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Mai la Vue

St. Catherine University, mivuee@gmail.com

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The Impact of Acculturation among Hmong Caregivers

by

Mai Ia Vue, B. A.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
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in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members

Renee Hepperlen, Ph. D., LICSW (Chair)

Carol Ashwood, MSW, LICSW

Natalie Thao, LGSW

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

Abstract

This research study explores the impact of acculturation among Hmong caregivers within the Twin Cities region, who the Hmong caregivers are today, and what caregiving in the Hmong community looks like today. A sample of four respondents were recruited in the Twin Cities region who are Hmong and are providing care for an older adult in the home. Two surveys were used to analyze the demographics and acculturation of the Hmong Caregivers. A qualitative survey explored how acculturation has impacted the respondents in terms of caregiving. The outcomes of the study indicated that majority of the caregivers were women who married into their husband's family. It also indicated that economically, most were doing well, however could still use financial support and additional resources. More than half the respondents have acculturated successfully in the mainstream culture. However, even with this finding, it is important to note that within these respondents and their families, the preferred method of caregiving is to keep the care recipient in the home. A continuum of conflict and utilization of supports of resources varied among the respondents in terms of acculturation. Recommendations for future research include targeting families, couples, and older adults, and other communities to focus on concerns and the needs of the caregivers. Further research should be conducted on how to find and effectively reach out to support and meet their needs; and how to work cross-culturally with Hmong caregivers. Implications for social work practice efforts should include having an understanding of caregiving within the Hmong culture, providing support for Hmong caregiver living in dual cultures, and continuing to reach out to this population so that Hmong caregivers are aware of the benefits that come from receiving additional supports and resources.

Keywords: hmong, acculturation, caregiver, caregiver stress, caregiver support, caregiving in the hmong community

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The Impact of Acculturation on Caregivers within the Hmong Community

According to the final report issued recently in 2015 by the National alliance for Caregiving and the American Association of Retired Persons Public Policy Institute (2015), an estimated, “43.5 million adults provided unpaid care to an adult or child within the past 12 months” (p. 14). Significantly, ethnic minority groups make up for more than half of that. Compared to their white counterparts, ethnic minority caregivers have a “poorer health status, less reliance on formal service systems, and greater reliance on religious coping” (Owens & Chadiha, 2013). Today, older adults rely heavily on their families to take care of their long term support services, especially for families of ethnic minorities. To help support these caregiving roles, the U.S enacted the Family Medical Leave Act (FMLA) to protect workers while caregivers cared for the care recipients. However, the drawback for ethnic minorities is that even if they did have access to it, they could not afford to take it because it was unpaid leave (Chen, 2016). A study on workers in California workers also revealed that, “Latinos, immigrants, low-wage workers, and less-educated employees,” had no knowledge of the resources available to them in regards of the California’s paid family leave (PFL) program (Chen, 2016, p. 393). Regardless of ethnicity or race, providing for older adults is a growing social concern that exerts expectations and demands on families to be socially responsible on providing care to its own family members in addition to raising their own children. (Kelley, Buckwalter & Maas, 1999; Owens & Chadiha, 2013).

Researchers project that caregivers born to the baby boomers (1946-1964) are expected to decline and will therefore, require other long term health services and support (Redfoot, Feinberg & Houser, 2013). Long term care (LTC) provides services to help those who are unable to

perform activities of daily living. Different settings include nursing homes, assisted living and residential care, adult day centers, personal care and in-home services. However, majority of the care recipients choose personal care and in-home services to remain in the community (Kane, 2016). Older adults who do not want to rely on family members may be contributing to the high health care costs and the increase of cost in long-term services (Redfoot, et.al 2013; Chen, 2016). Furthermore, other countries such as China, are also facing dilemmas with culture and the support available to take care of their elders (which is due partially due to the one child policy). Many of the family members report reasons for choosing long term care include: illness, busy, and housing problems (eliminating stairs was the biggest factor) (Zhan, Zhanlian,, Zhiyu, & Xiaotian 2011). However, it may be accurate to say that many caregivers do enjoy caregiving and try to do the best they can for their care recipients (Kelley, Buckwalter & Maas, 1999). The study in Nanjing, China revealed that even after the elders were institutionalized, the recipients' children continued to visit to show emotional support (Zhan et.al, 2011). Many caregivers were unfamiliar with the roles that they have taken on and need the support and resources to care for the recipients (Kelley, Buckwalter & Maas, 1999).

