2021

Younger Hmong People's Willingness to Communicate About Depression

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Younger Hmong People's Willingness to Communicate about Depression

By

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A Thesis Submitted in Partial Fulfillment of the

Requirements for the degree of

Master of Arts

In

Communication Studies

Minnesota State University, Mankato

Mankato, MN

November 2021

November 16, 2021

Title: Young Hmong People's Willingness to Communicate about Depression

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This thesis has been examined and approved by the following members of the student's committee.

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Acknowledgements

I would like to thank my thesis advisor and mentor, Dr. Anne Kerber. Your guidance and thoughtful feedback with questions and comments improved my knowledge and writing skills. And I would like to thank my second committee member, Dr. Deepa Oommen for providing insights in my project. And your role as a graduate course director has helped me throughout my graduate school years. I would like to thank my out-of-department committee member, Dr. Marlene Tappe for providing insights and more writing assistance. I would like to thank the Communication Studies Department for accepting me into their program, especially to professors who helped developed ideas writing drafts for my thesis. I would like to thank two of my supervisors: Dr. Laura Jacobi and Dr. Emily Sauter for supporting me when I was a teaching assistant. During my graduate school years, I would like to thank all my friends and colleagues, especially to my cohort: Enamul Kabir, Laurie Hiebert, Katrina Cronk, Nicholas Jurney, Richard Gadotor, Tony Comer, Jake Westpfahl, and Cecelia Otto-Griffiths. I would also like to thank Anthony Peavy for encouraging me to maintain positivity throughout my graduate school years. Also, during my first year of graduate school, I would like to thank my friend, colleague, and peer mentor Nolan Brinkman. Also, I would like to thank my undergraduate professors for helping me achieve my educational goals and reaching my destination where I am today

I would like to thank my family for their love, happiness, and support. My mother provided significant insights in my project. Thank you Niam (mother in Hmong). My father supported me as well. Thank you Txiv (father in Hmong). Next, I would like to

thank scholars including Mr. Yue Pheng Xiong and Dr. Lee Pao Xiong for providing me insights into Hmong history. Also, I like to thank other scholars, especially those included in my project.

And I would like to thank my friends, especially to one group I always connect with. During difficulties writing this project, all your humor have support me. Also, I would like to thank my former supervisors, manager, staff members, and co-workers at College Possible for their words of encouragement succeeding in graduate school. And I would like to thank my participants for their important insights about this topic. Without your support, this project would be not completed.

And I would like to thank and honor the veterans for their role in the Vietnam War, especially to my grandfather who served in the war.

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Abstract

This research examines the underlying issues about mental illness, particularly depression within the Hmong community. Previous scholars have focused on the Hmong culture's origins, mental health status of Hmong refugees arriving in the United States, martial roles and mental health on Hmong females, and comparisons of Hmong traditional healing and Westernized medicine. These studies intersect in fields including psychology, medicine and public health, Hmong history, and social work. However, one missing component to this body of scholarship has been communication. Thus, my study focused on younger Hmong people's willingness to communicate about depression within their families. Specifically, I conducted semi-structured interviews with five Hmong participants (three males, two females) ages 18-35 and conducted a thematic analysis of the data. Findings indicated the importance of maintaining and communicating family identity and barriers preventing Hmong people talking about depression. First, results shows that identity and adherence to family is significant in the Hmong culture, gender expectations and traditions are valued, and younger Hmong people maintain intersectional identities that influence how they choose to talk about depression within their dominant culture. Second, participants identified multiple barriers that prevent Hmong people from openly talking about depression, including its lack of visibility; its connection to spiritual and religious beliefs; and its stigmatization within both Hmong and American culture.

Chapter One: Introduction

When someone asks you to describe your "history," how do you respond? For many people, knowing about your cultural and historical roots is key to understanding your identity, in that it allows you to narrate yourself to others. Yet, what happens when you do not have clear understanding of your cultural roots? As a first-generation (born in the United States) Hmong American, this is an issue that I often experience. A case in point: During my master's program, I was in the graduate students' office one day working on a paper. Nearby, two colleagues (both from a different race and ethnic background) engaged in a lively conversation about their cultures' spiritual perspectives. One of my colleagues suddenly asked me what my culture thinks about spirits. I briefly paused to think about it. But my colleague sensed my hesitation, and responded that I was "too Americanized." Although his quick response brought a sense of shame, it also heightened my consciousness of needing to know more about my ethnic identity. After all, how could I explain the experiences of being Hmong if I did not know about my culture's spiritual perspectives?

I had previously experienced this need to both learn and share more about the Hmong culture during my high school's American history class. One day in the middle of the semester, we were told to read a chapter about the Vietnam War. I knew the war was a critical chapter in the history of the Hmong community, one that had left lasting cultural traumas for many Hmong families. It also had a significant impact on the prevalence of mental illness among Hmong immigrants, as they were displaced from their native lands, forced into refugee camps, and eventually resettled into the United States (Westermeyer

et al., 1984; Westermeyer, 1988). My parents had experienced many obstacles during the war, and it played an important role in their migration to the United States. When I opened the book, I felt confident it would include information about the Hmong community's support of the United States war efforts, and people would appreciate our involvement. Yet, I found no references to the Hmong. The erasure of the Hmong's role in the war surprised and confused me. It is not surprising that Americans still ask "What is Hmong?" and lack an understanding of their origins, culture, and understanding of how the war affected them. Even my own understandings of my cultural history, as a first-generation immigrant, are incomplete. Yet, there is no doubt this history has and will continue to affect me, by shaping the experiences of my parents and other older members of the Hmong community who have helped to frame my worldview.

My study represents an effort to help fill in the gaps of my cultural history while simultaneously connecting the topic to my research interests in health communication and psychology. Specifically, my study seeks to explore how family communication shapes the willingness of younger Hmong Americans to communicate regarding depression. Segrin (2013) stated, "Depression is one of the most pervasive mental health problems in the world" (p. 513). Yet, the Hmong language does not include a word for depression.

Two important individuals helped me develop ideas in finding words describing characteristics for depression. The first individual shared her knowledge about a Hmong term closest to depression. She knows the best of her ability to help me. My relationship with this person is that she is my mother. The second person my mother heard about

through the radio is Yue Pheng Xiong. He is important because he is a well-known Hmong scholar in maintaining Hmong history and culture. I established a relationship with him through his Hmong ABC store in St. Paul, Minnesota. When I had questions, I would ask him about Hmong history and culture. During informal conversations with these Hmong individuals, I learned that there is a word for "health" in Hmong, or 'kev noj qab nyob zoo' (Y.P. Xiong, personal communication, 2019). This term emphasizes a holistic approach to health, or what would be understood as the physical, intellectual, and spiritual dimensions of health in a Western perspective. Although there was no word for depression, the closest word for depression in Hmong is nu-shea (Lee, Lytle, Yang, & Lum, 2010) and more details on that will be explain in the literature review. I wanted to know a Hmong word in describing characteristics of depression. My mother told me that a Hmong Dictionary book describing characteristics of depression is hlwb (lu-lu) lus xav (sa), which indicates the mind (P.H. Xiong, personal communication, 2019). Mr. Xiong stated that kev xav (kay-sa) indicates the way of thinking (Y.P. Xiong, personal communication, 2019). Mr. Xiong further noted that Hmong people do not distinguish between the mind and brain, unlike the differences between the physical organism and nonphysical processes often included in Western medical jargon. Also, in the Hmong community, these communication challenges are culturally tied to language, which will be discuss further.

The lack of language for describing depression has important implications for the Hmong community. Although the Hmong written system was developed by missionaries, there is still no word for depression. Without a way to name or explain the experience of

depression (or other mental illnesses), it can be difficult for Hmong individuals to talk about such issues. Specifically, the lack of language can make it difficult to seek support from families or other members of the Hmong community. Complicating matters further, cultural stigmas and shame often prevent elderly Southeast Asian refugees (SEA) from seeking help outside of their families or community (Lee et al., 2010). Like most mental illnesses, depression is highly stigmatized in American culture (Corrigan & Watson, 2002). Even without a clear language for talking about mental illness, I have often heard Hmong individuals commenting on people's unusual behavior as "crazy," which is undoubtedly hurtful to a person with depression.

Moreover, the lack of vocabulary, along with vastly different cultural and spiritual beliefs, have the potential to constrain mental health practitioners' abilities to assist a Hmong person with depression. For instance, there are no medical terminologies in Hmong culture, which may hinder mental health practitioners' ability to clearly convey meaning (Johnson, 2002). Moreover, Western medicine views mental illness as a biological problem (Cohen-Woods et al., 2013), which contrasts sharply with Hmong perspectives on the spiritual roots of disease.

I am particularly interested in the role of family communication in how younger Hmong individuals come to understand depression as well as their willingness to talk about these issues. There are various factors that can influence a Hmong person's perceptions of and experiences with mental illness such as family types (Thompson et al., 2015), communication patterns (Pecchioni et al., 2015), and the ways in which parents or

other adults function as role models (Arroyo et al., 2016). I explore the role of these issues in more detail in the literature review.

Additionally, I seek to understand the role of intercultural communication in how Hmong people discuss mental health. Second and third-generation Hmong Americans often face issues of acculturation and identity tensions. The now-elderly first wave Hmong refugees who came to the United States frequently put pressure on younger generations to maintain their native culture (Faruque, 2003; Lee & Tapp, 2010, Vang, 2014). Despite interest in keeping their traditional views, younger generations also want to become more Americanized, which causes intrapersonal conflict and stress (Tatman, 2004). Thus, the process of navigating the dominant culture (Americanized) than their native culture (Hmong) can create mental health concerns for younger Hmong Americans.

Rationale

My project will study how younger members of the Hmong culture perceive and communicate about depression. Existing research has examined mental health within the Hmong culture from psychological, medical, and historical perspectives. For instance, multiple studies have focused on the prevalence of mental health concerns within the Hmong community following their arrival in the United States (Vang, 2014; Westermeyer, 1988; 1984). Most of this research is dated and was conducted between the late 1970's through the 1990's (Vang, 2014). Additionally, the existing literature focuses specifically on the first generation of Hmong-American immigrants, those who arrived here as adults and children. (It should be noted that Dr. Xiong considers them Generation

1.5; L.P. Xiong, personal communication, July 6, 2021). Vang (2014) noted that there is a lack of research on the mental health status of second-generation Hmong-Americans, or subsequent generations of Hmong who were born in the United States. My study aims to address this gap in the literature by focusing on the experiences of second- and third-generation Hmong Americans.

Moreover, there is little to no research that has specifically explored how the Hmong community's understandings of mental illness is shaped by multiple and intersecting communicative forces. As I discuss in the literature review, perceptions of depression are developed relationally, particularly through families and cultures. Additionally, the Hmong experience is compounded by cultural and historical legacies of trauma, forced migration, and acculturation. Hearing the stories of younger Hmong is undoubtedly valuable for understanding these experiences, and learning more about the differences between Hmong and Western perspectives on health. However, I am interested in understanding how these legacies are taken up in family communication about depression.

Exploring why depression is such a difficult topic for younger Hmong people to address is socially significant for multiple reasons. First, historic research has indicated a disproportionate prevalence of mental illness within the Hmong community, as compared to general Western populations (Westermeyer, 1988). Second, although there is little research on the prevalence of depression among younger Hmong-Americans, studies indicate mental illness are more common in younger generations in general. Lee (2007) conducted a research study on 50 first-generation young Hmong university students and

founded five variables that affected their mental health: frequent crying spells, not sleeping well, future rarely looking bright, feeling downtrodden, and situation being hopeless. My study examines underlying issues about how younger Hmong people communicate within the family context about depression. Additionally, I seek to explore communicative strategies for reducing the stigma surrounding depression in Hmong families.

Because my study focuses on how Hmong community members make sense of depression, I plan to use a phenomenological perspective. Faruque (2003) explained that the phenomenological perspective, "seeks to understand the life experiences of individuals and their intentions within the world around them" (p. 34). This perspective allows me to understand the lived experiences of how participants talk about depression within their families. My participants' experiences are unique and they illustrate the complex emotions, and relational and identity implications that emerge from such conversations.

In addition, I used self-reflexive practices that are consistent with a phenomenological perspective. Johnson (2009) stated a self-reflexive researcher is "actively engaged in critical self-reflection about his or her potential biases and predispositions" (p. 160). This is important because it allows me to examine how my standpoints, thoughts, and feelings will shape the way I interpret participants' perspectives. For example, Tracy (2013) shared how her own demographic characteristics (i.e., being an aunt, forty-something, and female) affects how she views a research topic. I identify as Hmong, thirty years old, male, and first-generation Hmong American. In

particular, my age and identification as Hmong provides me with some initial insights into how younger Hmong people think and talk about depression. I will be more primed in my research since I can notice both western and Hmong perspectives on depression. Also, I am a younger Hmong member, which allows me to connect easier to the younger Hmong community.

My study also privileges emic, rather than etic perspectives. Tracy (2013) explained emic perspectives as, "Understandings of the scene, which means that behavior is described from the actor's point of view and is context-specific" (p. 21). I intend to do take an emic approach in two ways: First, as a cultural insider, I will reflect on how participants' perspectives reflect experiences unique to Hmong communities. Second, my interpretations will be drawn from participants' perspectives, with an emphasis on how they account for family communication about depression and how it has shaped their understandings of this condition. I was born after many of the events that Hmong people encountered, especially the Vietnam War. Thus, I cannot share my personal experience but will share from the perspectives of individuals who experience the different events through text. As a reminder to my audience, Hmong people have their own experiences of interpreting certain events. For instance, each individual has a unique perspective on the war, the eventual resettlement in the United States, and acclimating to American culture. Thus, I have done my best to recount Hmong history and events generally, using them to provide context for the issues affecting Hmong people's mental health status, particularly depression.

