience?
    - What was this experience like for you/family/community? (e.g., how did it impact you physically, emotionally, and or spiritually?)

<u>Current experiences:</u>

- What do you think about Kajsiab House?

- What role do you currently serve at Kajsiab House? What services do you engage in?
    - What do you think about your role in Kajsiab House?
    - What do you think about the services you engage in?
- Are your concerns the same now as when you first arrived at Kajsiab House?
    - How are they different/the same?
    - What are your most important concerns right now?
- Has Kajsiab House impacted your family/community in any way?
    - If so, please explain (e.g., positive or negative)?
- How do you feel Kajsiab House has impacted your well-being? (e.g., mental, physical, economic, logistical, and spiritual)
- Do you feel able to care for yourself/family/community? (e.g., physical, economic, logistical, spiritual, mental)
    - If so, has Kajsiab House helped with this in any way? Please explain.
    - If not, please explain?
- What services have you found most helpful at Kajsiab House?
- What services do you wish Kajsiab House provided that are not currently available? (e.g., those that could help improve your ability to function and care for yourself/family/community)
- Is there anything else important that you would like me to know that I have not asked you about yourself/family/community or your experiences at Kajsiab House?
- How was this interview like for you? What would you have liked to be different?

Appendix B: Questions for Semi-Structured Interviews in Hmong

“Kuv yeej txaus siab xav paub txog yam koj ntsib dhau los, rau hauv koj lub neej tam sim no, thiab yam koj ntsib rau ntawm lub chaw Kajsiab House. Kuv yuav tham nrog koj txog koj lub neej thiab nug koj qee nqe lus. Kuv paub tias tej zaum yuav yog ib qho txawv uas tham txog koj lub neej nrog ib tug neeg zoo li kuv, yog tus neeg koj tsis paub thiab tsis nyob hauv koj lub zos. Koj tuaj yeem qhia rau kuv kom ntau li ntau tau raws li qhov koj muaj cuab kav qhia tau thiab koj tsis tas yuav teb nqe lus nug uas koj tsis xav teb. Nco ntsoov tias yog koj nyuaj siab thaum lub sijhawm xam phaj, thov qhia rau tus kws txhais lus thiab tus kws tshawb fawb paub."

<u>Tus kheej cov ntaub ntawv thiab cov haujlwm niaj hnub ua:</u>

- Qhia txog koj tus kheej (xws li koj muaj hnub nyoog puas tsawg xyoo?, koj nyob qhov twg?, leej twg nrog koj nyob?)
- Koj puas muaj haujlwm ua? Yog muaj, koj puas paub tias koj khwv nyiaj tau npaum li cas? Yog tsis muaj, koj tau nyiaj li cas los thiaj li ua rau koj nyob tau?
- Koj muaj haujlwm ua:
    - Koj xav li cas txog koj txoj haujlwm?
    - Txoj haujlwm no muaj txiaj ntsig li cas?
    - Txoj haujlwm no muaj tej yam nyuaj li cas?
- Kev nrhiav haujlwm ua puas yooj yim lossis nyuaj li cas?
- Koj lub luag haujlwm nyob hauv lub zos yog dab tsi?
- Koj xav li cas txog koj lub luag haujlwm nyob hauv lub zos no?
- Koj xav li cas txog koj lub zos?
- Koj puas yog neeg ntseeg kev cai? Koj ntseeg hom kev cai dab tsi? Cov haujlwm uas koj mus koom ntawm qhov kev ntseeg kev cai no yog dab tsi?
- Yam uas ua rau koj zoo siab, kaj siab, lossis txaus siab yog yam dab tsi?
- Yam uas ua rau koj xav phem/ntxhov siab/tu siab yog yam dab tsi? Thaum koj xav phem/ntxhov siab/tu siab koj ua li cas xwb?

<u>Yam ntsib yav dhau los</u>

- Qhia rau kuv txog yam koj ntsib yav dhau los thaum koj loj hlob los.
    - Koj yug qhov chaw twg?
    - Koj loj hlob rau qhov chaw twg?
    - Koj nyob nrog leej twg?