Minnesota is home to one of the largest population of Hmong residents. In 2013, the State of the Hmong American Community stated in their report, "The Hmong population in the United States increased by 40% from 2000-2010," (p. 6). Although many have acculturated successfully, there are others who continue to experience difficulty in this process even today. The last migration of the Hmong occurred in 2004, a year after the United States Department announced the resettlement of the group who had been living in Wat Tham Krabok, Thailand. Grigoleit (2006) followed their transition into the United States and found that some of the

Hmong in order to gain acceptance and respect from Hmong Americans, felt the pressure to adjust faster. In addition, they were faced with financial challenges, housing issues, employment. Current literature suggest that those who arrived in the United States as older adults with little to no English skills in reading, writing and speaking felt the most separated and were more likely to experience marginalization (Lee and Green, 2010). Today, these are likely to be Hmong elders who are being cared for by their children. Limitations in education and the English language places demands on the younger family members in the family to provide financial support (Tatman, 2004). The family is expected to work together to survive in addition to meeting the demands of family responsibilities such as taking care of siblings, household chores, etc... In past research, family responsibilities were reported as contributing stressor for many Hmong students. Many also felt stressed trying to get good grades and finding a job after graduation (Quang, Lee, & Khoi, 1996). With the demands of a new society, there is little research known about the caregivers in the Hmong community and the extent to which acculturation has made an impact.

Similar to the Western culture, the Hmong have a long tradition in caring for their elders and believe in a strong family support system. Family caregiving is defined by the National Alliance for Caregiving as, “unpaid assistance provided by relatives and friends to an older person who is unable to perform routine tasks of daily life, such as meeting personal-care needs and household chores” (Owens & Chadiha 2013, p. 1). However, exposure to Western values may have influenced the culture of caregiving in the Hmong community. There is little research on the demographic or characteristics of Hmong caregivers today and whether or not acculturation impacted the ways in facilitating care. There is also limited research on Hmong

utilizing caregiver services. As early arrival Hmong continue to adapt to the American society, the question is, do their perspectives on family caregiving change in a society where it is normative and portrayed that older adults live alone or in a residential facility? Does it impact their decision-making process on how to plan and facilitate care for older Hmong adults or their relatives? There is little research on the trend of Hmong caregiving to older adults in the United States or the specific impacts it may have on multiple generations since their immigration. The purpose of this paper is to examine what impact acculturation has on Hmong caregivers and what that may look like today. The paper also seeks to find out what the current demographics and characteristics of caregivers are today in the Hmong community located in the Twin Cities.

Literature Review

Hmong Background

The Hmong do not have a place to call their homeland. The earliest history of the Hmong indicates that the Hmong originated from China. However, because of the internal conflict during the Han Dynasty, a large number of the Hmong migrated down toward the southern region of Asia into Vietnam, Laos and Thailand. The Hmong continued to live an agrarian lifestyle in the mountainous regions of Indochina. In the early 1960s, the Hmong in Laos were recruited to help the Americans fight off the communist Pathet Lao (Lee & Tapp, 2010). When the war was lost, thousands of the Hmong fled to the jungles in order to survive and thousands of others made their way towards the refugee camps in Thailand. As a result, many were dispersed across the world with the majority of the population residing in California, Minnesota, and Wisconsin. Over the past forty years, new generations have emerged in the United States. Researchers have distinguished the different generations into the following:

- Generation 1: Hmong who came to the US as adults
- Generation 1.5: Hmong children who were born in Thailand or Laos and came to the United States between the ages of two and twelve years
- Generation 2: Hmong children who were born in the United States or Thailand or Laos and came here when younger than two years old (Lee & Green, 2010, para 3)

Each generation has been known to adapt differently to Western society and its demands.

