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The Hmong Experience with Modern Healthcare Services When Medical Intervention is Necessary

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Walden University

College of Psychology and Community Services

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Kristina Mauk

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Walden University
2023

Abstract

The Hmong Experience with Modern Healthcare Services When Medical Intervention is Necessary

by

Kristina Mauk

MA, Walden University, 2017

BS, University of Phoenix, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

November 2023

Abstract

The Hmong population in the United States have a documented history of struggling with modern Western healthcare practices and remedies. The Hmong population views their health concerns from a unique cultural and spiritual perspective that can often lead them to choose more traditional cultural remedies for their health problems. The focus of this study was to understand the Hmong experience when a physical health problem has been identified and how they perceive their physical health problems from a spiritual perspective. The framework to be used for this study is the social cognitive theory. The research questions guiding this study included understanding how Hmong described their experience when choosing a modern healthcare provider or traditional Hmong healer and how they described their experience when a modern healthcare provider diagnoses them with a physical health problem. Semi structured interview to collect data for this basic qualitative study. Nvivo software was used to organize the data. The coding and analysis of the data was guided by a five-step process. The findings of the study indicated Hmong health decisions are primarily driven by cultural influences within their environment, spiritual beliefs, if they can view health problems with their eyes, and level of their acculturation. The potential for social change resulting from these findings would include healthcare providers better understanding their Hmong clients, healthcare organizations being better able to accommodate the needs and beliefs of the Hmong population, and for policy changes to be implemented where needed to better support this population and their unique healthcare needs.

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Chapter 1: Introduction

Hmong immigrants, from northern Vietnam, Laos, Thailand, and the eastern parts of Myanmar, began settling in the United States heavily between the years 1970 and 2000, and continues today (Vang, 2018). The Hmong have unique cultural and religious beliefs having to do with their health that run counter to modern Western beliefs and practices related to health (Vang, 2018). These beliefs have led to conflicts with Western health providers because of the limitations these beliefs (e.g., refusal to have their bodies punctured, have surgeries, give blood, or take medications) place on Hmong and what they are willing to do or have done to their bodies (Vang, 2018). This has led to experiences with Western medicine and health providers that have been perceived as unaccommodating, frightening, stressful, and have hindered their integration of Western communities and health practices (Vang, 2018).

People from the Hmong culture have struggled with various aspects related to modern Western healthcare and practices. The Hmong often prefer to try their own culturally based remedies first which can include both herbal medicines and seeking spiritual healing from a shaman (Fang & Stewart, 2018). The Hmong are often reluctant to engage in modern health practices because the Hmong people are fearful of healthcare providers and associated procedures, want to protect their family reputation, often lack trust in doctors and healthcare services in general, and due to perceived discrimination (Fang & Stewart, 2018; Her-Xiong & Schroepfer, 2018). In general, the Hmong people have more faith in their own religious and spiritual practices because they view many physical ailments as spiritual problems and see modern Western healthcare as insensitive,

intrusive, unhelpful, and potentially damaging to their spirits that are then carried into the afterlife (Fang & Stewart, 2018; Her-Xiong, & Schroepfer, 2018; Johnson, 2002; Lor, Rodolfa, & Limberg, 2017; Lor et al., 2017; Thorburn, Kue, Keon, & Lo, 2012).

This study was necessary to better understand not only how the Hmong population perceives their health, but also how modern healthcare workers can take that perception into account when working with this population. The Hmong population has specific spiritual beliefs that impact how they experience and perceive their overall health and specific physical health problems. More about why this study was needed is explained further in this chapter.

This study has the potential to directly lead to positive social change in various ways. This would include increasing the overall healthcare quality of the Hmong population through a better understanding of their specific healthcare needs and perspectives. This could also include increasing access of the Hmong population to modern healthcare services by making them feel more welcomed and understood by their local modern healthcare providers.

Chapter 1 begins by my describing the general background of the study including a description of the gap in the literature and discussion about why the study was needed. I then discuss the problem statement, research problem of the study, and the purpose of the study. Next, specific research questions are outlined, and the theoretical framework of the study is explained. This is followed by a description of the nature of the study and a definition of key concepts, constructs, or terms I used within the study. I then explain the assumptions, I scope, and delimitations of the study including its boundaries and potential

transferability. This is followed by a description of any limitations in the study related to the design, methodology, transferability, dependability, biases, and an explanation of how these limitations could be addressed. Last, I end the chapter by describing the significance of the study and provide a summary of the main points discussed.

Background

In this study I sought to better understand how the Hmong population perceived their health and how modern healthcare workers can take that perception into account when working with this population. The Hmong population has specific spiritual beliefs that impact how they experience and perceive their overall and specific physical health problems. I sought to better understand the decision-making process of Hmong individuals in deciding whether to seek out a traditional Hmong healer or modern healthcare provider. Understanding the decision-making process involved with individuals' health behaviors and choices is a topic that has been thoroughly covered in the past. However, as noted by Lor et al. (2017) that much more research is needed concerning how Hmong perceive their physical health problems and their interactions with healthcare providers, especially as it relates to their culture, traditions, and spiritual beliefs. This is helpful in better understanding how the Hmong perceive their health problems and how better equipped Western healthcare providers can more effectively treat and interact with the Hmong population.

One of the areas I explored in this study is the treatment-seeking behavior of the Hmong population. The Hmong population has a myriad of factors that impact their treatment-seeking behaviors, such as their spiritual and cultural practices. However,

another factor is the level of acculturation of the Hmong individual (Areba et al., 2020; Xiong & Dauphin, 2018). The level of acculturation of an individual has been shown in other studies to play a role in the individual choosing healthcare services of the dominant culture. For example, a study by Markova et al. (2020) found that higher levels of acculturation by immigrants from Pakistan, Somalia, Russia, and Poland were more likely to use the health-related resources of the dominant culture.

How culture is perceived by healthcare workers can impact the type of care they receive. For example, how a healthcare worker perceives and interacts with clients from different cultures has been shown to impact the care the worker provides to the client (Shepherd et al., 2019). The more inaccurate the perception of the culture by the worker, the lower the quality of care is for that client (Shepherd et al., 2019). A I explored a similar concept, which is how the Hmong mental health perspectives and beliefs as viewed by modern healthcare workers. This topic is important to explore because past research has shown communication problems related to discussing the pain a Hmong patient was experiencing inhibited the ability of the healthcare provider to effectively treat the Hmong patient (see Lor et al., 2020). Furthermore, the communication between the healthcare worker and the Hmong patient was shown to be hampered by different beliefs about the pain and only improved when healthcare workers sought to improve their cultural competency related to their Hmong patients (Lor et al., 2020).

The way Western healthcare services are viewed can play a role in a culture's decision to use the services. For example, a study by Shepherd et al. (2018) evaluated the views African Americans, Native Americans, Latino/a Americans, and Asian Americans

had on western healthcare workers and services. Shepherd et al. indicated that the more culturally competent these populations viewed the workers and overall healthcare system, the more likely they were to seek out and use Western healthcare services. This same concept was explored in this study concerning the Hmong perspective of Western mental health services.

In this study, I explored concepts related to the gap in research outlined by Lor et al. (2017). I sought to understand how the Hmong perceive their physical health problems and their interactions with healthcare providers. This study was necessary because by interviewing members of the Hmong population and exploring their experiences and perceptions about their health and use of health care may help to lead to the improved culturally competent treatment of the Hmong population. This would include an increased understanding of the issues contributing to improved and culturally sensitive healthcare experiences for the Hmong people. This study was also needed because it could help communities and local providers with a Hmong population to be able to better understand the health needs and perspectives of the Hmong population. Finally, this study was needed to be able to improve the everyday health interactions between local modern healthcare providers and their Hmong clients.

Problem Statement

The Hmong have unique cultural and religious beliefs having to do with their health that run counter to modern Western beliefs and practices related to health (Vang, 2018). These beliefs have led to conflicts with Western health providers because of the limitations these beliefs (e.g., refusal to have their bodies punctured, have surgeries, give

blood, or take medications) place on Hmong and what they are willing to do or have done to their bodies (Vang, 2018). This has led to experiences with Western medicine and health providers that have been perceived as unaccommodating, frightening, stressful, and have hindered their integration into Western communities and health practices (Vang, 2018).

Purpose of the Study

The main purpose of this study was to understand the Hmong experience when a physical health problem has been identified and how they perceive their physical health problems from a spiritual perspective. This included factors and thought processes a Hmong person experiences when diagnosed with a physical health problem or the specific factors and past experiences that are associated with how a Hmong person decides to choose between a modern healthcare provider and a traditional Hmong healer. The secondary purpose of this study was to understand the Hmong experience with modern healthcare providers and services during this process.

Research Questions

RQ1: How does a Hmong person describe their experience when choosing a modern healthcare provider or traditional Hmong healer?

RQ2: How does a Hmong person describe their experience when a modern healthcare provider diagnoses them with a physical health problem?

Theoretical Framework of Study

The framework used in this study was the social cognitive theory (SCT). This theory was developed by Bandura in 1986 and evaluated the impact that an individual's

experiences, behaviors of others, and environmental factors have on the (health) behaviors a person engages in (Bandura, 1986; Sharma & Romas, 2012; Zinn et al., 2012). SCT can be used to understand and explain the factors that mediate health behaviors (Sharma & Romas, 2012; Zinn et al., 2012). SCT outlines and explains the specific constructs that impact health behaviors and experiences, which include reciprocal determinism, behavior capability, observational learning, reinforcements, expectations, and self-efficacy (Bandura, 1986).

Reciprocal determinism refers to the reciprocal influence on an individual, the behavior the individual engages in, and the social environment (Bandura, 1986; Lefrancois, 2019). This concept was important for this study to understand how the Hmong population, their behaviors, and their cultural environment plays a role in how they experience physical health problems and their expectations and experiences with modern healthcare providers. Behavior capability refers to a person having the ability to perform a behavior by possessing the necessary skills and knowledge to engage in the behavior (Bandura, 1986; Lefrancois, 2019). This construct applied to this study because certain members of the Hmong community believe that if their body is punctured or cut, their soul can be damaged or escape (Daly, 2019).

Nature of Study

The nature of this study is qualitative, and I used a generic qualitative method. Patton (2015) defined a generic qualitative research approach as “one that focuses on descriptions of what people experience and how it is that they experience what they experience”, and it “simply seeks to understand a phenomenon, a process, or the

perspectives and worldviews of the people involved" (p. 117). The specific form of generic qualitative research used for this study is basic research. Merriam and Tisdell (2015) described basic qualitative research as being motivated by an intellectual interest in a phenomenon and has as its goal the extension of knowledge…[and] its primary purpose is to know more about a phenomenon.

Key Phenomenon Investigated

This study was a qualitative exploration of the experiences of Hmong adults, 18 years and older, related to the healthcare system and physical illness. I explored their experiences with the modern Western healthcare system, how they perceived their physical illnesses, and the factors and experiences related to whether a Hmong person chooses a traditional Hmong healer or modern healthcare provider. The target sample, in this case, was the Hmong from a local Hmong community in the Central Midwest who had an interaction with the local modern healthcare system within the last 2 years and was deemed by a modern healthcare provider to have any physical health problem. I aimed to explore the experiences these Hmong adults have had with the local healthcare system, how they perceived their physical health problems from their traditional spiritual view on health and illness, and the factors and experiences related to whether the person chose to have their illness treated by a traditional Hmong healer or modern healthcare provider.

Methodology Summary

I conducted formal interviews using a semi structured interview format. Interview questions based on SCT were used to collect detailed accounts of the Hmong community

member's healthcare experiences and their spiritual perceptions of their illness (see Creswell, 2017; Decher, 2017). An interview guide was developed for this semi structured interview process. The interview guide was used to provide a list of questions and topics that were covered during the interview process and the order in which they were covered (see Creswell, 2017; Decher, 2017). The semi structured interview format allowed me to further explore topics that came up during the interview even when the topic is not included in the guide (see Creswell, 2017; Decher, 2017).

Definition of Terms

Availability of Traditional Interventions: The level of access a Hmong person has to traditional Hmong interventions for health concerns or health problems, such as a Shaman, religious leader, or healing ceremonies (Xiong & Dauphin, 2018).

Behavior Capability: A person's capacity to perform a specific act by possessing the necessary skills and knowledge to engage in the behavior (Bandura, 1986; Lefrancois, 2019).

Cultural Beliefs and Practices: The cultural beliefs and practices of the Hmong as it relates to their health, the reasons behind the state of their health, and what they do to address any problems with their health (Areba et al., 2020).

Cultural Identity: How strongly a Hmong person identifies with their Hmong cultural identity (Xiong & Barry, 2018).

Culturally Sensitive Care: Refers to providing health interventions and a healthcare experience for somebody from the Hmong population that considers and

respects their cultural beliefs and practices associated with their health (Her-Xiong & Schroepfer, 2018).

Expectations: The consequences of behavior anticipated by a person (Bandura, 1986; Lefrancois, 2019).

Health Behaviors: Actions taken by the Hmong population or a Hmong person that affects their health (Areba et al., 2020).

Health Seeking Behaviors: Any action taken or not taken by Hmong people who believe they have a health problem and in need of seeking a way to address the health problem (Yang, 2019).

Hmong Culture: The Hmong culture as it exists in the United States and the varying degrees of traditional culture, such as clan-based communities and spiritual and health beliefs (Fang & Stewart, 2018).

Hmong Experience: The experience of the Hmong population or a Hmong person related to their health, their health beliefs and practices, and their experience with the modern Western healthcare system (Fang & Stewart, 2018; Lor et al., 2017).

Hmong Population: Hmong immigrants, from northern Vietnam, Laos, Thailand, and the eastern parts of Myanmar who settled in the United States heavily between the years 1970 and 2000, and who continue to settle in the United States today (Lor et al., 2017; Vang, 2018).

Hmong Spiritual Beliefs and/or Perceptions: The views of the Hmong population or a Hmong person as it relates to their health, illness, and physical problems (Fang and Stewart, 2018; Vang, 2018).

Level of Acculturation: How much a Hmong person has acclimated American culture (Areba et al., 2020; Xiong & Dauphin, 2018).

Level of Culturally Traditional Observations: The type of health decision making and expectations a Hmong person was consistently observed from Hmong family, friends, and other tribal members (Lor et al., 2017; Vang, 2018).

Modern Western Health Beliefs and Practices: The health beliefs and practices found in modern America and American healthcare facilities to treat health problems and illness (Fang & Stewart, 2018; Lor et al., 2017).

Observational Learning: People observing behavior and then reproducing those behaviors, which is also referred to as the modeling of behaviors (Bandura, 1986; Lefrancois, 2019).

Reciprocal Determinism: The mutual influence of the individual, the behavior the individual engages in, and the social environment (Bandura, 1986; Lefrancois, 2019).

Reinforcements: Both the internal and external responses people receive from behaviors they engage in and impact whether the person will continue or stop the behavior.

Religious Beliefs: The specific religious beliefs central to the Hmong, which include a belief in the spiritual world, souls, shamans, and other tenets of the animist religion or the lack of these beliefs (Xiong & Dauphin, 2018; Vang, 2018).

Self-efficacy: How capable a person believes they are to engage in a behavior, including any barriers or facilitators that may exist (Bandura, 1986; Lefrancois, 2019).

Shamanism: Practiced by a shaman who is considered a healer of illnesses and disease by making offerings to spirits through meals or animal sacrifice (Helsel, 2019).

Social Cognitive Theory (SCT): The theory by Bandura that learning occurs in a social context with a dynamic and reciprocal interaction of the person, environment, and behavior (Bandura, 1986).

Traditional Hmong Healer: Also known as a shaman, the person some Hmong use for spiritual healing, herbal medicine, and other traditional practices to help them with a health problem or illness (Fang & Stewart, 2018; Her-Xiong & Schroepfer, 2018; Lor et al., 2017).

Western Health Providers: A healthcare provider that works in a modern American healthcare facility and practices modern American medicine (Fang & Stewart, 2018; Lor et al., 2017).

Assumptions

The basic underlying assumptions for this study were related to the theoretical framework of the study, which was SCT. This theory has five basic assumptions that were used in this study. The first is that people learn by observing others (Bandura, 1986; Connolly, 2017; Joseph et al., 2017). The second is that the learning that takes place is done internally and behavior change is not guaranteed (Bandura, 1986; Connolly, 2017; Joseph et al., 2017). Third, a person and the environment the person is in mutually influence the other (Bandura, 1986; Connolly, 2017; Joseph et al., 2017). Fourth, the behavior a person engages in is always carried out to pursue a particular goal. Last, over

time a person's behavior is increasingly self-regulated (Bandura, 1986; Connolly, 2017; Joseph et al., 2017).

The assumptions that are made by the SCT and outlined above were necessary for this study. These assumptions are required in the context of this study because they were used, in part, to help explain the concepts and the focus of scientific inquiry for this study. These concepts and focus of scientific inquiry are the experiences of the Hmong related to past physical health problems and exploring the factors related to those experiences and perceptions.

Scope and Delimitations

The scope of this study was limited to interviewing adult Hmong adults (18 years and older) who live in in a county located in the Central Midwest and have had a health problem for which they consulted with a local Western healthcare provider. I inquired about the experiences of the Hmong related to past physical health problems and explored the factors related to those experiences and perceptions. This was done to better understand how the Hmong population within this Central Midwest population perceived their physical health problems and explored the factors involved in this perception, including but not limited to their cultural and spiritual beliefs and their interactions with Western healthcare workers. These experiences were explored and recorded using a semi structured interview process.

The study population consisted of participants who are adult Hmong who live in in a Central Midwestern county, experienced a health problem as adults, sought out consultation for that problem with a Western healthcare provider, and were willing to

participate in a semi structured interview. If the participant did not meet these criteria, the person was excluded. This study strictly evaluated the Hmong population's experience with and perception of their health problems and interactions with the Western healthcare system and providers. No other experiences were explored in this study or during the interview. Only the data generated from the interviews were considered for use in this study and no other data that was previously collected related to this topic was used in this study.

Potential transferability for this study referred to the degree to which the research results could potentially be used in other contexts or with other respondents (Miles, Huberman, & Saldana, 2018). The context of this study was related to the specific health beliefs, perceptions, and behaviors of the Hmong population and how those beliefs, perceptions, and behaviors are impacted by Hmong cultural, traditional, and spiritual beliefs. Thus, the transferability of the results of this study is limited to other Hmong populations. The results of this study may be transferable to other contexts, if those contexts are related to the Hmong population and how their culture, traditions, and spiritual beliefs impact decision making in those contexts.

Limitations

Several limitations, challenges, and barriers existed for this study. This includes the distrust that Hmong have for people outside of their community and who are not Hmong themselves (see Thorburn et al., 2012). I addressed this issue by using local Hmong community liaisons who already have an established rapport, trust, and respect developed with the Hmong community. Hmong participants may be reluctant to say

anything they believe could disgrace their family, fear that outsiders will not understand, or simply not want to share their opinions with somebody they do not know (Fang & Stewart, 2018; Her-Xiong & Schroepfer, 2018; Thorburn et al., 2012). I mitigated this limitation by leveraging Hmong community leaders, and Hmong community liaisons who were able and willing to provide access to the Hmong community and explained the intent of the study.

The qualitative nature of this study did not allow results to be generalized easily for larger populations (see Miles et al., 2018). However, this study may allow a potentially better understanding and provision of healthcare services to the studied population. The transferability of the results of this study is limited as I focused specifically on the Hmong population, their perceptions, beliefs, and behaviors related to their health, and how factors such as tradition, culture, and spiritual beliefs shape these. However, the results of this study may be useful in informing future research on similar populations in a similar context in other areas of the United States.

The semi structured interviews used in this study had limitations. Developing an effective semi structured interview can be challenging as questions need to be written so as not to be leading. This limitation was mitigated by using Walden University resources and the expertise of my dissertation committee to inform the process. Another limitation of interviewing is that enough people have to be interviewed for me to be able to make conclusions, make comparisons, and isolate themes within the interviews. This limitation was mitigated by ensuring to interview as many participants as the dissertation committee deemed it necessary to collect an adequate amount of data for this study.

Another limitation of this study was the potential for a variety of biases. The biases include interviewer biases, which is when the interviewer's body language, tone, or facial expressions can bias impact the response of the person being interviewed (see Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019). I mitigated this by not giving opinions during the interview and staying neutral in how I dressed, spoke, and reacted (see Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019). The questions in the interview can create a bias if the questions are leading and even question order can create bias (see Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019). This was mitigated by keeping questions neutral, asking general questions first, then more specific questions, asking positive questions before negative questions, and asking behavior questions before attitude questions (see Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019).

Other biases that may have been present included consistency and acceptance biases. Consistency bias is when a person being interviewed attempts to appear consistent in their answers, biasing the person's answer (see Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019). This was mitigated by my asking clarification questions if an answer did not seem right (see Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019). Acceptance bias is when a person being interviewed answers the person believes the interviewer wants (see Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019). This was mitigated by my challenging the answer tactfully if what the person being interviewed is saying did not seem right (see Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019).

Other biases include references, sensitivity, and reporting biases. Reference bias is when a participant being interviewed develops a frame of reference from previous questions and topics that bias their answer in later questions and topics (see Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019). This was mitigated by logically ordering the questions and topics within the interview. Sensitivity bias is when a participant does not want to talk about a particular topic or answer certain questions, which can lead to false answers or no answers at all (see Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019). I mitigated this by building trust and rapport with each participant interviewed. Reporting bias is related to the individual characteristics of the interviewer that bias how the information obtained from the person being interviewed is perceived and articulated (see Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019). I addressed this bias by being aware it could occur and consciously look for it. I also had other people, including my dissertation committee, review the information to evaluate for bias.

Significance

This study contributes to the literature concerning the Hmong experience and perceptions when a physical health problem has been identified and how the Hmong perceive their physical problems from a spiritual perspective. Previous data show that the Hmong population tends to conceptualize their physical ailments in spiritual terms and prefer to treat their physical ailments with traditional and culturally based approaches such as spiritual healing with a tribal shaman and herbal medicines (Fang & Stewart, 2018). This preference for treating physical health issues through cultural and spiritual

means is related to their fear of modern healthcare services and procedures and may sometimes leave them feeling discriminated against (Fang & Stewart, 2018; Her-Xiong & Schroepfer, 2018).