    - Yam koj ntsib thaum koj tseem menyuam yaus thiab ua hluas yog dab tsi?
    - Yam koj ntsib thaum koj ua neeg laus lawm yog dab tsi?
- Ua ntej koj tsiv tuaj nyob rau Teb Chaws Meskas koj ntsib thiab pom dab tsi?
    - Koj nyob qhov chaw twg? (xws li lub teb chaws twg?, lub zos twg?, lub chaw saib xyuas neeg thoj nam twg?)
    - Yog koj tau nyob hauv ib lub chaw saib xyuas neeg thoj nam ua ntej tsiv tuaj, yam kev saib xyuas uas raug muab rau koj ntawd yog dab tsi?
        - Yam kev saib xyuas uas koj/koj tsev neeg pom tias muaj txiaj ntsig zoo tshaj plaws yog dab tsi?
        - Yam kev saib xyuas uas koj xav tau tab sis tsis raug muab saib xyuas rau koj thaum nyob hauv lub chaw saib xyuas neeg thoj nam ntawd yog dab tsi?
    - Puas muaj yam koj tau ntsib zoo rau hauv lub teb chaws uas koj nyob ua ntej tsiv tuaj rau Teb Chaws Meskas? Koj qhia txog tej ntawd rau kuv puas tau?
    - Puas muaj yam koj tau ntsib tsis zoo rau hauv lub teb chaws uas koj nyob ua ntej tsiv tuaj rau Teb Chaws Meskas? Koj qhia txog tej ntawd rau kuv puas tau?
    - Yam koj txhawj xeeb ua ntej tshaj plaws ua ntej tsiv tuaj nyob Teb Chaws Meskas yog dab tsi?
    - Koj lub zos koj nyob ntawd zoo li cas ua ntej koj tsiv tuaj nyob Teb Chaws Meskas?
    - Koj lub luag haujlwm nyob hauv lub zos ntawd yog dab tsi?
- Koj tsiv tuaj nyob Teb Chaws Meskas thaum twg lawm? Koj muaj puas tsawg xyoo?
- Vim li cas koj thiaj tsiv tuaj nyob Teb Chaws Meskas?
- Cov neeg uas koj tsiv nrog lawv tuaj nyob Teb Chaws Meskas yog leej twg? Puas muaj cov neeg hauv koj tsev neeg/lub zos uas koj tau tso tseg rau tom qab?
- Yam koj ntsib thaum tsiv tuaj nyob Teb Chaws Meskas yog dab tsi?
    - Yam koj txhawj xeeb ua ntej tshaj plaws thaum tsiv teb tshaws chaw tuaj nyob Teb Chaws Meskas yog dab tsi?
    - Yam koj pom tias nyuaj tshaj plaws thaum tsiv tuaj yog dab tsi?
- Lub xeev uas koj tsiv tuaj nyob Teb Chaws Meskas ua ntej tshaj plaws yog qhov twg?
- Yam koj ntsib tom qab koj twb tsiv tuaj nyob Teb Chaws Meskas yog dab tsi?

    - Puas muaj tej yam zoo tom qab koj twb tsiv tuaj nyob Teb Chaws Meskas lawm? Koj qhia txog tej ntawd rau kuv puas tau?
    - Puas muaj tej yam tsis zoo tom qab koj twb tsiv tuaj nyob Teb Chaws Meskas lawm? Koj qhia txog tej ntawd rau kuv puas tau?
        - Yam koj pom tias nyuaj tshaj plaws tom qab koj twb tsiv tuaj lawm yog dab tsi?
    - Yam koj txhawj xeeb ua ntej tshaj plaws tom qab koj twb tsiv tuaj nyob Teb Chaws Meskas yog dab tsi?
    - Koj puas muaj cuab kav saib xyuas koj tus kheej/tsev neeg tau thaum xub thawj koj tsiv tuaj nyob Teb Chaws Meskas?
    - Koj lub luag haujlwm hauv lub zos tom qab koj twb tsiv tuaj nyob Teb Chaws Meskas yog dab tsi? Lub luag haujlwm no puas zoo ib yam lossis sib txawv koj lub luag haujlwm thaum nyob hauv koj lub zos ua ntej koj tsiv tuaj?
    - Koj lub zos koj nyob ntawd zoo li cas lawm tom qab koj tsiv tuaj nyob Teb Chaws Meskas?
- Koj puas tau tsiv teb tsaws chaw zaum ob tom qab koj tsiv tuaj nyob Teb Chaws Meskas? Yog tau, vim li cas koj thiaj tsiv?
- Koj twb tsiv los nyob hauv Wisconsin thaum twg lawm? Vim li cas koj thiaj tsiv mus nyob hauv Wisconsin?
- Koj paub Kajsiab House li cas los?
- Koj tau tuaj hauv Kajsiab House thawj zaug li cas/thaum twg?
- Vim li cas koj thiaj tuaj hauv Kajsiab House?
- Yam koj xav tau thaum koj tuaj thawj zaug hauv Kajsiab House yog dab tsi? (xws li xav tau kev saib xyuas ib ce, kev pab txhawb, kev khwv nyiaj dhiav nyiaj, kev mob hlwb, kev pab txhawb feem kev ntseeg, kev xav)
- Yam kev saib xyuas uas raug muab raws li qhov koj xav tau thaum koj tuaj thawj zaug hauv Kajsiab House yog dab tsi?
- Yam koj xav tau kev saib xyuas uas Kajsiab House tsis tau muab rau koj yog dab tsi?
- Puas muaj ib tug neeg ntawm Kajsiab House nug yam koj xav tau thaum koj mus thawj zaug tom Kajsiab House?

- Puas muaj ib tug neeg ntawm Kajsiab House nug koj tias koj xav li cas txog cov kev saib xyuas uas raug muab los ntawm Kajsiab House?
- Koj puas tau mus koom ib lub rooj sib tham lossis cov rooj sib tham hais txog yam kev saib xyuas uas tseem ceeb rau koj lossis cov neeg Hmoob nyob hauv lub zos?
    - Yog tau, thov koj piav qhia seb zoo li cas?
    - Qhov tau mus koom no zoo li cas rau koj/tsev neeg/lub zos? (xws li nws cuam tshuam li cas rau koj lub cev, kev xav, thiab lossis kev ntseeg kev cai dab qhuas?)