Acculturation

Over the past several decades, the relocation of immigrants into a foreign country has been a topic of research in terms of acculturation. Acculturation is defined as, “the process of

cultural and psychological change that takes place as a result of contact between cultural groups and their individual members” (Berry, 2013, p. 6). When an individual is able to acculturate for a longer period of time, this turns into what is called adaptation. More importantly, it was discovered that acculturation styles were affected by different variables. They are assimilation, separation, integration, marginalization, and segregation. Assimilation occurs when an individual abandons their cultural identity. Separation occurs when the individual refuses the mainstream culture and keeps his or her cultural identity. Integration occurs when an individual keeps his or her cultural identity while interacting with the mainstream group. Marginalization occurs when an individual refuses both the cultural identity and mainstream culture (Schmitz, 2005). Out of all of the different strategies, research indicates that integration is the best method for individuals to be successful in both psychological and sociocultural adaptations. Marginalization received lower rates of successful adaptation (Berry, 2013).

Hmong. Although some are successful, the process of acculturation can be quite stressful in terms of challenges. Immigrants have to navigate a whole new system while either maintaining or changing their cultural identity. As a result, acculturative stress results in three different reactions: “homesickness, depression, and psychopathic behavior” (Schmitz, 2005, p. 91). However, the process of acculturation, including acculturative stress, varies from individuals to group. For the Hmong, this has not been an easy process for many. Current research suggests that no other recent immigrant group in history has faced more acculturation problems than the Hmong. Historically, many of the early first arrival Hmong were diagnosed with posttraumatic stress disorder. In conjunction with acculturation, the mental health diagnoses of these Hmong individuals found by Westermeyer were double the general Western

population. Acculturation was a significant stressor for the Hmong. Secondly, when the Hmong first arrived, in an effort to increase the rate of acculturation, the United States scattered the Hmong refugees across the states known as the, “scattering policy.” Because the Hmong highly value the family and clan system, this took away their support system and therefore, was indicated as a potential contributor to poor mental health. Today, research shows that the Hmong families who are more likely to lose their cultural identity and language faster are the ones who keep themselves isolated from other Hmong individuals. Depending on the geographical location, many of the Hmong adjusted differently in terms of employment. For example, the Hmong in California were more likely to be in the agriculture business compared to the Hmong in Michigan who own restaurants (Tatman, 2004). Additionally, as a result of acculturation, several problems for the Hmong United States have emerged to include “family conflicts, youth delinquency, a generation gap, poverty, physical and mental health, education, and a lack of access to information and resources” (Lee & Green, 2010, p. 1).

Underutilization of resources. Studies on acculturation in relation to caregiving suggest that there is a noticeable impact in underutilization of resources. A study performed in 1998 by Nguyen surveyed and examined the impact of acculturation on 95 Vietnamese caregivers in Southern California and found that the Vietnamese women who were less likely to institutionalized their care recipients were those who did not care much for adopting values from the American culture. Those were more likely to institutionalize were the women who had higher incomes. Nguyen (1998) also suggested that this may be the lack of education in understanding the services provided by institutions. Similar to the immigrant Korean American experience, Hong’s (2011) study found that they, too, neglect the services due to cultural and language

barriers. Cultural values were suggested to affect the burden placed on Korean American caregivers causing higher levels of depressive symptoms. English was found to be an important resource in navigating the system. Miyawaki (2016) found that in the data collected from the 2009 California health Interview Survey, third generation of Asians and Hispanics had little use for respite care which may suggest that, on the other hand, future generations are still maintaining cultural values. The Hmong also share a similar experience with both the Vietnamese and Korean American caregivers. Wilder Research in St. Paul, MN conducted a recent study in 2013 and found that the Hmong lacked awareness in services. In accessing the resources, the Hmong along with many other diverse populations were in need of culturally appropriate support resources and services in their language (Lindberg, Owen, & Ulstad, 2013).