Research Question

RQ1: How do younger Hmong people communicate with their family members about depression?

Precis of Remaining Chapters

Chapter Two focuses on the literature that will establish the purpose of conducting this research. In this section, I examine previous research that has focused on the intersections of family, intercultural, and health communication. These intersections are significant to explore to give further insights into how Hmong people talk about depression in their families. Furthermore, I provide some historical context about the origins of the Hmong community. I focus particularly on the Hmong involvement in the Vietnam War, and their acculturation into the United States as factors influencing the prevalence of mental illness. Finally, I address cultural differences between Hmong and Western perspectives on medicine, and how that further contributes to challenges of communicating about depression.

Chapter Three focuses on my research methods. I explain my reasons for choosing to use semi-structured, telephone interviews for conducting my study. Additionally, I articulate my recruitment procedures and participants. Finally, I conclude with my approach to analyzing my data.

Chapter Four focuses on my results section, where I explain the themes and subthemes that emerged out of conversations with participants.

Chapter Five focuses on my discussion section. I explain my findings' theoretical and practical implications, areas for future study suggested by this research, and this research's limitations.

Chapter Two: Literature Review

It is critical to examine the different threads of communication research that are connected to each other within this paper: family, intercultural, and health communication. I argue the interrelationships between these forms of communication contribute to how mental illness is perceived in the Hmong community. From an intercultural communication perspective, the Hmong have a unique language, traditions, beliefs, and shared history that creates and shapes their identity. Importantly, many of their shared beliefs are rooted in shamanism, which views depression as a spiritual problem. In terms of family communication, the Hmong community is a collectivistic culture, and is heavily reliant on families and fellow community members for social support. When depression is viewed as a spiritual problem, it can present relational challenges for individuals who experience this condition to seek and receive support from their families. Thus, having depression from a spiritual problem is viewed as a supernatural phenomenon, which cause families to distress. The supernatural phenomenon is unknowable, which requires a Hmong shamanism to diagnose using traditional artifacts and rituals in treating mental illness, particularly depression. Finally, from a health communication perspective, mental illnesses like depression take a toll on an individual's identity as well as their relationships with others in personal and professional aspects of their lives. Moreover, mental illness also impacts other aspects of a person's health. Given the importance of the intersections of family, intercultural, and health communication, I will address each of these areas in my literature review. Furthermore, I will talk about the history of the Hmong culture and how it contributes to

the ways Hmong people experience depression. To begin, I address the confluence of family and health communication.

Family and Health Communication

Before discussing how communication within families is essential to health, it is important to define what families are. Thompson et al. (2015) stated, "Scholarly and lay definitions of family vary widely" (p. 2). The most common types of family configurations in Hmong culture are traditional and Americanized. These are often tight-knit family structures in Hmong families that are also connected with larger clans for support.

Researchers have also noted that communication within families can take multiple forms. Ritchie and Fitzpatrick (1990) articulated two primary patterns, which is conformity-orientation and conversation-orientation. There is a high conformity-orientation and low conformity-orientation. High conformity-orientation is when families display unity in attitudes, beliefs, and values (O'Neil et al., 2004). Families establish these characteristics in bonding and helping each other. Low-conformity families do not emphasize on the importance of maintaining bonds with each other, which in turn affects the quality and quantity of family communication. On the other hand, Ritchie and Fitzpatrick (1990) further noted in conversation orientation that parents emphasize on being open and using frequent communication. High conversation-orientation families engage in frequent communication about family life and interaction (O'Neil et al., 2004). Low conversation-orientation families have much less frequent communication between members. The limited interaction in such families can lead children to view their family

structure negatively. Typically, Hmong families emphasize high conformity. The Hmong culture tends to be collectivistic, with members maintaining strong ties to immediate family and clan members. For instance, when a family member with a health condition seeks support, immediate family and clan members make the decisions on how to best treat the ill person (Johnson, 2002). Thus, they frequently engage conversations on how to best support the individual with mental health (Johnson, 2002).

Moreover, there are four specific types of family communication patterns that develop as a result of the family's conformity and conversation orientations: consensual, pluralistic, protective, and laissez-faire. The family communication patterns associated with more open communicative styles are consensual and pluralistic, whereas protective and laissez-faire patterns tend to indicate less family communication (O'Neil et al., 2004). However, the connection between openness and perceived autonomy within family structures is complicated. For instance, consensual families typically encourage others to openly express ideas, but their conformity orientation also indicates the importance of the traditional hierarchy within a patriarchal family. Pluralistic families allow for the expression of new ideas, but parents usually do not control their children and allow them to make their own decisions (O'Neil et al., 2004). Protective families frequently require following obedience and maintaining loyalty, but provide very little explanation or willingness to engage in dialogue with children (O'Neil et al., 2004). Laissez-faire families appear uninvolved, requiring members to make their own decisions without guidance (O' Neil et al., 2004). Pecchioni et al. (2015) stated, "Family communication emphasizing personal self-reliance, family cohesion, and alternativeness

leads to the most positive outcomes, whereas controlling, critical, overprotective, and distracting behaviors are associated with negative health outcomes" (p. 2). A Hmong family is typically a mixture of consensual and protective family. Most maintain a traditional hierarchy within a patriarchal family, with men as the heads of households. Additionally, Hmong children are frequently expected to demonstrate obedience towards their parents and elders (Duffy et al., 2004). Specifically, family communication patterns have the potential to influence whether and how a person who experiences depression talks about it. A family's open communicative style allow opportunities for interactions, whereas a family's lack of communication provides fewer opportunities for interaction.

Family Talk about Health

Health is often a subject of communication within families, and, as noted above, can have important implications for health. For instance, families have conversations about various health topics, such as talking to adolescents about sex and drugs; discussing how family dinners impact nutrition; or addressing how the aging process affects driving skills (Pecchioni et al., 2015). Each of these topics influences families' daily decisions related to personal and overall family health. Additionally, family members frequently expect support from their families about health topics. For instance, a family's openness (or lack thereof) to conversations about an illness can influence both the affected individual's and the family's coping abilities (Pecchioni et al., 2015). Health communication research indicates that a family's overall communication dynamics play an important role in how both individuals and the family (as a unit) talk about health-related issues (Pecchioni et al., 2015).

Parents are also role models for structuring how healthy behaviors and conversations about health should be displayed for children (Arroyo et al., 2016). If specific behaviors are positively reinforced, then children are likely to follow those reinforced behaviors (Arroyo et al., 2016). Thus, if parents display poor health behaviors, then those behaviors will likely influence children to make similar choices. In addition, Curran et al. (2017) stated, "Clearly, children learn how to communicate as a parent based, in part, on observing their parent's behaviors. The specific types of communicative messages reviewed above relate directly to conformity and conversation orientation" (p. 280). Specifically, parents' display of health behaviors and conversations also illustrates their attitudes and beliefs (Pecchioni et al., 2015). For example, when families display poor health behaviors or limited willingness to discuss a health-related issue, it stands to reason that children would develop similar behaviors, attitudes, and beliefs.

Family Communication and Mental Illness

Family communication can have important implications related to mental health and illness. First, the early development of a child's relationship with their primary caregiver influences the mental health outcomes. One particular parent-children interaction pattern that is linked to numerous mental health problems is "affectionless control" (Segrin, 2013). Parents within this view overprotect and use excessive care to control the child without any rationale (Segrin, 2013). However, this is not the only communication pattern related to poor mental health outcomes. Harmon and Schrodt (2012) stated, "Family communication environments that are supportive but lack firm

guidance and parental expectations, children may be less likely to develop effective decision-making skills that lead to a healthier mental well-being" (p. 155). If there is no or limited parental guidance, children are less likely to find ways to adapt to life stresses that impact their mental health. Furthermore, the presence of a family member with mental illness can create significant disruptions to family communication patterns (Segrin, 2013). For example, a parent's mental illness can affect the relationship they have with their child (Curran et al., 2017). Additionally, families that have one or more family members with depression have more conflict and hostility, and less communication than families whose members do not have depression (Downey et al., 1990). The changes to these communication patterns can also affect personal and familial identities as well. An individual with mental illness living with a family member can make that family member view their life as abnormal or deviant, compared to other family members (Sporer & Toller, 2017).

Talking About Depression in Hmong Families

Talking about depression within Hmong families is often challenging, even though it is the most prevalent mental health diagnosis for Hmong Americans (Lee, 2013). Despite the increased recognition of mental illness and availability of cost-effective treatment (Stuart, 2016), individuals are less willing to discuss mental health than physical health because of social stigma. Goffman (1963) defined stigma as "an attribute that is deeply discrediting" that reduces someone "from a whole and usual person to a tainted, discounted one" (p. 3). The stigma surrounding mental illness is particularly strong within the Hmong community, as it is often perceived as bringing

shame to the individual and their family (Tatman, 2004). Also, with bringing shame to themselves and their family, within Southeast Asian cultures, disclosing a mental illness leads to a loss of face, or identity (Lee et al., 2010). Hmong men have more difficulties expressing their emotions about mental illness, particularly depression (Tatman, 2004). Since depression is often viewed negatively in the Hmong community, children are likely to learn and display negative behavioral characteristics to those who disclose or demonstrate outward symptoms of depression. It is important to understand the source of these attitudes in order to develop applied communication interventions that would empower Hmong families to discuss mental health issues like depression more openly.

Family and Intercultural Communication

Although understanding the ways families communicate about depression is important, it is equally valuable to understand how such communication patterns are influenced by cultural histories. The historical experiences of the Hmong community are salient to both the prevalence of depression and how the condition is perceived within this group. This section begins by tracing the history and the Vietnam War migration to understand the legacies of trauma and displacement affecting the Hmong community. Then, I explore the impacts of acculturation on mental health. I conclude by contrasting cultural perspectives related to depression, and discussing their implications for intergenerational communication within the Hmong community.

Origins of Hmong Culture

It is important to examine the historical context of how Hmong people migrated to the United States to fully understand and contextualize how mental illness is

understood within this ethnic group. First, it should be noted the Hmong have no written records of their history. As a result, the culture's origins have sparked speculation and debate among scholars and community members (Yang, 2009; Duffy et al., 2004). Lee (2008) noted many theories of the Hmong origins including the mythical, biblical/Caucasian, genetic, linguistic, Middle-East/Siberia, and China in the North, East, South, West, and Center. One theory is the Hmong people originated from Mongolia because of the similar pronunciation between Hmong and Mongolia, sounding like 'Mong.' Savina (1924) argued that Hmong people originated from Mongolia, along possessing blue eyes and blond hair, but there is no evidence to support this claim. However, there is no correlation in relating the Hmong to Mongolia due to their different words and religious rituals (Yang, 2009). Also, the Hmong have folk tales of kings, unlike the emperors and khans found in Mongolia. Additionally, the Hmong were geographically located in jungles, rather than the grasslands of Mongolia (Yang, 2009).

Although the Hmong origins are still debated, China is viewed as the culture's most accurate initial location (Y.P. Xiong, personal communication, 2019; Quincy, 2017). The Hmong faced persecution from China, which led to an uprising. Moreover, the Chinese considered the Hmong as a barbaric influence upon their people (Duffy et al., 2004). A case in point: Miao is considered a derogatory term used for Hmong people since it means a "cat," literally comparing the ethnic group to animals (Yang, 2009; Entenmann, 2005; Yang, 1993). The term provides evidence of how the Hmong people's identity has historically been devalued by other cultures. Yet, according to Schein (2004), the Hmong in China have no issues regarding being called, "Miao." After the uprising,

the Hmong migrated towards different regions including Vietnam, Laos, and Thailand (Hilmer, 2010).

French Colonialism & Japanese War

The historical record is clear in outlining how the Hmong people who lived in Laos from 1893-1954 were oppressed by French colonialism (Lee, 2008). Specifically, the French demanded a corvee (unpaid labor) from Vietnamese and Lao farmers to build a road system as a means to make the region profitable (Hilmer, 2010). There were taxes placed on products such as rice, corn, and animals. In the mountains, Hmong males toiled as captives in gold mines and had horses carrying supplies for the French (P.H. Xiong, personal communication, February 12, 2021). Yang (2016) described further that, "The French were still in Laos, but we felt the heaviness of their influence only once or twice a year when they sent uniformed men to collect taxes from the Hmong villages of Phou Bia Mountain" (p. 66). According to Hilmer (2010), one individual, Pa Seng Thao, described the situation with French, "They [the French] even took our livestock and money… Some of the parents had to sell their children to pay for the taxes. Some parents were so upset that they committed suicide by taking poison" (p. 41). Not only that, Hmong people had to defend themselves from the French in battles. Lee (2008) noted during this time, the Hmong people became politically divided, with one side supporting the French under the Royal Lao government, and the other supporting independence from France. During the second World War, the Hmong allied with the French against the Japanese. Under Japanese rule, both the Hmong and French were persecuted (Hamilton-Merritt, 1993).

The Hmong's cultural legacies of trauma were further expanded and gave way to displacement following their involvement in the Vietnam War.