<u>Yam niaj hnub ntsib tam sim no:</u>

- Koj xav li cas txog Kajsiab House?
- Tam sim koj lub luag haujlwm ua rau ntawm Kajsiab House yog li cas? Yam kev saib xyuas uas koj tau koom nrog yog dab tsi?
    - Koj xav li cas txog koj lub luag haujlwm rau hauv Kajsiab House?
    - Koj xav li cas txog cov kev saib xyuas uas koj tau koom nrog?
- Tam sim no koj puas txhawj xeeb ib yam li thaum xub thawj koj mus rau tom Kajsiab House lawm?
    - Nws puas zoo sib txawv/zoo ib yam li qub lawm?
    - Yam koj txhawj xeeb tshaj plaws rau tam sim no yog dab tsi?
- Kajsiab House puas cuam tshuam zoo thiab phem li cas rau koj tsev neeg/lub zos?
    - Yog cuam tshuam, thov piav qhia (xws li yam zoo lossis yam phem)
- Koj xav tias lub chaw Kajsiab House muaj qhov cuam tshuam zoo li cas rau koj li kev noj qab nyob zoo? (xws li kev saib xyuas mob hlwb, lub cev, kev khwv nyiaj dhiav nyiaj, kev pab txhawb, thiab kev pab txhawb feem kev ntseeg)
- Koj puas xav tias koj muaj cuab kav saib xyuas tau koj tus kheej/tsev neeg/lub zos? (xws li xav tau kev saib xyuas lub cev, kev khwv nyiaj nrhiav nyiaj, kev pab txhawb, kev pab txhawb feem kev ntseeg, mob hlwb)
    - Yog li ntawd no, Kajsiab House puas tau pab li cas? Thov piav qhia.
    - Yog tsis tau, thov piav qhia?
- Yam kev saib xyuas uas koj pom tias muaj txiaj ntsig zoo tshaj plaws rau ntawm Kajsiab House yog dab tsi?

- Yam kev saib xyuas uas tseem tsis muaj rau ntawm Kajsiab House uas koj xav tau muaj yog dab tsi? (xws li yam uas tuaj yeem pab ua kom koj ua taus haujlwm thiab saib xyuas tau koj tus kheej/tsev neeg/lub zos)
- Puas muaj tej yam tseem ceeb uas koj xav kom kuv paub vim kuv tsis tau nug koj tus kheej/tsev neeg/lub zos lossis yam koj ntsib rau ntawm Kajsiab House?
- Koj xav tias qhov xam phaj no zoo li cas? Koj puas xav kom ua txawv dua qhov no?

Appendix C: Subset of Questions Used for Analyses

Personal information and daily activities:

- Tell me about yourself (e.g., how old are you?, where do you live?, whom do you live with?)
- Do you have a job? If so, do you know how much money you make? If not, how do you receive money to live?
- If you have a job:
    - What do you think about your work?
    - What are some benefits of this work?
    - What are some drawbacks of this work?
- How easy or hard is it to find work?
- What is your role in the community?
- What do you think about your role in the community?
- What do you think about your community?
- Are you religious? What religion do you follow? What kinds of religious activities do you engage in?
- What kinds of things make you happy, fine, or satisfied?
- What kinds of things make you feel bad/stressed/upset? What do you do when you feel bad/stressed/ upset?

Past experiences

- What were your experiences after you moved to the United States?
    - Were there positive experiences after you moved to the United States? Can you tell me about them?
    - Were there negative experiences after you moved to the United States? Can you tell me about them?
        - What did you find most difficult after you moved?
    - What were your primary concerns after you moved to the United States?
    - Did you feel capable of taking care of yourself/family when you first moved to the United States?

    - What was your role in the community after you moved to the United States? How was this role the same or different from your role in your community before you moved?
    - What was your community like after you moved to the United States?
- Did you relocate a second time after moving to the United States? If so, why did you move?
- When did you move to Wisconsin? Why did you move to Wisconsin?
- How did you learn about Kajsiab House?
- How/when did you first come into contact with Kajsiab House?
- Why did you come to Kajsiab House?
- What were your needs when you first came to Kajsiab House? (e.g., physical, logistical, economic, mental, spiritual, emotional)
- What services were available that addressed your needs when you first came to Kajsiab House?
- Was there anything that you needed that Kajsiab House did not offer?
- Did anyone at Kajsiab House ask you about your needs when you first came to Kajsiab House?
- Has anyone at Kajsiab House asked for your opinion about the services being offered at Kajsiab House?
- Were you/have you ever been involved in any individual or community meetings about what services would be important for you or the local Hmong community?
    - If so, could you please describe this experience?
    - What was this experience like for you/family/community? (e.g., how did it impact you physically, emotionally, and or spiritually?)

<u>Current experiences:</u>

- What do you think about Kajsiab House?
- What role do you currently serve at Kajsiab House? What services do you engage in?
    - What do you think about your role in Kajsiab House?
    - What do you think about the services you engage in?
- Are your concerns the same now as when you first arrived at Kajsiab House?

    - How are they different/the same?
    - What are your most important concerns right now?
- Has Kajsiab House impacted your family/community in any way?
    - If so, please explain (e.g., positive or negative)?
- How do you feel Kajsiab House has impacted your well-being? (e.g., mental, physical, economic, logistical, and spiritual)
- Do you feel able to care for yourself/family/community? (e.g., physical, economic, logistical, spiritual, mental)
    - If so, has Kajsiab House helped with this in any way? Please explain.
    - If not, please explain?
- What services have you found most helpful at Kajsiab House?
- What services do you wish Kajsiab House provided that are not currently available? (e.g., those that could help improve your ability to function and care for yourself/family/community)
- Is there anything else important that you would like me to know that I have not asked you about yourself/family/community or your experiences at Kajsiab House?
- How was this interview like for you? What would you have liked to be different?

Appendix D: HIPPA form for release of information for the qualitative histories provided during intake

Please see the attached PDF entitled “Release of Information for Research_JMHC” provided by Journey Mental Health Center

Journey
MENTAL HEALTH CENTER

Formerly known as the
Mental Health Center of Dane County Inc.