Attitudes of caregivers. Research shows that acculturation impacts the attitudes of caregivers. Compennolle (2015) found in his study that with increased education, the attitudes of wanting to provide care for older adults varied between genders. His study conducted in Nepal found that women were more likely to want to provide caregiving for their aging parents versus the male participants. This is interesting because in most ethnic groups, males more frequently take care of the aging parents and perhaps it may be possible that with more education, the attitudes of the Hmong population may also change as well. Nguyen's (1998) study also found a significant correlation between gender role attitudes and education. The women's perspective in the study required them to adapt to their social environment and education became one of main variable predictors of utilizing institutions.

Caregiving

Caregiving is primarily provided by family members but may also include friends, relatives, or even neighbors (Owens, & Chadiha, 2013). Caregivers provide tasks from personal care to household chores and may also include medical or nursing tasks (Redfoot et.al, 2013). For the older adult population, some may become physically disabled and unable to perform daily life skills such as taking out the trash or even taking a bath. Other times, inability to perform daily life skills to may be due to chronic illnesses (Owens, & Chadiha, 2013). In times like these, older adults turn to family. Often times, little family support may result in care recipients becoming institutionalized. However, home-based care allows the care recipient to receive care provided inside the home. Despite both options, the experience of caregiving is different and both are likely to cause some sort of physical, emotional and financial strain on the caregiver(s) (Redfoot et.al, 2013).

Sandwich Generation as Caregivers

A growing number of caregivers throughout belong to the Sandwich Generation as the life expectancy of older adults continue to increase (Owens and Chadiha, 2013). The Sandwich Generation refers to adult(s) or families that are responsible for the care of both aging parents and raising their own children. Zhiyoung & Xiaomei (2005) hypothesized in their study on Chinese working families that the sandwich generation were more likely to feel work-caregiving stress. Surprisingly, their study rejected that hypothesis. The sandwich generation had no effect on feeling stressed, however having conflicts with the spouse about caregiving and being the breadwinner (role, not a part of the sandwich generation) in the house increased the likelihood of being stressed. On the other hand, Mitchell (2014) found that her sandwich generation

respondents faced several challenges. She surveyed from 490 parents living in the Metro Vancouver area in 2006/2007 consisting of British, Chinese, South Asian, and South European. One theme from the respondents was that they felt pulled in many direction from both having to provide for the parents and the children. These were more likely to be seen from British women and those with a South Asian cultural background. Another theme Mitchell (2014) found was that many felt the challenge of not having enough hours in the day to provide care for both which again, was more likely to be seen in South Asian women. And lastly, there was no support. In fact, providing care for parents may result in positive relationship outcomes between both the care recipient and caregiver.

Positive social exchanges can happen between the caregivers and care recipients in the sandwich generation. Ingersoll-Dayton, Neal, and Hammer (2001) explored the kinds of help sandwiched-generation adults received from aging parents, the extent of help (whether there was a gender influence as far as quantity) and the effects it had on the relationship through a longitudinal study that targeted couples in upper and middle class families. The study surveyed four measures of help, “...(a)financial assistance (money); (b) emotional support (someone to talk with); (c) help with watching/caring for your children; (d) help with household tasks. The findings of the study revealed that the quality of the relationship between the caregiver and care recipient improved with emotional support as the best predictor for this. However it is important to note that on the other hand, some caregivers who received tangible assistance felt guilty, frustrated, and annoyed as some discovered that their parents did not have the capacity to do the things they used to. Husbands and wives both reported that they worked effectively as a result of their concern for their parents.

Caregiver Stress

Overtime, caregiving can take a toll on a caregiver's health. It can cause physical, emotional and financial strains on caregivers. Co-resident caregivers reported a 25% physical strain verses the 17% who live separately. Nearly half of caregivers felt that their situation was stressful (National Alliance for Caregiving (NAC) & AARP Public Policy, 2015). Physical strain and high reports of emotional stress were related to burden of care, care duration, lack of choice in taking on their caregiving role, and performing medical/nursing tasks. Co-residence created the most strain for caregivers on top of emotional stress (National Alliance for Caregiving (NAC) & AARP Public Policy, 2015)