The results of this study could potentially support professional practice and allow for practical application in several ways. A better understanding of these issues may contribute to the improved and culturally sensitive healthcare experiences for the Hmong people. The results of this study could help communities and local providers with a Hmong population to be able to better understand the health needs and perspectives of the Hmong population. Finally, the results of this study could potentially be able to be directly applied to the everyday health interactions between local modern healthcare providers and their Hmong clients.

This study has the potential to directly lead to positive social change in various ways. This could include increasing the overall quality of healthcare quality to the Hmong population through a better understanding of their specific healthcare needs and perspectives. This could also include increasing access of the Hmong population to modern healthcare services by making them feel more welcomed and understood by their local modern healthcare providers.

Summary

In Chapter 1, I described the general background of the study. This was followed by a discussion of the problem statement, research problem of the study, and purpose of the study. I then explained the research questions and theoretical framework of this

current study. I followed this was a description of the nature of the study and key concepts, constructs, and terms used within the study.

I described the assumptions I made in this current study, as well as the scope and delimitations of the study and the study boundaries and potential transferability. This was followed by a description of any limitations in the study related to the design, methodology, transferability, dependability, biases, and an explanation of how these limitations were addressed. Lastly, I described the significance of the study and the potential impact of positive social change. In Chapter 2, the current literature related to the topic and the identified gap within the literature are reviewed. This chapter provides a more in-depth look at the theoretical foundation of the study, related concepts, and constructs under investigation.

Chapter 2: Literature Review

Hmong immigrants began settling in the United States heavily between the years 1970 and 2000. The Hmong have cultural and religious beliefs related to their health that conflict with modern Western beliefs and practices (Vang, 2018). These Hmong beliefs conflict with modern health care practices because of the limitations of these beliefs (Vang, 2018). This conflict has led to the Hmong population have led to experiences with Western medicine and health providers as being perceived by this population as unaccommodating, frightening, stressful, and have hindered their integration into Western communities and health practices (Vang, 2018).

In this chapter, I provide an outline of the literature search strategy, the theoretical foundation, the conceptual framework, and an exhaustive review of the current literature related to my topic. This literature is related to Hmong cultural and spiritual beliefs related to physical health problems, the making of healthcare decisions and what factors may play a role in that process. I included literature related to research that has been done in other cultures and subpopulations and literature that focuses on the Hmong population as it relates to research that has been conducted in areas of health and healthcare. Where relevant, each of these concepts were explored through the lens of SCT. This chapter concludes with a summary of the major themes in the literature, what is known as well as what is not known in the discipline related to the topic of study, and how this study fills the gap in the literature and will extend knowledge in the discipline.

Literature Search Strategy

Many Walden University electronic databases were used in this study to search for scientific articles that were relevant to this study. These included PsycINFO, PsycArticles, PsycBooks, PsycCritiques, PsycExtra, and PsycTests. Non-Walden University electronic databases were also used for this study, such as Google Scholar. The key terms used in the searches included *Hmong, Hmong health decisions, Hmong cultural health factors, Hmong views on physical health problems, culture and health decisions, cultural health decisions, factors related to health decisions, SCT, concepts of SCT, Hmong physical health problems,* and *factors impacting health decisions*.

These terms were used in searches in a variety of ways using a combination of these terms that were interchangeable and for individual independent searches. Each of these sources was obtained in a digital format. The literature review was done primarily using current and relevant literature related to information and studies from 2015 to 2020. A small part of the literature was outside of this time frame and was used to source the foundational material and information that allowed for context to be provided for the theoretical framework and foundational context associated with SCT.

Theoretical Foundation

The framework used for this study is the SCT. This theory was developed by Bandura in 1986 to evaluate the impact that an individual's experiences, behaviors of others, and environmental factors have on the (health) behaviors a person engages in (Bandura, 1986; Sharma & Romas, 2012; Zinn et al., 2012). SCT can be used to understand and explain the factors that mediate health behaviors (Sharma & Romas,

2012; Zinn et al., 2012). SCT outlines and explains the specific constructs that impact health behaviors and experiences, which include reciprocal determinism, behavior capability, observational learning, reinforcements, expectations, and self-efficacy (Bandura, 1986).

Major Theoretical Concepts

Reciprocal determinism refers to the shared influence of an individual, the behavior the individual engages in, and the social environment (Bandura, 1986; Lefrancois, 2019). This concept was important for this study to understand how the Hmong population, their behaviors, and their cultural environment plays a role in how they experience physical health problems and their expectations and experiences with modern healthcare providers. Behavior capability refers to a person having the competency to perform a behavior by possessing the necessary skills and knowledge to engage in the behavior (Bandura, 1986; Lefrancois, 2019). This construct applied to this study because certain members of the Hmong community believed that if their body is punctured or cut their soul can be damaged or escape (see Daly, 2019).

Observational learning refers to people viewing a behavior and then reproducing those behaviors, which is also referred to as the modeling of behaviors (Bandura, 1986; Lefrancois, 2019). This construct applied to the study in that this observational learning by individual Hmong vary depending on the type and level of culturally traditional observational learning they engaged in, which in turn will impact their individual experiences and expectations concerning modern healthcare providers and how they view their physical problems and symptoms (see Lor et al., 2017; Vang, 2018).

The level of culturally traditional observations refers to the type of health decision making and expectations a Hmong person was consistently observed from Hmong family, friends, and other tribal members (Lor et al., 2017; Vang, 2018). For example, first generation Hmong people who came to the United States from Laos more likely observed Hmong family, friends, and other tribal members base all their health decisions from a spiritual perspective and regularly used a shaman for health issues (Lor et al., 2017; Vang, 2018). However, second and third generation Hmong people who either came over to the United States as young children or were born in the United States likely have had fewer observations of family, friends, and other tribal members making health decisions strictly from a Hmong cultural perspective and have had more experiences observing health decisions being made from a modern healthcare perspective (Lor et al., 2017; Vang, 2018).

Reinforcements refer to both the internal and external responses people receive from behaviors they engage in and impact whether the person will continue or stop the behavior (Daly, 2019). This concept applied to this study because the responses a Hmong person gets about their health beliefs and behaviors from family, friends, and other members will play a role in whether those beliefs and behaviors are maintained. Furthermore, the more culturally traditional the environment is for a Hmong person will determine what behaviors and beliefs will be reinforced (Daly, 2019).

Expectations refer to the consequences of behavior anticipated by a person (Bandura, 1986; Lefrancois, 2019). This concept applied to this study in that the expectations a Hmong person has concerning their health problems will determine how

they experience their health problem and the advice provided by a modern healthcare provider. For example, if a Hmong person believes their health problem is spiritual in nature, then they are not likely to have the expectation modern treatments will help them and will seek a spiritual healer (Daly, 2019; Fang & Stewart, 2018).

The last construct is self-efficacy and refers to how capable a person believes they are to engage in a behavior, including any barriers or facilitators that may exist (Bandura, 1986; Lefrancois, 2019). This construct applied in two ways to this study. First, self-efficacy refers to whether a Hmong person believes they can engage in the necessary behavior to address what they perceive as either a spiritual or physical problem. Second, self-efficacy refers to whether the Hmong person is in an environment that will support or not the behavior the person wants to engage in and will shape how they experience their health problem (see Bandura, 1986; Lefrancois, 2019).

Previous Application of Theoretical Foundation

Studies employing SCT as a theoretical foundation have been conducted in numerous patient populations and health-related contexts, some of which used semi structured interviews as the primary method of data collection (see Olson, 2016). SCT is also often used to develop health behavior interventions to understand how individuals interact with their environment in health-related context, and to examine the factors associated with and impacting health decisions (Bandura, 1986; Sharma & Romas, 2012; Zinn et al., 2012).

For example, Kim et al. (2016) evaluated the perceptions of young adult women and their health decisions and perceptions on diet, diet problems, and other factors related

to diet. The researchers also evaluated how the three main SCT factors (cognitive, behavioral, and environmental factors) influenced this perception (Kim et al., 2016). The findings of this study indicated that the participants' health decisions and perceptions of diet and diet problems were all heavily influenced by each of the three SCT factors noted above (Kim et al., 2016). Papinczak et al (2017) ued SCT to evaluate the human behavior and motivation behind cannabis dependent people seeking treatment. They were reported that treatment seekers had a much higher negative outcome expectation for cannabis use and much lower belief in self-efficacy to refuse cannabis when experiencing emotional distress (Papinczak et al., 2017).

Theory Choice Rationale

Furthermore, SCT can be used by a researcher to better understand the social factors related to people's health and health decisions and how their experiences impact their current health decisions and health behaviors (Sharma & Romas, 2012; Zinn et al., 2012). For example, Smith et al. (2017) evaluated the health experiences, perceptions, and decisions of patients with posttraumatic stress disorder (PTSD). Using SCT, the researchers evaluated the impact that social support barriers, perceived social support, self-efficacy, negative and positive social interactions, past trauma experiences, and past experiences with social acknowledgment of traumatic experiences had on the health decisions and perceptions with people who suffered from PTSD (Smith et al., 2017). SCT has been used in numerous health-related contexts and its constructs have considerable explanatory power in such settings; this made it seem an acceptable choice for my study.

Relation of SCT to Present Study

SCT allowed me to understand several crucial factors. First, this framework allowed me to better understand the experience of the Hmong population when faced with a physical health problem through the six constructs outlined by SCT. This means when understanding how a Hmong person experiences their physical health problems the experience was understood in relation to how reciprocal determinism, behavior capability, observational learning, reinforcements, expectations, and self-efficacy impact this experience (see Bandura, 1986), which formed the basis of my qualitative interview. Second, this framework allowed me to use the six constructs outlined by SCT to better understand the experience the Hmong population has when interacting with a healthcare provider and choosing whether to use a traditional Hmong healer or a modern healthcare provider to treat their physical symptoms. This theoretical framework allowed a better understanding of Hmong health perspectives, and experiences based on their previous experiences, and the impact of these six SCT constructs on those experiences (see Bandura, 1986; Sharma & Romas, 2012; Zinn et al., 2012).

Review of the Literature

In this literature review I evaluate key concepts related to this study and provide a review of the current literature related to the topic of study. I first evaluate the literature related to the qualitative methodological approach which is then followed by the literature related to past research approaches of the study topic and other cultures. Next, I present the literature related to the rationale for the concept selection within the study and the specific constructs under investigation. This includes literature related to the

description of the phenomena, concepts, any controversy related to the concepts, and what is remaining to be studied about the concepts.

I then present literature related to the research question. This literature covers many diverse topics including treatment seeking, end-of-life and culturally sensitive care, factors impacting healthcare choices, and SCT and PTSD. This literature review also covers topics focusing exclusively on the Hmong population including trust and discrimination in the population, health status, behaviors of the population, acculturation and health behaviors, health perspectives, perceptions of primary care providers, and health-seeking behaviors. The last part of the literature review includes topics related to Hmong health behaviors, Hmong use of traditional healers and shamans, and the meaningfulness of the approach.

Studies Related to Research Questions

The following list of studies is related to the research questions for this study. The studies below are reviewed and synthesized for clarity and to show the connection between these past studies and the research questions. The meaningfulness of each study is evaluated concerning this study.

Treatment Seeking

The study by Fang and Stewart (2018) is a study that analyzes the Hmong population's willingness to engage in community-based hepatitis B screening interventions based on their social and cultural perceptions and traditional beliefs. The results of the study indicated several cultural and traditional heath beliefs serve as barriers for the Hmong population in receiving modern healthcare services (Fang &

Stewart, 2018). These cultural and traditional beliefs include protecting the family's reputation, fear of doctors, medical procedures, and test results; distrust in healthcare providers and service; and preference toward using traditional herbal medicines and spiritual healing (Fang & Stewart, 2018).

End-of-Life and Culturally Sensitive Care

The study by Her-Xiong and Schroepfer (2018) is a study that describes the Hmong view on end-of-life beliefs and rituals, and how healthcare providers can provide culturally sensitive care. The results of the study indicated Hmong elders have heterogeneity when it comes to their end-of-life traditions and beliefs (Her-Xiong & Schroepfer, 2018). This included believing that the family should be the one that provides end-of-life care, the importance of soul calling, spiritual offering, and the power of prayers. The study also indicated that modern healthcare providers should be open to including traditional healers in the care and decision-making of Hmong family members (Her-Xiong & Schroepfer, 2018).

Hmong Mental Health Perspectives

The study by Lor, Rodolfa, and Limberg (2017) is a study that evaluates the Hmong perspective of mental health services and the impact this has on their willingness to see a mental health counselor. This study indicated that 53 % of the Hmong participants in the study practice Shamanism (Lor, Rodolfa, & Limberg, 2017). The results indicated there was a significant positive correlation between the Hmong culture and their willingness to seek out counseling services, as well as a positive significant

correlation between expression of attitudes and perception of stigma (Lor, Rodolfa, & Limberg, 2017).

Social Cognitive Theory (SCT) and Posttraumatic Stress Disorder (PTSD)

The study by Smith, Felix, Benight, and Jones (2017) is a study that evaluates the health experiences, perceptions, and decisions of patients with PTSD. This study used the survey method with 141 students from the University of California Santa Barbara. The researchers for this study used SCT variables to evaluate the impact they have on the health decisions and perceptions of people who suffer from PTSD (Smith, Felix, Benight, and Jones, 2017). The variables included social support barriers, perceived social support, self-efficacy, negative and positive social interactions, past trauma experiences, and past experience with social acknowledgment of traumatic experiences.

The findings of the study indicated positive health decisions and health outcomes related to traumatic stress symptoms and depression related to some post-event experiences (Smith, Felix, Benight, and Jones, 2017). These experiences included those of low perceived social support barriers, high perceived social support and self-efficacy, low negative and high positive social interactions, and positive experiences with social acknowledgment of traumatic experience (Smith, Felix, Benight, and Jones, 2017). The researchers concluded that these positive factors increased a person's coping self-efficacy, which in turn led to positive health decisions and outcomes (Smith, Felix, Benight, and Jones, 2017).

Trust and Discrimination in Hmong Population

The study by Thorburn et al. (2012) is a study that provided data about the lack of trust and discrimination Hmong women face related to breast and cervical cancer screening. The study indicated that some in the Hmong community mistrust Western medicine and the modern healthcare system (Thorburn et al., 2012). This mistrust was related to their overall lack of understanding of Western medicine and familiarity with the services and procedures, cultural beliefs, and traditions. The results of the study also indicated that some mistrust of Western medicine was perceived instances by Hmong of being treated differently because they were Hmong or perceived overt acts of discrimination towards them. These experiences led to Hmong reporting feeling disrespected, angry, sad, and a decrease in willingness to seek out modern healthcare services in the future (Thorburn et al., 2012).

Health Status and Behaviors of Hmong Population

A study by Lor (2018) reviewed how the Hmong population experienced disease and illness. The study focused on two primary areas, which included health status and health behaviors. Health status was mainly related to breast and cervical cancer (Lor, 2018). The review by the researcher indicated that disparities existed within the adult Hmong population related to health promotion and disease prevention. The researcher indicated that one explanation for why this disparity existed with this population was related to the lack of health data collected and that more data needs to be collected related to the social determinants that are related to why this population is placed at an increased risk (Lor, 2018).

Hmong Acculturation and Health Behaviors

Areba et al (2020) investigated the health behaviors of the Hmong population. This study evaluated the link between the level of acculturation and the well-being of Hmong adolescents. The specific health behavior relationships concerning the level of acculturation were substance abuse, socioemotional well-being, and academic achievement (Areba et al., 2020). The results of the study indicated the significant interactions between the Hmong adolescent level of acculturation and academic achievement. The researchers concluded that when attempting to prevent substance use behavior with Hmong adolescents that it is important to support protective factors of adolescent Hmong, which includes social support, family, and cultural beliefs (Areba et al., 2020).

Perceptions of Primary Care Providers

A study by Lor, Rabago, and Backonja (2020) evaluated the healthcare experience and Hmong health beliefs from the perspective of modern primary care providers (PCPs). In this qualitative study, the researchers evaluated how the PCPs interacted and interpreted the perception of pain and how they were able to effectively communicate with the Hmong patient. In this study, fifteen PCPs were interviewed, including physicians, nurses, and physician assistants (Lor, Rabago, & Backonia, 2020).

The findings of the study were that in general there were communication problems related to discussing the pain Hmong patient was experiencing and that these problems communicating inhibited the ability of the PCPs to provide culturally competent care (Lor, Rabago, & Backonia, 2020). The study concluded that three major

themes characterized the interactions of the Hmong patients and PCPs (Lor, Rabago, & Backonia, 2020). This included the following three themes:

- PCPs experienced problems of communication about pain to the Hmong patient because of language barriers.
- PCPs were able to readily perceive that the Hmong patient had different beliefs about pain.
- PCPs actively sought out different ways to improve their communication with the Hmong patient (Lor, Rabago, & Backonia, 2020).

Factors Impacting Healthcare Choices

Research shows that whether a Hmong person decides to seek out modern healthcare services can relate back to several factors. A study by Xiong and Dauphin (2018) evaluated how levels of acculturation, cultural identity, cultural beliefs and practices, availability of traditional interventions, and religious beliefs can impact whether a Hmong person seeks out services from modern healthcare providers. The results of the study showed that whether a Hmong person was likely to seek out services from modern healthcare providers was most highly correlated to their level of acculturation and level of their traditional beliefs and practices (Xiong & Dauphin, 2018). What the researchers concluded was that if a Hmong person had a low level of acculturation, strong traditional beliefs, and a high degree of engaging in traditional practices, can lead to a lower likelihood of the person seeking out modern mental health services (Xiong & Dauphin, 2018).

Hmong Health Seeking Behaviors

Research has been conducted to evaluate the various health-seeking behaviors of the Hmong population. A study by Yang (2019) evaluated the mental health-seeking behaviors of the Hmong population. This study looked at the common problems the Hmong population experienced when engaging in these behaviors. This study concluded that the Hmong population, especially ones who had migrated to the United States between 1980 through 2000, had a lower rate of seeking Western treatment for a variety of reasons (Yang, 2019). These reasons relate to how the culture is structured, which entails the Hmong population traditionally seeking out a Hmong shaman, herbs, and elders for assistant and treatment for health issues, and because they viewed Western treatments as being less reliable (Yang, 2019).

Constructs Under Investigation

This study investigated the phenomenon in question and Hmong health decisions by using the constructs related to SCT. SCT outlines and explains the specific constructs that impact health behaviors and experiences, which include reciprocal determinism, behavior capability, observational learning, reinforcements, expectations, and self-efficacy (Bandura, 1986). These constructs were evaluated as they related to the health behavior, health experiences, and health decisions of the Hmong population.

Description of Phenomena

Health decisions can be explained in many ways. The Hmong health decisions are being explained using SCT. This theory was used to describe how the constructs listed above impact the overall health decisions of the Hmong population. Cultural health

decisions, as with the Hmong population, are described as being influenced by a person's culture, cultural beliefs, and cultural conceptualization of reality (Ji, 2019). Furthermore, culture impacts many different factors, which includes:

1. How people perceive their overall health
2. Illness
3. Death
4. Cause of disease
5. How to approach or treat an illness
6. How the illness is experienced and expressed
7. Where people go to get help for the illness
8. Types of treatment people request or are willing to accept (Ji, 2019)

Description of Concepts

Papinczak et al (2017) is a study that uses SCT to evaluate human behavior and motivation behind cannabis-dependent people seeking treatment. Using SCT as a framework, researchers evaluated the differences between seekers and non-seekers of the treatment related to their cannabis use outcome expectations and their self-efficacy to refuse cannabis (Papinczak et al., 2017). The study used comprehensive measures to assess treatment outcome expectations and self-efficacy related to the client's ability to refuse cannabis. In this study, outcome expectations and self-efficacy are defined in line with SCT. Outcome expectations are defined as the consequences participants anticipate for healthy behavior and self-efficacy. It is also defined as the participants' judgment of their ability to carry out healthy behavior (Papinczak et al., 2017).

The study had 269 participants in the non-seeking treatment group and 195 participants in the treatment-seeking group (Papinczak et al., 2017). The findings of the study indicated that treatment seekers had much higher negative outcome expectations for cannabis use and a much lower belief in self-efficacy to refuse cannabis when experiencing emotional distress (Papinczak et al., 2017). The researchers concluded that the motivation for a cannabis-dependent person to seek treatment may be influenced by high negative outcome expectations and low refusal self-efficacy (Papinczak et al., 2017).

This study specifically used the SCT constructs of outcome expectancy and self-efficacy. These constructs have specific descriptions that were outlined within the study. Outcome expectancy is described as what the person expects from the outcome for making a particular health decision or engaging in certain health behavior, and the value the person ascribes to that outcome (Papinczak et al., 2017). Self-efficacy is described as the belief the person holds on their ability to both control behavior and to perform a particular health behavior or action (Papinczak et al., 2017). This is the definition of these constructs used within this current study.

A study conducted by Schiavo et al (2019) used the reciprocal determinism construct from SCT. This study assesses the interaction of a person's behavior, other personal factors, and challenges within the environment. The equilibrium of the overall system was evaluated, and the researcher analyzed the stability of the system (Schiavo et al., 2019). The system dynamics and equilibrium were evaluated using the point of view of SCT. This approach was taken by the research because it may be beneficial in better understanding how humans adapt to challenges within their environment (Schiavo et al.,

2019). This includes stress that occurs during a person's daily life and traumatic events. The study resulted in the development of a deterministic dynamical systems model and the findings indicated that there were seven prototypical scenarios within this model and when interpreted from the SCT perspective, the system was shown to be stable (Schiavo et al., 2019).

This study specifically used the SCT construct of reciprocal determinism. This construct had a specific description that was outlined within the study. This study defined reciprocal determinism as the interaction between three main factors (Schiavo et al., 2019). These factors include the individual, which is a person with their own unique set of experiences, the social context of the person's environment, and how they respond to a stimulus to achieve the desired outcome (Schiavo et al., 2019). This is the definition of this construct used within this current study.