CONSENT FOR RELEASE OF INFORMATION

A PHOTOCOPY, FAX OR ELECTRONIC IMAGE OF THIS CONSENT SHALL BE AS VALID AS THE ORIGINAL

1 **I hearby authorize:** Kajsiab House
3518 Memorial Drive, Building #4, Madison, WI. 53704

2 ☐ **To release information to:** ☐ **To obtain information from:**
(Check one box or both. By checking both, you are authorizing an exchange of information between the agencies/individuals listed).

Agency and/or individual: _____

Street/City/State/Zip Code: _____

3 **From the records of:**
Consumer Name: _____ Date of Birth: _____

Other names used: _____

4 **Purpose of need for disclosure: (check all that apply)**

☐ Service Coordination
☐ Crisis Management
☐ Mental Health and/or Substance Abuse Assessment/Treatment
☐ Other (specify): _____

5 a) **Time Period of Information Requested: From:** _____ **To:** _____

b) **Types of information to be disclosed: (check all that apply)**
☐ Mental Health ☐ Alcohol & Other Drug ☐ Medical ☐ HIV/AIDS
☐ Educational ☐ Developmental Disabilities ☐ Human Services
☐ Other (specify): _____

c) **Specific information to be disclosed: (check all that apply)**
☐ Intake Summary ☐ Progress Notes ☐ Treatment Plans ☐ Clinical Impressions
☐ Assessments + Diagnoses ☐ Medication Notes ☐ Summary Reports ☐ Consultations
☐ Lab Results ☐ Discharge Summary

Other (specify): _____

6 **I understand that:**
(a) My records are protected under State and Federal regulations governing confidentiality.
- Mental Health - Sec. 51.30, Wis. Stats.; & HFS 92, Wis. Admin. Code
- Alcohol & Other Drug Abuse - 42 CFR, Part 2; Sec. 51.30, Wis. Stats.; & HFS 92, Wis. Admin. Code
- Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, pts 160 & 164

(b) I will receive a copy of this form and have the right to inspect/receive a copy of materials to be disclosed.
(c) If the person(s) and/or organization(s) authorized by this form to receive my health information are not health care providers or other people who are subject to federal health privacy laws, the health information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release my health information without my prior permission.
(d) I am not required to sign this form and may refuse to do so. Except as permitted under applicable law, JMHC many not deny me services because I refuse to sign.
(e) I may revoke this consent at any time by giving written notice to my JMHC service provider(s) or to the JMHC Records Department, except to the extent that information has already been disclosed based on this release.

7 **This consent (unless revoked earlier) expires in one year.**

_____ _____
Consumer Signature Date

_____ _____
Signature of Other Person Authorized to Consent for Consumer (where applicable) Date

_____
Relationship to Consumer

_____ _____
Witness Signature (if Consumer can not sign his/her name) Date

Appendix E: Consent Form in English

Consent to Participate in a Research Study

And

Authorization to Use and/or Disclose Identifiable Information for Research

Title of the Study: Evaluating the efficacy of interventions for a Hmong refugee community

Principal Investigators: Sarah Palasciano-Barton (phone: 214-682-1638, bartonsn@miamioh.edu) and Virginia Wickline, Ph.D. (phone: 513-217-4180, email: wicklivb@miamioh.edu)
Mailing Address: Sarah Palasciano-Barton
Department of Psychology, Miami University
90 N. Patterson Ave.
Oxford, OH 45056

Invitation

You are invited to participate in this research study about the health needs of the local Hmong community and the impact Kajsiab House has hand on your health and daily functioning. In order to participate you must be of Hmong descent, currently be 18 years of age or older, and have accessed services at Kajsiab House during the past year.

By participating in this project, you will help improve our understanding of what services at Kajsiab House have been helpful and what services are still needed to address the needs of the local Hmong community. Approximately 7 to 12 individuals will participate in this study.

Your participation in this research study is voluntary and you may stop participating at any point during the study. There is no penalty for not participating and your services at Kajsiab House will not be affected if you decide not to participate.

A. What is the purpose of this study?

The purpose of the research is to examine the impact of services provided by Kajsiab House on the local Hmong community. We will be evaluating how well the services provided address the needs of the community more specifically related to mental health and empowerment.

Results from the study will be provided to Kajsiab House staff in the form of a report to help them better understand what services help clients at Kajsiab House. The findings will also be presented in a dissertation and published in an academic journal as a manuscript.

B. What will my participation involve?

If you decide to participate in this research you will be asked to complete an in-person interview with an interviewer who speaks Hmong and English, and a researcher who only speaks English. The interview will be held at Kajsiab House, in your home, or at a location of your choosing and will last one to two hours.

During the interviews we will collect general information about you including birth date, income, employment, and current living situation. We will ask you about your current and past mental and physical health, as well as trauma you have experienced. This will include your experiences before, during, and after moving to the United States. We will also ask you questions about your experiences at Kajsiab House, such as what services have been helpful and in what ways they have been helpful. We will also ask about areas in your life you still struggle and what services you think would be helpful if Kajsiab House does not currently offer them.

C. Are there any benefits to me?

Most participants will not benefit immediately from this study. However, results will provide information to the leadership of Kajsiab House about what interventions are effective and which areas need to be improved. We hope that the leadership of Kajsiab House will use these results to improve services for the local Hmong community. The results will also be published in an academic journal in order to inform professionals in the field about the needs of the Hmong community.

D. Will I be paid for my participation?

You will receive $20 worth of rice for participating in this study.