Responsibility. For multicultural caregivers, it is suggested that cultural values and dynamics influence the motivation of caregiving (Owens, & Chadiha, 2013). Filial Caregiving is a common reason for why many individuals are caregivers. Literature suggest that this is related to the sacrifice made by the parents during the childrearing years. Between men and women, a study conducted on 460 young and middle age men and women, found that women felt more obligated than men did to take care of their parents. The young respondents were students from Midwestern University and were asked to invite one of their parents to complete the questionnaire about their own parents as well. Compared to the middle age adults, the younger adults felt more obligated to full caregiving responsibility as they have not paid them back (Stein, Wemmerus, Ward, Gaines, Freeberg, & Jewell, 1998). Not only does it apply to many cultures including the western culture, but specifically in the Asian culture, filial piety plays an important role in the culture as adults enter a reciprocal process for taking care of their aging parents. It is a stage that everyone enters (Miywaki, 2016).

Negative risks are determined by the caregiver's gender and relationship to the care recipient. Female caregivers in China were more likely to feel stressed (Owens & Chadiha, 2013). For example, John, Resendiz and De Vargas (1997) found in their study that solidarity of family in the Mexican families was more important than acknowledging that there were negative health outcomes to caregiving. In addition, their study found that family duty was reinforced on the caregiver, and the caregiver's choice to keep the care recipient in the home (John, Resendiz et.al, 1997).

Financial burden. Furthermore, family members continue to provide care even at the cost of their own financial well-being (Owens & Chadiha, 2013). "In 2007, the estimated economic value of family caregivers' unpaid contributions was about \$375 billion, increased to an estimated \$450 billion by 2009" (Owens & Chadiha, 2013, p. 392). Financial hardships caring for older adults were reported in nearly a third of family caregivers in 2009 (Chen, 2016). In the 2015 Caregiving in the U.S. Report, caregiving tasks impacted work. It was reported that some left their job to care for their loved ones. Caregivers who put in more hours are more likely to lose their jobs due to their caregiver duties (NAC & AARP Public Policy, 2015). The individuals who were more likely to report the struggles in employment were the women, less educated workers, and first-generation immigrant caregivers (Chen, 2016).

Balancing work. Caregivers have to maintain a balance with both work and caregiver tasks. The Family and Medical Leave Act (FMLA) was enacted by Congress in 1993 to protect caregivers from losing their jobs while they supported their families. Under the FMLA, employees are entitled to 12 work weeks of unpaid leave while maintaining their health insurance benefits. However, these conditions only apply to employees who have worked for at

least 12 months and have contributed at least 1,250 hours. Employees can only take leave specifically, “ for the birth, adoption, or placement of a child; to care for a spouse, son, daughter, or parent who has a serious health condition; or to care for the employee’s own serious health conditions that make her or him unable to perform her or his job” (Chen, 2016, p. 392).

However, three gaps were found--one, employers are not required to provide FMLA if the business has fewer than 50 employees; two, working class cannot afford unpaid leave; however states did help to finance respite care or in-home services; and third, these services varied state to state in terms of what funds were available (Owens & Chadiha, 2013).

Household income. Caregiving in the US Final Report in 2015 found a correlation between household income and the caregiver’s health. Households who made less than 30,000 reported a fair or poor health. Similarly, education had the same correlation with caregiver’s health as well. (National Alliance for Caregiving (NAC) & AARP Public Policy, 2015). In Minnesota, the median income for Hmong family household is \$56,500 which is lower than the U.S. population median income of \$62,100 (Vang, 2013). Limited education, low-paying jobs and the use of very limited English disables Hmong adults to increase the median household income forcing many to turn to welfare for temporary assistance (Vang, 2013; Toft, Hollister, & Martin, M., 2013). Toft et.al (2013) found the study on the impact of welfare reform on the Hmong that a large number of the Hmong participants had large family households (6.14 average persons) and suggested that that might have been a factor in the amount of income going towards the family. At this rate, it may be suggested that financial problems, as well as stress, make it difficult for older Hmong adults care for their aging parents.