Vietnam War Migration

Previous research has extensively focused on Hmong people's migration during the Vietnam War to the United States, as well as how this relocation affected their mental health. In 1960-1975, Hmong people worked with the U.S. military, and the Central Intelligence Agency (CIA) in their campaign against the rise of communism in Southeast Asia, including Laos (Rairdan & Higgs, 1992; Vang & Bogenschutz, 2011). This "Secret War" included "a 10-year air and ground campaign that cost an estimated $20 billion" (Duffy et al., 2004, p. 5). Hmong people known as the Royal Lao, especially adults and males as young as twelve, who sided with the United States, engaged in combat against the North Vietnamese and Lao communists, known as the Pathet Lao. Hamliton-Merrtitt (1992) described how General Vang Pao commanded men and boys who left their families in homespun clothes, bringing crossbows and flintlocks to battle. Although some soldiers and their families escaped, others who fought on the front lines left their families behind (P.H. Xiong, personal communication, February 12, 2021). Some Hmong women provided medical aid for Hmong soldiers and civilians (Vang, 2010). The Royal Lao Army and CIA, with its allies (including the South Vietnamese, Laos, and Thailand) utilized artillery conducted airplane strikes, rescued downed American pilots, provided radio contact, and spied against the communists (Hilmer, 2010; Duffy et al., 2004).

Despite the heavy casualties sustained by the Hmong, misperceptions persist about their relationship with the CIA. As Hilmer (2010) noted, "simply saying the CIA

was simply trying to help the Hmong is a bit disingenuous" (p. 85). Specifically, interviews with Americans involved in the war indicate the CIA "didn't promise them anything. They didn't want to be promised anything. That's what a lot of people miss . . . All the Hmong wanted to do was to stay there, and they wanted their freedom" (Hilmer, 2010, p. 85). Stories from Hmong leaders indicate a different narrative, where the CIA wanted to arm them to defend themselves against the communists. One of the most respected and well-known Hmong leaders, General Vang Pao, accepted their offer, saying, "I agree because I read it like this: World War I, World War II, the Americans won. The Vietnamese wouldn't be of a match for them… I felt encouraged, so I agreed" (Hilmer, 2010, pg. 85). Moreover, the documentary film, 'The Meo' showed that there were Hmong people who did not want to be involved in the war (Moser & Curling, 1972). After losing the war, American officials airlifted military personnel and their family out of Long Cheng. However, masses of Hmong civilians struggled to get inside these planes to leave Laos and resettle elsewhere (Vang, 2010; Hamilton-Merritt, 1993). After General Vang Pao departed Laos, it triggered mental health symptoms including depression, and sadness among the Hmong civilians left behind, who had to make difficult decisions about whether to now obey the ruling communists, or flee to hide in the jungles (P.H. Xiong, personal communication, July 12, 2021).

Despite the different perspectives on how the Hmong became involved in the Vietnam War, there is little debate about the trauma it generated for the culture. Following the war, Hmong villages were targeted for extermination by the communists. Hmong soldiers that allied with General Vang Pao and the United States were taken as

prisoners into ‘seminar camps’ under the communist’s new law of controlling Laos (P.H. Xiong, personal communication, July 11, 2021). Furthermore, communists captured some Hmong civilians as prisoners, although some Hmong civilians and soldiers escaped while others disappeared without a trace (Hamilton-Merritt, 1993). Communities were forced to migrate from Laos to escape. However, not every family would survive. Rairdan and Higgs (1992) noted that many died along the way, and families were split. Yang (2008) described in a family memoir, “A third of the Hmong people died in the war with the Americans. Another third were slaughtered in its aftermath” (p. 3). Beyond the war casualties, families were torn apart and scattered as the Hmong fled the communist forces (Hamilton-Merritt, 1993; Yang, 2016).

The migrants sought to escape to refugee camps, with most ending up at the Ban Vinai Refugee Camp in Thailand, which eventually housed more than 45,000 Hmong (Yang, 2008). Yet, the journey was dangerous and required crossing the rapidly moving Mekong River. Hilmer (2010) noted the Hmong people were mountain people and many of them never learned to swim. Therefore, families would often drown while crossing or watch helplessly as others did (Hilmer, 2010). However, there were further challenges for those who made it across. Some Hmong families lost their lives (especially children) during skirmishes with the communists, while other Hmong died from starvation and disease (Xiong P.H., July 11, 2021; Duffy et al., 2004). From 1975-1992, the Hmong lingered in Ban Vinai with assistance of non-profit organizations including “United Nations High Commission for Refugees (UNHCR), the International Organization for Migration (IOM), the International Rescue Committee, Refugees International, and the

Thai Ministry of the Interior" (Minnesota Historical Society, 2015). Eventually, the majority of refugees were resettled in the United States, with some families migrating to France, Germany, Argentina, Australia, and Canada.

Both the war and forced migration inflicted significant trauma upon the Hmong community. Dhooper and Tran (1998) stated, "The war and violence have destroyed their old ways," which included roaming freely and engaging in agriculture" (p. 69). In the camp, refugees experienced hopelessness and powerlessness, along with a case of an undressed young male who cried and missed his parents (Vang, 2010). Refugees also experienced mistreatment and violence from the Thai bodyguards (Quincy, 2017; Yang, 2016). These experiences of displacement from leaving their country, losing their families, and being positioned in a camp hindered Hmong people's mental health. My mother and some other family members have shared their own feelings of sadness in leaving their life and homelands behind while escaping from Laos to the Ban Vinai Refugee Camp (P.H. Xiong, personal communication, 2021).

After the war, Hmong people were divided into three groups (P.H. Xiong, personal communication, 2019). The first group consisted of those who escaped the war, left Laos, and migrated to different places around the world. After the war with the communist conquering Laos, the second group consisted of Hmong people joining the Red Laos (P.H. Xiong, personal communication, 2019). The third group, called, "Chao Fa" is currently living and surviving in the jungles. In addition to losing the fabric of their communities, many Hmong women and men experienced war-related post-traumatic stress disorder (PTSD) (Tatman, 2004). Moreover, when the Hmong were re-settled, the

challenges of adapting to a new and significantly different culture also impacted the prevalence of mental health concerns within their community.

Resettlement and Acculturation

Although some Hmong refugees were resettled in Australia, Canada, and France, the majority immigrated to the United States (Johnson, 2002; Hamilton-Merritt, 1999). Priefer et al. (2010) found that, "In 2010, the largest Hmong population continued to reside in California (91,224), followed by Minnesota (66,181) and Wisconsin (49,240), states that have ranked second and third since the 1990 Census" (p. 2). Also, Priefer et al. (2010) found that the Hmong population for the 2010 Census consisted of, "260,073 persons of Hmong origin were counted in the 50 U.S. states, the District of Columbia and Puerto Rico" (p. 2).

Regardless of where in the United States members of the Hmong community resettled to, early research indicated they faced disproportionately high rates of mental illness; more than double (43%) than the standard rates among Western populations (15-20%) based DSM-III axis 1 diagnoses (Westermeyer, 1988). Although high rates of post-traumatic stress were viewed as contributing to this issue, research by Westermeyer (1988) proposed a diagnosis termed "refugee acculturation syndrome" or "chronic acculturation syndrome" that also played a significant role for Hmong refugees (p. 198). In other words, the acculturation process for refugees coming to what they viewed as an "unfit" environment functioned a source of chronic stress, and triggered specific diagnoses ranging from depression and low self-esteem to obsessive worry and suspiciousness (Tatman, 2004; Westermeyer, 1988; see related arguments by

Westermeyer et al.,1984). For instance, Westermeyer et al. (1984) found that men and the elderly initially expressed more depression, whereas women expressed more fear. More recently, Lee and Chen's (2000) study of Chinese Canadian adolescents supported Westermeyer's claims that acculturation "can adversely affect psychological health and lead to maladjustment" (p. 767).

There were several reasons why the Hmong viewed America as an "unfit" environment for resettlement. The Hmong faced several challenges for adapting to their new environment: language barriers, challenges attaining education, and different cultural practices from their host country (Vang, 2014). Her and Buley-Meisser (2010) stated, "As recently as 1970s, Hmong were still referred as 'migrants of the mountains'" (p. 10). For many, the vast differences between their home environment (in Laos) and a new one (the United States) was unsuitable, and made it difficult for maintaining their native identity. The Hmong community had to adjust to the native language, weather, and daily tasks. For example, one of the main duties for Hmong people in Laos was harvesting and farming, which is only viewed as a daily task in the United States for individuals with access to land and resources (e.g., farmers) that were not available to early refugees. Hmong women expressed fear of walking down the streets since their role in Laos was usually to stay at home (Westermeyer et al., 1984). Kim (1990) stated, "The new environment presents numerous messages and events that do not follow the familiar patterns of the home environment. As strangers, they are subject to pressures to conform to the communication patterns of the home environment" (p. 193). Eventually, the Hmong refugees began to adapt to life in the United States. Hmong men focused on

traditional roles (i.e., fishing, hunting) and/or took on new ones (i.e., welding, auto repair) (Westermeyer et al., 1984). However, there was a significant adaptation period for Hmong people to understand their environment and how American culture operated.

The Next Generation: Hmong Identity and Intergenerational Communication

Although many Hmong families have now acculturated to the United States, a number of enduring challenges to mental health have lingered within their communities. Specifically, tensions surrounding cultural identity exist between the initial wave of refugees and subsequent generations. When I discuss the "younger" generation of Hmong, I am referring to those who arrived here as children, and/or who were born here in the United States during or after the 1990s. This generation of Hmong is between 18-35 years of age. Although the younger generation has experienced fewer complications adjusting to American lifestyles (see Faruque, 2003; Vang, 2014), they have encountered other challenges to intergenerational communication and mental health.

When Hmong people migrated to the United States, many expected that their children and future generations would learn about and keep Hmong traditions, values, religion, customs, and language (Lee, 2013). For example, Hilmer (2010) noted that Hmong women reported feeling confined by their parents' traditional expectations, especially related to gender roles. When a Hmong woman marries, she moves in along with the spouse's family. However, a Hmong male keeps the family heritage. These expectations are communicated through oral telling, and seeing traditional rituals (i.e., weddings, funerals, clan gatherings, and holidays). Despite these expectations, many younger Hmong experience tensions between retaining their cultural identity and the

desire to become more Americanized (Faruque, 2003). Lee and Tapp (2010) stated, "Often younger people show little interest in Hmong traditions, language, or history, to the great concern of many in the older generation" (p. 20; see related arguments by Kim, 1990). As a result, such tensions and concerns manifests in intergenerational conflict:

> Younger Hmong may encounter both intrapersonal conflict and familial stress by choosing the dominant culture over native identity. This process of choosing one culture over the other may also lead to feelings of separation between themselves and family members who choose to maintain traditional or native cultures. (Tatman, 2004, p. 226)

The stress of perceived familial separation, and concern over the continuation of cultural traditions and identity can negatively affect mental health for both younger and older generations of Hmong (see related arguments by Lee & Chen, 2000). Additionally, specific cultural and familial expectations, such as marrying young, also have been found to contribute to higher rates of depression (Vang & Bogenschutz, 2011).

Other issues further compound the difficulties of intergenerational communication within the Hmong community. As Faruque (2003) noted, "The experience of each family's migration was a source of great stress and ultimate struggle for all" (p. 43). Although seeking social support, or communicating with others is often seen as vital for healing from trauma, older Hmong are often less willing to talk about either their experiences related to the Vietnam War or the resettlement in the United States and its impact on mental health (Vang, 2014). As a result, it may be challenging for younger Hmong to fully understand their cultural history and its impact upon family

communication patterns. Moreover, the reticence to talk about the past may contribute to less willingness in the older generations to speak about mental illnesses, such as depression. Thus, it can be difficult for younger generations to break the spiral of silence surrounding depression. However, as I discuss in the next section, this issue is made more complicated by differences in Hmong and Western perspectives on mental illness.

Communicating About Depression in Hmong Culture

One final factor that makes it challenging for Hmong people to communicate about depression is cultural perspectives on medicine, particularly as it relates to mental illness. For instance, one of the leading medical manuals for assessing mental health issues, the Diagnostic and Statistical Manual of Mental Disorders does not have a definition for depression, only a criteria for diagnosis (American Psychiatric Association, 2013; B. H. Hinrichs, personal communication, July 4, 2021). Hinrichs (2013) defines depression as, "The mental and emotional suffering that some people experience when they have a very low mood, problems sleeping and eating, feelings of hopelessness, and other disturbances" (p. 53). Yet such a definition is likely to be unsatisfactory from a Hmong point of view given the culture's orientations toward mental illness, treatment, and overall perspectives on healing. Additionally, as I noted in the introduction, there is no definition of "depression" in the Hmong language. The following section outlines the differences between Hmong and Western perspectives on medicine, and how these contrasting views contribute to challenges for communicating about depression in Hmong communities.

Comparing Hmong and Western Perspectives on Mental Health

As noted earlier, mental illness is viewed as bringing shame to the afflicted individual and their family in the Hmong culture (Tatman, 2004). Therefore, it is not often discussed. The Hmong are a collectivistic culture, which means that an individual's decisions and actions are often considered through the lens of how they will affect the family directly or indirectly. Yet, the Hmong culture's views on the details and causes of mental illness are fundamentally different from Western perspectives.

Mental Illness as Biological. Western perspectives of depression highlight how the condition is biological, caused by a chemical imbalance in a person's body (Lee et al., 2010). Additionally, research has indicated there may be genetic links, where depression is inherited from previous generations (Cohen-Woods et al., 2013).