A study conducted by Guntzviller, King, Jensen, and Davis (2017) used the behavioral capability and self-efficacy construct from SCT. This study surveyed 100 low-income Spanish-speaking people in the United States, who had a low ability to speak English, and who were predominantly of Mexican ancestry about their nutrition and exercise behaviors (Guntzviller et al., 2017). These participants specifically reported on their self-efficacy related to nutrition and exercise, their health literacy, and their behaviors related to nutrition and being physically active (Guntzviller et al., 2017).

This study specifically used the SCT constructs of behavioral capability and self-efficacy. Each of these constructs had a specific description that was described within the study. The study defined behavioral capability as a person having both the understanding

and necessary skill to perform a specific health behavior (Gruntzviller et al., 2017). This is the definition of this construct used within this current study. This study by Gruntzviller et al., (2017) also defined self-efficacy, but this study already has another identified source for the definition of this construct, therefore, the definition from Gruntzviller et al (2017) is not provided. The definition of behavioral capability provided by the Gruntzviller et al (2017) study is used in this current study.

A study conducted by Kazemi, Toghiyani, and Nekoei-Zahraei (2020) used Social SCT as the framework for the study and the SCT construct of observational learning. This study evaluated the physical activity of pregnant women in Isfahan, Iran. This is a cross-sectional study that had 220 participants who were in the process of going through prenatal care (Kazemi, Toghiyani, & Nekoei-Zahraei, 2020). The SCT construct of observational learning was measured using a questionnaire designed by the researchers (Kazemi, Toghiyani, & Nekoei-Zahraei, 2020).

The results of the study showed that observational learning was the most significant factor related to the physical activity of Iranian women (Kazemi, Toghiyani, & Nekoei-Zahraei, 2020). Furthermore, the results of this study showed the importance of observational learning. The results also showed that increasing the activity level of pregnant women and any interventions focusing on increasing or improving the physical activity of pregnant women should focus on the use of observational learning (Kazemi, Toghiyani, & Nekoei-Zahraei, 2020).

This study specifically used the SCT construct of observational learning. This construct had a specific description that was described within the study. The study

defined observational learning as a person, in this case, the pregnant Iranian woman, watching the behaviors of others and observing the outcomes of those behaviors of others who were performing the behavior the person is considering engaging in (Kazemi, Toghiyani, & Nekoei-Zahraei, 2020). The definition of observational learning provided by the Kazemi, Toghiyani, and Nekoei-Zahraei (2020) study was used by this current study.

A study conducted by Badillo-Camacho et al (2020) used the reinforcements construct from SCT and SCT as the framework for the study. This study focused on the reinforcements associated with eating habits and the level of a person's physical activity. Specifically, the study evaluated the participants of the study's reinforcement factors related to their beliefs, behaviors, and experiences as it related to their habits concerning their diet and physical activity.

The results of the study indicated that various factors played a significant role in the reinforcing of the diet, physical activity behaviors, and habits. The results of the study indicated that the diet and physical activity behaviors of the participants were impacted by reinforcements, but also barriers and facilitators (Badillo-Camacho et al., 2020). The reinforcements included economic bonuses, company meetups, and various events. Barriers included were workplace policies and facilitators included availability of water, free food, dining rooms, and recreational areas (Badillo-Camacho et al., 2020).

This study specifically used the SCT construct of reinforcement. This construct had a specific description that was described within the study. The study defined reinforcements as incentives or rewards that promoted and encouraged a participant to

engage in the desired behavior (Badillo-Camacho et al., 2020). The definition of reinforcement provided by this study was used by this current study. Although other terms were defined in this study, those terms have either already been defined by other sources or were not relevant to this current study.

Related Controversy of Concepts

The only information available in the literature about any controversy surrounding SCT and related concepts had to do with the limitations of the concepts within the theory. One controversy related to the concepts associated with SCT is that if the environment changes, this will automatically cause changes within an individual (Basil, Diaz-Meneses, & Basil, 2019; Duchesne, & McMaugh, 2018). The role that environment plays in the SCT concepts of reciprocal determinisms, observational learning, and reinforcements are assumed to be constant and applied uniformly and consistently. Many researchers argue this is not a valid assumption that can be made concerning these concepts and the environment (Basil, Diaz-Meneses, & Basil, 2019; Duchesne, & McMaugh, 2018).

Another controversy concerns the concept of reciprocal determinism, which refers to the dynamic and reciprocal interactions between an individual, the environment, and their behavior. This concept is treated as a constant in SCT, however how these three factors themselves have been called into question. This is because many researchers argue that two important facts are still not properly understood (Basil, Diaz-Meneses, & Basil, 2019; Duchesne, & McMaugh, 2018). These facts that still need to be clarified include:

1. The extent to which the individual, environment, and behavior factor into the actual behavior a person engages in.
2. The influence of each factor and whether one factor carries more influence over another (Basil, Diaz-Meneses, & Basil, 2019; Duchesne, & McMaugh, 2018).

Another controversy associated with SCT, and the related concepts is that each of the concepts is associated exclusively with the processes of learning. This means that none of these concepts allows for the consideration of how biological and hormonal predispositions may influence no matter what a person's expectations may be or what the person may have experienced in the past (Basil, Diaz-Meneses, & Basil, 2019; Duchesne, & McMaugh, 2018). The lack of focus on emotion or motivation is another controversy involving SCT and the related concepts. Critics argue that the concepts related to SCT only allow for minimal consideration of how emotion or motivation impacts behavior.

The only consideration provided to focusing on or considering emotion and motivation is related to past experiences. Past experiences are said to play a role in reinforcements, expectations, and expectancies, but critics argue still does not allow for enough consideration of the role of emotion and motivation of a person and the person's behavior (Basil, Diaz-Meneses, & Basil, 2019; Duchesne, & McMaugh, 2018). However, critics argue that this is not nearly enough to provide an understanding of the role of emotion and motivation plays on or influences behavior (Basil, Diaz-Meneses, & Basil, 2019; Duchesne, & McMaugh, 2018).

The last identified controversy related to SCT, and related concepts was that they are considered to be too general and broad at times. Critics argue that this overgeneralization and broad understanding of behavior and the influence of behavior creates problems with the real-world use of these concepts. Specifically, the broad and overly general view of the behavior and behavioral influences does not allow or can be difficult to allow for effective real-world operationalization of these concepts, their assumptions, and their conclusions about individuals and their behaviors.

Remaining to be Studied About Concepts

What remains to be studied about these concepts can be traced back to the limitations of SCT and the controversy surrounding the concepts discussed above. Based on the controversy surrounding SCT and the concepts alone shows that the following still needs to be understood and studied about these concepts:

1. Better understanding the role, the environment plays in behavior and the role the environment plays in the various concepts of SCT, such as reciprocal determinism, observational learning, and reinforcements.
2. Better understanding the role of reciprocal determinism and how the dynamic and reciprocal interaction of the individual, environment, and behaviors and how this relates to the actual behaviors a person engages in.
3. Better understanding the specific influence of the individual, environment, behaviors, and actual behaviors.
4. Better understanding which of the specific factors of the individual, environment, and behaviors has more influence over the other if any.

5. Better understanding and integrating biological and hormonal predispositions into the SCT concepts and how these factors may influence behavior.
6. Better understanding the role of emotion and motivation on behavior and within the concepts of SCT.
7. Better understanding how SCT and the related concepts can be operationalized and applied in the real world and to specific behaviors (Basil, Diaz-Meneses, & Basil, 2019; Duchesne, & McMaugh, 2018).

Studies related to what needs to be better understood about these concepts, several studies were found related to how better understand the concepts related to SCT. For example, a study by Connolly (2017) using SCT to determine the role it plays in the behaviors of athletes and the behavior change associated with the coaching process. This study concluded that more research needs to be conducted to better understand how the constructs related to SCT can be understood and applied to the coaching process (Connolly, 2017).

Another study by Schunk and DiBenedetto (2020) explored SCT and the associated construct motivation. Motivation is studied as it relates to instigating and sustaining goal-directed activity and the role this construct plays in SCT. In this article, the researchers discuss the critical issues that complicate a full understanding of this theory. Specifically, the researchers indicated that more needs to be understood about SCT and its related concepts as it relates to diversity and culture, methodology, and long-term effects of interventions (Schunk & DiBenedetto, 2020). Furthermore, the researchers indicated that more is needed to be understood about the concepts as it is

related to contexts, clarity, the distinctiveness of social cognitive constructs, and technology (Schunk & DiBenedetto, 2020).

The researchers indicated that context refers to a better understanding of how SCT and learning take place in schools, homes, workplaces, after-school programs, and communities. Furthermore, the researchers argued that there is more need to be better understood how personal influences, such as personal goals and social comparisons, interact within these contexts (Schunk & DiBenedetto, 2020). The researchers indicated that the clarity and distinctiveness of social cognitive constructs refer to several factors. These included more specific and consistent measurement and use of the concepts within research, such as self-efficacy, better merging or differentiating variables associated with motivation such as self-concept, ability beliefs, expectancies for success, perceptions of competence, intentions, and grit (Schunk & DiBenedetto, 2020).

Researchers indicated that the concerned technology refers to the fact that SCT was developed before technology. In general, more needs to be better understood about how SCT relates to technology and how technology impacts and relates to the individual SCT constructs (Schunk & DiBenedetto, 2020). More specifically, the researchers need to better understand how SCT, and the related constructs relate to social media and the use of social media, especially how it can interfere with learning (Schunk & DiBenedetto, 2020).

Concept Selection Rationale

The concepts evaluated by this study are the health beliefs of the Hmong population and how this impacts their health decisions and their perception of

information they receive from a modern healthcare provider concerning their physical health. The rationale for the selection of these concepts was that the Hmong population has unique health beliefs that impact how they view illness and respond to illness (Lor et al., 2017). This view of their illness can impact whether they seek out treatment from a traditional healer or a modern healthcare provider, and how healthcare providers can help (Her-Xiong, & Schroepfer, 2018; Lor et al., 2017). Furthermore, the literature surrounding these concepts was not entirely clear as it related to how the Hmong cultural health beliefs impact their experience in deciding between a modern and traditional healthcare provider, and how they perceive an illness described as a physical health problem by a modern healthcare provider (Lor et al., 2017).

An example of why the cultural health beliefs of the Hmong population were chosen for this current study is illustrated in a study by Hickman (2021). In this study, the researcher evaluated and discussed how Hmong believe that their physical health and general well-being are directly tied to having the proper relationship with their deceased ancestors. This ethnographic analysis described the importance of the spiritual world and the afterlife in the actions, decisions, and perceptions the Hmong have in the world they live in (Hickman, 2021).

Another study that illustrates the importance of the concept being evaluated in this current study as it related to Hmong with different cultural beliefs. For example, Hmong from more traditional backgrounds were more heavily influenced by their cultural beliefs and engaged in or requested traditional health services like soul calling or spiritual offering (Her-Xiong, & Schroepfer, 2018). Hmong from less traditional backgrounds

were more likely to request modern healthcare services and believe in the power of prayer, as opposed to using or requesting traditional Hmong services (Her-Xiong, & Schroepfer, 2018). The better understanding a modern healthcare worker has concerning the various Hmong health beliefs, the better they can understand their overall health experience and perception, and better meet the needs of the Hmong population (Lor et al., 2017).

Other Cultures

Other researchers have evaluated the health decisions or health behaviors of cultures in other ways. For example, a study by Walters et al (2020) evaluated the health behaviors and cultural health options of the American Indian, Alaska Native, and Native Hawaiian Communities. In fact, these communities have been shown to demand more culturally responsive healthcare options, which is the foundation of this study (Walters et al., 2020).

The researchers evaluated how in the past healthcare interventions for these Native American communities were adapted from healthcare interventions that were validated for the non-Native American population. Furthermore, the researchers noted that these communities have begun to demand that health programs and interventions designed for their communities are fully grounded and designed with their cultural worldview at the center (Walters et al., 2020). However, the researchers asserted that currently "there is limited information on how Native communities and health researchers have successfully collaborated to design culturally based prevention efforts rooted in

indigenous knowledge, protocols, and practices from the ground up" (Walters et al., 2020, p. 555).

The researchers of this study evaluated five research projects focusing on indigenous research and how they can be used to inform Native American health interventions research. The researchers concluded that the approaches within these projects were useful in developing cultural health interventions for Native American populations within a research framework (Walters et al., 2020). According to Walters et al (2020), this type of research would be guided by the following criteria:

- Original instructions
- Relational restoration
- Narrative transformation strategies

Furthermore, the researchers concluded that any future research on the health behaviors and health needs of the Native American population should include three interrelated research themes (Walters et al., 2020). The first theme included documenting and articulating indigenous knowledge to help identify measurement categories and constructs. The second theme is to fully understand the foundation and cognitive processes involved in Native American ways of knowing. The final theme was to identify and understand how indigenous and western knowledge is integrated within an intervention approach. Finally, the researchers indicate the importance of researchers and Native American populations working together to ensure the success of such research and future culturally valid health interventions (Walters et al., 2020).

Another example of research on cultural health decisions or behaviors is a study by Sun, Cheng, Wun, and Lam (2017) evaluating the health decisions of the Chinese population in Hong Kong. The researchers evaluated the health decision-making processing of the Hong Kong Chinese when it came to deciding using Traditional Chinese Medicine (TCM). The researchers noted that, unlike the China mainland where doctors can practice both TCM and western medicine, Hong Kong doctors are only allowed to practice one or the other (Sun et al., 2017).

The researchers described the main factors that played a role in the health decision making of the Hong Kong Chinese treatment decisions when choosing between TCM and Western medicine. These factors included institutional forces, health beliefs, treatment outcomes, habits, convenience, risk of adverse effects, and health literacy, which were all conceptualized through their Chinese culture (Sun et al., 2017). The researchers concluded that most of the study participants preferred Western medicine over TCM, and that the majority of the participants saw TCM as "old fashioned" and less credible than Western medicine (Sun et al., 2017). However, conversely, most participants were more open to using TCM when Western medicine was not helping them (Sun et al., 2017).

Other researchers have used SCT to explain other behavioral decisions of a culture. For example, Hui and Lent (2018) used SCT to examine culturally relevant factors that may contribute to how Asian Americans consider entering employment fields they are overrepresented and underrepresented. This study used 802 participants of Asian

American descent with a focus on several factors including family support, self-efficacy, outcome expectations, interest, and career choice consideration (Hui & Lent, 2018).

To assist in the cultural context of SCT, the researchers also collected information concerning acculturation/enculturation, referring to how closely the participants adhered to Asian values and generation status (Hui & Lent, 2018). Researchers concluded in this study that the data did not support cultural variables impacting the SCT constructs (e.g., self-efficacy, expectancy, and outcome expectation) involved in the participants' decision making and behaviors when choosing a career field where Asians were either underrepresented or overrepresented. The researchers further concluded that the decision-making process and behaviors, as related to the SCT constructs, concerning the research topic were not impacted by the cultural indicators (Hui & Lent, 2018).

Another example of SCT used to evaluate health decisions or behaviors is a qualitative study by Joseph, Ainsworth, Mathis, Hooker, and Keller (2017) examining the cultural relevance of SCT when designing interventions for African American women relating to their physical activity levels. This study used 25 African American women to determine the role that 5 SCT constructs (i.e., Behavioral Capability, Outcome Expectations, Self-efficacy, Self-regulation, and Social Support) play in influencing or can be used to influence the activity levels of the participants (Joseph et al., 2017). The researchers concluded that SCT had utility in changing the physical activity levels of African American women and made the following conclusions related to each of the SCT constructs:

1. Behavioral Capability: The participants in this study were mostly not aware of what was needed relating to improving their physical activity to achieve increased health benefits, therefore were not able to determine their capability. This meant the participants did not know how much, how intense, or the types of physical activity needed to achieve these results (Joseph et al., 2017).
2. Outcome Expectations: The outcome expectations of physical activity played a role in the change of behavior of the participants with the expectations being related to increased energy, improved health, weight loss, and positive role-modeling behaviors (Joseph et al., 2017).
3. Constructs of Self-efficacy and Self-regulation: Both constructs were present during the study and were elicited from the participants. This was able to be achieved by the participants recognizing that they were their own main barrier to being more physically active (Joseph et al., 2017).
4. Social Support: The participants expressed a need for social support to be able to improve their physical activity with an emphasis on family, friends, and other participants within the program (Joseph et al., 2017).

Past Research Approaches

Past research focusing on the Hmong conceptualization of health played a central role in informing this current study. One such study was conducted by Hickman (2007) that evaluated the conflict between the Hmong spiritual conceptualization of health and non-physiological etiologies and the modern healthcare system. Specifically, this study acknowledges that past research on Hmong health beliefs has focused exclusively on how

it is different from modern health beliefs, the spiritual and non-physiological nature of the beliefs, and advocating for culturally sensitive modern health (Hickman, 2007). The researcher of this study indicates that his study focuses on how healthcare in Alaska has merged modern healthcare practices and Hmong spiritual health beliefs together. This has resulted in a modern healthcare system in the Alaskan Hmong community that focuses on spiritual and physical root causes for health concerns. This in turn leads to both physical and spiritual diagnoses for health problems (Hickman, 2007).

This study had many strengths as it is related to the results of the study. The findings of the study helped to increase the overall understanding of the health-seeking behavior of the Hmong population (Hickman, 2007). The results of the study indicated that the best way to understand and treat the Hmong population who engage in health-seeking behaviors is to approach their concerns from a health perspective that merges the modern healthcare approach and Hmong spiritual health beliefs. This in turn leads to better treatment outcomes for this population (Hickman, 2007).

This study was not without its weaknesses. One weakness was that the study is ethnographic. These types of studies can only be conducted properly if the researcher is well-trained in this type of research. These types of studies also require the researcher to embed themselves within the culture to build trust within the culture, and there is no measure of how effective the researcher was able to do this (Boeri & Shukla, 2019). These types of observational studies are also ripe for other kinds of problems, especially bias. This includes selection, confounding, and information biases (Boeri & Shukla, 2019). These types of biases can impact the findings of an ethnographic study and there is

no mention of how the researcher attempted to mitigate these biases (Boeri & Shukla, 2019; Hickman, 2007).

The study by Johnson (2002) is an ethnographic study that evaluated Hmong, their unique cultural beliefs, and views and how these factors affected their overall experience with Western medicine and medical services. This study used two focus groups to gather and analyze data findings. The data from the study indicated that modern biomedical terms were difficult for the Hmong to translate and understand related to human physiology and anatomy (Johnson, 2002).

Along with the new information, there were many strengths within this study related to the findings. This included that these medical terms and the related diagnoses did not have a direct translation in the Hmong language. They had to be translated using numerous indirect terms and were only to approximate the meaning of these terms and diagnoses (Johnson, 2002). The study concluded the problematic translations and the differences between Hmong traditional beliefs and modern healthcare practices that serve to create a lack of understanding between the Hmong population and modern healthcare providers. This, in turn, leads to negative healthcare experiences, fear, and the lack of trust from the Hmong community towards modern healthcare providers, services, and procedures (Johnson, 2002).

The weaknesses of the study included that the study used a small participant sample and two focus groups. This is a weakness because the results of the study do not allow for them to be generalized to the population (Creswell, 2017). The weakness of the focus group in this study is that the results of the focus groups come from a small

population and that the opinions expressed by this small population do not necessarily represent the opinions of this population (Creswell, 2017).

The study by Lor et al (2017) is an exploratory qualitative source of the gap of this current study. Data was collected using semi-structured interviews with Hmong participants focusing on the healthcare-seeking decision process associated with what provider (Hmong traditional healer vs. modern healthcare provider) they chose to use (Lor et al., 2017). This study had many strengths related to the results of the study. The study results indicated that the decision process was influenced by whether the participants viewed their illness as spiritual or not and how they viewed the effectiveness of the proposed treatment options (Lor et al., 2017).

The results also indicated the combination of the expectations of treatment effectiveness and physical evidence of an illness (e.g., an X-ray) had the most influence on the decision process and evidence of a physical illness often led the participant to seek a modern healthcare provider (Lor et al., 2017). Furthermore, Lor et al (2017) indicated that much more research is needed concerning how Hmong perceive their physical health problems and their interactions with the healthcare providers. Specifically, the study indicated the need for future research to explore how Hmong perceive their physical health problems, the physical manifestations of their health problems, and the factors associated with whether a Hmong person chooses a modern healthcare provider or traditional Hmong healer (Lor et al., 2017).

The first of the several weaknesses of this study, as noted by the researchers, is the researchers were not able to completely capture the overall nature of the decision-

making process behind the healthcare decisions of the Hmong participants in the study (Lor et al., 2017). Another weakness of the study was that the Hmong participants used in this study had recently visited a Western healthcare provider and these providers may have already been inclined to choose to use Western medicine (Lor et al., 2017).

Other older studies that have helped to build the foundation of understanding the Hmong spiritual conceptualization of health will also be used to assist in informing this current study. One such study was conducted by Capps (1994) that evaluated the health beliefs of Hmong who were migrating Laos to the United States and how those beliefs were slowly changing. Specifically, this study evaluated the traditional health beliefs and practices of Hmong people, which included shamanism and ancestor worship, but have slowly changed their health ideas and practices. The study evaluated some of the Hmong spiritual health beliefs that still exist, including spirit illness and soul loss, and how this impacts their overall health beliefs and illness patterns.

The strength of this study is that it helps to provide an understanding of the Hmong population's perspective on their health. Specifically, the author concludes that the Hmong population is slowly developing its own unique medical culture as it incorporates modern healthcare practices into the traditional methods they use for healing. This study does have a few weaknesses. This includes that the study has a small population that is based on Kansas City and the results of the study are not able to be generalized to the population. In general, the study is small and does not allow too many generalizations to be made, and only provides a basic understanding and not more of an in-depth understanding of their health beliefs.

Older Studies

Below is a variety of past studies that are relevant to this current study but are much older than five years. These studies were chosen for inclusion in this review for several reasons. One reason is these studies are related to the current topic of this current study. Second, these older studies are used to help inform this current study topic and helped to inform this study by evaluating past studies conducted relating to this current study topic.