A large family household size is common in the Hmong community and still continues to be significantly higher than the U.S. population today (Lee & Tapp, 2010; Vang, 2010). Having a large family to the Hmong may mean one of several things :(a) they have a large extended family; (b) they desire for many sons; (c) they maintain social grouping within a family household; and (d) they desire manpower (Lee & Tapp, 2010). However, due to the growing influence of Western education and values, Lee & Tapp (2010) suggest that younger Hmong are moving away from living in multigenerational households. Yet, on the other hand, Gerdner (2013) found in her study of aging Hmong participants that having a son was important as a widow was worried that there would be no one to bury her. Daughters who are married join their husband's family as a part of their family clan and cannot take care of the burial process (Lee & Tapp, 2010). A large family may mean a pillar of financial and social support but in reality, living in a Western society may mean that families are at a socioeconomic disadvantage.

Caregiver Support with Medicare and Medicaid

Medicare and Medicaid emerged in 1965 when President Lyndon B. Johnson signed the bill into law. Over the years, Congress has made several changes to both insurance plans.

Medicare. Today, older adults, 65 and older, are eligible for Medicare, including people with End-Stage Renal Disease. There are different parts to Medicare, Medicare Part A, Medicare Part B, and Medicare Part C and Medicare Part D. Medicare Part A covers hospital insurance which includes, inpatient hospital stays, admission and care to a skilled nursing facility/hospice, and some home health care (“What Medicare covers”, n.d.). Home health care may be recommended by physicians so that patients and their caregivers can receive additional support to live independently such as physical therapy, speech therapy, or occupational therapy.

The home health care also provides oxygen or walkers for patients to ambulate (“What caregivers need to know about medicare”, 2016). Medicare Part B covers medical insurance which includes doctors’ services, outpatient care, medical supplies, and preventive services. Medicare Part C is a private plan contracted with Medicare to provide both benefits of Part A and B. Medicare D covers prescription drugs (“What’s medicare”, n.d.)

Medicaid. In the state of Minnesota, Medical Assistance (MA) is Minnesota’s Medicaid program. This health coverage plan covers millions of Americans, which include but is not limited to older adults and low-income adults below a certain income level (Minnesota Medicaid, n.d.). Over 700,000 Minnesotans are covered each month and people over 65 or those who have disabilities make up one fourth of that. If an older adult requires long-term care at a nursing home, Medicaid may be able to provide coverage on a case by case basis. Home health care is a short-term service, however if the patient needs additional long term help, Medicaid can help cover for a personal care assistant. (“What caregivers need to know about medicare”, 2016; Personal care assistant program, 2017). Personal care assistants are ordered by physicians and is only meant for those who need additional help with activities of daily living (“Personal care assistant program”, 2017). Personal care assistance is provided under the Minnesota’s Alternative Care and Elderly Waiver program to help not only caregivers receive additional support but also to keep older adults in the community . Additional services include but are not limited to delivered meals, support training for family caregivers, adult day care services, transportation, companion and home maker services (“Aging: program overview”, 2017).

Caregiving in the Hmong Community

Across the literature, aging for many Hmong elderly refugees has been difficult since their arrival. On top of the tremendous amount of loss and constant travel, they were faced with weakness in physical abilities, social isolation/loneliness, immobility of traveling, and most significantly, the language barrier that contributed to their slow pace of adaptation upon arriving in the United States (Gernder, 2013). The status of elderly Hmong adults also changed whereas in Laos, they were once viewed with having knowledge and wisdom; however, now their advice is no longer relevant to the needs of the new Western society (Lee & Tapp, 2010). With too many challenges, the Hmong elderly adults remain at home and depend on their children financially (Gerdner, 2013). Typically, caregiving in the Hmong community is not a job but a duty.