E. Are there any side effects or risks to me?

The main risk of taking part in this study is that you may become upset when describing your progress in treatment as it may remind you of past traumatic experiences. If you become distressed during the interview, you may discontinue at any time. You may also experience some discomfort when speaking with our translator or the researcher (who is not part of your community). Our interviewers will work to make the experience as pleasant as possible and will help you obtain follow-up care if it is necessary.

F. How will my privacy be protected and who will use my health information?

All information collected will be stored in a secure location so that no one besides you and the researchers can see it. This study will be reporting information about your identity such as your age, gender, and specific details about your experiences. However, we will not report your name. This information is important to understand the experiences of each participant and how the specific services at Kajsiab House have impacted your life and your community. The information collected from you during this study will be used by the researchers from Miami University. The results from the study will be shared with Kajsiab House staff leadership, used for a dissertation, and published in an academic journal.

G. Is my permission voluntary and may I change my mind?

Yes, your permission is voluntary. You do not have to provide verbal consent or sign this form and you may refuse to do so. If you refuse to sign this form, however, you cannot take part in this research study.

You may completely withdraw from the study at any time during participation. If you want to withdraw from the study after it has begun, please inform the translator and or researchers and you will still receive full payment. If you withdraw, your information will be removed from the study.

If you decide not to participate in this study or if you stop while the study is underway, the health care you receive from Kajsiab House will not be affected in any way.

H. How long will my permission to use my health information last?

By verbally consenting and signing this form you are giving permission for your personal information to be used by and shared with the individuals and institutions described in this form. Unless you withdraw your permission in writing to stop the use of your health information, there is no end date for its use for this research study. You may withdraw your permission at any time by writing to the person whose name is listed below:

Sarah Palasciano-Barton
Department of Psychology, Miami University
90 N. Patterson Ave.
Oxford, OH 45056

If you do not speak English you may contact Doua Vang (phone: 608-280-4760) or Frederick Coleman (phone: 608-280-2700) and they will assist you with contacting the researchers listed above.

Beginning on the date you withdraw your permission, no new information about you will be used. Any information that was shared before you withdrew your permission will continue to be used.

J. Who should I contact if I have any questions?

Please take as much time as you need to think over whether or not you wish to participate. If you have any questions about this study at any time please contact Sarah Palasciano-Barton (phone: 214-682-1638, e-mail: bartonsn@miamioh.edu) or call Virginia Wickline (phone: 513-217-4180, e-mail: wicklivb@miamioh.edu).

If you do not speak English you may contact Doua Vang (phone: 608-280-4760) or Frederick Coleman (phone: 608-280-2700) and they will assist you with contacting the researchers listed above.

AGREEMENT TO PARTICIPATE IN THIS STUDY AND PERMISSION TO USE AND/OR DISCLOSE MY PERSONAL INFORMATION

I have been read this consent and authorization form by a translator which describes the research study procedures, risks, and benefits, what personal information will be used, and how my personal information will be used. I have had a chance to ask questions about the research study, including the use of my personal information, and I have received answers to my questions. I understand that this study will be reporting information about my identity such as my age, gender, and specific details about my experiences, but will not report my name. I agree to participate in this research study and permit the researcher to use and share my personal information as described during the consent process.

** YOU SHOULD RECEIVE A COPY OF THIS FORM AFTER SIGNING IT**

_____

Name of Participant (please print)

_____ _____

Signature of Participant Date

_____ _____

Signature of person obtaining consent and authorization Date

WITNESS:

I served as a witness to the consent process and agree that the content of this authorization form was conveyed orally to the participant.

_____

Name of Witness (please print)

_____ _____

Signature of witness to consent and authorization Date

Appendix F: Consent Form in Hmong

Kev Pom Zoo Mus Koom Qhov Kev Tshawb Fawb

Thiab

Kev Tso Cai Siv thiab/lossis Tshaj Tawm Cov Ntaub Ntawv Uas Muaj Tus Kheej Ntiag Tug Lub Npe rau Qhov Kev Tshawb Fawb

Lub Npe ntawm Qhov Kev Tshawb Fawb: Kev tshuaj ntsuam xyuas txog kev pab txhawb tau zoo ib tug neeg Hmoob thaj nam

Cov Kws Tshuaj Ntsuam: Sarah Palasciano-Barton (xov tooj: 214-682-1638, bartonsn@miamioh.edu) thiab Virginia Wickline, Ph.D. (xov tooj: 513-217-4180, email: wicklivb@miamioh.edu)

Qhov Chaw Xa Ntawv: Sarah Palasciano-Barton

Department of Psychology, Miami University

90 N. Patterson Ave.

Oxford, OH 45056

Daim Ntawv Caw

Koj raug caw mus koom qhov kev tshawb fawb ntsig txog feem xav tau kev saib xyuas kev noj qab haus huv rau ntawm lub zos Hmoob thiab qhov ua tau tshwm sim txog kev saib xyuas kev noj qab haus huv rau koj txhua hnub los ntawm lub chaw Kajsiab House. Koj yuav tsum yog neeg Hmoob, tam sim no muaj hnub nyoog 18 xyoo lossis siab dua thiab tau txais kev saib xyuas rau ntawm lub chaw Kajsiab House hauv lub xyoo dhau los koj thiaj tuaj yeem mus koom qhov kev tshawb fawb no tau.

Qhov mus koom qhov kev tshawb fawb no, koj yuav pab ua kom peb nkag siab zoo txog cov kev saib xyuas rau ntawm lub chaw Kajsiab House seb muaj txiaj ntsig zoo li cas thiab yuav muab kev saib xyuas dab tsi ntxiv thiaj li pab daws tau yam xav tau ntawm lub zos Hmoob hauv ib cheeb tsam no. Yuav muaj thaj tsam li 7 txog 12 leeg mus koom qhov kev tshawb fawb no.