Hmong Health Behaviors

Other older studies of the Hmong population have been conducted in the past that have helped researchers better understand Hmong health behaviors and decisions, and cultural factors impacting these decisions. For example, a study by Lee and Chang (2012) evaluated the health behaviors and decisions of the Hmong population as these related to mental health. The results indicated that although the Hmong participants had high rates of being diagnosed with depression compared to other Southeast Asian groups, this population also has the lowest rate of seeking Western treatment solutions for mental health problems compared to these same Southeast Asian groups.

Traditional Healer and Shaman Use

Another older study by Pinzon-Perez, Moua, and Perez (2005) evaluated the use of traditional healer or shaman of 115 Hmong participants from Southern China, Laos, North Vietnam, and Thailand who had immigrated to the United States. This study sought to better understand the health decisions and behavior of this Hmong population as it is related to the use of the traditional healer or shaman. The study found that the

participants in this study used a traditional healer or shaman regularly as a part of their overall healthcare process (Pinzon-Perez, Moua, & Perez, 2005).

Specifically, this study sought to better understand how satisfied this Hmong population was with the use of the traditional healer or shaman, and the services or rituals provided. These services or rituals included animal sacrifice, traditional practices that were conducted either inside or outside of their home, and by shamans of both genders (Pinzon-Perez, Moua, & Perez, 2005). The results of the study indicated that the Hmong participant was more likely to be satisfied with the traditional healer or shaman if the services were provided at their own homes and live animals were used (Pinzon-Perez, Moua, & Perez, 2005). The participants were less satisfied if they had to travel to the shaman and a dead animal was used for the sacrifice. The gender of the shaman or traditional healer was shown to not play any significant role in the satisfaction of the provided services (Pinzon-Perez, Moua, & Perez, 2005).

Meaningfulness of Approach

This study sought to contribute to the literature concerning the Hmong experience and perceptions when a physical health problem has been identified and how the Hmong perceive their physical problems from a spiritual perspective (Lor et al., 2017). Previous data show that the Hmong population tends to conceptualize their physical ailments in spiritual terms and prefer to treat their physical ailments with traditional and culturally based approaches such as spiritual healing with a tribal shaman and herbal medicines (Fang & Stewart, 2018). This preference for treating physical health issues through cultural and spiritual means is related to their fear of modern healthcare services and

procedures and may sometimes leave them feeling discriminated against (Fang & Stewart, 2018; Her-Xiong & Schroepfer, 2018).

The results of this current study could potentially support professional practice and allow for practical application in several ways. A better understanding of these issues may contribute to the improved and culturally sensitive healthcare experiences for the Hmong people. The results of this study could help communities and local providers with a Hmong population to be able to better understand the health needs and perspectives of the Hmong population. Finally, the results of this study could potentially be able to be directly applied to the everyday health interactions between local modern healthcare providers and their Hmong clients.

This current study has the potential to directly lead to positive social change in various ways. This could include increasing the overall quality of healthcare quality to the Hmong population through a better understanding of their specific healthcare needs and perspectives. This could also include increasing access of the Hmong population to modern healthcare services by making them feel more welcomed and understood by their local modern healthcare providers.

Summary

Many different major themes emerged from the literature evaluated. One theme was that when researchers used SCT, they oftentimes only used some of the constructs (e.g., self-efficacy, social support, reciprocal determinism, etc.) from the theory and not all of them. Another theme within the literature was that many researchers who were studying health behaviors and health-related decisions often used SCT and the related

constructs to help explain and understand these concepts. Another common theme within the literature was the use of qualitative research when using SCT since this theory relies so heavily on the experience of the person or persons being studied.

Many other themes and various research studies emerged from the literature evaluated. These other themes included:

- Hmong health beliefs, behaviors, general perceptions, and illness perception were influenced by:
    - Levels of acculturation
    - Traditional and cultural beliefs and practices
    - Social support and pressure
    - Cultural observations
    - Access to traditional treatments or services
- Perceptions of illness are impacted by whether the Hmong person can see the illness or its evidence.
- Illness disparity perception between modern healthcare providers and Hmong patients.
- Many of the SCT constructs were not applied or defined generally by the various researchers who used them in their studies.
- Generational disposition of Hmong person seeking treatment for a physical illness or engaging in a health-seeking behavior or making a health-seeking decision.

- SCT is a commonly used theory for understanding the decisions and behaviors of other cultures and to understand the health decisions and behaviors of individual populations better.

Hmong Health Experiences

The topic evaluated in this current study involved a better understanding of the experiences of Hmong related to their physical health problems. Some information is known about this topic such as Hmong can perceive their physical health problems as either physical or spiritual (Fang, D. M., & Stewart, 2018; Her-Xiong, & Schroepfer, 2018; Johnson, 2002; Lor, Rodolfa, & Limberg, 2017; Lor et al., 2017; Thorburn, Kue, Keon, & Lo, 2012). Whether the Hmong determine if a physical health problem is physical or spiritual is based on whether they can physically see what is wrong with them (Fang, & Stewart, 2018; Her-Xiong, & Schroepfer, 2018; Johnson, 2002; Lor, Rodolfa, & Limberg, 2017; Lor et al., 2017; Thorburn, Kue, Keon, & Lo, 2012).

However, much is still not known about this topic which is in part why this study was conducted. First, it needed to be understood how the Hmong view physical health problems, how these physical health problems occurred, and the factors related to whether a Hmong person chose a traditional healer or a modern healthcare provider (Lor et al., 2017). Also, more needed to be better understood how the Hmong view modern healthcare providers, how different Hmong generations viewed these factors, and how each of these unknown factors potentially impacted the physical health of the Hmong (Lor et al., 2017). Other information not known about this topic included how the cultural competency of a modern healthcare provider could impact the health perceptions,

decisions, and behaviors of the Hmong population. How level of assimilation into US culture impacted these same factors and the stability of health perceptions and behaviors from one generation to the next (Fang, & Stewart, 2018; Her-Xiong, & Schroepfer, 2018; Johnson, 2002).

Concerning what is known about the topic, the literature was clear on this. Much is known about the traditional, spiritual, and cultural beliefs the Hmong have when it comes to physical illness. Much is also known about the communication problems between modern healthcare providers and the lack of cultural competency of these same providers and the negative impact this can have on the Hmong experience (Vang, 2018). Other researchers have helped to illuminate that the Hmong populations do not view health problems and illnesses the same way as American culture and that this culture not only takes into account other factors when deciding if a health problem is physical or spiritual, but oftentimes considers their traditional treatments (e.g., animal sacrifice, herbs, etc.,) as a realistic and helpful alternative to Western treatments (Pinzon-Perez, Moua, & Perez, 2005).

This current study sought to fill the gap identified by Lor et al. (2017) which was the first study to examine the decision-making process of Hmong individuals in deciding whether to seek out a traditional Hmong healer or modern healthcare provider. As reported by Lor et al. (2017), the decision was largely based on whether a Hmong person determined their problem to be physical or spiritual (Lor et al., 2017). The researchers from this study indicated that much more research is needed concerning how Hmong

perceived their physical health problems and their interactions with healthcare providers (Lor et al., 2017).

Specifically, the study noted the need for future research to explore how Hmong perceive their physical health problems, the physical manifestations of their health problems, and the factors associated with whether a Hmong person chooses a modern healthcare provider or traditional Hmong healer (Lor et al., 2017). The researchers further indicated that more research is necessary to better understand the experience of the Hmong population relating to the perceptions of their health problems, perceptions of modern healthcare providers, generational cultural experiences, and how these factors may impact their overall perception of their physical health problems (Lor et al., 2017). This current study achieved this by examining the experiences of the Hmong related to past physical health problems and explored the factors related to those experiences and perceptions through semi-structured interviews. The research design and rationale, researcher role, methodology, and issues of trustworthiness of this study will be explained in chapter 3.

Chapter 3: Research Methods

The main purpose of this study was to understand the Hmong experience when a physical health problem has been identified and how they perceive their physical health problems from a spiritual perspective. This included factors and thought processes a Hmong person experienced when diagnosed with a physical health problem or the specific factors and past experiences that are associated with how a Hmong person decides to choose from a modern healthcare provider and a traditional Hmong healer. The secondary purpose of this study was to understand the Hmong experience with modern healthcare providers and services during this process. Chapter 3 is divided into four separate main sections. The first section is about the research design and rationale of the study. The second section concerns the role of the researcher. The third section covers the methodology of the study. The fourth section discusses any issues of trustworthiness.

Research Design and Rationale

In this section, the research questions, central concepts of the study, and research tradition of this current qualitative study are discussed. This section also provides the rationale for the research tradition chosen. Each of these topics is discussed in detail below.

The nature of this current study was to study the experiences of Hmong adults, 18 years and older, related to the healthcare system and physical illness and is qualitative. A quantitative approach would not have been proper for this study. In general, the quantitative approach is concerned with evaluating measurable, thus numerical, and data associated with a phenomenon (Creswell, 2017; Decher, 2017). The data collection is

done with the quantitative approach by measuring the variable identified in the research. This data is then analyzed numerically through statistical comparisons and inferences. The data and results of the research are reported using various statistical analyses techniques (Creswell, 2017; Decher, 2017). The results are also typically able to be generalized across a larger population. Since I sought to understand the experiences and perceptions of the Hmong population in a nonnumerical way, the quantitative approach would not be an appropriate approach for this study (Creswell, 2017; Decher, 2017).

This study was a qualitative exploration of the experiences of Hmong adults, 18-years and older, related to the healthcare system and physical illness. I explored their experiences with the modern Western healthcare system, how they perceived their physical illnesses, and the factors and experiences related to whether a Hmong person choose a traditional Hmong healer or modern healthcare provider. The target sample, in this case, were Hmong from the local Hmong community in a central Midwestern county who had an interaction with the local modern healthcare system within the last 2 years and were deemed by a modern healthcare provider to have any physical health problem. I aimed to explore the experiences these Hmong adults have had with the local healthcare system, how they perceived their physical health problems from their traditional spiritual view on health and illness, and the factors and experiences related to whether the person chose to have their illness treated by a traditional Hmong healer or modern healthcare provider.

Formal interviews were conducted using a semi structured interview format. Interview questions grounded in SCT were used to collect detailed accounts of the

Hmong community members' healthcare experiences and their spiritual perceptions of their illness (see Creswell, 2017; Decher, 2017). An interview guide was developed for this semi structured interview process. The interview guide was used to provide a list of questions, topics, and the order in which they were covered during the interview process (Creswell, 2017; Decher, 2017). However, the semi structured interview format allowed for topics that come up during the interview to be further explored even when the topic is not included in the guide (see Creswell, 2017; Decher, 2017).

A generic qualitative method was chosen for this current study for several reasons. Patton (2015) defined a generic qualitative research approach as "one that focuses on descriptions of what people experience and how it is that they experience what they experience", and it "simply seeks to understand a phenomenon, a process, or the perspectives and worldviews of the people involved" (p. 117). Patton's approach to generic qualitative inquiry (GQI) was used as the model for this current qualitative study.

Patton's GQI model was chosen because it did not require strict adherence to any one theoretical, philosophical, epistemological, or ontological tradition (see Patton, 2015). A GQI model also allowed for the use of qualitative methods, such as in-depth interviews, fieldwork observations, and document analysis (Patton, 2015). I used in-depth interviews for data collection. The GQI also allowed for the data to be analyzed by coding data, finding patterns, developing categories, labeling themes, which is how this c current study analyzed the data and then explained this data in narrative form (Patton, 2015). However, the results of this current study are not likely to be generalized to the

larger Hmong population as the results of a qualitative approach are typically not able to be generalized across a larger population (see Creswell, 2017; Decher, 2017).

Research Questions

RQ1: How do Hmong people describe their experience when choosing from a modern healthcare provider and traditional Hmong healer?

RQ2: How do Hmong people describe their experience when a modern healthcare provider diagnoses them with a physical health problem?

Central Phenomenon

The central phenomenon I investigated was Hmong health decisions by using the constructs related to SCT. Specifically, I sought to understand the Hmong experience when a physical health problem has been identified and how they perceived their physical health problems from a spiritual perspective. This included factors and thought processes a Hmong person experiences when diagnosed with a physical health problem or the specific factors and past experiences that were associated with how a Hmong person decided to choose between a modern healthcare provider and a traditional Hmong healer. This also included seeking to understand the Hmong lived experience with the modern healthcare providers and services during this process.

Role of Researcher

The qualitative researcher has many roles when conducting interviews to collect data concerning a phenomenon of interest (Billups, 2019; Leavy, 2020). This includes effectively constructing the interview questions and building a rapport with study participants to assist in eliciting a response from participants that allows the research to

understand their thoughts, feelings, and experiences related to the phenomenon of interest (Billups, 2019; Leavy, 2020). The researcher's responsibility also includes protecting the information collected from these participants (Billups, 2019; Leavy, 2020). Another role of qualitative research in this sort of study would be to categorize and analyze the information collected from the participants to identify various themes relating to the responses of the participants (Billups, 2019; Leavy, 2020).

As the sole researcher for this study, I constructed interview questions, built a rapport with study participants, and conducted interviews with participants to better understand the Hmong experience of physical health problems and interactions with modern healthcare providers from their unique spiritual and cultural perspectives. I transcribed the interviews for each participant. I also organized, analyzed, and coded the data into categories and themes. This data and the results were then reported in Chapter 4.

A researcher must always be aware of their biases impacting a study. Researchers cannot rid themselves of their biases, but they can identify and manage them (Basden, 2019; Flick, 2018). Bias can permeate all aspects of a research study and must be guarded against from start to finish. To avoid biases a researcher must reflect and identify what biases they may face that could potentially impact the study (Basden, 2019; Flick, 2018). This can be augmented by having a plan to assist the researcher in identifying any possible biases (Basden, 2019; Flick, 2018). In this current study, I used my dissertation committee to assist in reviewing and identifying any potential biases I may have overlooked in my work.

Another factor that must be considered is any possible existing power relationship. In this case, I made every effort to mitigate any perceived power relationships between myself and the participants (Basden, 2019; Flick, 2018). I had no personal or professional relationship with any of the study participants. I explained the importance of the role the participant is serving in, built rapport and trust with the participant, and established my positive intent with them (see Basden, 2019; Flick, 2018).

Methodology

In this section I discuss the participant selection process and the instrumentation I used in this study. Next, the procedures for recruitment, participation, and data collection are outlined for this study. I then the participants who would exit the study, planned follow-up procedures, and the data analysis plan.

Participant Selection

In this section, I discuss how the participants were selected. I identify the population selected and the sampling strategy that was used for this current study. I then discuss the participation selection criteria and how the participants are known to meet the criteria. Next, I will discuss the number of participants and the participant selection procedures for use in this study. Last, I will explain the relationship between saturation and sample size.

In this study, the general population is the entire population of a Central Midwestern county. In qualitative research, the two populations of interest are the target and accessible populations (Ames et al., 2021; Creswell, 2017). The target population is a subsection of the general population that has the attributes needed for the study and is

relevant to the purpose of the study (Ames et al., 2021; Creswell, 2017). The accessible population is simply the target population the researcher has access to. The target and accessible populations selected for this current study were the same and were the adult Hmong population that resides in this Central Midwestern county.

I used a purposive sampling strategy for this study. This sampling strategy was used to select participants for this study that meet narrow and specific criteria for this study. Purposive sampling is also known as selective, subjective, or nonprobability sampling and involves the researcher using their own judgment when deciding what participants to select for the study (Ames et al., 2021; Flick, 2020). The purposive sampling strategy was chosen to use to assist in finding participants who were from the adult Hmong population, from different generations of acculturation, fluently spoke English, and who have had interactions with modern healthcare workers concerning a physical health problem.

The participants' selection criteria for this current study were narrow. The participants had to be 18 years or older, had to live in a Central Midwestern county, had to be 100 % of Hmong descent, and had to have had a physical health problem and interacted with a modern healthcare provider in the last 2 years. I looked for Hmong from different generations, so whether they followed or had traditional Hmong beliefs was not a criterion for inclusion. I also looked for Hmong who fluently spoke English.

As far as exclusion criteria, this included anybody who did not meet the above-listed criteria. However, another exclusion criterion included any Hmong person who was part of a protected population. This included, but was not limited to, Hmong inmates,

those who had severe mental health disorders, those who were severely ill, and any adult of diminished capacity (see Mackey & Elvey, 2020). The participants met these criteria through self-disclosure and reporting as to whether they met the inclusion or exclusion criteria for this study.

When studying a phenomenon, it is recommended that enough participants are recruited until saturation is reached (Ames et al., 2021; Creswell, 2017). The recommended number to reach saturation is between five to 25 participants (Ames et al., 2019; Chivanga & Monyai, 2021; Creswell, 2017). I aimed to have 25 participants to ensure the study was firmly within this range. This study continued recruiting until 25 participants were successfully recruited.

The Hmong community in the targeted county in the Central Midwest is highly concentrated and connected. I also have a high number of contacts with the local Hmong community, Hmong leaders, and Hmong people in the general population. The identifying, contacting, and recruiting participants for this study was conducted exclusively via word-of-mouth and the distribution of flyers for this study through my Hmong contacts within the Hmong population. Once a potential participant was identified I called the person to gauge their interest in participating in the screening process for the inclusion to participate in the study.

The relationship between saturation and sample size is a direct relationship. In general, saturation is reached when no new themes or patterns emerge from the responses of each additional participant interviewed (Patton, 2015). This ties directly into what relevant research has indicated about needing five to 25 participants (see Ames et al.,

2019; Chivanga & Monyai, 2021, Creswell, 2017). The number needed was determined when no new patterns or themes were identified from each successive interviewed participant.

Instrumentation

In this section, four separate factors are identified related to the instrumentation used in this study. This included first identifying the instruments used and then identifying the source of the instruments. Next, the sufficiency of the instruments will be explained. Last, the published instruments are examined in relation to who developed them, date of publication, appropriateness, content validity, and any context or culture issues.

In qualitative studies seeking to evaluate a phenomenon, the data is typically collected by the researcher conducting interviews of participants who share their experiences of the phenomenon (Ames, Glenton, & Lewin, 2019; Chivanga & Monyai, 2021; Creswell, 2017). These interviews were used by the researcher to record the phenomenon as experienced by these participants with no regard to measuring, categorizing, or interpreting the information collected (Seidman, 2019).

In this current study, I used semi-structured interviews to collect data (Howitt, 2019). A semi-structured interview was used because it allowed for direct interaction with the participants and allowed for flexibility in questioning. This flexibility allowed the researcher to ask follow-up questions, clarify statements made by the participant, and gather more details and additional information from the participant (Howitt, 2019; Seidman, 2019). Semi-structured interviews have established questions that are used to

guide the interview, but they do not have to be done in any order and allow for probing questions by the researcher (Howitt, 2019; Seidman, 2019).

Any probing questions were done to illicit more information from a participant, but not done in a way that interrupts the participants. The initial questions in a semi-structured interview are typically open-ended, while the probing questions may sometimes be close ended depending on the context or if asked to clarify a participant's response (Howitt, 2019; Seidman, 2019). The interview questions developed for this current study were done using SCT concepts, which included reciprocal determinism, behavior capability, observational learning, reinforcements, expectations, and self-efficacy (Bandura, 1986). These concepts were used to explore the Hmong lived experiences from their cultural and spiritual perspective relating to physical health problems and interacting with modern healthcare providers. The questions were developed and used to explore this experience from the Hmong participants' perspective as it related to and was impacted by these SCT concepts.

A qualitative semi-structured interview is structured in a specific way guided by the theory informing the questions. The first question associated with exploring a specific phenomenon focuses on eliciting responses that focus on the phenomenon in question (Connolly, 2017; Decher, 2017; Kim, Lee, & Kim, 2016; Olson, 2016; Seidman, 2019). In the case of this current study, the initial questions focused on eliciting responses related to the Hmong participants' cultural and spiritual experiences related to being diagnosed with a physical problem within the modern healthcare system and their interactions with modern healthcare works. The follow-up questions focused on better

understanding these responses while keeping the focus on the phenomenon of focus (Connolly, 2017; Decher, 2017; Kim, Lee, & Kim, 2016; Olson, 2016; Seidman, 2019). The semi-structured interview tailored and guided with SCT allowed for the formulation of questions that sufficiently explored the phenomenon in question.

In general, the questions were formulated using the SCT concepts identified above. This included questions that focused on the following information:

- Open-ended questions meant to elicit detailed responses related to the phenomenon in question.
- Questions intended to understand how the participants perceived their physical health problems and interactions with modern healthcare providers from a spiritual and cultural perspective.
- Questions tailored to the concepts related to SCT, which were reciprocal determinism, behavior capability, observational learning, reinforcements, expectations, and self-efficacy (Bandura, 1986).
- Probing questions followed any answers to these questions for purposes of clarity, increased understanding, and improved comprehension of the participants' responses.

Instrument

In the case of this current study, the instrument was not previously developed or published. The instrument was developed by this researcher using concepts associated with SCT (Bandura, 1986) to guide the formulation of the interview questions. This instrument is appropriate for this study because studies exploring a phenomenon is meant

to understand this phenomenon as described by the participants in the study question and allows for clarification to better understand the cultural and spiritual context of this population (Connolly, 2017; Decher, 2017; Kim, Lee, & Kim, 2016; Olson, 2016; Seidman, 2019). To ensure content validity and accuracy of the statements made by the participants' follow-up questions were asked to confirm meaning or for clarification.

The interviews started with ice breaker questions followed by generational and acculturation questions. The main questions in the interview focused on the real-world experiences of the participants as they related to their interactions with the modern healthcare system and providers after being diagnosed with a physical health problem. The questions focused on understanding if the participant interpreted the health problem from a physical, cultural, or spiritual perspective or a combination of the three. The questions also focused on one of the concepts of SCT, which were self-efficacy, behavioral capability, expectations, expectancies, self-control, observational learning, and reinforcements. Below each interview question, a rationale is provided for each main question and related follow-up questions concerning the SCT concepts the questions were attempting to evaluate.

Ice-breaker Questions:

- Who was the first person in your immediate family born in the United States?
- How strongly do you feel connected to your Hmong cultural and spiritual heritage?