However, Hmong people (and especially those from the initial generation of immigrants) usually do not perceive depression from a biological perspective. Not only did they have no prior knowledge of Western medicine in Laos, most medical terminology could not be directly translated into Hmong (Johnson, 2002). For instance, Johnson's (2002) study found that Hmong people's understanding of human anatomy were limited, making it difficult to clearly explain medical conditions. Additionally, the refugee community was skeptical about U.S. medical institutions, and rumors about doctors experimenting on Hmong people were rampant (Johnson, 2002). As the Hmong community and subsequent generations have become more settled in the United States, it is becoming more of a norm for members of the culture to be familiar with medical terms. However, it is still critical for medical providers to understand the challenges that

may be faced for helping individuals fully understand and trust the medical establishment when it comes to mental illness (Faruque, 2003).

Additionally, Western views of medicine are based on the biomedical model, which is focus on empirical, verifiable, and observational results (Du Pre, 2018). This contrasts to Hmong people's perspective that supernatural phenomena causing mental health problems. With the Hmong's belief in the spiritual world, one aspect that causes mental health problems is soul loss (Johnson, 2002). For instance, if a Hmong person falls on the ground and does not say, "Please get up. You don't belong here" in Hmong, their soul remains lost from their physical body. Thus, losing their soul can result in illness (Johnson, 2002). Also, Hmong people view symptoms of mental health, or nyuaj siab (nu-shea) from spirits and ghosts, especially from one's own family and ancestors (Lee et al., 2010). For instance, an individual using their official name to speak to a deceased family member at a burial site or disturbing particular spaces (such as throwing a rock in a lake or to going unwanted places) can cause those spirits to become disturbed and cause mental health problems.

How Mental Illness is Experienced. Western medical and Hmong perspectives also differ in their understanding of how depression is experienced. For example, western medicine conceptualizes depression as distress that interferes an individual's daily life, and manifests in symptoms like insomnia, persistent negative, and fatigue. However, this is very different from how depression might be experienced by Hmong individuals, and with important implications for caregiving. First, given elderly Hmong's limited medical vocabulary, they are more likely to describe their depression in terms of physical

symptoms such as a lack of sleep, loss of appetite, and back pain (Lee et al., 2010). Additionally, the closest word for depression in Hmong is nyuaj siab (nu-shea), which means worry or distress (Lee et al., 2010). It is a general distress of everyday life and does not fit the criteria of depression (Lee et al., 2010). For example, when a Hmong person feels distress, they would talk of not wanting to live, which is culturally acceptable and has a different meaning compared to Western perspectives (Lee et al., 2010). A non-Hmong caregiver would likely interpret conversations about death as suicide ideation and to seek immediate intervention. However, elderly Hmong people often view those symptoms of depression as normal stressors and would not need medical interventions from mental health professionals (Lee et al., 2010). This would make it difficult for them to be willing to seek medical interventions. This is a particularly significant cultural difference to understand, particularly when considering how to treat mental illness.

How Mental Illness is Treated. Finally, there are important differences between Western medical and Hmong approaches to treating mental illness. At the most basic level, Western medicine typically looks to the afflicted individual to make decisions regarding their care. However, the Hmong culture is collectivistic, meaning that families make decisions together regarding a person's care (Johnson, 2002). This makes it complex for medical practitioners to navigate situations where Hmong patients need to rely on their family for creating treatment plans (Johnson, 2002). Therefore, this makes it a great challenge for individuals operating from Western and Hmong perspectives to understand each other.

Additionally, the Hmong are less likely to turn to medical institutions for care due to their religious beliefs in shamanism, which is similar to animism. Shamanism emphasizes that every person and objects such as a tree, lake, and rock have a spirit. One of the main roles of a shaman is finding the cause of the spiritual illness and identifying its treatment (Johnson, 2002). According to Fadiman (2012), one task for a shaman is performing a ceremony to bring the soul of the individual with mental illness back into a healthy state. The shaman would wear a cloth (most shamans wear a black cloth than red cloth, P. H. Xiong, personal communication, November 6, 2021) on their face to travel in the spiritual world and find the person's missing soul. They would go into a trance state, jumping back and forth on a wooden bench (other shamans sits on a bench while chanting, P. H. Xiong, personal communication, November 6, 2021). Such approaches are clearly different from the western perspectives, which often privilege medication and counseling to treat mental health diagnoses. Not only can such cultural differences cause conflict and misunderstanding, they make it likely for Hmong people to disclose mental health concerns to Western medical practitioners (Lee et al., 2010).

In conclusion, illuminating the intersections of family, health, and intercultural communication and developing an understanding of the Hmong community's experiences are foundational to undertaking this study. After examining the literature, it is clear that while previous research has focused on the experiences of elderly Hmong, more research is needed on younger generations of Hmong Americans. Additionally, such studies do need to emphasize the complex dynamics of family within this population. In the next chapter, I discuss how I conducted my research.

Chapter Three: Research Methods

The goal of this research is to explore how communication shapes the perceptions of younger members of the Hmong community regarding depression. In this chapter, I will justify why I have chosen qualitative research methods to study this topic and outline my plans for how I conducted my study.

First, taking a qualitative approach to my project will allow me to better understand how perceptions of depression are shaped by the words, emotions, and meanings that reside in people. Denzin and Lincoln (2011) explain that qualitative research encompasses "a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including fieldnotes, interviews, conversations, photographs, recordings, and memos to the self" (p. 3). Given the stigma surrounding mental health concerns, particularly in the Hmong community, a qualitative approach will allow me to render perceptions about depression visible, explore different perspectives, and highlight the deeper meanings participants attach to these issues. Because I seek to uncover and analyze rich details about participants' subjective experiences, a qualitative approach makes more sense than a quantitative one.

Gathering Data

I used semi-structured interviews to gather my data. Jamshed (2014) defined semi-structured interviews as, "In-depth interviews where the respondents have to answer preset open-ended questions and thus are widely employed by different healthcare professionals in their research" (p. 87). The key characteristic of a semi-structured

approach to interviewing is that it allows me to be flexible in how I ask questions, allowing them to unfold with the conversation. In contrast, a structured approach offers limited questions and responses such as, "Sometimes" and "Always." Although each participant is given the same questions, a semi-structured interview enabled me to explore the deeper meanings of their answers.

Specifically, I conducted in-depth qualitative interviews to collect stories about younger Hmong community members' communication regarding depression. Lindlof and Taylor (2011) stated, "The qualitative interview is a storytelling zone par excellence. It is an opportunity for people to tell their stories as they see fit and, in so doing, to achieve some coherence in shaping their own understandings" (p. 174). In an in-depth interview, questions can be structured to provide participants with the opportunity to provide rich details and examples about their experiences. Yet, it was important for me to remember that talking about depression in the Hmong community is stigmatized. Thus, it was essential for me to use research methods that ensured participants' confidentiality, comfort, and willingness to share about these issues.

Additionally, I reduced the stigma and potential face threat surrounding conversations regarding depression by conducting the interviews via telephone. Face threat is "feelings of embarrassment, shame, humiliation, agitation, confusion, defensiveness, or chagrin" (Redmond, 2015, p. 8). Conducting a telephone interview allows for the reduction of face threat by empowering participants to share their stories without physically being seen. Added benefits of using telephone interviews further include an expanded the geographic range of potential participants, and enhanced

accessibility, as it is not always convenient for participants to meet face-to face. By conducting the interviews via phone, participants will also be able to select a private location that is convenient and comfortable for them to engage in conversation. There are some potential disadvantages to conducting telephone interviews, such as the lack of visual cues, lack of rapport, and trust between the researcher and participant. However, research indicates there are advantages that outweigh such drawbacks. Novick (2008) stated, "although loss of rapport, inability to probe, or deception via telephone may be thought to result in loss of or distortion of verbal data, there is no evidence that these problems arise" (p. 8).

Moreover, I conducted respondent interviews. Respondent interviews focus on the participant's sharing of their subjective experiences (i.e., emotions, feelings) rather than objective facts (Lindlof, 2017). It also allows participants to share their view, how they construe their actions, and how they conceptualize the life world (Lindlof, 2017). My goal is not examining at the objective truth of participants but examining their experiences. For a complete list of questions, see Appendix B.

Participants

I interviewed five Hmong people between the ages 18-35 (2 females and 3 males) using a purposive sampling method. In my study, I used pseudonyms names for participants. When conducting a purposive sample, a researcher "will intentionally sample a group of people that can best inform the researcher about the research problem under examination" (Creswell & Poth, 2018, p. 148). This sampling method fits with this study's goals by allowing me to find participants that have a specific type of experience

(e.g., membership in and an understanding of depression in the Hmong community). I am choosing to focus on younger Hmong participants because elderly Hmong are more likely to have limited English skills, and may need to seek a translator for support. This would increase face threat for discussing an already sensitive subject. Moreover, younger Hmong participants are more likely to be comfortable and/or familiar with discussions surrounding mental illness, such as depression. I chose five participants to keep the scope of the study manageable.

Recruitment

I focused my initial recruitment efforts in the Midwest region. I have been enrolled in four colleges and universities in Minnesota, and have connections to Hmong student organizations which was useful for identifying potential participants. Additionally, Minnesota is one of the largest Hmong populations in the United States, which means it makes sense for my recruitment efforts. For initial recruitment, I emailed messages to Hmong student organizations at colleges and universities in Minnesota and one in Wisconsin, and invite students to participate in my research. Email allows participants to self-select into the study, making it less likely for them to feel pressured into volunteering for the project. I was able to recruit three participants in this way. Afterward, I turned to snowball sampling for my study. Snowball sampling is when, "Researchers begin identifying several participants who fit the study's criteria and then ask these people to suggest a colleague, a friend, or a family member" (Tracy, 2013, p. 136). I asked my participants to share the details of my study with individuals that they knew who may be interested in and fit my study's purpose. (See recruitment materials in

Appendix A). However, snowball sampling did not work, due to the COVID-19 pandemic and the shutdown of in-person learning at most Minnesota colleges and universities in Spring 2020. I ended up reaching out to individuals I knew that could fit my study's criteria. I successfully managed to recruit two participants through this way.

Procedures

Participants were asked to contact me by email. When individuals contacted me, I set up a time for the interview that was mutually convenient and responded to any questions they had about the study. In my initial email to them, I also reminded them that depression is a sensitive topic, and they should be careful to select a location that was private and free from distraction to ensure they felt comfortable sharing their experiences.

Additionally, I sent the participant a consent form to their email prior to our conversation. Prior to our scheduled interview, I went over the consent form with the participant if they had any questions. Additionally, I reminded them that I kept their names and any potentially identifying information confidential in any write-ups of the data. Then, I asked the participant what pseudonym they prefer that I use to refer to them. Finally, I discussed the audio recording process, so the participant had a clear understanding of its purpose, and to ensure I had their consent to record the conversation. All my participants consented to being recorded and only took brief notes for my first participant and last participant (my first participant had a lot of noises in the background and last participant had individuals with her).

Once I addressed the informed consent and audio recordings, I began the interview. Although I did not see visual cues that might prompt me to ask another

question or that participants were having a hard time talking about the topic, I relied on listening to what they were saying to understand my participant's messages. If I noticed my participants were having a difficult time or having a distress discussing this topic, I asked how they were feeling. In addition, I asked if they wanted to continue talking on this topic. If they agree to continue, then we did so. If they decided to withdraw, we would discuss a different topic, or end the conversation if necessary. After my interview, I transcribed my data on Microsoft Word while listening to the recording on my phone or Zoom.

Data Analysis

After completing my interviews and transcriptions, I examined my data using thematic analysis. Brawn and Clarke (2006) defined thematic analysis as, "A method for identifying, analyzing, and reporting patterns (themes) within data" (p. 79). More specifically, Scharp and Sanders (2019) stated that, "Braun and Clarke's thematic analysis method is an iterative process consisting of six steps: (1) becoming familiar with the data, (2) generating coding categories, (3) generating themes, (4) reviewing themes, (5) defining and naming themes, and (6) locating exemplars" (p. 118). Thus, a researcher must be knowledgeable in the data to code their categories in finding themes that fits with the overall research question.

Thematic analysis is significant in helping qualitative researchers understand in linking different ideas, words, and phrases to find themes. With me asking questions about depression, it gives insights into my participants' perspectives. Thematic analysis enabled me to look for patterns across all the interviews, to construct a broader

understanding of these experiences. Thematic analysis also allowed me to be flexible to the kinds of theoretical insights that emerge from the data. Although I was curious about understandings of depression, I remained open to exploring other salient communication issues (e.g., family communication patterns, intergenerational conflict) that came up in these conversations.

Chapter Four: Results

I conducted telephone interviews with five participants that focused on my research question about how younger Hmong people communicate with their families about depression. After analyzing my interview data, two themes emerged: Identity, Family, and Communication; and Barriers to Talking about Mental Health.

Identity, Family, and Communication

Identity and Adherence to Family/Cultural Values

The first theme is about identity and how it influences family communication. Identity is defined as, "the definitions that are created for and superimposed on the self" (Baumeister, 1997, p. 683). Family identity emphasizes the importance of family life to an individual's sense of connection, belonging, and values (Bennett et al., 1988). Participants indicated that families with more Americanized (as opposed to traditional Hmong) values were more open to talking about depression. Additionally, participants reported having close family relationships and discussed the importance of traditional gender roles, which are common within the Hmong community (Tatman, 2004; Johnson, 2002).