Kev mus koom qhov kev tshawb fawb no yog kev yeem dawb xwb thiab tuaj yeem tso tseg tsis mus koom rau thaum ib lub sijhawm uas tseem ua qhov kev tshawb fawb no. Nws yeej tsis muaj

kev nplua dab tsi thiab tsis cuam tshuam dab tsi rau cov kev saib xyuas koj rau ntawm lub chaw Kajsiab House yog koj txiav txim siab tsis mus koom.

A. Lub hom phiaj ntawm qhov kev tshawb fawb no yog dab tsi?

Lub hom phiaj ntawm qhov kev tshawb fawb no yog tshuaj xyuas qhov tshwm sim tau los ntawm cov kev saib xyuas uas lub chaw Kajsiab House tau muab saib xyuas rau lub zos Hmoob. Peb yuav tshuaj ntsuam xyuas seb nws muab kev saib xyuas tau zoo li cas rau hauv lub zos no xws li kev saib xyuas mob hlwb thiab kev pab txhawb nqa.

Qhov ua tau los ntawm qhov kev tshawb fawb no yuav raug muab hais qhia rau cov neeg ua haujlwm ntawm lub chaw Kajsiab House kom lawv thiaj li nkag siab tau zoo thiab pab saib xyuas rau cov neeg qhua rau ntawm lub chaw Kajsiab House tau zoo ntxiv. Yam tshawb nrhiav tau los kuj yuav raug muab luam tawm thiab raug muab tshaj tawm rau hauv cov ntaub ntawv xov xwm sau qhia ua kev paub.

B. Qhov kuv mus koom no yuav tau ua dab tsi xwb?

Yog koj txiav txim siab mus koom qhov kev tshawb fawb no, lawv yuav xam phaj koj nrog ib tug kws txhais lus ua lus Hmoob thiab lus Askiv, thiab ib tug kws tshawb fawb uas tsuas paub hais lus Askiv xwb. Qhov xam phaj no yuav xam phaj rau ntawm Kajsiab House, hauv koj lub tsev, lossis rau ntawm ib qho chaw raws li koj xaiv thiab yuav siv sijhawm ntev li ib txog ob teev.

Thaum lub sijhawm xam phaj peb yuav sau koj lub hnub yug, cov nyiaj khwv tau los, kev ua haujlwm, thiab kev ua neej nyob tam sim no. Peb yuav nug koj txog kev mob hlwb thiab mob ib ce ntawm koj tam sim no thiab yav dhau los thiab qhov koj muaj mob yav dhau los. Tej no muaj xws li yam koj muaj mob ua ntej, thaum lub sijhawm thiab tom qab koj tsiv tuaj nyob rau Teb Chaws Meskas. Peb kuj yuav nug koj txog qhov koj mus saib xyuas rau ntawm lub chaw Kajsiab House, xws li yam kev saib xyuas uas muaj txiaj ntsig zoo rau koj yog dab tsi thiab vim li cas thiaj li muaj txiaj ntsig. Peb kuj yuav nug koj txog yam koj tseem muaj teeb meem kev nyuaj siab yog dab tsi thiab yam kev saib xyuas uas koj xav tias yuav muaj txiaj ntsig rau koj tab sis lub chaw Kajsiab House tseem tsis tau muab saib xyuas rau koj tam sim no.

C. Puas muaj txiaj ntsig dab tsi rau kuv?

Feem ntau ntawm cov neeg mus koom qhov kev tshawb fawb no yeej tsis muaj dab tsi rau lawv kiag tam sim ntawd. Txawm li cas los xij, yuav muab yam tshawb nrhiav tau los ntawd qhia rau feem thawj coj ntawm lub chaw Kajsiab House xws li yam kev pab txhawb tau zoo thiab yam yuav tsum tau hloov kho. Peb vam thiab cia siab tias feem thawj coj ntawm lub chaw Kajsiab House yuav siv qhov tshawb nrhiav tau los no coj los tsim kho nws cov kev saib xyuas rau cov neeg hauv lub zos Hmoob no. Qhov tshawb nrhiav tau los no kuj raug muab tshaj tawm rau hauv cov ntaub ntawv xov xwm qhia rau cov kws ua haujlwm saib xyuas rau hauv lub zos Hmoob.

D. Qhov kuv mus koom no puas them nyiaj rau kuv?

Koj yuav tau txais ib qho nyiaj $20 rau qhov mus koom qhov kev tshawb fawb no.

E. Puas muaj mob tshwm sim tsis zoo lossis muaj pheej hmoo tsis zoo rau kuv?

Feem ntaus tsuas yog ua rau koj xav tsis tawm thaum koj piav qhia txog kev khomob rau koj vim pheej hais txog qhov muaj mob ntawm koj yav dhau los. Yog koj nyuaj siab thaum lub sijhawm xam phaj, koj tuaj yeem tsum tau thaum lub sijhawm twg los tau. Tej zaum koj yuav ntxhov siab me ntsis thaum tham nrog peb tus kws txhais lus lossis tus kws tshawb fawb (tus neeg uas tsis nyob hauv koj lub zos). Peb cov kws txhais lus yuav ua kom tsis nyuaj siab thiab yuav pab koj taug qab xyuas kev saib xyuas mob nkeeg yav dhau los.