- When was the last time you were diagnosed with a physical health problem in any way by a modern healthcare provider?
- Have you used both the traditional shaman and modern healthcare provider for a health problem in the past?

Research Question 1: How does a Hmong person describe their experience when choosing from a modern healthcare provider or traditional Hmong healer?

- What factors do you take into consideration when deciding to choose from a modern healthcare provider or traditional Hmong healer?
    - Follow-up Question: Where did you learn about these factors?
    - Follow-up Question: How important are these factors to you and why?
    - Follow-up Question: Please explain if you feel like you have to consider these factors or do you consider these factors because you believe they are important? Please explain why.

These questions were asked to explore if the participant was modeling past observed behaviors (i.e., observational learning), any influences the participants, their behavior, and their environment may have had (i.e., reciprocal determinism), and if there were any internal or external responses the participant had received from engaging in the behavior (i.e., reinforcements) described (Bandura, 1986; Lefrancois, 2019).

- Please explain if anybody else in your family is involved in this decision. Why are they involved and in what way?

    - Follow-up Question: Please explain if you believe you are free to choose the type of healthcare provider you believe is best for you. And why?

These questions were meant to determine if the participant was modeling past observed behaviors (i.e., observational learning), any influences the participants, their behavior, and their environment may have had (i.e., reciprocal determinism), and if there were any internal or external responses the participant received from engaging in the behavior (i.e., reinforcements), and if the participants believed they were capable of engaging in a behavior, including any barriers or facilitators that may have existed (i.e., self-efficacy) in the participants' environment (Bandura, 1986; Lefrancois, 2019).

- What outcome do you expect to attain by choosing one type of provider over the other?
    - Follow-up Question: Do you feel that depending on the type of problem you are experiencing that one provider will provide you with a better outcome than the other?

These questions were meant to determine if there were any internal or external responses the participant received from engaging in the behavior (i.e., reinforcements) and the consequences of the anticipated behavior (i.e., expectations) by the participant (Bandura, 1986; Lefrancois, 2019).

- Other than the health benefit, what are the factors outside yourself that encourage you to choose one type of provider over the other?

    - Follow-up Question: Based on the decision you take, will your family, friends, or other people in your community think or treat you differently? If so, why?

These questions were meant to determine if any influences the participants, their behavior, and their environment may have had (i.e., reciprocal determinism), any internal or external responses the participant received from engaging in the behavior (i.e., reinforcements), and if the participant believed they were capable of engaging in behavior including any barriers or facilitators that may have existed (i.e., self-efficacy) in the participants' environment (Bandura, 1986; Lefrancois, 2019).

- Do you feel more comfortable getting help for a health problem from a modern healthcare provider or traditional Hmong healer, or there is no difference? Please explain why.
    - Do you think a modern healthcare provider or traditional Hmong healer is more capable of resolving your health problem when it's in their realm of treatment and why?

These questions were meant to determine if the consequences of anticipated behavior (i.e., expectations) by the participant and if the participant was modeling past observed behaviors (i.e., observational learning) from their environment (Bandura, 1986; Lefrancois, 2019).

- What other factors, influences, or other things that we haven't discussed yet do you take into consideration when choosing to use a modern healthcare provider and a traditional Hmong healer?

- Follow-up Question: Do you feel you could seek out and find the modern healthcare provider or traditional healer you need. Please explain why or why not?

This last question was a catch-all question. This main question along with the follow-up questions have the potential to cover all SCT concepts (i.e., self-efficacy, behavioral capability, expectations, expectancies, self-control, observational learning, and reinforcements). The follow-up question was developed to cover one SCT concept that was not covered in other questions, which is behavioral capability. This last follow-up question for research question 1 is meant to determine if the participant could perform a behavior by possessing the necessary skills and knowledge to engage in the behavior (Bandura, 1986; Lefrancois, 2019).

RQ2: How do Hmong people describe their experience when a modern healthcare provider diagnoses them with a physical health problem?

- What are your thoughts, feelings, and the factors you consider when a modern healthcare provider provides a diagnosis with a physical health problem?
  - Follow-up Question: What aspects of your Hmong culture and spiritual beliefs impact these thoughts, feelings, and factors?
  - Follow-up Question: In what ways do these aspects of your Hmong culture impact these thoughts, feelings, and factors?

These questions were asked to explore if the participant was modeling past observed behaviors (i.e., observational learning), any influences the participants, their

behavior, and their environment may have had (i.e., reciprocal determinism) on their behavior, and if there were any internal or external responses the participant received from engaging in the behavior (i.e., reinforcements) described (Bandura, 1986; Lefrancois, 2019). These questions were also meant to explore if the participant believed they could engage in a behavior, including any barriers or facilitators that may have existed (i.e., self-efficacy) in the participants' environment and the consequences of the behavior anticipated (i.e., expectations) by the participant (Bandura, 1986; Lefrancois, 2019).

- What are the specific factors you consider determining if you believe a problem, you are experiencing is physical or spiritual in nature?
    - Follow-up Question: Are you the only person who determines if the problem is physical or spiritual in nature? If not, who else is involved and what role do they play?

These questions were asked to explore if the participant were modeling past observed behaviors (i.e., observational learning), any influences the participants, their behavior, and their environment may have had (i.e., reciprocal determinism) on their behavior, and if there were any internal or external responses the participant received from engaging in the behavior (i.e., reinforcements) described (Bandura, 1986; Lefrancois, 2019). These questions were also meant to explore if the participants believed they could engage in a behavior, including any barriers or facilitators that may have existed (i.e., self-efficacy) in the participants' environment and the consequences of

behavior anticipated (i.e., expectations) by the participant (Bandura, 1986; Lefrancois, 2019).

- Where or who did you learn from to determine if a health problem you are experiencing is physical or spiritual in nature?
    - Follow-up Question: Is this your sole source of information on determining if a health problem is physical or spiritual in nature or are there other influences? If so, please explain why?

These questions were asked to explore if the participant was modeling past observed behaviors (i.e., observational learning), any influences the participants, their behavior, and their environment may have had (i.e., reciprocal determinism) on their behavior, and if there were any internal or external responses the participant was receiving from engaging in the behavior (i.e., reinforcements) described (Bandura, 1986; Lefrancois, 2019). These questions were also meant to explore if the participant believed they could engage in a behavior, including any barriers or facilitators that may have existed (i.e., self-efficacy) in the participants' environment (Bandura, 1986; Lefrancois, 2019).

- Do you believe you have a choice to perceive a health problem as physical or spiritual? If so, why?
    - Follow-up Question: Are there any pressures or expectations on you to perceive a health problem as physical or spiritual? If so, in what ways?

These questions were asked to explore if any influences the participants, their behavior, and their environment may have had (i.e., reciprocal determinism) on their behavior, if there were any internal or external responses the participant was receiving from engaging in the behavior (i.e., reinforcements) described (Bandura, 1986; Lefrancois, 2019). These questions were also meant to explore if the participants believed they were capable of engaging in a behavior, including any barriers or facilitators that may have existed (i.e., self-efficacy) in the participants' environment, and meant to determine if the participant could perform a behavior by possessing the necessary skills and knowledge to engage in the behavior (i.e., behavioral capability) required for the given situation (Bandura, 1986; Lefrancois, 2019).

- How does the way you view a health problem impact the way you view the problem, how it is caused and treated?
    - Follow-up Question: Do you view all health problems as either physical or spiritual, or do health problems ever overlap into both? If so, please explain in detail how this impacts your overall view of the health problem.
    - Follow-up Question: Do you feel that you are more capable of having a physical or spiritual health problem treated?
    - Follow-up Question: Do you feel more capable of seeking help for a physical health problem, a spiritual health problem, or both, and why?

These questions were asked to explore if the consequences of behavior anticipated (i.e., expectations) by the participant impacted their behavior and if there were any internal or external responses the participant was receiving from engaging in the behavior (i.e., reinforcements) described (Bandura, 1986; Lefrancois, 2019). These questions are also meant to explore if the participant believes they were capable of engaging in a behavior, including any barriers or facilitators that may exist (i.e., self-efficacy) in the participants' environment, and meant to determine if the participant could perform a behavior by possessing the necessary skills and knowledge to engage in the behavior (i.e., behavioral capability) required for the given situation (Bandura, 1986; Lefrancois, 2019).

Study Procedures

This section focuses on discussing the procedures for recruitment, participation, and data collection. Specific information is presented concerning the data collection which includes where and who collected the data, information concerning the frequency of data collection events, and how long these data collection events occurred. Last, if enough participants were not recruited, information is presented concerning how the data is recorded and the follow-up plan.

The Hmong community in the targeted county in the Central Midwest is highly concentrated and connected. I also have a high number of contacts with the local Hmong community, Hmong leaders, and Hmong people in the general population. Given this information, the recruitment for this study was conducted exclusively via word-of-mouth and the distribution of flyers for this study through my Hmong contacts within the Hmong population.

The criteria each participant must meet to be eligible for participation in this study is as follows:

- Any adult Hmong living in an Upper Midwest county.
- Participants must be 18-years or older to ensure legal adult consent for participation in this study.
- Participants must have had an interaction with a modern healthcare provider and been diagnosed with a physical health problem in the past two years in this Upper Midwest county.
- Volunteer participants only.

I collected the data myself through semi-structured interviews from the Hmong community in targeted Midwestern county. The interviews were scheduled around the availability of the participants and conducted at the County Public Library in a private conference room. The interviews were conducted by me. The interviews were recorded using the built-in microphone of my password-protected personal laptop. The audio was recorded and stored using the Voice Recorder application on my password-protected personal laptop. The frequency of the data collection events was as many as necessary until the number of identified participants was met. The duration of the data collection events was as long as necessary to complete the interview of each of the participants.

The recruitment follow-up plan to ensure enough participants were recruited, included word-of-mouth through my Hmong community contacts, phone calls, and emails. This was done until the number of participants needed for the study had been met. The participants exited the study after having nothing else to say concerning their

experiences or if they choose to terminate for another reason. Participants were debriefed by asking them if they had further information to add and by expressing appreciation for their participation.

Data Analysis Plan

The data analysis plan involved the use of NVivo software. This software was used to analyze the concepts and phrases commonly used by the participants interviewed. This process was used to assist in pinpointing the themes that were present in the responses provided by the participants. The specific process that was used was the five-step coding and analysis process outlined by Adu (2019) and is explained below in more detail. If any discrepant cases were present, they were not used and were excluded from the study (Adu, 2019).

The coding and analysis for this study was guided by the five-step process outlined by Adu (2019) and used SCT to interpret the data and to understand how the concepts of SCT influenced the participants' experience of the phenomenon in question. The five-step process for coding and analyzing the data that was collected from the interviews was as follows:

1. The data collected from the interviews were first prepared and organized. This included transcribing the interviews into transcripts and organizing my notes. The source and demographics of the interviews and the generational information from each participant were organized as well.
2. The data was then reviewed and explored. Each transcript was read several times to get a good grasp of the information present. This process was completed while

keeping in mind the concepts associated with SCT and the cultural and spiritual aspects associated with the Hmong participants who were interviewed. The transcripts were then uploaded into NVivo to start the coding process. Each transcript was uploaded and coded separately in NVivo and this was done only after frequent words used by the individual were identified and color-coded using the "text search query."

3. NVivo's mind map was then used to help visualize and organize the information from each transcript and to gather and separate the information within each of the transcripts in a process referred to as "noding."
4. Once all the significant data had been parsed out, they were transcribed in the third person to assist in identifying the meaning behind the experiences described by the participants. This process entailed taking the experiential information to be provided by the participants about the phenomenon explaining it from their cultural and spiritual perspective and using the concepts associated with SCT to guide and inform the process.
5. Once all transcripts were individually coded using NVivo, the transcripts and coding information were compared with each other. This information was then structured into common themes. This step focused on the experience of the Hmong participant from their cultural and spiritual perspective and was described in relation to the concepts related to SCT, which were reciprocal determinism, behavior capability, observational learning, reinforcements, expectations, and self-efficacy (Adu, 2019; Bandura, 1986).

Issues of Trustworthiness

To ensure the study was credible (i.e., internal validity) and as transferable as possible (i.e., external validity), caution was taken to make sure content is valid and interpretation was as accurate as possible. Triangulation, identifying any potential biases, the dissertation committee review process, and member checking was used to help ensure the credibility of this study (Adu, 2019). Triangulation was used with the results and findings of this study to compare them against other studies.

The dissertation committee review process allowed for biases and other flaws to be identified by the committee. Member checking involved the follow-up with the participants of this study. This allowed the participants to review the quality of the data collected and for the accuracy of the themes. Transferability was supported by ensuring that transcripts were checked for accuracy, and to ensure the data was properly organized during the coding process. To protect and secure the reliability of the interviews, all documentation, notes, coding material, and original data were secured for later review and the potential replication of the identified themes and concepts.

Ethical Procedures

Before engaging in any recruitment, interviews, and data collection, the researcher secured institutional review board (IRB) approval from Walden University. The researcher completed “Protecting Human Research Participants Online Training” and received a certificate for this training. I ensured each participant went through an informed consent process. This informed consent process involved each participant receiving information concerning the following aspects of this study:

- Purpose
- Procedures
- Possible risks and benefits of participation
- How the participants' anonymity, privacy, and confidentiality would be protected
- Consent to have interviews' audio recorded.

All this information was verbally explained to each participant. Each participant had it explained to them that participation in the study was voluntary, and they could drop out at any time. Each participant was provided an opportunity to ask questions before their signatures were obtained to participate in this study. Participants were not pressured to share their experiences and the interview itself was not anticipated to cause any distress or harm to the participants.

To protect the anonymity, privacy, and confidentiality of each participant several steps were taken including assigning each participant an interview number, ensuring no identifying information was recorded in the study materials and study data, and all files were stored in a locked file cabinet, or a password-protected laptop. Direct quotes were used in this study, but none of the quotes contained any information that could have potentially compromised a participant's anonymity. Given the relatively small sample size of this study and the increased possibility of a participant being identified as being a part of this study, the risks and limitations of a participant's anonymity were discussed with each participant before they were interviewed.

Summary

This chapter evaluated four separate main sections. The first section was about the research design and rationale of the study. The second section was concerning the role of the researcher. The third section of this chapter covered the methodology of the study. The fourth section discussed any issues associated with trustworthiness.

The first section covered the research questions, the central concepts of the study, and the research tradition associated with this study. The second section defined the role of the researcher and researcher biases, any personal and professional relationships, any power relationships, and other ethical issues. The third section discussed participant selection, instrumentation, procedures for recruitment, participation, data collection, how participants exit the study, follow-up procedures, and the data analysis plan. The fourth section discussed the study and related credibility, transferability, dependability, confirmability, reliability, and ethical procedures. Chapter 4 of this study focused on outlining the results, findings and any other information associated with the collection and analysis of the data collected.

Chapter 4: Results

The purpose of this study was to understand the Hmong experience when a physical health problem has been identified and how they perceive their physical health problems from a spiritual perspective. This includes factors and thought processes a Hmong person experiences when diagnosed with a physical health problem. This also included the specific factors and past experiences that are associated with how a Hmong person decides to choose from a modern healthcare provider and traditional Hmong healer.

The first research question for this study involved the Hmong study participants describing their experience when choosing a modern healthcare provider or traditional Hmong healer. The second research question for this study involved the Hmong study participants describing their experience when a modern healthcare provider diagnoses them with a physical health problem. I collected data for this study by interviewing 12 Hmong adults who participated in the data collection process. In this chapter, I provide a summary of data collected from the interviews and the results of the study used to describe the phenomena described above.

Chapter 4 provides a description of the setting of this study and the demographics of the study. I will describe and discuss the data collection and the data analysis process. Next evidence of trustworthiness is discussed as it relates to credibility, transferability, dependability, and confirmability. Next, the results are discussed, which includes information concerning the research questions, data to support findings, and a final summary.

Setting

Participants were recruited for this study via word-of-mouth and the distribution of flyers through my Hmong contacts in the Hmong population. The Upper Midwest was chosen for participants because of its large Hmong population. Participants agreed to meet at the county public library in a private conference room. No personal or organizational conditions were present that influenced participants or their experience at time of study that would have influenced interpretation of the study results.

Demographics

Twelve Hmong participated in the study and served as a representative sample from an Upper Midwest county. This sample taken from this county was because of the high concentration of Hmong in this area and because of the limited research on the Hmong community relating to this population's health decision behaviors. Table 1 lists the demographics for each participant. To participate in this study, five criteria had to be met:

- Any adult Hmong living in an Upper Midwest county.
- Participants must be 18-years or older to ensure legal adult consent for participation in this study.
- Participants must have had an interaction with a modern healthcare provider and been diagnosed with a physical health problem in the past two years in this Upper Midwest county.
- Volunteer participants only.

Table 1
Participant Demographics

Pseudonym	Gender	Age	Occupation
F1	Female	22	Cashier
F2	Female	34	Law office clerk
F3	Female	37	Stay-at-home-mom
F4	Female	25	College student
F4	Female	63	Front line: Manufacturing
F5	Female	47	Corrections officer
F6	Female	39	Elementary school teacher
F7	Female	42	Bank teller
M1	Male	51	Customer service rep
M2	Male	28	Machine operator
M3	Male	37	911 dispatcher
M4	Male	49	Social worker
M5	Male	44	High school teacher

Data Collection

In this section I discuss several topics including the number of participants from whom data was collected and the location, frequency, and duration of the data collection using the semi structured interviews as the data collection instrument. A description is provided of how the data was recorded. Minor variations in the data collection from the plan were noted. Minor unusual circumstances were encountered during the data

collection process. The minor variations and unusual circumstances are discussed below in this chapter.

Participants

had a high number of contacts with the local Hmong community and Hmong leaders within the Hmong community. Given this information, the recruitment for this study was conducted via word-of-mouth and the distribution of flyers in the selected county, which has a highly concentrated and connected Hmong population (see Appendix A). A total of 25 potential participants were recruited for this study and 12 participated. After agreeing to participate, each participant agreed to meet the researcher at the county public library in a private conference room.

Each participant had the study explained to them in detail, was provided an informed consent form that each participant signed and returned. The purposive sampling strategy was chosen to use to assist in finding participants who were from the adult Hmong population, from different generations of acculturation, and who have had interactions with modern healthcare workers concerning a physical health problem (see Ames et al., 2021; Flick, 2020).

After IRB approval was received for this study, participants were recruited and those who were interested had the study briefly explained to them. If the participants agreed to participate, I invited them to meet at the private conference room at the county public library where I described the study in detail and the informed consent form was signed. Participants who did not want to participate in the study would have been thanked for their time and not contacted further. However, none of the participants who agreed to

meet at the local public library declined to participate. The participants who agreed to participate were enough to meet the targeted sample size. Each participant who signed the informed consent form was provided with a copy of the form.

Semi structured Interviews

The data collected for this study was done via face-to-face semi structured interviews, which I conducted. The interviews explored the lived experiences of the Hmong population in the selected county concerning their experiences with the modern Western healthcare system, how they perceive their physical illnesses, and the factors and experiences related to whether a Hmong person chooses a traditional Hmong healer or modern healthcare provider. The interviews were recorded using the built-in microphone of my password-protected personal laptop.

The duration of the data collection events was as long as necessary to complete the interview with each participant. The participants exited the study after having nothing else to say concerning their experiences. Participants were debriefed by asking them if they had further information to add and by expressing appreciation for their participation.

Variations or Unusual Circumstances

The only variation to report for this study had to do with the willingness to share information about specific experiences. Some participants were more willing than others to discuss their experiences as it related to the factors impacting their health decisions. Some participants were willing to go into more detail about their Hmong culture, belief systems, health decision making, and spiritual beliefs. This hesitance by some participants did not prevent the collection of data relating to their experiences. This

hesitance led to some participants providing less details than others. Overall, all participants answered all questions during the interview, some participants just provided more details than others. No other variations or unusual circumstances were present during the interviews or the study.

Data Analysis

I analyzed and coded the collected data using the five-step coding and analysis process outlined by Adu (2019). The data was collected from 12 study participants using face-to-face interviews that were audio-recorded to ensure the transcription of the responses were accurate. NVivo was used to analyze the concepts and phrases commonly used by the participants interviewed. I used SCT to interpret the data. SCT was also used to understand how this theory's constructs influenced the participants' experiences related to the phenomenon in question.

Once the data was completed being collected, I started to process the data using the five-step process noted above. I first prepared and organized the data by transcribing the interviews, organizing my notes, and organizing the source and demographics of the interviews and the generational information from each participant (see Adu, 2019; Bandura, 1986). Each transcript was read multiple times to ensure the information was completely understood. This process was completed through the lens of the concepts associated with SCT and the cultural and spiritual aspects of the Hmong participants.

The transcripts were uploaded in NVivo and coded separately. An NVivo mind map was created to assist in visualizing and organizing the information. Once all significant data was collected the transcripts were transcribed in the third person to help

identify the meaning of the experiences. These meanings were then explained from the Hmong cultural and spiritual using the SCT concepts to guide the process. Last, the transcripts and coding information were compared to each other to identify any common themes focusing on the Hmong cultural and spiritual perspectives and described as they related to the SCT concepts.

When the final analysis was done on the data, several themes and subthemes emerged from this analysis. The main themes derived from the interviews included the following:

- Cultural impact on health decisions
- Spiritual beliefs impact on health decisions
- Visibility of health concern

These main themes were derived from the responses provided by the participants during the interviews. An example for the first theme, cultural impact on health decisions, was from Participant F4, who stated, “I come from a very traditional Hmong family, so there is an expectation that I check in with our Shaman.” The analysis determined that within this first main theme were three subthemes.

These subthemes included cultural expectations, comfort using a particular remedy, and family pressure. The first subtheme, cultural expectations, was derived by participant responses, such as this one from Participant F2, who stated, “and you know, no matter if I go to Aspirus [local health clinic] or not later, I’m still always expected to talk to the Shaman first.” The second subtheme, comfort using a particular remedy, was derived from participant responses, such as Participant F4, who stated, “Ultimately, I

believe modern drugs cause more harm than good…. I'm more comfortable using the herbal stuff our healer gives us." The third subtheme, family pressure, was derived by participants who made similar statements to Participant M4, who stated, "growing up I didn't have a choice, my father always made us go see the shaman." Statements like these are what is incorporated within these subthemes.