Regardless of culture, families are an important influence on personal identity and values because they represent a key site of socialization. Families of origin are often where individuals first come to understand how to care for their bodies, and how to define what is (not) normal with their health. This is particularly the case in the Hmong community, where members identify with family first before their personal identities (Dhooper & Tran, 1998). Hmong families bond, maintain close ties, and rely heavily

upon each other for support. They also emphasize the importance of upholding cultural traditions and values through rituals including marriages, funerals, animal sacrifices (e.g., sacrificing a chicken as a payment for the sick person, butchering a cow), khi tes (hand string tying), hu plig (soul calling), and other cultural practices. One participant named Sarah shared the importance of family identity, "They still do shaman rituals- And umm… still have family events and Hmong events. We go to Hmong New Year, we have uh Hmong food, we speak Hmong. It's all really prominent." These gatherings and events continuously involve immediate and extended families, as well as friends in maintaining Hmong culture. In my own experience, as the oldest son in my family, participating in such rituals is how I display my respect for my family (immediate and extended families) and culture.

Participants indicated their perceptions of family and Hmong identity significantly shaped multiple elements of their personal identity. For instance, participants were asked two questions: "How would you describe your family's *current* connection to Hmong culture? (e.g., would you consider them to be traditional? Americanized? Or somewhere in between?)" and "How would you describe your *current personal connection* to Hmong culture? (e.g., would you consider yourself to be traditional? Americanized? Or somewhere in between?)" When asked the first question, three participants mentioned being in-between (one mentioned that their family is becoming more Americanized) and two participants mentioned traditional (one mentioned that their family is 'very' traditional). When asked about the next question, "How would you describe your *current personal connection* to Hmong culture? (e.g.,

would you consider yourself to be traditional? Americanized? Or somewhere in between?)", four participants described themselves as being in-between (although one participant later said, "I'm more towards Americanized.").

In the specific context of this study, there was a connection between cultural and family identities and beliefs regarding depression-related talk. Participants who identified as "Americanized" emphasized the influence of Westernized values on how they thought about and communicated regarding mental illness (e.g., perceiving mental illness as a biological and/or environmental problem). Nero described how people with more traditional beliefs were often hesitant to talk about depression, but explained that those who considered themselves more Americanized would "mostly likely, they will open up." Although none of my participants identified as being fully traditional in their beliefs, many self-identified as being between traditional and Americanized views. For instance, Alex explained, "You know there are still some, umm, traditional standards and practices that I still (sic) adhered to or respect . . . I do believe and follow in the American way." Despite Alex's somewhat Americanized identity, he also expressed fear surrounding discussions of mental health. "It doesn't matter if it's a western or even like traditional culture," Alex said, "It takes a lot to, to muster up the courage to tell people that, you know, I'm not feeling you know, myself, I'm not feeling well." Alex's comments reflect the challenges of moving between traditional Hmong and Americanized beliefs on depression. Yet, they also signal the stigmatized nature of depression within both cultures, which will be discussed in another theme in this chapter.

Even though participants' adherence to traditional and/or Westernized values differed, all of them indicated they felt a strong sense of closeness to their families. "You know, friends are amazing," Sarah commented, "But at the end of the day, family will be there no matter what – so family is super important to me." The strength of family ties can be closely connected to the collectivistic orientation of the Hmong culture. As previously mentioned in this chapter and chapter 2, Hmong families heavily rely upon each other for support. Participants were asked, "What does family mean to you?" Sarah replied, "Family is everything to me . . . It's important to care about my family and give back." Nero similarly replied, "Pretty much family means to stick together." Overall, my participants' comments centralize the importance of family, which in turn shapes personal values. I can relate to this in my own experiences as well. First, as the oldest son, family has been prioritized in my decisions to live with and support my parents and brother. Second, I value that my parents have always supported me and my siblings. Third, my mother and I always have conversations on health (connected both to Hmong and Westernized perspectives of health). Her influence has affected my personal willingness to have mental health-related conversations. Thus, these family aspects have had a significant impact on my personal values. However, another way in which family identity can affect the willingness to talk about depression includes the gender roles shaping family communication.

Gender Roles within Hmong Families

Identity matters to my participants' connection to Hmong culture because it affects how they think, behave, and speak the language. Galvin (2006) argued that

families co-construct their identity through membership and relationship within the family and society. Moreover, how individuals communicate within a family system can foster potentially problematic values related to mental illness, and how to deal with it when a family member experiences it (see, for instance, Sporer & Toller, 2016; Nishio & Bilmes, 1987, as cited in Tatman, 2004). Although each individual identified different family dynamics, one common thread within their comments centered on how gendered roles within Hmong families both influenced the quality of a person's mental health and constrained communication about depression.

Gender influences how a Hmong person should behave, follow expectations, and learn traditions within their family (Lee, 2013). Traditionally, Hmong individuals follow a strict patriarchy. Women are traditionally viewed as being submissive in making decisions, while men are more dominant and viewed as the protectors of their family's heritage (Vang, 2014). Participants' comments supported existing research that adhering to traditional Hmong gender roles, such as marrying at a young age, is often correlated with depression (Vang & Bogenschutz, 2011). Alex explained, "I know a lot of young women who battled through depression because of structures of a family in like, you know, of . . . who wears the pants in the household per se, no matter the situation." Robin similarly noted, "That's what puts all the all the women into depression." However, she added that the quality of a person's marriage was essential to protecting Hmong women's mental health, "If their spouse is somebody who, who actually like . . . gives her love and respect then they're okay." The patriarchal structure also influences others' perceptions of Hmong marriages. A case in point: When a husband is unfaithful, the wife is usually

considered to be to blame. This not only strains communication, but also makes it difficult for Hmong women to seek support from their families when experiencing marital challenges. Previous studies have linked this lack of support for Hmong women to higher rates of depression (Vang, 2014).

Gender roles surrounding masculinity are equally complicated. Like many cultures, Hmong men are expected to be stoic protectors of their families. Duffy et al. (2004) explained, "In the Hmong patriarchal system, the family is under the authority of the male head of household, who is the oldest male in the family or the oldest adult married son" (p. 13). Displays of masculinity are viewed as essential to providing support for the family. Participants noted two specific ways that the Hmong performance of masculinity constrained communication about mental health. First, Hmong men are not expected to show emotions, which can make it difficult for others to want to open up to them. Sarah described how she didn't talk about her experiences with depression with her father because she knew he wasn't likely to reciprocate by sharing his feelings. "So I know with him, when I was going through my stuff, we never talked about it," she said. Likewise, Alex described how his mother's unwillingness to discuss her mental health became a silent burden for his family. "She battled with depression a lot," he explained, "And now, going back and reflecting upon it. It's always a dark horse that we've never talked about." As Sarah and Alex's comments indicate, the cross-gender silence regarding depression influenced perceptions of support (or the lack thereof) for mental health within their families. Additionally, Alex's comments suggest that such silence can

also have significant relational implications for a family's overall communication dynamics.

Second, participants noted the cultural expectations surrounding masculinity make it difficult for Hmong men to disclose their own mental illnesses and seek support from families or health providers. Culturally norms surrounding masculinity not only prevent emotional expression, but also dictate what is considered "appropriate and proper" subjects for discussion (Philipsen, 1975, p. 22; see also Ogrodniczuk & Oliffe, 2011; Tatman, 2004). Several participants noted the challenges in getting Hmong men to disclose mental health concerns, such as depression. Robin argued, "They first got to actually admit and acknowledge… that's a problem . . . they need to fix, you know?" However, she noted that recognizing the problem was often difficult, "Some Hmong men, they don't even notice that they're in depression, you know?" Even when Hmong men do recognize signs of depression, participants stated it tends to be ignored. Sarah commented, "I think my dad like knows, but he doesn't understand or acknowledge it (depression)." As noted above, the acts of expressing emotion and acknowledging mental illness stand in contrast to cultural expectations of masculinity (see related arguments by Philipsen, 1975), particularly in Hmong culture. Unfortunately, such social and cultural norms fosters further silence around depression.

Intersectional Identities

Beyond gender and cultural values, participants identified other identities that influenced their willingness to talk openly about depression with their families. In listening to their stories, I perceived multiple intersectional identities (e.g., age; being a

first-generation immigrant to the United States; family communication patterns; overall perspectives on mental illnesses) that influenced participants' views on the willingness to talk about mental health. For instance, Sarah's and Robin's identities (e.g., being female, Hmong-American, their personal openness to talking about mental illness) primed them to notice how unwilling most Hmong men were to talk about depression. In contrast, Alex, Josh, and Nero's positionality (specifically related to their gender and age) empowered them to notice double-standards in cultural expectations for Hmong women's cultural expectations that they view as creating mental health concerns. Alex observed:

> So I think a lot of women suffer their depression or their mental illness from that. I know the Hmong families are like the traditional ways are very strict on that. So they don't let women voiced their own opinions, or are sometimes they won't even let the daughters go out and get highly educated outside of the boys or they treat the boys differ from the girls. A lot of you know, maybe their start of depression or mental illness probably stemmed from a younger age, when they start to notice the trend of like, why? Why can my brother go out all night and party and be fine but you know all of the sudden- I want to go, hang out my friends, after curfew met at night, you know- just like leads up all the way up to, when they get involve in a relationship. Why does the guy's opinion matter more than mine or why is it always his way over mine?

Alex comments revealed younger Hmong males see the submissive positionality of Hmong females as potentially problematic, and worthy of exploration and change through discussion of the impact it has on mental health. However, individuals who

identify as older and more traditional may simply perceive such issues as “the way it has always been” and not be as willing to discuss it. I’ve witnessed these issues in my own experiences with talking about depression, as a male and first-generation immigrant in a traditional family. For example, I’ve heard hurtful comments about those with mental illness, and seen how the hegemonically masculine expectations of having dominance can be harmful to mental health.

In addition to age and adherence to traditional values, one participant explicitly mentioned how education has enhanced the willingness of younger Hmong to talk about depression. “With the older generations (Hmong elders), that's why they don't talk about it because it (depression) was never really brought up,” Sarah initially observed. However, she commented that younger generations were likely to be more willing to talk about depression because educational settings have opened up spaces for dialogue. “We go through college, we go through school- and like we meet a lot of people that tell us, ‘Oh, yeah, mental illness is real. Like here are some resources,’” she said. Sarah’s comments reflect the existing research on how elderly Hmong tend to view depressive symptoms as normal reactions to life stressors (Lee et al., 2010). Yet, it seems the experiences of younger Hmong are different as they gain increased awareness of depression and other mental illnesses. These changes are likely to impact how they talk with their own families regarding these issues moving forward.

Identity and family present a number of intersectional and intercultural issues for understanding the willingness to talk about mental health. However, there are other barriers to speaking about depression which I will address in the next theme.

Barriers to Talking About Mental Health

The second theme illustrates the different types of barriers that interfere with Hmong people's ability to talk about mental health in general. The Hmong community faces different types of mental health issues such as anxiety, PTSD, and paranoid symptoms (Lee, 2013). Paradoxically, it is difficult for Hmong families to talk about depression even though it is the most prevalent mental illness affecting them (Lee, 2013). Participants, especially Alex, described being afraid of the stigma attached with any mental illness, like depression, from the Hmong community and, more specifically, the family. He explained, "Either afraid of the stigma that's attached… declaring that you are not, mentally stable right now or going through depression... from the community or within the family. It kind of loops back to the being honest and open part." My subthemes explore how the stigmas surrounding depression are complicated by depression's lack of visibility and the Hmong community's spiritual and religious beliefs.

(In)Visible Illness

The first sub-theme emphasized Hmong people's difficulties with talking about depression because of its lack of visibility. Participants indicated the issues with visibility manifest on two levels. First, mental illness cannot be seen in the same ways as physical illness or injuries. A person with a bone injury, influenza, or a cold has physical symptoms of ill health that can be seen or measured by another person. In contrast, a person with depression may appear to look "normal" to someone who does not know about their condition because there are few outward markers of mental illness. Participants indicated that it is challenging for Hmong people to communicate about

something (e.g., depression) they cannot see. Sarah said, “Yeah, it's like - it's hard because mental illness is kind of like a[n] invisible illness. Hmm . . . Like not a physical thing that you see.” Although there are some nonverbal cues that may indicate a person is experiencing depression (e.g., a lack of sleep, loss of appetite, back pain), these indicators are often subtle (Lee et al. 2010). Alex observed, “Unlike cancer or other terminal illness that kinda show signs, you know, signs for mental illness and depression are very hard to pick up on.” As a result, participants noted it was difficult for them to identify when a family member was experiencing depression. Participants also noted that family members further complicated depression’s visibility by concealing their experiences. “It's hard sometimes with communicating with, uh, family,” Alex said, “Sometimes they might be going through to that stage or through that . . . And they're not open to sharing or they're not open to being honest with themselves.” Alex comments reveal an important implication of depression’s invisibility: Unless the individual who is experiencing this condition is willing to reveal their experiences, others may not be aware enough to start a dialogue about it.

Participants’ comments echoed the findings of health communication scholars regarding the experience of other invisible physical or mental illnesses. When health conditions are not visible, those who experience them must disclose their health status in order to receive support or care from others (Horan et al. & Johnson, 2009). Disclosing a hidden diagnosis can be perceived as both personally and professionally risky, as the individual experiencing a health issue may be uncertain of other’s attributions or abilities to maintain privacy boundaries (Defenbaugh, 2013). Kundrat and Nussbam (2003)

similarly noted the identity challenges for people with invisible illnesses, particularly when they compare their different experiences to people without illness.