Care facilitation appears to be slowly changing. In some cases, older adult Hmong children have no choice but to send their aging parents to assisted living or nursing homes (Lee & Tapp, 2013). This may not be the preferred method since there is little to no research on the Hmong utilization of these health care facilities. Of course, the preferred method for most people, not only the Hmong, is to have the elderly in the comfort of their own home with people they know. Sending them may be seen as a sign of abandonment to other extended family members. Today, Medicare and Medicaid has enabled many Hmong Americans to remain in the home, many of whom are taken care of by other family members under Minnesota's personal care assistant program ("Personal care assistant program", 2017; "State of the Hmong American Community," 2013; Vang, 2013;). The sons generally take on the role of caregiving. If the sons are married, then their wives are also expected to take care of the aging parents (Lee & Tapp,

2010). Although caregiving is a round the clock job, the Hmong do not view caregiving for their aging parents as a job (Lindberg, Owen, & Ulstad, 2013). There is little research in the specific needs of caregivers in the Hmong community and how to support them. So the question is, how do Hmong caregivers cope with stress or find other support if they are unable to take care of their elderly adults?

Caregiving of the elders is expected to be placed on both the extended family and adult children in the Hmong community. Moreover, Hmong families frequently live in households that contain multiple generations. Although most of the Hmong have acculturated successfully, it is reported that there are a large number of Hmong families who are struggling economically. This study serves to explore the following questions within the Hmong adult population in Minnesota who will be or are taking care of their parents or in-laws. This area is chosen due to the large population of Hmong and within range of the researcher to find: (1) Has acculturation made an impact on Hmong caregivers? (2) What are the demographics or characteristics of Hmong caregivers in the community? and (3) What does caregiving in the Hmong community look like today?

Conceptual Framework

The lens in which the study will be examined is through Acculturation Theory. The interest in researching acculturation developed from the change of one culture entering another during the European domination of colonial and indigenous people. Acculturation theory considers the changes in both the groups and individuals. The framework works by mapping out both the cultural and psychological level of acculturation between two or more groups.

The formulation of the cultural level stems from two definitions; one, there is generated culture change in either one or both groups (not to be confused with assimilation) and two, it is believed that culture change

can be delayed (because internal adjustments, presumably of a cultural and psychological character, take time), and can be reactive (i.e., rejecting the cultural influence and changing toward a more traditional way of life rather than inevitably toward greater similarity with the dominant culture). (Chun, Balls Organista, & Marin, 2003, p. 19)

Each cultural group has their own unique cultural characteristics. Acculturation theory examines these prior the cultural group making any interaction with another cultural group. After the contact between the two cultural groups are made, the acculturation theory looks to examine how the groups' cultural characteristics have changed after that. The Acculturation Theory in this instance, examines the changes in the participants' cultural group after making contact with another cultural group.

At the psychological level, there is more focus on the individual and the changes that the group/individual undergo in their new situations. These include behavioral changes and acculturation stress. The psychological level is defined as

changes in an individual who is a participant in a culture-contact situation-a person who is being influenced directly by the external culture and by the changing culture of which the individual is a member. (Chun et al., 2003, p. 19)

Each and every participant experience is unique to the study. The acculturation theory also examines the experience of each participant at the individual level specifically the display of behaviors.

Acculturation Theory identifies the change of culture shift from the group level to the individual. It is appropriate to this theory in the study as the study seeks to identify the impact on a minority group after resettling in a different cultural group.

Method

Design

The research design to explore these hypotheses used mixed approach. A quantitative method was used to measure acculturation and other important characteristic information. In order to explore the impact of acculturation on Hmong caregivers, the qualitative method was most appropriate to explore the subjective experience of the participants. Using both methods would allow not only the identification of the research participants, but also the human experience (Grinnell, Williams, & Unrau, 2016).

Sample

The study sample consisted of four female participants. The participants in this study were selected based on their ethnicity as Hmong, role as a caregiver for an older adult, and living location around the Twin Cities Region.

The participants were recruited through the snowball sampling method (Heckathorn, 2011). The research provided recruitment information to one of the researcher's committee members, friends, and acquaintances. After receiving notification from participants with their agreement in the research, the researcher contacted the participants to explain the purpose of the study, why they were chosen to participate, the voluntary nature of the study, confidentiality, how to contact the researcher with any questions and provided an email or phone number on how to contact the researcher. Additionally, the researcher sent the Consent form via email or via mail to per the participants' preference and confirmed the participant received it before proceeding with the meeting. The Consent form was also translated into Hmong and sent to the

participant if it was requested. The researcher gave the option of conducting the interview in Hmong or in English. Only one participant requested the interview to be in Hmong.