An example for the second theme, spiritual beliefs impact on health decisions, is shown by the statement made by Participant M3. This participant stated, "If I get sad or depressed, I always check in with our shaman first to make sure there isn't a problem with my soul…. that would lead it [the soul] to leave for some reason." The analysis of this second main theme determined there were three subthemes.

These subthemes included separation of soul, evil spirits, and angry ancestors. The first subtheme, separation of soul, was derived by participant responses, such as this one from Participant F7, who stated,

> And I was always raised to safeguard my soul because bad things can happen to it. That's why I have never had a surgery if I absolutely didn't have to. Surgeries can allow for our souls to escape…. I then have to have the shaman return the soul…otherwise many bad things can happen to my health.

The second subtheme, evil spirits, was derived from participant responses, such as Participant M5, who stated, "My grandparents raised me to be wary of evil spirits…evil spirits can make you sick or steal your soul." The third subtheme, angry ancestors, was derived by participants who made similar statements to Participant F5, who stated, "if an ancestor is upset…that ancestor can cause the person to have a disease or illness…this is

not something modern medicine is equipped to deal with." Statements like these are what is incorporated within these subthemes.

An example for the third theme, visibility of health concern, was shown by the statement made by Participant M4. This participant stated, "If I can see what then problem is, like a growth on my body, rash, or something else I can see with my own eyes…I am not going to consider that to be a spiritual problem…but a physical one." The analysis of this third main theme determined there were two subthemes.

These subthemes included outward visible health problems and health problems visible via modern technology. The first subtheme, outward visible health problems, was derived by participant responses, such as this one from Participant F6, who stated, "In general, I have to be able…to see what is making me sick to be sure it is a physical illness." The second subtheme, health problems visible via modern technology, was derived by participants who made similar statements to Participant F2, who stated, "seeing test results, blood work, x-rays, scans, or something of that nature convinces both me and my family a health concern is a physical problem as opposed to spiritual." Statements like these are what is incorporated within these subthemes.

Evidence of Trustworthiness

To ensure the study is credible (i.e., internal validity) and as transferable as possible (i.e., external validity), caution was taken to make sure content was valid and interpretation was as accurate as possible. To ensure transferability was as high as possible I made sure the study topic, phenomenon of interest, and methodology were as specific as possible. In the case of this study the transferability is limited to a specific

population and focus. However, although specific, the transferability of the results of this study may help better understand the Hmong population in other contexts or other areas.

The transferability of this study and its focus is first limited to the Hmong population. Second, the transferability is limited specifically to the health beliefs, perceptions, and behaviors of the Hmong population and how those beliefs, perceptions, and behaviors are impacted by Hmong cultural, traditional, and spiritual beliefs. The results of this study may have some limited transferability to other contexts; however, this was limited to those contexts relating to the Hmong population and how their culture, traditions, and spiritual beliefs impact decision-making in those contexts.

The dependability of this study was protected by using several strategies. Triangulation, identifying any potential biases, the dissertation committee review process, and member checking were used to help ensure the credibility and dependability of this study (see Adu, 2019). Triangulation was used with the results and findings of this study to compare them against other studies. The dependability strategies assisted in increasing credibility in a multitude of ways. This included reducing interview bias by not giving opinions during the interviews and staying neutral in how I dressed, my tone, and my facial expressions (see Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019).

Interview bias was reduced by keeping questions neutral, asking general questions first, then more specific questions, asking positive questions before negative questions, and asking behavior questions before attitude questions (see Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019). Consistency bias was minimized by asking clarification questions if an answer seemed incomplete (see Aparasu & Bentley, 2019;

Ary et al., 2018; Williams, 2019). Acceptance bias was mitigated by challenging answers tactfully if what the person being interviewed was saying seemed off (see Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019).

The confirmability of this study included assuring the data associated with the results of this study were checked and rechecked throughout the entire data collection and analysis process (see Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019). This was done to ensure that the results of this study would be able to be repeated by others in future studies. This confirmability process involved several key factors to ensure the study could be repeated in the future.

To ensure confirmability I documented the process for coding and categorizing the data. The patterns that were identified during analysis were clearly outlined. The themes that resulted from this pattern analysis were outlined and described in detail. This included providing specific quotes from participants that related to each of the themes. The subthemes within each main theme were outlined and described in detail. This included providing specific quotes from participants that related to each of the subthemes.

The dissertation committee review process allowed for biases and other flaws to be identified by the committee. Member checking involved the follow-up with the participants of this study. This allowed the participants to review the quality of the data collected and for the accuracy of the themes. Transferability was supported by ensuring that transcripts are checked for accuracy. To protect and secure the reliability of the

interviews, I secured all documentation, notes, coding material, and original data for later review and the potential replication of the identified themes and concepts.

Results

The two research questions guiding this study were (a) *How does a Hmong person describe their experience when choosing a modern healthcare provider or traditional Hmong healer?* and (b) *How does a Hmong person describe their experience when a modern healthcare provider diagnoses them with a physical health problem?* Using SCT and a basic qualitative research framework I explored the lived experiences of 12 Hmong adults from an Upper Midwest county related to the modern Western healthcare system, how they perceive their physical illnesses, and the factors and experiences related to whether a Hmong person chooses a traditional Hmong healer or modern healthcare provider. Another purpose of this study was to address a gap in the literature identified by Lor et al. (2017) which was the first study to examine the decision-making process of Hmong individuals in deciding whether to seek out a traditional Hmong healer or modern healthcare provider. Lor et al. indicated more research was needed concerning how Hmong perceive their physical health problems and their interactions with healthcare providers.

The interview questions were developed with several factors in mind. These factors included addressing the two research questions, a completed and clear understanding of the participants lived experiences and understanding these lived experiences as they apply to SCT and the related concepts within that theory. Great care

was taken in constructing these interview questions to ensure they aligned with each of these factors.

I use the five-step process outlined by Adu (2019) for coding and analysis and SCT to analyze, understand, and code the meanings and patterns that emerged from the information collected from the participants' lived experience relating to how they perceive their physical illnesses, and the factors and experiences related to whether they chose a traditional Hmong healer or modern healthcare provider.

Theme 1: Cultural Impact on Health Decisions

The theme of "Cultural Impact on Health Decisions" was mainly focused on how the participants' culture directly impacts the health decisions they make. The subthemes that emerged under this main theme were (a) cultural expectations, (b) comfort using a particular health remedy, and (c) family pressure. These subthemes are presented in Tables 2-4.

Cultural Expectations

All of the participants in the study reported experiencing some form of cultural expectation to use a shaman, or what others called a healer or herbalist, for health problems. One participant reported that "there is an expectation that I check in with our Shaman." (see Table 2). For example, Participant F5 described how community members within the Hmong population would show their displeasure if her mother didn't take her to see the healer stating, "they would frown if she [her mother] said she only went to the walk-in clinic and hadn't spoken with the healer." M1 discussed how his family strongly

believes that shamans are better equipped at helping Hmong with their health problems stating, “shamans are better at helping with certain issues as it relates to our health”.

However, not all of the Hmong participants reported Hmong culture having an impact on their health decisions and that they were more aligned with western culture when it came to health decisions. F1 discussed this more western view of health stating, “I didn’t grow up in a very traditional Hmong family or environment… nobody really mentions that magical healing stuff or whatever voodoo magic some of them [other Hmong] use in my family…. we only use modern doctors and clinics.” M2 concurred with this more modern view of treating health problems stating,

> I consider our family to be fairly modern. I respect the more traditional people in my family and in the community, but we are not very close with any of them…as far as I know nobody in my immediate family considers using a Hmong healer and only goes to Aspirus for health problems (see Table 2).

Comfort Using a Particular Health Remedy

During the interview seven of the participants mentioned some form of being comfortable using a particular remedy for a health problem. Sometimes they were more comfortable with a traditional Hmong shaman, some were more comfortable with using modern western health services, and for some of them it depended on a variety of factors whether they were more comfortable with a Hmong shaman or western health provider (see Table 3). For example, Participant F4 stated, “Ultimately, I believe modern drugs cause more harm than good…. I’m more comfortable using the herbal stuff our healer gives us.” However, some participants felt very different, such as Participant F1 who

stated, “One important factor is if I think something is going to work…I don’t think the herbal concoctions the healer gives me work, while the meds I get from my doctor do” (see Table 3).

However, the majority of the participants, six in total, described that feeling comfortable with a shaman or modern western remedy depended on a variety of factors (see Table 3). For example, Participant M3 stated, “for me it really depends…sometimes I’m more comfortable going to our healer and sometimes I’m more comfortable going to see my doctor at [the local hospital] …depends on what’s going on with my health.” Participant F7 described the factors that she takes into consideration when choosing to use a shaman or western health provider stating, “oftentimes I’ll use what the herbalist [Hmong Shaman Herbalist] gives me because they have always seemed to work for me…I only go to the clinic if they [herbal medicine] don’t work, which isn’t often.”

Family Pressure

During the interview all of the participants reported some form of family pressure whether to use traditional Hmong remedies or modern western medicine. The participants reported a variety of pressures from their family and other community members (Table 4). For example, Participant M4 stated, “growing up I didn’t have a choice, my father always made us go see the shaman.” Participant F2 reported a similar experience stating, “…and there was a lot of pressure within my community and my family to use healers and traditional cures.” Not all of the participants minded the family pressure, although the family pressure was still present. For example, Participant F6 stated, “we were always

expected by the people in our family to visit the healer first, but I don't mind….I feel like he's done a lot of good for me."

However, other participants reported different kinds of family pressure. For some participants this was pressure from family to ignore the more traditional family members. For example, Participant F3 reported, "…I also don't come from a very traditional family. I had always been warned to be polite, but that shamans and healers were nothing more than superstitions and people wanting to see what they wanted to." Participant M5 stated, "…but my mom always told me it was my choice…concerning my health…and not worry about the pushy and nosey elders."

Table 2

Cultural Impact-Cultural Expectations

Subtheme	Participant Responses
	"I come from a very traditional Hmong family, so there is an expectation that I check in with our Shaman."
	"…and you know, no matter if I go to Aspirus [local health clinic] or not later, I'm still always expected to talk to the Shaman first."
	"growing up whenever we had a health problem my family always went to our local Hmong healer first to get advice. Culturally, we always talk to the healer first, even if we later go to a county clinic later."
	"even in normal conversation I remember as a child people asking my mom about what the healer had to say about this or that illness that one of us were experiencing…they would frown if she said she only went to the walk in clinic and hadn't spoken with the healer."

Subtheme	Participant Responses
Cultural Expectations	"no matter what, most people in my family always talked to the Shaman first…to get their advice about a health matter."
	"and the local elders, Hmong community leaders or whatever you want to call them, supported the Hmong community…. maintaining our cultural roots an traditions…which included consulting with our Shaman even if we later went to the clinic."
	"I grew up visiting our healer and always found him to be nice and helpful. I always speak to him about any of my health problems."
	"except that I didn't grow up in a very traditional Hmong family or environment…nobody really mentions that magical healing stuff or whatever voodoo magic some of them [other Hmong] use in my family….we only use modern doctors and clinics."
	"I consider our family to be fairly modern. I respect the more traditional people in my family and in the community, but we are not very close with any of them…as far as I know nobody in my immediate family considers using a Hmong healer and only goes to Aspirus for health problems.
Cultural Expectations	"In my family it is understood that shamans are better at helping with certain issues as it relates to our health."
	"In general, I think if you are Hmong you are expected to practice some sort of traditional Hmong practices….at least that's been my experience with my family.

Table 3

Cultural Impact-Comfort

Subtheme	Participant Responses
	"Ultimately, I believe modern drugs cause more harm than good…. I'm more comfortable using the herbal stuff our healer gives us."

Subtheme	Participant Responses
Comfort Using a Particular Remedy	"I'm sure there are a lot of misconceptions about Hmong and our cultural remedies, but I'm very comfortable using our Shaman for many of my family's health problems."
	"I'm leery of using many of the drugs that local doctors want to prescribe me…I feel they do more harm than good sometimes."
	"I'm more likely to go see a regular doctor at Aspirus because I honestly don't think the concoctions my family try to give me from our local healer do any good…it's a waste of time."
	"I respect my family's beliefs, but I have no interest in putting some of the stuff they want me to take into my body let alone my mouth."
	"and from my experience I have seen the meds I get from my doctor at the Weston Clinic help me a lot more than any of the stuff the healer has ever given me…. which is why I don't typically use the healer."
Comfort Using a Particular Remedy	"One important factor is if I think something is going to work…I don't think the herbal concoctions the healer gives me work, while the meds I get from my doctor do."
	"for me it really depends…sometimes I'm more comfortable going to our healer and sometimes I'm more comfortable going to see my doctor at Aspirus…depends on what's going on with my health."
	"oftentimes I'll use what the herbalist [Hmong Shaman Herbalist] gives me because they have always seemed to work for me…I only go to the clinic if they [herbal medicine] don't work, which isn't often."
	"and my grandfather was called to be a shaman…he is very good at what he does…and I was always comfortable having him treat me."

Table 4

Cultural Impact-Family Pressure

Subtheme	Participant Responses
Family Pressure	"as I got older my mother didn't push me one way or the other concerning whether I chose to use our healer or go to the normal doctor."
	"growing up I didn't have a choice, my father always made us go see the shaman."
	"my mother doesn't care, but my grandmother guilts us into seeing the healer."
	"my father would never let us go to the clinic unless he was convinced the healer couldn't do anything else for us."
	"even after I moved out of the house my family always pushed me to go see the healer for my problems and would lecture me if I only went to go see my doctor at Aspirus."
	"and of course I want to make my family happy so I'll go see the healer if I have to or to at least to say that I did."
	"I was always forced to go see the healer as a child…. but as soon as I moved out I refused to go."
	"we get a lot of flak from the older people in my family to use the shaman."
	"we were always expected by the people in our family to visit the healer first, but I don't mind…. I feel like he's done a lot of good for me."
Family Pressure	"…I also don't come from a very traditional family. I had always been warned to be polite, but that shamans and healers were nothing more than superstitions and people wanting to see what they wanted to."
	"…and there was a lot of pressure within my community and my family to use healers and traditional cures."

Subtheme	Participant Responses
	"Growing up we didn't have a choice. We had to see the shaman whether we wanted to or not."
	"…and my grandparents always made sure we consulted the shaman."
	"…but my mom always told me it was my choice…concerning my health…and not worry about the pushy and nosey elders."

Theme 2: Spiritual Beliefs Impact on Health Decisions

The "Spiritual beliefs impact on health decisions" theme focused on the specific spiritual beliefs of the Hmong participants that impacted their decision making with making health decisions. The participants provided responses that were highly interconnected and associated with the main theme. These subthemes included (a) separation of soul, (b) evil spirits, and (c) angry ancestors. These subthemes are presented in Tables 5-7.

Separation of Soul

The separation of the soul was discussed by six of the participants in the study interview concerning factors associated with their health decisions and deciding when to use a shaman or modern western health services. However, the separation of the soul was mentioned in a variety of contexts (Table 5). For example, Participant M3 stated, "If I get sad or depressed, I always check in with our shaman first to make sure there isn't a problem with my soul…. that would lead it [the soul] to leave for some reason." Participant F7 reported a similar experience. F7 stated,

> …and I was always raised to safeguard my soul because bad things can happen to it. That's why I have never had a surgery if I absolutely didn't have to. Surgeries can allow for our souls to escape…. I then have to have the shaman return the soul…otherwise many bad things can happen to my health.

However, when discussing the separation of the soul with other participants, they brought up different aspects of soul separation. For example, Participant M1 stated, "If I have a bad dream and I wake up not feeling right I will get ahold of our shaman. This is because getting too scared or having…. a really bad dream…can cause the soul to leave or to get stuck in the dream." Participant F6 also mentioned soul separation as it was related to having dreams by stating,

> When I was younger, I used to have a lot of nightmares and was sick a lot. My parents took me to our local healer a lot when I was young to make sure there wasn't something wrong with my soul or make sure it wasn't missing or stuck somewhere else...and my mother told me she wanted to make sure my soul wasn't stuck in the nightmare.

Evil Spirits

Evil spirits were mentioned by eight of the study participants during the interview. The participants mentioned evil spirit in a variety of contexts concerning their health and in relation to their use of Hmong traditional remedies (Table 6). For example, Participant M5 stated, "My grandparents raised me to be wary of evil spirits…evil spirits can make you sick or steal your soul." Another participant reported similar concerns about evil spirits and the need for a shaman. Participant F5 stated, "Evil spirits are always

a concern and only something the shaman can fix…evil spirits can make you sick and cause diseases."

Other participants reported the reasons why evil spirits cause illness and what the shaman has to do to assist in curing them. For example, Participant F2 stated, "…and if a person is not a good person and does bad things…. evil spirits will come for them…. make them sick. A shaman can assist in making offering to the spirits and asking to forgive the person for their bad deeds." Participant F4 discussed the shortcomings of local western doctors and discussing evil spirits stating, "The doctors at Aspirus just smile whenever I bring up evil spirits. They don't believe us…try to make us take drugs. Our shaman is the only one that only understands." Other participants during the interviews expressed concerns about evil spirits and the impact the spirits can have on their health. For example, Participant M4 stated,

> …people do not take evil spirits serious enough…that's why sometimes modern medications don't work. I have some people in my family and community…that have been cursed by an evil spirit or are…crazy…because they were not good. Only the shaman can help them and sometimes the shaman cannot help either.

Angry Ancestors

During the study interviews another common spiritual concern impacting health decisions discussed by five of the participants was related to angry ancestors who had already passed. Although similar to some degree to evil spirits, this spiritual concern was specific to the Hmong participants ancestors and was understood in a different way (Table 7). For example, Participant F5 discussed the problem angry ancestors can cause

stating, "…if an ancestor is upset…that ancestor can cause a person to have a disease or illness…this is not something modern medicine is equipped to deal with." Participant F7 described the concern of offending an ancestor stating, "Offending an ancestor is not good…an ancestor has been offended the ancestor can make a person ill…I would ask our shaman for help if I thought I may have offended one of my ancestors."

Other participants discussed not only angry ancestors, but also how to appease them. For example, Participant M1 discussed both the offending of ancestors and how to appease them stating, "health problems and illness can be caused by offending ancestors…by neglecting the worship of them. A shaman can assist with making this right by helping with an animal sacrifice to provide the ancestor food…among other things." Participant M5 discussed how angry ancestors can cause illness and how to address this stating,

> …if an angry ancestor is making me sick the best way to fix the problem is by providing them food through a sacrifice, burning money so they can use it in the spiritual world, or making other offerings…and yes, usually a shaman helps with this.

Table 5

Spiritual Beliefs Impact-Separation of Soul

Subthemes	Participant Responses
	"If I get sad or depressed, I always check in with our shaman first to make sure there isn't a problem with my soul…. that would lead it [the soul] to leave for some reason."
	"…and I was always raised to safeguard my soul because bad things can happen to it. That's why I have never had a surgery

Subthemes	Participant Responses
	if I absolutely didn't have to. Surgeries can allow for our souls to escape…. I then have to have the shaman return the soul…otherwise many bad things can happen to my health."
	"I know some people do not understand this, but if there is something wrong with our spirit, if it escapes or stolen…this can lead to a lot of different health problems…and only our healer can help us with that."
	"The soul is very important in our culture, and it was something my family takes very seriously."
Separation of Soul	"…and something else you may not know is that in my culture we have more than one soul in our body…this includes our individual body parts. If one of the soul's escapes, it can throw everything out of balance and cause sickness."
	"When I was younger, I used to have a lot of nightmares and was sick a lot. My parents took me to our local healer a lot when I was young to make sure there wasn't something wrong with my soul or make sure it wasn't missing or stuck somewhere else...and my mother told she wanted to make sure my soul wasn't stuck in the nightmare."
	"I heard a lot of stories growing up about people in our family getting sick and dying or have severe health problems because of their souls leaving or being stolen by an evil spirit…we have
Separation of Soul	many souls, but an evil spirt can steal one of them and cause many health problems."
	"…even though one of our souls can be stolen…the shaman is very good at getting it back to us…helping us regain balance."

Table 6

Spiritual Beliefs Impact-Evil Spirits

Subtheme	Participant Responses
Evil Spirits	"My grandparents raised me to be wary of evil spirits…evil spirits can make you sick or steal your soul."
	"Evil spirits are always a concern and only something the shaman can fix…evil spirits can make you sick and cause diseases."
	"…and if a person is not a good person and does bad things…. evil spirits will come for them…. make them sick. A shaman can assist in making offering to the spirits and asking to forgive the person for their bad deeds."
	"…people do not take evil spirits serious enough…that's why sometimes modern medications don't work. I have some people in my family and community…that have been cursed by an evil spirit or are…crazy…because they were not good. Only the shaman can help them and sometimes the shaman cannot help either."
	"Evil spirits do lots of bad things…they steal souls…curse people and make people sick…and try and steal the souls of babies."
	"Evil spirits have caused a lot of problems in my family."
	"the shaman is the only one who can help with a curse or problems with an evil spirit…the Aspirus doctors don't believe us and can't help."

Table 7

Spiritual Beliefs Impact-Angry Ancestors

Subtheme	Participant Responses
Angry Ancestors	"…if an ancestor is upset…that ancestor can cause the person to have a disease or illness…this is not something modern medicine is equipped to deal with."
	"Offending an ancestor is not good…an ancestor has been offended the ancestor can make a person ill…I would ask our shaman for help if I thought I may have offended one of my ancestors."
	"health problems and illness can be caused by offending ancestors…by neglecting the worship of them. A shaman can assist with making this right by helping with an animal sacrifice to provide the ancestor food…among other things."
	"if an angry ancestor is making me sick the best way to fix the problem is by providing them food through a sacrifice, burning money so they can use it in the spiritual world, or making other offerings…and yes, usually a shaman helps with this."
	"If an ancestor is offended, they can cause a lot of problems…including health problems."
	"Offended ancestors are only something a shaman…can help with. A person who is ill because of an ancestor will not get better until the ancestor is…no longer upset."