Moreover, people with invisible health issues frequently experience challenges communicating the legitimacy of their condition and the meaning(s) of their diagnoses to others. Depression's invisibility can make it particularly problematic for individuals to feel as if their condition is legitimate enough to seek help, whether from family or from health professionals. Sarah contended:

> Like if you break a leg, you have a broken leg. You see it. Obviously, you got to go to the doctor, but then . . . mental health, you don't see it. Especially if they don't acknowledge or understand it. It's like, why are they going to pay five hundred dollars for nothing? And you- it's hard to because sometimes you don't even- like sometimes [if you] don't understand it, [you] don't see getting better. But [the doctors] don't understand.

Sarah found justifying and talking about her depression with health professionals to be frustrating. However, she found it was even more challenging to share her health condition with her mother. "Yep, with my mom, um, when I was trying to explain that I had depression, she didn't understand." Sarah's comments reveal how difficult it can be to convey the meaning mental illness without visual or embodied cues that another individual can "read." Her experiences can also be linked directly to the second factor contributing to depression's lack of visibility: the lack of Hmong language for discussing it.

As noted in Chapter 2, there is no specific word for depression in the Hmong language (Lee et al., 2010). The written form of Hmong language is relatively new as Hmong has historically been an oral culture. Psychologists and communication theorists have long argued that language plays a significant role in shaping how members of a culture develop their world view. For instance, the Sapir-Whorf hypothesis contends that language "determines the habits of thought and behavior in that culture. It is not because of structures within culture that the world is organized as it is; rather it is the structure of language that is crucial" (Littlejohn et al., 2017, p. 114). Kenneth Burke (1984) similarly argued the choice to name something not only implies an attitude towards it, but also can create "trained incapacities" or ways of (not) seeing possibilities and outcomes (p. 7).

Like Sarah, other participants' comments indicated the lack of specific language creates misunderstandings and confusion among how Hmong people perceive depression. "It's hard to, like, find a specific word that has the same meaning," Robin explained, "it just has to do with the whole part of . . . translating it from one language to the next." Participants noted the limits of existing language created confusion when they tried to talk with family members. Sarah reported that her mother misunderstood when she initially revealed her depression to her. It wasn't until later that she felt her mother truly understood her illness. She described the experience as "not really like forcing someone to change what (you) believe, but just like- just having more openness and understanding, um, including everyone except you." Robin related how her mother also struggled to share her experiences in a way other family members understood. Despite being "really open with how she's feeling," Robin found her mother's discussion of depression to only

be implied, rather than explicit. “If someone was to actually listen to the words she saying, they will understand that how what she's talking about and why she's depressed and everything like that,” Robin explained. However, Robin said the lack of language made it difficult for her to be precise.

Without specific vocabulary, Hmong individuals must depend on Western medical explanations in order to understand depression. However, as Alex explicitly noted, accepting Western definitions of mental illnesses and how to treat them is something “that the Hmong community is having a hard time with.” Nero similarly stressed that even when a translator is involved, cross-cultural understanding about depression and other mental illnesses can be challenging. Not only is it difficult for Western medical practitioners to fully understand a Hmong person’s worldview, it creates confusion and misunderstanding for the Hmong patient to understand options for addressing their mental health. The invisible nature of mental illness is further complicated for Hmong individuals because depression is linked closely to spiritual and religious beliefs. I explore this issue further in the next sub-theme.

Spiritual-Religious Beliefs

Instead of viewing depression as a psychological and/or physical health problem that could be addressed through medicine or therapy (e.g., Western approaches), the Hmong culture fundamentally links mental illnesses back to the affected person’s spirit. As previously mentioned in the literature review, when depression is viewed as a spiritual problem, it can present relational challenges for families to talk ways in that help the person with depression. “At times, the Hmong community doesn’t acknowledge it or

doesn't think that it exists," Sarah explained, "Or . . . they think it is something spiritual." Like Sarah, participants' comments indicated the importance of spirituality when talking about depression, and noted that both the influences of Shamanism and Christianity made it difficult for treating mental health issues.

Such spiritual-religious beliefs create another layer of challenges for talking about depression because it is tied to non-visible and (in some belief structures) supernatural phenomena. Koenig (2012) defined spirituality as, "Intimately connected to the supernatural, the mystical, and to organized religion, although also extends beyond organized religion (and begins before it)" (p. 3). When talking about a person's soul or spirit, members of the Hmong community refer to their very essence. Depression is thus transformed from simply a physical or psychological condition to being an indication that something is wrong or unbalanced with the entire person.

Spirits are significant to Hmong people's understandings of mental health. As previously mentioned in chapter 2, the Hmong people view mental health as a significant problem because of cultural beliefs surrounding soul loss. For instance, if a child falls to the ground and a parent does not say in Hmong for the child's spirit stand back up and not be left behind, it is believed that the child will get sick (Johnson, 2002). Such illness is viewed as soul loss. When a person loses their soul, it affects their body and mind. The body began to feel unwell because their soul wandered off. Also, traditional beliefs note it not advisable for Hmong people to visit graveyard sites or throw objects in a lake because of the potential for individuals to lose their soul.

Like spirituality, religion similarly refers to a person's belief system in a higher or supernatural power (Omiliion-Hodges et al., 2019). However, these terms differ in important ways: Religion is a set of customs people devote to with prayer and group gathering. (Omiliion-Hodges et al., 2019), while spirituality emphasizes understanding oneself in relation to people (Bregman, 2004). Participants explained that their families differed in their religious beliefs, with some identifying as believing in a mix of traditional Hmong views, such as Shamanism, alongside more American views. Alex and Josh identified as holding a mix of traditional and Americanized views, whereas Nero defined himself as Americanized but still being knowledgeable about traditional approaches. Sarah and Robin identified as holding Christian beliefs.

Both traditional Hmong and Western religions like Christianity have their own customs for treating mental health problems. Christians are encouraged to seek spiritual healing through prayer. For traditional Hmong believers, the use of Shamanism is considered essential for treating depression or soul loss. For instance, a shaman enters the spiritual world and calls back a person's spirit back into the patient's body. A shaman must find the cause of a person's illness and payment of sacrificing an animal (e.g., chickens, pigs, or cows) to help the person who is sick (Johnson, 2002). For instance, if the patient gets pranked by another person pretending to see an animal or spirit, then the patient's spirit will get scared. Thus, for this case, a shaman would use a spiritual remedy to pinch and massage the patient's hand and palms (P.H. Xiong, personal communication, June 10, 2021). Usually, there are two ceremonies that are conducted: When the diagnosis is made and healing happens (Johnson, 2002).

Regardless of which faith tradition participants associated with, they noted that depression was viewed by members of the Hmong community as a malady of the soul. “For some odd reason, you know, within the Hmong community, it's always brought back to your spirit,” Alex observed. Sarah likewise noted that the quality of a person’s mental health was associated with spirituality, but argued the emphasis on spirituality had more to do with cultural instead of religious beliefs. “It's not shamanism and being a Christian,” she contended.

The framing of depression as a spiritual issue has two implications, according to the participants. First, it creates complications around the shame associated with disclosure and seeking treatment for depression. Disclosing a mental illness is inherently more risky when it is perceived to be associated with a person’s essence, rather than compartmentalized as an issue that can be dealt with through medication or therapy. Moreover, depression doesn’t always follow a linear path from diagnosis to treatment and recovery when treated either from a traditional Hmong or Western medical approach. Nero, for instance, questioned what happened when spiritual remedies were ineffective. Is the failure to successfully recover from depression further equated with an individual’s soul? Second, the gaps between Western and Hmong beliefs regarding depression as a malady of the soul (as opposed to the body) can present relational challenges within the family. Johnson (2002) noted that when Hmong individuals have health issues, clan (or extended family) members frequently become involved in decision-making processes regarding treatment. The presence of conflicting or contradictory beliefs within a family

surrounding what ought to be done to address depression can further contribute to an unwillingness to discuss these issues.

A person's religious or spiritual beliefs influences people whether they are (un)willingly to talk about depression. In the next section, I address a significant cause of the fears surrounding depression talk: The stigma surrounding it, and how it contributes to the disease's invisibility.

Stigma

Not only is depression physically and symbolically absent within the Hmong culture, it is often considered to be stigmatized when it is present. Stigma is a negative attribute associated with certain personal characteristics that deviate from perceived social norms, such as physical attributes, moral or character flaws, and identity affiliations such as race, nationality, or religion (Goffman, 2013). Unlike physical attributes, stigmas associated with perceived moral or character failings or certain identity associations are often invisible. According to Gray (2002), the disclosure of such characteristics may lead to stigmatization or discrimination from others (enacted stigma) or lead to feelings of shame and expectations of discrimination (felt stigma).

Several participants noted that depression, as with many other mental illnesses, has been highly stigmatized in American culture (Corrigan & Watson, 2002). Sarah commented, "Especially now, I think overall mental health in America has had a bad stigma and it is now resurfacing. We're starting to acknowledge it overall." Mental illnesses have historically been represented in social discourses in negative and deviant ways, signifying danger, evil, and/or personal weakness and other character flaws

(Lippert et al., 2019). Stereotypes associated with mental illnesses have fostered prejudice (Corrigan & Watson, 2002) and other forms of enacted stigma, or discrimination against people with depression (Oexle et al., 2017; Hilton, Hippel, 1996; Krueger, 1996; Devine, 1989). A case in point: Participants in Crisp et al.'s study (2000) reported believing that people with depression were perceived as being difficult to talk to (62%), should pull themselves together (19%), and were dangerous to others (23%). Given the strength of these negative stereotypes, it is unsurprising that individuals with depression often feel as though they must hide their experiences from others.

Unfortunately for Hmong-Americans who experience depression, there is a another layer of stigma associated mental illness, which is viewed within the Hmong culture as bringing shame to the affected individual and their family (Tatman, 2004). According to my participants, the reasons for this stigma are tied to the Hmong's cultural history. Josh noted that the inability to talk openly about depression "comes from, like, way in the past." Nero's comments provided deeper contexts for these observations, as he highlighted how people's difficulties with talking about the traumas of war, life in refugee camps, and forced resettlement was the cause of both depression and their hesitation to talk about it. "We're talking about what makes [people] depressed actually by their back story and stuff that people are struggling to talk about," he observed, "the stigma for real comes from depression or most likely . . . those regrets." Nero explained how his father was reluctant talking about his experiences of struggles from the Vietnam War:

> He was also (sic) one of the people that got out of the war and actually pretty much experience the gunfire as well they (the Hmong people) were waiting way back in Laos. It was worse for him. I believe that he's pretty much a peaceful man because he doesn't want to experience that again but sometimes you got to pretty much actually want to know about what happen next you know?

Nero's comments illustrate how depression for the Hmong is often associated with people's past struggles and cultural traumas. His father struggled through the war and did not want to experience the trauma again by discussing it. Alex likewise noted that many who came through the war struggled to raise awareness of post-traumatic stress disorder (PTSD) and other mental illness for decades. "Veterans are suffering from PTSD, mental illness and depression and (sic) people are dying without anyone knowing," he observed. "Unless someone points a flashlight and show it to the light (sic) not lot of people are going to look into the darkness." Taken together, Nero, Josh, and Alex's comments indicate how mental health conversations are hindered by the ongoing processes of healing from deeper cultural wounds, and the aftermath of multiple traumas.

Although history plays an important role, there are also cultural privacy rules at play. For many Hmong people, talking about personal struggle is also not considered appropriate. Robin explained the concept of "reputation" in Hmong families when talking about depression, "They don't want anyone to know about this; about . . . depression because they're supposed to like, you know, like their life is supposed to be like the best, you know." Robin's comment refers to Hmong families' concern with protecting their face, or identity. Face-threatening acts (FTAs) include any behaviors or characteristics

"that potentially could fail to meet positive or negative face needs" (Littlejohn et al., 2017, p. 134). In the Hmong culture, talking about mental illness is construed as an FTA because the subject brings shame to a family's status. Interestingly, it is considered socially acceptable to share physical (somatic) symptoms of mental illness, such as headaches, stomach pains, seizures, and paralysis (Nishio & Bilmes, 1987). However, openly expressing emotions that are considered to be attached to depression, such as sadness or helplessness, are more often construed as signs of weakness.

Coupled together, the lack of visibility and perceptions of face-threat hinder the communication needed for Hmong individuals to seek support. Without a vocabulary or accepted social spaces for depression talk, individuals who experience mental illness may suffer indefinitely. Josh shared:

> I think my dad has some mental health problems and my mom does too. We don't really talk about it. They just go in the day and it's normal. They're not really open about it, which I [sic] officially worried.

At best, the silence within families creates tensions and lingering anxieties. However, in the worst case scenarios, participants described how they had witnessed untreated depression lead to self-harm. Alex explained:

> It's, you know, it's something that we, we rarely talk about. Umm, I've had umm, you know, family members who, who committed suicide because they were depressed. I've had friends who committed suicide because they were depressed. Umm, so yeah, I believe overall between families and community as a whole, it's a topic that has not been- the light has not been shined on that dark spot yet.

Alex's comments underscore how frequently mental illness is both invisible and stigmatized within the Hmong community, and the importance of creating safe spaces for individuals with depression to share their experiences and seek support.

The intersections of American and Hmong cultures doubly stigmatizes the shame surrounding mental illness, creating both enacted and felt stigmas. An enacted stigma creates social rules or norms that render discrimination against people who experience mental illness. An example of enacted stigma is the social script to police masculine expressions of emotion (e.g., telling people to "Man up" or noting "Men don't cry."). Felt stigma refers to the internalization of these social norms, which make people feel shameful for having a stigmatized characteristic. Felt stigma can lead people to isolate or withdraw from public. Within the Hmong community, people fear they might be labeled as, "vwm" (crazy) or "ruam" (stupid) (Wilder Research, 2010). It thus isn't surprising that the dual layers of cultural stigma hinders Hmong people's willingness to speak about depression.