F. Yuav pov thaiv kuv tus kheej ntiag tug li cas thiab leej twg yuav siv kuv cov ntaub ntawv kev noj qab haus huv?

Yuav tsum khaws txhua cov ntaub ntawv rau ntawm ib qho chaw ruaj khov yog li ntawd thiaj tsis muaj leej twg saib tau, tsuas yog koj thiab cov kws tshawb fawb thiaj li saib tau nkaus xwb. Qhov kev tshawb fawb no yuav sau txog koj tus kheej ntiag tug xws li koj lub hnub nyoog, qhov yog txiv neej los yog poj niam, thiab tej yam tshwj xeeb uas koj ntsib. Txawm li cas los xij, peb yuav tsis sau koj lub npe rau daim ntawv teev num. Cov ntaub ntawv no yog ib co ntaub ntawv tseem ceeb ua rau nkag siab txog yam ntsib dhau los ntawm txhua tus neeg thiab paub tias cov kev saib xyuas tshwj xeeb rau ntawm lub chaw Kajsiab House tau cuam tshuam zoo li cas rau

koj lub neej thiab hauv koj lub zos. Cov kws tshawb fawb hauv lub tsev kawm ntawv qeb siab Miami University yuav siv cov ntaub ntawv uas muab los ntawm koj thaum lub sijhawm tshawb fawb. Yuav muab qhov ua tau los ntawm qhov kev tshawb fawb no qhia rau lub chaw Kajsiab House cov neeg ua haujlwm, feem thawj coj, raug siv rau kis tsis zoo, thiab raug muab tshaj tawm rau hauv cov ntaub ntawv xov xwm.

G. Kuv qhov pom zoo puas yog kev yeem dawb thiab kuv puas hloov siab tau?

Tau, kev pom zoo ntawm koj tsuas yog kev yeem dawb xwb. Koj tsis tas yuav hais tias pom zoo lossis kos npe rau daim ntawv foos no thiab koj tuaj yeem tsis kam lees kos npe. Yog koj tsis kam lees kos npe rau daim ntawv foos no, koj tsis tuaj yeem mus koom qhov kev tshawb fawb no tau.

Tej zaum koj yuav thov tawm ntawm qhov kev tshawb fawb no tau txhua lub sijhawm thaum lub sijhawm mus koom. Yog koj xav tawm ntawm qhov kev tshawb fawb no tom qab twb pib ua lawm, thov qhia rau tus kws txhais lus thiab lossis tus kws tshawb fawb thiab koj tseem tau cov nyiaj them rau koj ntawd tag nrho. Yog koj tawm, yuav muab koj cov ntaub ntawv tshem tawm kom tag hauv qhov kev tshawb fawb no.

Yog koj txiav txim siab tsis mus koom qhov kev tshawb fawb no lossis yog koj tso tseg thaum tseem tab tom ua qhov kev tshawb fawb no, yuav tsis cuam tshuam txog kev saib xyuas mob nkeeg rau koj rau ntawm lub chaw Kajsiab House.

H. Kuv qhov pom zoo cia siv kuv cov ntaub ntawv kev noj qab haus huv yuav ntev npaum li cas?

Kev pom zoo los ntawm hais lus thiab kos npe rau daim ntawv foos no, koj yeej pom zoo cia siv thiab tshaj tawm koj tus kheej cov ntaub ntawv rau cov neeg thiab cov chaw ua haujlwm uas tau hais tseg rau hauv daim ntawv foos no lawm. Tshwj tsis yog koj sau ntawv mus thim koj qhov pom zoo kom tsum tsis txhob siv koj cov ntaub ntawv kev noj qab haus huv, yeej tsis muaj hnub tag rau kis siv rau qhov kev tshawb fawb no li. Tej zaum koj yuav sau ntawv mus thim koj qhov pom zoo tau txhua lub sijhawm rau tus neeg uas muaj npe nyob hauv qab no:

Sarah Palasciano-Barton
Department of Psychology, Miami University
90 N. Patterson Ave.
Oxford, OH 45056

Yog koj hais lus Askiv tsis tau, koj yuav tau hu rau Doua Vang (xov tooj: 608-280-4760) lossis hu rau Frederick Coleman (xov tooj: 608-280-2700) thiab lawv yuav pab txuas lus nrog cov kws tshawb fawb uas muaj npe saum toj saud.

Cov ntaub ntawv tshiab uas hais txog koj yuav tsis raug siv mus ntxiv lawm txij hnub koj pib thim koj qhov pom zoo. Cov ntaub ntawv uas yeej raug muab tshaj tawm ua ntej koj thim koj qhov pom zoo tseem yuav raug siv mus ntxiv.

J. Yog kuv muaj lus nug kuv yuav hu rau leej twg?

Koj yuav tsum tau xav ntau lwm tias koj puas xav mus los yog tsis mus koom qhov kev tshawb fawb no. Yog koj muaj lus nug txog qhov kev tshawb fawb rau thaum ib lub sijhawm twg, thov hu rau Sarah Palasciano-Barton (xov tooj: 214-682-1638, e-mail: bartonsn@miamioh.edu) lossis hu rau Virginia Wickline (xov tooj: 513-217-4180, e-mail: wicklivb@miamioh.edu).

Yog koj hais lus Askiv tsis tau, koj yuav tau hu rau Doua Vang (xov tooj: 608-280-4760) lossis hu rau Frederick Coleman (xov tooj: 608-280-2700) thiab lawv yuav pab txuas lus nrog cov kws tshawb fawb uas muaj npe saum toj saud.