Theme 3: Visibility of Health Concerns

The "Visibility of health concerns" theme focused on the visibility of a health concern as it related to a its impact on a Hmong participant determining if a health concern is physical in nature or spiritual in nature. The participants provided responses that were highly interconnected and associated with the main theme. The subthemes

included (a) outward visible health problems and (b) health problems visible via modern technology. These two subthemes are distinct in that with one a Hmong participant can easily view the health problem with their own eyes, while with the other they can only view the health problem with the aid of modern technology. These subthemes are presented in Tables 8-9.

Outward Visible Health Problems

During the study interviews a common discussion point by the Hmong participants was that one of the most important factors in determining if a health problem is physical or spiritual in nature is if the participant could visibly see the health problem. A total of nine of the participants discussed being able to visibly see a health problem with their own eyes was a major factor in helping them to determine if the problem was of a physical or spiritual origin (Table 8). For example, Participant M3 stated, "If I see something physical on me my first thought is that it's a physical problem…like if I break my arm…or have a cut or something." Participant M4 reported a similar view stating, "If I can see what the problem is, like a growth on my body, rash, or something else I can see with my own eyes…I am not going to consider that to be a spiritual problem…but a physical one."

During the study interview all nine of these Hmong study participants mentioned being able to see the health problem with their own eyes played a crucial role in determining that the problem was physical in nature. For example, Participant F2 expressed the importance of seeing the physical health problem stating, "…if I have a headache or feel bad…I can't see what is causing this I will talk to our healer to make

sure there isn't something wrong with my soul." Participant F2 expanded on this stating, "I will work with the healer to do something called a soul calling if I think I'm suffering from a problem that may be spiritual." Participant F6 reported a similar experience stating,

> If I can't see what is causing my pain or to be sick…then I have to consider that maybe what is going on is spiritual. I can't give you an example, but if I can't see what is making me sick or causing my pain, I'll check with our healer first…to make sure it's not something from the spirit realm.

Health Problems Visible Via Modern Technology

During the study interviews another common discussion point by the Hmong participants was that seeing a health problem didn't mean physically seeing it. A total of seven Hmong participants mentioned being able to see a physical health problem by way of modern technology (i.e., x-ray, CT scan, etc…) as being enough to help them to determine if a health problem is physical or spiritual in nature (Table 9). For example, Participant M5 explained the importance of modern technology helping them to see what is wrong with their physical health stating, "…and it's a lot easier for me to understand I have a physical health problem if a doctor can show me what's wrong." Participant M5 elaborated stating, "….like if they can show me an x-ray or something…or some sort of scan…then it's easier for me to see it's physical." Participant F4 discussed the importance of modern technology helping her to understand her physical health problem stating,

> When my doctor showed me the tumor on my breast from the scan, I knew right away it was a physical problem. Without the scan I would not have been sure what the problem was and would have spent more time with our shaman trying to figure it out.

During the interviews some of the Hmong participants shared personal their personal experiences where being able to see a physical health problem via modern technology allowed them to understand the health problem as physical in nature. For example, Participant F5 shared her experience stating, "…my family and I were both convinced I was experiencing problem with an evil spirit that was attacking my soul…related to something I had done." Participant 5 went on to explain how being able to visually see the problem changed his mind stating, "However, seeing the spot on the x-ray where the doctor showed me, I had cancer…allowed me to accept this was something physical." Participant M1 shared a similar experience stating,

> My doctors understand my beliefs…and have been very understanding. When I had to have my gallbladder removed…the doctors knew I wouldn't agree to surgery…unless I could see proof that there was something physically wrong with me. The doctor was very good at explaining the ultrasound and CT scan to me so I understood my gall bladder had to be removed and what would happen if I didn't.

Table 8

Visibility of Health Concern-Outward Visible

Subthemes	Participant Responses
Outward Visible Health Problems	"If I see something physical on me my first thought is that it's a physical problem…like if I break my arm…or have a cut or something."
	"If I can see what then problem is, like a growth on my body, rash, or something else I can see with my own eyes…I am not going to consider that to be a spiritual problem…but a physical one."
	"If I can't see what is causing my pain or to be sick…then I have to consider that maybe what is going on is spiritual. I can't give you an example, but if I can't see what is making me sick or causing my pain, I'll check with our healer first…to make sure it's not something from the spirit realm."
	"…if I have a headache or feel bad…I can't see what is causing this I will talk to our healer to make sure there isn't something wrong with my soul. I will work with the healer to do something called a soul calling if I think I'm suffering from a problem that may be spiritual."
	"In general, I have to be able…to see what is making me sick to be sure it is a physical illness."
	"…most doctors do not understand that just because I have what they think is a headache…doesn't mean it can be treated the way they think."
	"…and at times I'm not sure if something is physical or spiritual…especially if I can't see what is causing me to not feel well or be sick. Usually consulting with our shaman can help me figure it out."
	"…sometimes a physical problem is not something I can easily see, so I think there may be something wrong with me on a spiritual level."

Subthemes	Participant Responses
	"…if I can see what is causing me to be in pain, I know it's physical."
	"…and being able to see what is wrong…is important for my understanding…. important for me to know if my problems are physical or if I have more of something spiritual going on."

Table 9

Visibility of Health Concern-Via Modern Technology

Subtheme	Participant Responses
Health Problems Visible Via Modern Technology	"…and it's a lot easier for me to understand I have a physical health problem if a doctor can show me what's wrong…like if they can show me an x-ray or something…or some sort of scan…then it's easier for me to see it's physical."
	"When my doctor showed me the tumor on my breast from the scan, I knew right away it was a physical problem. Without the scan I would not have been sure what the problem was and would have spent more time with our shaman trying to figure it out."
	"…my family and I were both convinced I was experiencing problem with an evil spirit that was attacking my soul…related to something I had done. However, seeing the spot on the x-ray where the doctor showed me, I had cancer…allowed me to accept this was something physical."
	"…seeing test results, blood work, x-rays, scans, or something of that nature convinces both me and my family a health concern is a physical problem as opposed to spiritual."
	"…and a big part of being able to see that a health problem is physical is not only important to me…but also important to convincing my family…and our shaman of it [health problem] being something physical, as opposed to something non-physical."
	"…being able to show my family an x-ray or some other documentation from my doctor helps to convince my family I

Subtheme	Participant Responses
	have something wrong with my physical health…otherwise my family can be a pain and…want me to see our healer."
	"My doctors understand my beliefs…and have been very understanding. When I had to have my gallbladder removed…the doctors knew I wouldn't agree to surgery…unless I could see proof that there was something physically wrong with me. The doctor was very good at explaining the ultrasound and ct scan to me so I understood my gall bladder had to be removed and what would happen if I didn't."

Summary

This study was conducted to understand the Hmong experience when a physical health problem has been identified and how they perceive their physical health problems from a spiritual perspective. All of the participants in this study reported experiencing or observing how the Hmong culture and spiritual beliefs impacted their health decisions, and the importance of being able to view a health problem to determine if it was physical or spiritual. The participants described several factors related to each of these experiences.

Concerning the experiences with the cultural impact of health experiences participants reported cultural expectations, comfort using a remedy, and family pressure as the main factors. Concerning experiences with spiritual beliefs impacting health decisions participants reported concerns of the separation of their soul, evil spirits, and angry ancestors being the primary factors impacting their health decisions. Last, participants reported being able to physically see a health problem or see it via modern technology to help them determine if a health problem was physical or spiritual. All of

the Hmong participants were willing to share their experiences concerning impacted their health decisions, however some participants were more willing than others to share more details about these experiences.

Chapter 4 provided a detailed overview of the results of this study. This overview included the main themes and the subthemes that were extrapolated from analysis of the data. Chapter 5 includes an overview of the study and an interpretation of the results. Chapter 5 also includes an overview of the limitations of the study, future research recommendations, social change implications, and the overall conclusions made from the results of the study.

Chapter 5: Discussion

The purpose of this qualitative study was to understand the Hmong experience when a physical health problem has been identified and how they perceive their physical health problems from a spiritual perspective. This included factors and thought processes a Hmong person experiences when diagnosed with a physical health problem. This also included the specific factors and past experiences that are associated with how a Hmong person decides to choose from a modern healthcare provider and traditional Hmong healer.

The first research question for this study involved the Hmong study participants describing their experience when choosing a modern healthcare provider or traditional Hmong healer. The second research question for this study involved the Hmong study participants describing their experience when a modern healthcare provider diagnoses them with a physical health problem. This study was conducted to better understand the Hmong experience when a physical health problem has been identified and how they perceive their physical health problems from a spiritual perspective. In Chapter 5 I explain the key findings of the study, my interpretations of the findings, the limitations of the study, the recommendations for future research, the implications of the results of the study, and a conclusion explaining the overall essence of the study.

Key Findings

After interviewing 12 participants about their lived experiences in an American Midwest county, the key findings included three main themes and eight subthemes. In RQ1, I explored the cultural and spiritual experiences of the Hmong population when

choosing a modern healthcare provider or traditional Hmong healer through the SCT framework. In RQ2, I explored the cultural and spiritual experiences of the Hmong population when a modern healthcare provider diagnoses them with a physical health problem through the SCT framework.

The first main theme to emerge involved the impact of the participants' culture on their health decisions. In this study the cultural impact referred to the competing cultural influences within the Hmong participants environment (i.e., Western culture and traditional Hmong culture). The three subthemes subsumed under this main theme included (a) cultural expectations, (b) comfort using a particular remedy, and (c) family pressure. The second main theme to emerge involved the impact of the Hmong participants spiritual beliefs on their health decisions. The three subthemes subsumed under this main theme included (a) separation of soul, (b) evil spirits, and (c) angry ancestors. The third main theme to emerge involved the visibility of the health concern for the Hmong participants. The two main subthemes subsumed under this main theme included (a) outward visible health problems and (b) health problems visible via modern technology.

Interpretation of the Findings

The research questions were interpreted through the theoretical framework of SCT. SCT can be used to understand and explain the factors that mediate health behaviors (Sharma & Romas, 2012; Zinn et al., 2012). SCT outlines and explains the specific constructs that impact health behaviors and experiences, which include reciprocal determinism, behavior capability, observational learning, reinforcements,

expectations, and self-efficacy (Bandura, 1986). In the following sections I provide a thorough discussion of the subthemes and how they emerged into the major themes described above. I also thoroughly describe the contributions of this information to the previous literature discussed in Chapter 2.

Theme 1: Cultural Impact on Health Decisions

The first theme emerged from the following three subthemes: (a) cultural expectations, (b) comfort using a particular remedy, and (c) family pressure. Each of the participants mentioned the varying degrees of how either Hmong or American culture, or a combination of the two cultures, impacted their health decisions, and how these cultural influences influenced their overall health decisions. For example, Participant M1 discussed how his family strongly believes that shamans are better equipped at helping Hmong with their health problems.

Participant F3 had a similar view about traditional Hmong healers stating, "Ultimately, I believe modern drugs cause more harm than good…. I'm more comfortable using the herbal stuff our healer gives us." Participant F6 reported a similar view acknowledging that even though she is pressured to go see a healer first, she still prefers it stating,

> "We were always expected by the people in our family to visit the healer first, but I don't mind…. I feel like he's done a lot of good for me. I have always used a healer since they have always been able to help me with my health needs."

However, some Hmong participants denied their traditional culture had any impact on their health decisions and instead reported having more Western views on

making health decisions. For example, F1 discussed this more western view of health stating, “I didn’t grow up in a very traditional Hmong family or environment… nobody really mentions that magical healing stuff or whatever voodoo magic some of them [other Hmong] use in my family…. we only use modern doctors and clinics.”

Participant M2 had a similar view and a more modern and Western view of treating health problems stating,

> I consider our family to be fairly modern. I respect the more traditional people in my family and in the community, but we are not very close with any of them…as far as I know nobody in my immediate family considers using a Hmong healer and only goes to Aspirus for health problems.

Other participants described both their traditional Hmong culture and Western culture impacting their health decisions depending on the health concern. For example, Participant F7 described the factors that she takes into consideration when choosing to use a shaman or western health provider stating, “oftentimes I’ll use what the herbalist [Hmong Shaman Herbalist] gives me because they have always seemed to work for me…I only go to the clinic if they [herbal medicine] don’t work, which isn’t often.” Participant F2 had a similar view stating,

> And you know, no matter if I go to [local health clinic] or not later, I’m still always expected to talk to the Shaman first. There is a lot of pressure in my family to always go to a Shaman, which I’m willing to do depending on the health problem I’m struggling with. I have…learned enough about American culture and medicine that there are some things I would only go to a Western doctor for.

These types of findings reflect the cultural impact the Hmong participants experienced from either the Western culture they lived in, the Hmong culture they grew up in, or a combination of the two. These findings support some of the previous findings in previous studies like Fang and Stewart (2018), who suggested that Hmong populations social and cultural perceptions and their traditional beliefs can serve as a barrier for this population to seek treatment from modern healthcare services. Specifically, the findings of this previous study indicated that some Hmong have a fear of Western doctors and medical procedures, distrust in the healthcare providers and services, and prefer traditional Hmong herbal medicines and spiritual. These same concerns among the Hmong population were seen in this study as well.

The findings from this study also support the previous findings by Thorburn et al. (2012) who indicated some from the Hmong population were reluctant to use modern health services because of not being familiar with the services or procedures and cultural beliefs and traditions that conflicted with modern healthcare procedures. In other words, the findings of these studies say that oftentimes the Hmong population is more comfortable using their own traditional and spiritual health procedures. These findings are also indicated that the Hmong population is reluctant to use modern health services because they either do not understand them or the procedures directly conflict with their beliefs and traditions, such as their soul escaping or poisoning their soul in the afterlife (Fang & Stewart, 2018; Thorburn et al., 2012).

These same concerns were expressed by the participants in this study as well. All these findings were in line with and a result of the overall subthemes, which were cultural

expectations, comfort using a particular remedy, and family pressure. The participants from this study also expressed those cultural expectations, whether they were Hmong, Western, or a combination of the two, impacted their health decisions. The participants also reported their reluctance to use a particular remedy, health service, or health procedure if they did not understand it, if they did not believe it would work, or if it directly conflicted with their cultural beliefs and traditions. Last, each of the participants to varying degrees described experiencing family pressure to use a particular health remedy whether it be Western, traditional, or a combination of the two depending on the health concern.

However, not all the cultural expectations, comfort using a particular remedy, and family pressure were for the same reasons. One consistent finding in this study was the different levels of influence Western and Hmong culture had on the health decisions for the Hmong participants in this study. What this means is the health decisions of the Hmong participants were influenced by the level of acculturation within their Western environment. For example, the Hmong participants with the highest levels of acculturation were the most willing to use Western health services, the least acculturated were the most reluctant to use Western health services, and the more moderate level of acculturated participants were more open to using both Western healthcare services and traditional Hmong herbal medicine and spiritual healing depending on how they viewed the health problem they were concerned about.

These findings supported the previous finding of a study by Xiong and Dauphin (2018) who indicated levels of acculturation directly impacted the healthcare choices

among the Hmong population. For example, the findings from this study indicated that the likelihood of a Hmong person choosing to use either modern healthcare providers and services or traditional Hmong remedies had a high correlation between their level of acculturation and the extent to which they held traditional beliefs and engaged in traditional practices. The results indicated that the Hmong participants who had the lowest level of acculturation and strong traditional beliefs and actively engaged in traditional practices were the most likely to not seek out modern health care services.

Theme 2: Spiritual Beliefs Impact on Health Decisions

The second theme emerged from the following three subthemes: (a) separation of soul, (b) evil spirits, and (c) angry ancestors. Many of the participants mentioned the various spiritual beliefs they held that directly impacted the decisions they made about their health. For example, when it came to the topic of soul separation, Participant F6 stated:

> When I was younger, I used to have a lot of nightmares and was sick a lot. My parents took me to our local healer a lot when I was young to make sure there wasn't something wrong with my soul or make sure it wasn't missing or stuck somewhere else...and my mother told she wanted to make sure my soul wasn't stuck in the nightmare.

Participant F7 similarly stated:

> And I was always raised to safeguard my soul because bad things can happen to it. That's why I would have never had a surgery if I absolutely didn't have to.

> Surgeries can allow for our souls to escape…. I then have to have the shaman return the soul…otherwise many bad things can happen to my health.

The findings from this study support the findings of the previous studies. Each of these studies touched on the concept of Hmong beliefs about their soul's ability to separate from their bodies for a variety of reasons, which they believe can cause health problems (see Day, 2019; Her-Xiong & Schroepfer, 2018; Capps, 1994). Each of these studies also touched on the concept of soul calling, which is to bring a separated soul back to the person's body (see Day, 2019; Her-Xiong & Schroepfer, 2018; Capps, 1994). This is also a concept described by some of the participants of this study who discussed soul calling as part of the assistance they would receive from their local healer or shaman.

Some of the participants reported that sometimes their health problems are attributed to evil spirits. For example, Participant F4 stated, "The doctors at Aspirus just smile whenever I bring up evil spirits. They don't believe us…try to make us take drugs. Our shaman is the only one that only understands." Similarly, Participant F5 stated:

> Evil spirits are always a concern and only something the shaman can fix…evil spirits can make you sick and cause diseases. …my family and I were both convinced I was experiencing problem with an evil spirit that was attacking my soul…related to something I had done. However, seeing the spot on the x-ray where the doctor showed me, I had cancer…allowed me to accept this was something physical.

The findings from this study support the findings of the previous study by Yang (2019) who indicated the extent that Hmong believe evil spirits can impact their lives and

health. The results of the study indicated the Hmong believe that an evil spirit can capture a person's soul. The results indicated that Hmong believe that evil spirits can also attach to a person's body and cause them all. In this way Hmong believes that evil spirits can cause health problems that only a shaman or healer can help with, and Western health services are incapable of understanding or helping. The Hmong participants in this current study indicated similar beliefs about evil spirits and the impact they can have on their health as shown above in the participant quotes.

Some of the participants reported that sometimes their health problems are attributed to angry ancestors. For example, Participant M5 stated:

> If an angry ancestor is making me sick the best way to fix the problem is by providing them food through a sacrifice, burning money so they can use it in the spiritual world, or making other offerings…and yes, usually a shaman helps with this.

Participant F5 similarly reported, "if an ancestor is upset…that ancestor can cause the person to have a disease or illness…this is not something modern medicine is equipped to deal with." The findings from this study support the findings of several previous studies concerning Hmong ancestors and Hmong health. For example, Hmong practice ancestor worship. This is done because of the interdependence the Hmong believe their physical world has with the spiritual world, which includes worshiping ancestors who are charged with protecting the person, family, and their overall health (Gerdner, 2012; Gerdner et al., 2007). Past research studies have shown that the Hmong believe if they violate cultural norms and ignore the practice of rituals that this will anger

ancestors who can cause harm, including health problems, to the offender Hmong person, their family members, and even future descendants of the person (Gerdner, 2012; Gerdner et al., 2007).

The findings from this study confirmed the findings of other previous studies. This included that approximately 70% of Hmong practice ancestor worship and believe ancestors can have a direct impact on their health (Gerdner, 2012; Pfeifer & Lee, 2005). The results of some of these studies show that when health problems are attributed to an angry ancestor that Hmong believe that only a shaman can intervene and help them improve the health problem and find a way to negotiate with or appease the angry ancestor (Gerdner, 2012; Gerdner et al., 2006). The Hmong participants in my study indicated similar beliefs about angry ancestors and the impact they can have on their health as shown above in the participant quotes.

Theme 3: Visibility of Health Concerns

The third theme emerged from the following two subthemes: (a) outward visible health problems and (b) health problems visible via modern technology. Many of the participants mentioned how the ability to see a health concern, either visually or with the aid of modern technology, played a major role in whether they determined the health concern was spiritual or physical in nature. For example, concerning the importance of being able to visibly a health problem, Participant F2, stated:

> I have a headache or feel bad…I can't see what is causing this I will talk to our healer to make sure there isn't something wrong with my soul. I will work with

> the healer to do something called a soul calling if I think I'm suffering from a problem that may be spiritual.

Similarly, Participant F6 stated:

> If I can't see what is causing my pain or to be sick…then I have to consider that maybe what is going on is spiritual. I can't give you an example, but if I can't see what is making me sick or causing my pain, I'll check with our healer first…to make sure it's not something from the spirit realm.

The findings from this study also support the previous findings by Lor et al. (2017). Lor et al. discussed the importance of a Hmong person being able to see a health problem with their naked eye for them to be able to accept the health problem was physical in nature and not spiritual. The results of this study indicated that most Hmong were willing to accept that their health problem is physical if they are able to see it with their eyes. An example of this would be able to see that a finger or other bone was broken because they could see with their naked eye the physical distortion of the broken bone. The Hmong participants in my study indicated similar beliefs about being able to see a health problem with their naked eye to be able to accept that the problem is physical and not spiritual in nature.

Participants of my study also reported the importance of being able to see a health problem with the aid of modern technology. For example, Participant M4 stated, "If I can see the problem, like a growth on my body, rash, or something else with my own eyes…I am not going to consider that to be a spiritual problem…but a physical one." Participant F5 similarly stated:

> My family and I were both convinced I was experiencing problem with an evil spirit that was attacking my soul…related to something I had done. However, seeing the spot on the X-ray where the doctor showed me, I had cancer…allowed me to accept this was something physical."

The findings from this study also support the previous findings by Lor et al (2017). The results of this study discussed the willingness of Hmong people to be more willing to accept that a health problem was physical in nature if they could see it with the use of modern technology. This means the Hmong person can see with their own eyes using modern technology that there was a health problem that was physical in nature. An example of this would be showing a Hmong patient with an X-ray or other radiographic tests to see that there was cancer in their body or a CT scan showing they had a brain bleed. The Hmong participants in this current study indicated they had similar beliefs about being able to see a health problem when using modern technology and be able to accept that the problem is physical and not spiritual in nature.

Interpretation of Findings Related to Theoretical Framework

The framework to be used for this study is Albert Bandura's Social Cognitive Theory (1986). Social Cognitive Theory (SCT) evaluated the impact that an individual's experiences, behaviors of others, and environmental factors have on the (health) behaviors a person engages in (Bandura, 1986; Sharma & Romas, 2012; Zinn et al., 2012). SCT can be used to understand and explain the factors that mediate health behaviors (Sharma & Romas, 2012; Zinn et al., 2012).