Overall, the two themes: identity, family, and communication, and barriers to talking about mental health illustrated important insights on participants regarding Hmong people communicating about depression. The first theme on identity, family and communication illustrated the significance of family identity and how families communicate about depression. Hmong families maintain identities through traditions, gatherings, and events; including gender roles and legacies of trauma deeply affecting the Hmong community mental health status. The second theme on barriers to talking about mental health illustrated obstacles that hindered Hmong people willingness to

communicate about depression. These obstacles include (in)visible illness (difficulties noticing another person with depression), spiritual-religious beliefs (spiritual and religious beliefs affecting a Hmong person's soul), and stigma (discriminated against for talking about depression).

Chapter Five: Discussion

My study sought to answer the question, "How do younger Hmong people communicate about depression?" In this chapter, I review the theoretical and practical implications of my findings, and address future avenues for scholarship as well as the limitations of my study.

Theoretical Implications

First, my findings supported and extended existing research from multiple fields (e.g., psychology, health sciences, history, social work, nursing) on Hmong culture and the willingness to communicate about mental health issues. My study highlights how communication scholarship can add nuance and deeper understandings of the issues identified in this body of research, particularly as it relates to the stigma surrounding mental illness (Goffman, 1963), the lack of language for talking about depression (Lee et al., 2010; Östman & Kjellin, 2002), Hmong gender roles (Vang, 2014; Tatman, 2004; Johnson, 2002) and the cultural legacies of trauma related to the Vietnam War (Hilmer, 2010; Duffy et al., 2004). For instance, participants highlighted how multiple, intersecting identities (e.g., age, gender, adherence to traditional/American values, education) influence a Hmong person's awareness of and willingness to engage in Western-style conversations about mental health. Their comments simultaneously illustrated how complex it can be to "break the silence" given the strength of intercultural and familial communication norms related to depression. A case in point: Communication Privacy Management theory argues that the disclosure of personal information (such as mental health status) requires individuals to weigh the risks and

benefits of sharing said information (Hall, 2020; Littlejohn, Foss, & Oetzel, 2017; Griffin, Ledbetter, & Sparks, 2015). As participants' comments demonstrated, the risks of disclosing depression are plentiful for younger Hmong. Not only is depression stigmatized by both American and Hmong cultures, the ability to express one's mental health is often hindered by identity-related concerns. Participants cited gendered norms and expectations, family concerns related to reputation, and generational perspectives regarding "normal" vs. "traumatic" lived experiences as reasons why the spiral of silence surrounding depression continues within Hmong culture. Such concerns also manifested in patterned ways that depression was communicated within Hmong family units as well. For instance, female participants only reported disclosing depression or mental health concerns to mothers (and not to fathers), and one male participant noted that his mother had difficulty with cross-gender openness about her depression. This finding is consistent with CPM theory's existing body of literature, which explores family types, rules, and conversations on decisions to disclose personal health information within public and private boundaries (e.g., both within and outside of the family) (Arroyo, Sergin, Curran; 2016,; O'Neil et al., 2004; Ritchie & Fitzpatrick, 1990).

In terms of new findings, my study illustrates a potential intercultural communication extension for CPM theory. Developed by Sandra Petronio in 1991, CPM theory currently focuses on a three-part system impacting how individuals negotiate tensions surrounding the sharing of private information in relationships. The system emphasizes the interrelationships between privacy ownership (e.g., controlling ownership of private information based on privacy rules); perceived privacy control (e.g., how

others become co-owners of private information after disclosure; the development of privacy rules), and privacy turbulence (e.g., how individuals manage perceived violations of privacy rules) (Griffin et al., 2015; Petronio, 2013; Petronio, 2002). Although CPM scholarship has acknowledged culture plays a role in how individuals make disclosure decisions or develop privacy rules (see, for example, Brummett & Steuber, 2015; Cho & Sillars, 2015; Simmons, 2012), researchers have yet to specifically acknowledge how this calculus may be impacted by the linguistic resources available to individuals. As participants indicated, the lack of culturally appropriate language coupled with the dearth of visual markers of acute illness hindered their ability to provide others with an effective cross-cultural explanation of depression. Despite speaking openly with her mother about mental health, Sarah described how her mother "did not understand" her experiences or needs for support. Likewise, Robin felt comfortable disclosing to family members, but noted the lack of social scripts related to depression made these conversations difficult. Social scripts provide individuals with a set of patterned conversational resources for addressing particular subjects, and are learned through everyday interactions and community rituals and/or traditions. These scripts are "culture-specific, i.e., if one is born and brought up in a certain culture community, they internalize social scripts with characteristics of that community" (Meng, 2008, p. 132). As the participants' comments indicate, the lack of linguistic resources may disproportionately weight the costs of disclosing depression over its potential benefits (e.g., seeking support and understanding from others), particularly if there are few culturally appropriate ways to discuss the

subject. My study illustrates how a deeper exploration of the connections between culture, language, and CPM theory is warranted.

Despite the potential risks and challenges for openly addressing depression, younger Hmong indicated it is a subject they *want* to talk about within their families. From a CPM perspective, participants illuminated several benefits for opening the dialogue, including generating, "more openness and understanding" (Sarah) and noting it as important step for "how we can grow as a community overall" (Alex). Specifically, Alex used poetic metaphors to describe the potential for dialogue about depression, noting "the light has not been shined on that dark spot." In metaphorical terms, the "dark" represents depression and the "light" represents conversations on such issues. Seeing the darkness progressively fade away through dialogue was particularly important to Alex, who reported losing both friends and family to depression. He argued that more openness about this issue was key to generating necessary change and community healing.

Moreover, existing health communication scholarship has been slow to investigate the connections between mental health and religious/spiritual beliefs, particularly in the context of everyday health communication. Much of the existing literature explores the relationships between spirituality and depression in individuals with chronic illness (e.g., Taha, Eisen, Abdul-Rahman, Zouros, Norman; 2020), or other conditions that threat an individual's quality of life (e.g., Zhang, Xiao, & Chen, 2019; Chen, Xiao, Yang, 2017). Additionally, scholars have explored the links between spirituality and occupation-based stresses leading to depression, particularly among nurses (Van Nieuw Amerongen-Meeuse et al., 2021; Batalla et al., 2019). One notable

exception is Lippert et al. (2019), who studied how self-talk about religious and spiritual beliefs offered benefits for individuals to accept or overcome an illness identity. My study demonstrates how Hmong people's religious and spiritual worldviews significantly influence their perceptions of depression, and depression-related talk. Sarah and Alex indicated that Hmong understandings of depression are deeply rooted in spirituality, regardless of one's religious beliefs. As noted in Chapters Two and Four, Shamanistic and Christian perspectives differ significantly on the root causes and potential treatments for mental health. Yet, both perspectives can be read as potentially constraining for talking about depression, given how spiritual discontent is connected to sin (Christianity) or spirits (Shamanism). In addition, both are stigmatizing, in that sin and spiritual malaise are linked to deficiencies in personal choices. More research is needed to understand how religious and spiritual belief systems construct mental health identities, as well as how these identities are integrated by individuals, and their potential to influence social support among families and faith-based communities.

When the links between spirituality and depression have been studied in Hmong culture, research has focused primarily on Shamanism (Johnson, 2002). The participants' comments indicated that the intersections between Christianity and Hmong identity are increasingly important and warrant further exploration. For instance, Robin shared, "We've converted into [being] more Americanized, where we go to church and say we don't have restrictions for this and for that, like how some families do." Unpacking these intersections, specifically how Hmong assimilate Christian values around spiritual and physical well-being, is complex. "It's not [just] Shamanism and being a Christian," Sarah

noted, "Western culture has a lot of Western talk." In other words, Christianity is rooted in Western thought, and represents a significant departure from traditional Hmong perspectives on the body and the soul. It is important to continue investigating the processes and tensions that emerge from integrating these worldviews, and particularly to explore how they influence perceptions of mental health and depression.

Additionally, previous research has not examined the relational implications of religious or spiritual beliefs and the willingness to talk about depression. Family privacy rules, particularly when coupled with religious and spiritual beliefs, have the potential to enable or constrain depression-related talk. For instance, immediate and extended families may differ in their levels of willingness to engage in conversations based on specific religious/spiritual beliefs, which in turn may influence personal willingness to discuss or disclose depression. A more rigorous exploration of the intersections of culture, privacy, and CPM theory should engage these issues as well.

Finally, my research underscores how for certain populations, the willingness to engage in depression-related talk is both stigmatized and deeply tied to cultural traumas. Nero and Josh indicated how unraveling the stigma associated with mental illness requires a historical reckoning as well as an interrogation of the emergent cultural and family discourses stemming from collective trauma. Previous scholars have examined the Hmong's historical context to understand the *prevalence* of mental illness (Lee, 2013; Tatman, 2004; Westermeyer, 1984, 1988). However, they have been slower to explore how the legacies of war and forced resettlement have impacted multi-generational communication about mental health. Continued exploration is warranted to understand

the ongoing evolution of Hmong-American identities in light of this history, and to assess its impact on how perceptions of depression shift over time.

Practical Implications

In addition to theoretical insights, my findings provide insights into practical strategies that families, organizations, and health providers could enact to assist with opening depression-related dialogues in the Hmong community. First, my findings suggest that younger Hmong people are becoming more acculturated to Westernized ways, particularly when it comes to engaging in mental health-related talk (Johnson, 2002; Dhooper & Tran, 1998). Participants' stories also indicated that there are some places where in-roads have been made for talking about depression with Hmong elders within recent decades. As the younger generation continues to normalize conversations about depression, the stigma surrounding it will be lessened. Stigma Communication Theory offers some useful tools for assisting with this, as it illustrates potential reactions and responses to different types of stigmatizing messages (e.g., moral, physical, social) and utilizes strategies (e.g., accepting, avoiding, evading) for management outcome (health achievement) (Meisenbach, 2010). To continue this progress, Hmong families can learn to communicate about stigmatizing messages and utilize strategies in supporting another. For example, one potential strategy for de-stigmatizing depression would be to have Hmong clan leaders speak upon such issues. Sarah explained the importance of Hmong leaders' influence, noting "they (the Hmong community) look up to them and then having Hmong clans, the top leader, to talk about it, it will help reduce the stigma within the Hmong community." Because clan leaders are highly respected for their

positions in the Hmong community, they are likely to be influential voices on mental illness, and particularly depression. Clan leaders could also play an important role in addressing cultural norms that hinder communication regarding depression, such as gendered expectations surrounding emotional expression and cross-gender disclosure of mental illness.

Second, participants identified a number of contextual factors that are useful for individuals to consider when engaging in depression-related talk. For instance, Nero noted the importance of maintaining a private space when talking with family members. Alex similarly identified patience as the key to finding opportunities to engage in dialogue. He commented he strove to take "time to really process what kind of message my communication came to them when whenever I speak with them or have interactions with them." Moreover, he found that maintaining a supportive and non-judgmental tone helped with sustaining the conversation:

> If it's a good day and they feel like sharing a little bit and you're just being acceptable being able to listen. If they are wanting input, offer a little bit input but if they are just waiting to vent, which talk about how they're feeling or what's making them feel the way that they are. You know, just listening.

Alex's comments highlighted the importance of being sensitive to the other's needs in conversations about depression. Sarah similarly underscored the importance of not pushing others to talk until they were ready. The importance of these contextual factors are consistent with existing research on family communication patterns and the influences of parental modeling with regard to health behaviors (Pecchioni, Overton, &

Thompson, 2015). For instance, Hmong parents who engage in supportive communication regarding health related-issues are more likely to influence children to be open to discussing such concerns. Thus, Hmong parental modeling regarding health behaviors influences their children's decisions and reflection upon such behaviors.

Third, participants identified several opportunities for Hmong families to engage with different organizations to promote and advocate for mental health literacy. Although individual efforts are useful, larger organized efforts would provide significant recognition and support for these issues among the broader Hmong community (Stuart, 2016). There are only a few nonprofit organizations actively addressing issues of mental illness, and particularly depression, within the Hmong community. For instance, the Wamhersth Wilder Foundation assesses the Hmong mental health needs and services in Ramsey County, Minnesota (Wilder, 2010). The Hmong American Partnership likewise provides the Hmong community with additional mental health support and resources (Hmong American Partnership, 2021). Yet, some participants expressed a desire for new advocacy efforts. Sarah offered, "Maybe like a Hmong depression foundation . . . Where the community can donate to get to, like, know more about it." Although the existing organizations provide essential infrastructure and support for individuals with depression, a new organization similar to Sarah's suggestion could engage clan leaders and health professionals to facilitate discussion.

Mental and physical health practitioners could also benefit from this study's findings, which underscore the ethnic and cultural factors that sustain the silence around depression in the Hmong community (Tatman, 2004). One practical thing health

practitioners should do is allow Hmong families discuss and decide a specific treatment (Westernized or traditional) for the ill individual. Given the lack of language for describing depression and meeting the needs of the Hmong community, health practitioners should avoid using medical jargons and describe depression in simplified details on how it affects the body (e.g., describing depression as feeling sad). Second, they should understand the Hmong's concept of spirituality and religious beliefs. As previously mentioned, Western practitioners typically perceive depression as a biological and/or environmental problem, whereas traditionally Hmong view depression as a spiritual problem. Understanding about the Hmong's spiritual and religious beliefs leads to cultural competence and awareness. Third, hospitals should (when possible) allow a shaman (or pastor) perform a healing ceremony (or prayer in a pastor's case) for an ill family member, when appropriate. A case in point: Shamans are currently working within the Merced (California) Hospital, where there is a large Hmong population. Their presence creates positive support for the Hmong community, and generates cross-cultural dialogue between Westernized health practitioners and Hmong patients (Laws & Chilton, 2013). Fourth, practitioners should avoid (when possible) discussing the ill person's mental health status in front of family members as such conversations can induce shame. Finally, Lippert et al. (2019) further underscored the importance of having training and educational programs for Hmong shamans and medical practitioners, noting that shared dialogue may provide insight into "the best strategies for recognizing, responding to, and providing assistance for those with mental health problems" (p. 16-17). Although the

Hmong community experiences such issue, the silence still perpetuate surrounding depression.