KEV POM ZOO MUS KOOM QHOV KEV TSHAWB FAWB THIAB TSO CAI CIA SIV THIAB/LOSSIS TSHAJ TAWM KUV TUS KHEEJ COV NTAUB NTAWV

Ib tug kws txhais lus twb nyeem daim ntawv pom zoo thiab daim ntawv foos tso cai no rau kuv mloog lawm, cov ntaub ntawv no hais txog txheej txheem ua, feem muaj pheej hmoo tsis zoo, thiab cov txiaj ntsig los ntawm qhov kev tshawb fawb no, thiab tus kheej cov ntaub ntawv yuav raug siv li cas thiab koj tus kheej cov ntaub ntawv yuav raug siv li cas. Kuv yeej muaj sijhawm nug txog qhov kev tshawb fawb no, suav txog kev siv kuv cov ntaub ntawv thiab kuv twb tau txais cov nqe lus teb rau kuv cov nqe lus nug lawm. Kuv nkag siab tias qhov kev tshawb fawb no yuav hais qhia txog kuv tus kheej ntiag tug xws li kuv lub hnub nyoog, qhov yog txiv neej los

yog poj niam, thiab tej yam tshwj xeeb uas kuv ntsib dhau los, tab sis yuav tsis sau kuv lub npe. Kuv pom zoo mus koom qhov kev tshawb fawb no, thiab tso cai cia tus kws tshawb fawb siv thiab tshaj tawm kuv tus kheej cov ntaub ntawv raws li tau piav tseg rau hauv qhov txheej txheem lus pom zoo.

** KOJ YUAV TAU TXAIS IB DAIM NTAWV FOOSTHEEJ NTAWM DAIM NTAWV FOOS NO TOM QAB KOS NPE**

_____

Tus Neeg Mus Koom Lub Npe (thov sau)

_____ _____

Tus Neeg Mus Koom Kos Npe Hnub

_____ _____

Tus neeg tau txais kev pom zoo thiab kev tso cai kos npe Hnub

TUS NEEG UA POV THAWJ:

Kuv yog ib tug neeg ua pov thawj rau daim ntawv pom zoo no thiab kuv pom zoo tias cov ntaub ntawv ntawm daim ntawv tso cai no yeej raug muab hais tawm rau tus neeg mus koom lawm.

_____

Tus Neeg Ua Pov Thawj Lub Npe (thov sau)

_____ _____

Tus neeg ua pov thawj pom zoo thiab tso cai kos npe Hnub

Appendix G: Debriefing Form in English

Debriefing Form

Thank you for participating in our study. By participating in this project you have helped improve our understanding of what services at Kajsiab House have been helpful to you and your community and what services are still needed to address the needs of the local Hmong community. The purpose of the research is to better understand your experiences as a Hmong community member and how well the services provided at Kajsiab House address your needs and the needs of the community related to mental health and empowerment.

If you have any additional questions or would like a more detailed description of the study and questions answered, please contact the researchers at the information listed below. If you do not speak English, you may contact either Doua Vang or Dr. Frederick Coleman at the contact information listed below and they will assist you with contacting the researchers.

Researchers (for English speakers):

- Sarah Palasciano-Barton (phone: 214-682-1638, email: bartonsn@miamioh.edu)
- Virginia Wickline, Ph.D. (phone: (phone: 513-217-4180, e-mail: wicklivb@miamioh.edu).

Kajsiab House contacts (for non-English speakers):

- Doua Vang (phone: 608-280-4760)
- Dr. Frederick Coleman (phone: 608-280-2700)

Appendix H: Debriefing Form in Hmong

Daim Ntawv Foos Nug Tom Qab Tshawb Fawb Tag

Ua tsaug uas tuaj koom peb qhov kev tshawb fawb. Qhov mus koom qhov kev tshawb fawb no, koj tau pab ua kom peb nkag siab zoo txog cov kev saib xyuas rau ntawm lub chaw Kajsiab House seb muaj txiaj ntsig zoo li cas rau koj thiab koj lub zos thiab yuav muab kev saib xyuas dab tsi ntxiv thiaj li pab daws tau yam xav tau ntawm lub zos Hmoob hauv ib cheeb tsam no. Lub hom phiaj ntawm qhov kev tshawb fawb no yog ua kom nkag siab zoo ntxiv txog yam koj ntsib thiab pom raws li yog ib tug tswv cuab nyob hauv lub zos Hmoob no thiab Kajsiab House tau muab kev saib xyuas mob hlwb thiab pab txhawb nqa rau koj thiab cov neeg hauv lub zos tau li cas.

Yog koj muaj lus nug ntxiv dab tsi lossis yog koj xav kom piav qhia ntxiv txog qhov kev tshawb fawb no thiab cov nqe lus teb rau cov nqe lus nug no, thov hu rau cov kws tshawb fawb raws li muaj npe hauv qab no. Yog koj hais lus Askiv tsis tau koj tuaj yeem hu rau Doua Vang lossis Dr. Frederick Coleman rau ntawm tus xov tooj hauv qab no thiab lawv yuav los pab txuas lus nrog cov kws tshawb fawb.

Cov Kws Tshawb Fawb (rau cov neeg hais Lus Askiv):

- Sarah Palasciano-Barton (xov tooj: 214-682-1638, email: bartonsn@miamioh.edu)
- Virginia Wickline, Ph.D. (xov tooj: (xov tooj: 513-217-4180, e-mail: wicklivb@miamioh.edu).

Kajsiab House cov xov tooj (rau cov neeg hais lus Askiv tsis tau):

- Doua Vang (xov tooj: 608-280-4760)
- Dr. Frederick Coleman (xov tooj: 608-280-2700)