This theory suggests that SCT outlines and explains the specific constructs that impact health behaviors and experiences, which include reciprocal determinism, behavior capability, observational learning, reinforcements, expectations, and self-efficacy (Bandura, 1986). The majority of the descriptions provided by the participants of this study touched on all of the SCT concepts with their responses. However, to show how the SCT concepts were consistent in all of these responses as many participants and their responses were used in interpreting the findings related to these concepts.

Reciprocal determinism refers to the reciprocal influence on an individual, the behavior the individual engages in, and the social environment (Bandura, 1986; Lefrancois, 2019). This concept is important for this study to understand how the Hmong population, their behaviors, and their cultural environment plays a role in how they experience physical health problems and their expectations and experiences with modern healthcare providers. Behavior capability refers to a person who could perform a behavior by possessing the necessary skills and knowledge to engage in the behavior (Bandura, 1986; Lefrancois, 2019). This construct applies to this study because certain members of the Hmong community believe that if their body is punctured or cut, their soul can be damaged or escaped (Daly, 2019).

Observational learning refers to people observing behavior and then reproducing those behaviors, which is also referred to as the modeling of behaviors (Bandura, 1986; Lefrancois, 2019). This construct applies to the study in that this observational learning by individual Hmong vary depending on the type and level of culturally traditional observational learning they engaged in, which in turn will impact their individual

experiences and expectations concerning modern healthcare providers and how they view their physical problems and symptoms (Lor, Rodolfa, & Limberg, 2017; Vang, 2018). The level of culturally traditional observations refers to the type of health decision making and expectations a Hmong person was consistently observed from Hmong family, friends, and other tribal members (Lor, Rodolfa, & Limberg, 2017; Vang, 2018).

For example, 1st generation Hmong people who came to the United States from Laos more likely observed Hmong family, friends, and other tribal members base all of their health decisions from a spiritual perspective and regularly used a shaman for health issues (Lor, Rodolfa, & Limberg, 2017; Vang, 2018). However, 2nd and 3rd generation Hmong people who either came over to the United States as young children or were born in the United States, likely have had fewer observations of family, friends, and other tribal members making health decisions strictly from a Hmong cultural perspective and have had more experiences observing health decisions being made from a modern healthcare perspective (Lor, Rodolfa, & Limberg, 2017; Vang, 2018).

Reinforcements refer to both the internal and external responses people receive from behaviors they engage in and impact whether the person will continue or stop the behavior. This concept applies to this study because the responses a Hmong person gets about their health beliefs and behaviors from family, friends, and other members will play a role in whether those beliefs and behaviors are maintained. Furthermore, the more or less culturally traditional the environment is for a Hmong person will determine what behaviors and beliefs will be reinforced (Daly, 2019).

Expectations refer to the consequences of behavior anticipated by a person (Bandura, 1986; Lefrancois, 2019). This concept applies to this study in that the expectations a Hmong person has concerning their health problems will determine how they experience their health problem and the advice provided by a modern healthcare provider. For example, if a Hmong person believes their health problem is spiritual in nature, then they are not likely to have the expectation modern treatments will help them and will seek a spiritual healer (Daly, 2019; Fang & Stewart, 2018).

The last construct is self-efficacy that refers to how capable a person believes they are to engage in a behavior, including any barriers or facilitators that may exist (Bandura, 1986; Lefrancois, 2019). This construct applies in two ways to this study. First, self-efficacy refers to whether a Hmong person believes they can engage in the necessary behavior to address what they perceive as either a spiritual or physical problem. Second, self-efficacy refers to whether the Hmong person is in an environment that will support or not the behavior the person wants to engage in and will shape how they experience their health problem (Bandura, 1986; Lefrancois, 2019).

Theme 1

The first theme that emerged from the study is the *cultural impact on health decisions*. The related subthemes included: (a) cultural expectations, (b) comfort using a particular remedy, and (c) family pressure. In theme 1 study participants described the cultural expectations from either their traditional culture, American culture, or a combination of the two relating to their health concerns and how to treat them. They also described their level of comfort using a particular remedy and the varying amounts of

family pressure they had to endure to pursue a specific kind of health remedy. The responses from the participants touched on all six of the SCT concepts, which included reciprocal determinism, behavior capability, observational learning, reinforcements, expectations, and self-efficacy.

In relation to reciprocal determinism, all the study participants reported being impacted by reciprocal determine meaning how their environment, themselves as individuals, and their health behaviors were all interconnected. For example, Participant F1 described her experience growing up in a more acculturated family and not believing in using traditional Hmong remedies. She mentioned she did not "grow up in a very traditional Hmong family" and how this impacted her health choices.

She mentioned that her family and herself "only use modern doctors and clinics" and this was mainly because this is what they saw as the best choice for their health. She described how she was always encouraged by her family to use modern medicine and was always "discouraged from listening" to her grandparents and other elders concerning using traditional Hmong remedies. She described how this experience growing up shaped the services she uses for her health problems, which are modern healthcare services.

Participant F1's description of her experience growing up in this more acculturated touched on other SCT concepts (i.e., behavior capability, observational learning), just as the other participants did. Participant F1 described these other concepts when she explained how that because she grew up in this more acculturated Hmong family that she had the ability and knowledge to engage in the use of modern health remedies because of growing up in a more "modern American family" who consistently

used “modern healthcare services” when she was growing up. This description she provides also touches on observational learning, also known as modeling behaviors, because she described modeling the behaviors of her parents who emphasized using modern healthcare services.

Similarly, Participant M2 describes growing up in a “modern family” where his family stayed away from using traditional Hmong remedies to treat health problems and exclusively used modern healthcare services. His descriptions of his experience mirrored that of many of the other study participants. The experience described by Participant M2 touched on the other SCT concepts, which included reinforcements, expectations, and self-efficacy.

For example, he described how his continued use of modern healthcare services was always reinforced by and that he didn’t “know nobody in his immediate family” that wasn’t using modern healthcare services. He acknowledged that there was expectation in his family to use modern healthcare services because nobody in his family “expected to get better” by using traditional Hmong remedies. He also described how there were no barriers for him to use modern healthcare services, but there would have been a lot of barriers to use traditional Hmong healers because “nobody thought they would do any good.”

An important point to this description of the SCT concepts as they related to the participants of this study is that even though all of the participants touched on all of the concepts, they did not touch on them in the same way. For example, as shown above these SCT concepts (i.e., reciprocal determinism, behavior capability, observational

learning, reinforcements, expectations, and self-efficacy) were all from participants who came from more acculturated families. However, these same concepts applied to other participants from more traditional families in different ways.

For example, Participant F5 described the concept of reciprocal determinism and behavioral capability when she discusses her growing up in a "more traditional" Hmong family. She described how she grew up with pressure from her family and community to "always see the healer first." This in turn meant that no matter what she always saw the healer first before doing anything else concerning a health problem. She reported knowing how and where to get these services, so she "always made sure" that she used the shaman first and continues to do so.

Participant F4 described a similar experience growing up in a more traditional Hmong family. The description of her experience touches on the SCT concepts of observational learning and reinforcements. She described that growing up her mother "always took her to a healer first" and now that she is older, she "does the same thing." She also described how most of her family was "very traditional" and that if her family didn't see the shaman first there "would be hell to pay" from other family members and close friends.

A similar experience was described by Participant M1 who touched on the SCT concepts of expectations and self-efficacy. He described his experience managing health problems and this his family "strongly believes" that their health problems are better treated by shamans and that "shamans are better at helping" when it came to certain types of health problems. He also described that the biggest barrier to "using any sort of health

remedy" was his family, so he would only "seek out help" for a health problem that he knew his family would be okay with. These types of responses relating to theme 1 and the individual SCT concepts were common among all the participants within this study. However, as described above, these SCT concepts applied in different ways depending on the acculturation of the participants and their families.

Theme 2

The second theme that emerged from this study is the *spiritual beliefs impact on health decisions*, which included the following subthemes: (a) separation of soul, (b) evil spirits, and (c) angry ancestors. In theme 2 study participants described any concerns they had about health problems related to the separation of their soul, evil spirits, and angry ancestors. This theme only applied to participants who were less acculturated and engaged in more traditional Hmong practices. However, the responses from the participants who did describe this concern touched on all six of the SCT concepts (i.e., reciprocal determinism, behavior capability, observational learning, reinforcements, expectations, and self-efficacy).

Participant F4 described her experience with health problems as it related to theme 2 and touched on the SCT concepts of reciprocal determinism and behavior capability. She described how she engages in the health decisions she makes and why she feels comfortable engaging in them as it related to her health concerns and theme 2. She described how because she grew up in a "very traditional Hmong family" she was concerned about the impact of "evil spirits" on her health and soul. She discussed how she was very comfortable using "our shaman" when she believes her health concerns are

related to an evil spirit. However, she was unable to talk to “doctors at Aspirus” who never seemed to take her seriously.

Participant F4 further described how she doesn’t like going to modern doctors because they just want to “make us take drugs.” She reported that their shaman “is the only one that only understands.” She described that because of these experiences growing up and support from her family, she continues to use a shaman when she is concerned about “evil spirits.” She also described feeling “very comfortable” using the shaman.

Participant F5 described her experience with health problems as it related to theme 2 and touched on the SCT concepts of observational learning and reinforcements. In her response she describes each of the subthemes within this main theme, which include health concerns related to the separation of her soul, evil spirits, and angry ancestors. Her responses touched on the SCT by describing how her health behaviors were modeled from her family members and she received positive reinforcements from her “family and community for using a shaman” to address these kinds of health concerns. She described how “evil spirits were always a concern” and that people in her family always visited the shaman when they believed an “evil spirit” was harming their soul or health.

Participant F5 further described how her family members always went to see a shaman if they believed an “upset ancestor” was the cause for an illness or disease. She described how only the shaman could “negotiate with an upset ancestor” to fix a health problem and the shaman is who she “always turns to as well.” She also reported how

"one of her souls" could become separated for a variety of reasons, which included problems with evil spirits and angry ancestors. Either way, she knows from "watching her family" that if she suspected there was a problem with her soul then she "always goes to a shaman."

Participant M5 described his experience with health problems as it related to theme 2 and touched on the SCT concepts of expectations and self-efficacy. In his response he similarly describes each of the subthemes within this main theme, which include health concerns related to the separation of her soul, evil spirits, and angry ancestors. His responses touched on the SCT by describing how the health behaviors he engaged in were driven by the fact that he expected them "to work," he was able and capable in engaging in them, and there were no barriers to him engaging in them.

First, Participant M5 described his experience growing up that he was raised to be "wary of evil spirits" and that "angry ancestors" can make him sick. He also believed that is soul and health could be harmed because an angry ancestor or evil spirits could "steal your soul." He described he strongly believed in seeing a shaman for these problems because the shaman could "make a sacrifice," could make "other offerings," or even do a "soul calling" if necessary to help him. He described that the did these things because his family supported and he was "comfortable doing it," and that he truly believed the shaman and his "remedies worked."

Theme 3

The third theme that emerged from the study was the *visibility of health concerns*, which included the following subthemes: (a) outward visible health problems and (b)

health problems visible via modern technology. In theme 3 some study participants described how their health decisions and how they view their health problems as being physical or spiritual is related to whether they can visibly see the health concern with their own eyes. This theme only applied to participants who were less acculturated and engaged in more traditional Hmong practices. However, the responses from the participants who did describe this concern touched on all six of the SCT concepts (i.e., reciprocal determinism, behavior capability, observational learning, reinforcements, expectations, and self-efficacy).

Participant F2 described the importance of being able to see a health problem to determine if it is physical or spiritual in nature. Her description touched on the SCT concepts of reciprocal determinism and behavior capability. She described that being raised in a family that was "willing to use" both traditional Hmong remedies and modern healthcare services, that she learned from her family "what to look for." She described learning growing up and later practicing in life wanting to "see test results, blood work, x-rays, scans," or anything else that would convince her a health problem was physical and not spiritual.

Participant F2 further described her experience being able to see something was the "most important" and whether it was with her own eyes, or "modern technology" didn't matter. This was always "important to her family" growing up and that was instilled in her at a young age. She felt capable of determining if a health concern was spiritual or physical if she could "somehow see it." Otherwise, she would likely see the problem as "being spiritual" and would go see the shaman first.

Participant F6 similarly described the importance of being able to see a health problem to determine if it is physical or spiritual in nature. Her description touched on the SCT concepts of observational learning and reinforcements. She described how when she was growing up, she was "expected by the people in our family" to always make sure she went to the shaman first. However, she explained that even though they were expected to go to the shaman first that in her family they "could see what is making them sick" then they usually believed the health problem was physical and not spiritual. She elaborated by describing how her family was "open to being able to see" any sort of health concern they may have used medical technology if "it was explained to them what they were seeing."

Participant F6 described there was a lot of family pressure to always "use a healer first," but that there was also acceptance within her family that "being able to see" a health problem made them more open to believing it was physical and not spiritual. She described that because she "grew up in this environment" when it came to making health decisions, she continues to "practice them herself." She admitted that her family's "openness" to using modern technology and accepting and "supporting her health decisions" makes it a lot easier.

Participant M3 and similarly, Participant M4, described the importance of being able to see a health problem to determine if it is physical or spiritual in nature. Their descriptions touched on the SCT concepts of expectations and self-efficacy. Participant M3 described growing up in a more "traditional Hmong" family. He was always expected to see "shaman first" and "didn't have a choice." However, he described that growing up

in his family he learned the importance of "being able to see" a health problem to "better understand" what was causing. He learned from his family about the importance of "being able to see" a health problem if its physical, which is what he "still does today."

Participant M4 described a similar experience. He described how he was "forced by his father" to always see the shaman first. However, he also described how he learned from his dad that if he "couldn't see the problem" then it was probably a spiritual problem that only the shaman could help with. However, he also learned from his father that "shamans are more trustworthy" than any provider from modern health facilities. Furthermore, both Participants M3 and M4 reported that all these health behaviors and decisions about their health are "supported by" their families and Participant M3 described how their "would be hell to pay" if he skipped seeing the shaman first. Both participants denied any barriers engaging in the above-described health barriers, but there were many barriers for "ignoring" them. Participant M4 described how it was easy to keep doing what he had grown up doing because he already knew what to do and was "comfortable doing it" that way.

Limitations of Study

No new limitations were apparent during this study that were described in Chapter 1. However, some of the limitations that were described in Chapter 1 were present during the study. One limitation was the distrust that Hmong have for people outside of their community and who are not Hmong themselves (Thorburn, Kue, Keon, & Lo, 2012). This distrust was apparent during the study when interviewing the Hmong participants who were older and less acculturated. These participants appeared to be more reluctant

and hesitant to share information with me during their interviews. However, the answers provided by the participants were assumed to be truthful and there was no indication the participants were dishonest in any of their responses.

Another limitation is the qualitative nature of this study. The results of a qualitative study do not allow for the easy generalization of these results to a larger population (Miles, Huberman, & Saldana, 2018). This study only included 12 participants ($N = 12$), which is not a large enough sample to generalize the results of this study to represent all Hmong or all Hmong in the Midwest and their lived experiences. The results of this study can be applied only to the small population interviewed in the Midwest related to the phenomenon that was being explored.

Other limitations, although precautions were taken to mitigate, were still assumed to be present. One assumed limitation was interviewer biases, which is when the interviewer's body language, tone, facial expressions, etc., can impact the response of the person being interviewed (Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019). Other limitations would include consistency bias and acceptance bias. Consistency bias is when a person being interviewed attempts to appear consistent in their answers, biasing the person's answer (Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019). Acceptance bias is when a person being interviewed answers the person believes the interviewer wants (Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019).

Other assumed limitations within this study, even though precautions were taken to mitigate them, were reference bias, sensitivity bias, and reporting bias. Reference bias is when a participant being interviewed develops a frame of reference from previous

questions and topics that bias their answer in later questions and topics (Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019). Sensitivity bias is when a participant doesn't want to talk about a particular topic or answer certain questions, which can lead to false or no answers at all (Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019). Reporting bias is related to the individual characteristics of the interviewer that bias how the information obtained from the person being interviewed is perceived and articulated (Aparasu & Bentley, 2019; Ary et al., 2018; Williams, 2019).

Recommendations

Recommendations for future studies should include additional qualitative studies exploring this studies phenomenon of interest on other Hmong populations throughout the United States. Another recommendation is to use the results of this study to conduct a larger quantitative study to analyze if any data could be generalized to the larger Hmong population in the United States. Another recommendation is for a future more culturally sensitive qualitative study to be conducted using the same phenomenon of interest as this study. To accomplish this, it is recommended that a qualified Hmong researcher conduct the study and the interviews to further minimize the distrust that Hmong have for people outside of their community and who are not Hmong themselves (Thorburn, Kue, Keon, & Lo, 2012).

There are two main reasons for this recommendation. First, is to see if the Hmong participants are more open with a Hmong researcher and if the descriptions the participants provide are richer and more detailed. Another reason for this recommendation is because a Hmong researcher may have a better understanding of the

cultural context of a participants answer, may be able to structure more culturally authentic interview questions, and may better understand non-verbal cues during the interviews. This in turn could lead to more authentic and richer descriptions of the Hmong participants' experiences.

During this study one factor that appeared to impact all of the responses by the study participants and their health behaviors was their level of acculturation. The study by (Areba et al., 2020) showed the significant impact that the level of acculturation of the Hmong participants had on substance use and academics. Another study by Xiong and Dauphin (2018) showed that the level of Hmong acculturation was one factor that impacted their use of modern healthcare providers.

The level of acculturation appears to be a far-reaching factor within the Hmong population that impacts all aspects of the Hmong population that live in the United and is also relatively understudied. It is recommended that more studies, especially studies that focus on health decisions and use of modern health services, are done with a focus on the level of acculturation of Hmong participants. This would allow for a richer and more clear understanding of the role acculturation plays in a Hmong person's experiences and decision making, especially as it relates to health behaviors, use of health remedies, and understanding of a health problem.

Implications

This study provided insights into the important factors associated with Hmong health decisions and how they view their health problems. The main implication for social change associated with the results of this study involves the increased

understanding of how Hmong culture, acculturation, spiritual beliefs, and the visibility of a health problem impacts the health decisions this population makes. This implication for positive social change applies to the Hmong population on several different levels.

These different levels would include the individual, family, organizational, and at a policy level. Individual providers within the modern healthcare system could help to expand the understanding of providers on how to better treat individual Hmong clients by better understanding how and why this population makes the health decisions they do. This in turn may increase the providers cultural understanding and approach to Hmong clients and their families, and how different levels of acculturation can impact the health decisions made.

By better understanding the factors impacting Hmong health decisions this could potentially allow for modern healthcare facilities in the Midwest to consider making organizational and policy changes. These changes could have a positive impact on social change for the Hmong population by changing how the modern healthcare facility views and treats the Hmong population. This would also likely lead to policy changes within the organization to formalize these organizational changes.

Furthermore, on a social level these changes in how providers and modern healthcare facilities view, approach, understand, and treat the Hmong population could lead to positive social change. This would relate to the overall positive improvement for the Hmong population concerning their interactions and treatment with the modern healthcare system. This could also include this population feeling better understood by modern healthcare providers.

Concerning recommendations for practice, the findings in this study could be used to increase the cultural awareness and cultural sensitivity of individual modern healthcare providers. This would include taking the time for individual providers taking the time to better understand the acculturation of their Hmong clients. This would also include the healthcare providers taking the time to find out how individual Hmong clients view their health problem, any cultural factors impacting their health decisions, any spiritual factors impacting their health decisions, and the importance of being able to see any health problem the provider says the Hmong client has. This could potentially lead to an overall improvement for both the Hmong clients and the individual healthcare providers.

Conclusion

The research concerning Hmong health decision and the factors impacting those decisions is limited. However, the results of this study can contribute to existing literature relating to these topics. This study was designed to better understand the Hmong experience relating to how they perceive their health problems and the factors impacting their health decisions as it related to the theoretical framework of Albert Bandura's Social Cognitive Theory (1986) and the six related factors. These factors (i.e., reciprocal determinism, behavior capability, observational learning, reinforcements, expectations, and self-efficacy) were shown to play a substantial role in how the Hmong participants in this study described their experiences relating to their health decisions, how they perceived their health problems, and choosing between using a modern healthcare or traditional Hmong health remedies. The results of this study provide experiential information relating to the cultural and spiritual factors relating to how and why they

make the health decisions they did and the importance for less acculturated Hmong participants in being able to see health problem to be able to better determine if it was physical or spiritual in nature. Lastly, the results of this study helped to provide clarity about many of the factors and influences that impact on not only how they make the health decisions they do, but also why they make these decisions the way they do.

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Appendix A: Recruitment Flyer

Volunteers Needed

For Hmong Healthcare Experience Research Study

The primary purpose of this study is to understand the Hmong experience when a physical health problem has been identified and how they perceive their physical health problems from a spiritual perspective. The secondary purpose is to understand the Hmong experience with modern healthcare providers and services during this process. The long-term goal of this study is to improve Western healthcare providers understanding of the Hmong population and their health views and to improve the overall quality of healthcare for the Hmong population. The study is being conducted by PhD Doctoral Candidate Kristina Mauk from Walden University.

Volunteers Must:

- Be ethnically Hmong and fluently speak English
- Be 18 years of age or older
- Live in Marathon County
- Experienced health problems as an adult
- Sought consultation for health problem with a Western healthcare provider

If you agree to be in this study, you will be requested to attend a face-to-face interview with the researcher for this study. Prospective participants will have the option to interview by phone or zoom as alternatives to face-to-face. The screening session and interview will last approximately 1 hour. Your privacy will be maintained throughout the entire process for this study.

Location & COVID Precautions

Face-to-face screening and interview will be conducted at a room space that is quiet and private at the local library in Wausau, WI. All CDC guidelines will be followed concerning COVID.

If interested in participating in this study, please contact Kristina Mauk at:

Email: Kristina.Mauk@Waldenu.edu
Phone: (715) 297-3827

No compensation is provided for participation