Limitations

There were some limitations to my study's claims. From a methodological perspective, I was only able to complete 5 interviews given recruiting challenges amid the COVID-19 pandemic. Because many colleges ceased in-person courses during Spring 2020, I had difficulty recruiting participants in the manner I initially planned (e.g., recruiting through Hmong Student Associations). Thus, the next route to access students was using email to find and recruit participants. Unfortunately, even after conducting outreach during the pandemic, I received few responses and switched to snowball sampling to identify respondents. I had no prior relationship with three participants, but did have a prior relationship with two participants. My familiarity and level of comfort with these individuals did produce some differences in the amount of data collected (e.g., conversations were longer, participants disclosed further details about themselves and family members). Additionally, phone conversations were useful for reaching participants. However, the lack of face-to-face contact may have caused me to miss some insights, such as non-verbal cues, that would have been apparent in an in-person conversation. Additionally, I chose to focus on individual interviews. Focus groups might have been helpful to allow participants to hear others' perspectives, and engage collaboratively in more organic sharing of their personal experiences. It would have also allowed me to more deeply probe new insights, such as gender roles, that came up during my individual interviews. Finally, all of my research interviews were conducted in

English. If researchers are conducting similar conversations, it might be useful to allow participants to choose whether to converse in English or Hmong based on the language that is most comfortable to them.

Moreover, my participants were similar in several demographic categories, such as age; geographic location; and identification with Hmong and American beliefs. Previous research suggests that older members of the Hmong community, particularly those who identify with more traditional beliefs or newer immigrants to the United States, may have different views on communication regarding depression. Additionally, Josh mentioned that there may be geographic differences influencing Hmong people's willingness to talk about depression as well. As previously mentioned, the primary areas most Hmong migrated to were California, Minnesota, and Wisconsin. Future research should study Hmong people in different geographic regions, or from other countries, to highlight any emergent differences in their willingness to communicate about depression. For instance, the willingness to engage in depression-related talk may significantly differ among Hmong residing in rural versus suburban areas, or among those with diverse lifestyles.

Future Research

Researchers should continue exploring broader insights into Hmong people's talk about depression and mental health. First, interviewing Hmong people who identify themselves as bi-racial can explore how they navigate between two different cultures. This information would provide important insights into a bi-racial individual's willingness to communicate about mental illness, particularly depression. For example, a

multi-cultural family background may influence how individuals interpret Hmong history, as well as the racial and cultural norms surrounding gender, spirituality, and depression-related talk. Moreover, researchers should carefully consider gender representation among their respondents. Participants provided important insights about Hmong gender roles, and specifically the challenges of being female in a patriarchal system. Future studies should also probe the gendered dynamics of depression-related talk, such as how gender impacts the willingness and degree of disclosure; as well as family norms and rules that govern such conversations.

Additionally, researchers should continue to explore intercultural communication issues related to the disclosure of health issues, particularly when linguistic tools are limited or not present for aiding understanding or communicating a health issue's legitimacy. Specific cultural groups have distinct codes of disclosing and discussing about depression. The lack of linguistic tools for communicating depression presents challenges in misunderstanding intercultural family communication dynamics and patterns. For instance, linguistic tools would explore different intercultural communication patterns for disclosing depression with family members, friends, or others.

Although my findings are generalizable only to the Hmong population, future research should explore similar health communication concerns within other immigrant communities. In these communities, they may not have a vocabulary that translates to depression, which can cause difficulties talking about it. A case in point: The Somali refugee community in Minneapolis (and elsewhere) shares several commonalities with

Hmong Americans, including the historical traumas of war and resettlement; and spiritual/religious beliefs that differ from Western methods of talking about mental health. Researchers should continue investigating these issues to bridge understandings between immigrant communities and health practitioners to continue developing both health literacy and cultural competencies.

My research focused specifically on depression because it is the most prevalent mental illness within the Hmong community. Future research should explore Hmong people's willingness to communicate regarding other mental illnesses, including PTSD, anxiety, and adjustment disorder. Having broader insights would support and reduce barriers to addressing all mental illness in the Hmong community.

Finally, I chose younger Hmong people for their understanding of traditional and Americanized perspectives. Future research should include different generational perspectives. Interviewing elderly Hmong people may present linguistic challenges (e.g., many have limited English proficiency, information can be lost in translation) and they may lack the ability to access technological devices (see arguments by Lee, 2013; Vang, 2014). However, their extensive knowledge of Hmong traditions and multi-generational experiences would present valuable insights.

Conclusion

This study explored in understanding younger Hmong people's willingness to communicate about depression. Results indicated participants' conversations on depression within these themes: Identity, Family, and Communication and Barriers to Talking about Mental Health. Family identity is central to Hmong people, as clan

gatherings and events are highly valued. (In)visible illness is the stigma that hinders talking about depression. Theoretical implications suggests multiple reasons with families difficulties talking about depression including dual layers of stigma, religious and spiritual beliefs, lack of visibility related to cultural wounds, and spiral of silence in talking about depression. Practical implications suggests multiple strategies in order to overcome depression-related stigma, including engaging cultural leaders and organizations to expand dialogue; noticing contextual factors in personal conversations; and implementing techniques for health professionals. In my personal experiences, it is difficult when individuals express hurtful comments to those with mental illness. This complicates an open space where dialogue should be approached. In the future, I hope Hmong people (including other race and ethnicities) will support another in reducing the stigma surrounding depression.

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Appendix A: Recruitment Materials

Recruitment Email (This will be posted to college students email to recruit potential participants)

Who: Wa Yang (Minnesota State University, Mankato) is looking for participants for a research study on talking about depression within the Hmong community.

What: Participation in the study involves taking part in a confidential 30-60 minute telephone interview.

Eligibility: To participate in the study, participants must be Hmong at ages 18-35 years of age and be willing to share stories about perceptions of depression in conversations within their families.

For more information, contact:
Wa Yang at wa.yang.2@mnsu.edu and phone number: 651-428-8092

Email to Respond to Potentially Interested Subjects

Greetings,

Thank you for your interest in being part of my study on talking about depression in the Hmong community. As you may already know, you must be between 18-35 years of age, and willing to discuss how depression is understood and discussed among members of the Hmong community.

Participation in the study will involve a confidential 30-60 minute telephone interview, which can be conducted at a mutually convenient time.

If you meet the criteria (outlined above) and are interested in participating in the study, please contact me via phone or email to arrange the details for the completing the interview. Once we schedule your interview, I will send you a consent form that discusses the study in more detail and outlines your rights as a research participant. We can talk about this document prior to the interview, and I can answer any questions you may have about it then.

I look forward to talking with you. If you have questions, please contact me via the contact information listed below.

Best regards,

Wa Yang, Minnesota State University- Mankato
wa.yang@mnsu.edu and 651-428-8092

Email Message with Consent Form

Greetings,

Thank you for your interest in being part of my study talking about depression in the Hmong community. I look forward to our conversation on [date / time]. If you need to reschedule for any reason, please contact me at the email or phone number listed below.

As I mentioned in my earlier [phone call/email], I am sending you a consent form that discusses the study and outlines your rights as a participant in research. You will be asked to sign this form at the time of the interview, so I ask that you read through it document prior to our meeting. I will discuss it with you in more detail and can answer any questions you may have at that time. Please don't hesitate to contact me if you have any questions about it beforehand, though.

Again, please don't hesitate to reach out if you have any questions or need to reschedule our discussion.

Best,

Wa Yang, Minnesota State University- Mankato
wa.yang.2@mnsu.edu and 651-428-8092

Appendix B: Informed Consent

Title: Young Hmong People's Willingness to Communicate About Depression
Investigators: Wa Yang & Dr. Anne Kerber, Department of Communication Studies, Minnesota State University, Mankato
Description: The purpose of this research is to understand how young Hmong people share perspectives on depression within their families. Specifically, you will be asked to complete an in-depth interview. Wa will discuss this form with you at the time of your interview, and you will have the opportunity to ask any questions you might have about study and your rights as a participant. The interview will be conducted in English unless specific words need to be clarified in Hmong. With participants' permission, the interview will be audio-recorded and transcribed (or typed out in written form) by Wa. *Please note*: Recorded audio will be retained until they are transcribed, or for one year. Recording will then be destroyed. If you do not wish to be audio-recorded, the interview can still be conducted and the investigator will take notes on the conversation. My initials following this statement indicate I agree that the interview may be audio-recorded: _____

Confidentiality: Your answers will be kept confidential, as your name and any personally identifying details will not be included on the transcript, or in any write-ups of the research. Consent forms will also be kept separately from the data. All data will be kept either in Dr. Anne Kerber's locked office or on password-protected computer that only the investigators have access to.

Time Commitment and Payment: There will be no compensation for your participation in the study. We anticipate it will take 30-60 minutes to complete the interviews for this project.

Risks and Benefits: There are no direct benefits for participating in this research. However, you may develop greater awareness of your (and others') experiences. Society, and particularly the Hmong community, might benefit from this research through increased understanding of strategies to reduce the stigma of talking about depression. The anticipated risks of participating in this research are minimal, but may include some emotional discomfort during or after your participation. Should you experience such discomfort, please contact the National Alliance on Mental Illness (NAMI) HelpLine at 1-800-950-6264 or info@nami.org, or by texting "NAMI" to 741741; or the Substance Abuse and Mental Health Services Administration (SAMHSA) HelpLine at 1-800-662-4357. These hotlines will direct you to appropriate resources based on your location and needs. PLEASE NOTE: **You** would be responsible for any costs associated with seeking mental health services.

Right to Withdraw: Your participation in the research is entirely voluntary. Participants have the right to end the interview if they experience discomfort or no longer wish to participate in the study. Additionally, you have the right to withdraw from the study after

the interview has concluded by contacting the investigators. Your decision whether or not to participate will not affect your relationship to Minnesota State University, Mankato; and refusal to participate will involve no penalty or loss of benefits. You will be provided with a copy of this consent form for your records.

If you have questions or concerns regarding this study please contact Wa Yang (wa.yang.2@mnsu.edu) or Dr. Anne Kerber (507-389-1407; anne.kerber@mnsu.edu). If you have questions about the rights of research participants, please contact the Administrator of the Institutional Review Board at 507-389-1242.
Statement of Consent: By signing this consent form you agree that you are at least 18 years of age and are willing to participate in the project entitled, "Young Hmong People's Willingness to Communicate about Depression."

_____	_____	_____
Signature	Printed Name	Date

Date of MSU IRB approval:

Appendix C: Interview Protocol

Introductory script: Thank you for taking the time to talk with me today. As I mentioned when we schedule this meeting, I would like to discuss your experiences in talking about depression in the Hmong community. Before we begin, I need to ask you to read this form, which describes the purpose of my study, and sign at the bottom to indicate that you agree to be a part of this research project. To return the consent form to me, there are two methods. First, you can sign it online (or print the paper and sign it), scan it, and send it to my email that I provided in my email messages. Or second, you can take a picture of the signed form and text or email it to me. Please know that I will keep your answers to these questions confidential, which means that any potentially identifying information about you will be removed from write-ups of this study. Do you have any questions for me before we get started?

Opening: Demographic Questions

1. What is a pseudonym you would like for me to use when referring to you in any write-ups of this research?
2. How old are you?
3. How would you describe your gender identity?
4. When did your family immigrate to the United States?
5. How would you describe your family's *current* connection to Hmong culture? (e.g., would you consider them to be traditional? Americanized? Or somewhere in between?)
6. How would you describe your *current personal connection* to Hmong culture? (e.g., would you consider yourself to be traditional? Americanized? Or somewhere in between?)

Body: Health, Family, and Intercultural Communication Questions

7. What does "family" mean to you?
8. What does the term "mental health" mean to you?
9. Where or how did you learn about what mental health is?
10. In your experience, how open are Hmong families to talking about mental health?
    a. What do you think are some of the reasons for this?
11. In your experience, how open is your family to talking about mental health?
    b. What do you think are some of the reasons for this?
12. Depression is defined as "A common mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration" (Marcus, Yasamy, Ommeren, Chisholm, and Saxena , 2012, p. 6) Without naming specific names, would you say that anyone in your family meets this description?
    c. **IF YES**:

i. Do you know if this individual has sought diagnosis or treatment for their mental health?
ii. Has the person spoken openly within the family about their mental health?
    1. If so, what was the response?
    2. If not, why do you think that is?
iii. How do you feel this individual's mental health influences your communication with them?
iv. How do you feel this individual's mental health influences communication within your family?

d. IF NO: How comfortable do you feel a person would be with talking about depression in your family? Why?

13. In your experience, what are some factors that might make people comfortable with talking about depression in Hmong families?
14. In your experience, what are some factors that might make people uncomfortable with talking about depression in Hmong families?

Closure

15. Are there any other important issues that we haven't talked about yet?

Do you have any questions for me?