Protection of Human Subjects

Prior to filling out the survey and interview, the participant were provided with the Informed Consent form approved by the University of Saint Thomas and Saint Catherine University Institutional Review Board (IRB). The consent form explained the nature of the study, the confidentiality procedures, the risks and benefits, and option to redraw from the study at any given time. Once the consent form was explained to the participant, and the participant read and signed the consent form, the researcher moved forward with the study.

To ensure confidentiality and anonymity, the researcher also recorded and deleted the recording 24 hours after the interview once it was uploaded into One Drive. The survey and other paper documents were scanned and deleted 24 hours after the interview once they are uploaded into One Drive. All surveys, paper documents, and audio recordings were uploaded into One Drive which is password protected and encrypted. The researcher ensured that the computer required a password every thirty minutes that it was idle.

Data Collection

There were three instruments used for this study; two surveys and an interview. The participant were informed via email that the interview would take about an hour with the request of audio recording the interview and two short surveys. Prior to the interview, the participants were given the choice to conduct the interview in Hmong or English. Only one participated requested the interview in Hmong with the researcher as the translator. Two did not request the interview in Hmong but spoke both languages to the researcher.

The consent form was discussed prior to beginning to the process. To begin, the participant was given an acculturation survey to start with. The acculturation survey was derived from the Suinn-Lew Asian Self-Identify Acculturation Scale (SL-ASIA) using fifteen questions. The scale originally has 21-item measures assessing Asian-American clients. For this specific research, it was appropriate to use an acculturation scale that has been used widely among Asian-Americans (Suinn, Ahuna, Khoo, 1992). The acculturation survey was followed by the interview, and then the demographic survey. The literature and inquiries from the interviewer guided the questions for the interview process and demographic survey about caregivers in the Hmong community. The interview questions began with their explanation of taking on the role of a caregiver and moves towards the impact of caregiving in the participant's life.

Setting

The meeting location was determined by the participant in an open and safe location. Two participants chose their home setting while two others chose a school setting to conduct the interviews. There were several distractions with the home interview as people went in and out of the home. The school setting had no distractions as it was in a closed room.

Data Analysis plan

The quantitative data was collected analyzed using descriptive statistics. Descriptive statistics focus summarizing the variables for the sample. The qualitative data was collected and analyzed using the grounded theory methodology. It was transcribed and coded by the researcher into themes for analysis (Grinnell et al. 2016).

Findings

The research was designed to explore the demographics of the caregivers and the impact of acculturation on Hmong caregivers located in the Twin Cities. The findings indicated that majority of the caregivers were women who married into their husband's families. It also indicated that economically, most were doing well, however could still use financial support and additional resources. In regards to acculturation, more than half of the respondents believed in both the Hmong culture and the American culture, indicating that more than half the respondents have acculturated successfully in the mainstream culture. However, even with this finding, it is important to note that within these respondents and their families, the preferred method of caregiving is to keep the care recipient in the home. Acculturation was also found to be varied in its impacts among these respondents in three specific areas: cultural traditions, conflicts, and utilization of supports and resources.

Additional Demographics

During the qualitative survey, all four respondents stated the relationship between them and the care recipient was daughter-in-law. One respondent marked and considered herself "Other Relative." After careful consideration and looking at the data, the researcher concluded to include that respondent's data as a part of the research due to the data being enriching. The other three respondents marked "Daughter-in-Law."

Awareness of caregiver support services. Of the four respondents, one respondent is unaware of caregiver support services.

Current support services. One respondent does not have any current support services. Two respondents indicated "PCA" services for self as the only service. One respondent used,

“Paid Caregiving,” as the number one most used service followed by case management, skilled nurse visits, healthcare, supplies/equipment and lastly, home modifications (as needed).

Additional services caregiver would like to learn about. One respondent indicated, “n/a.” One respondent indicated, “English Translation.” One respondent indicated, “Other: Financial Support for mother-in-law.” One respondent indicated, “Transportation and Housing Support.”

Concerns about receiving caregiver support. One respondent’s concern was, “Do not trust service providers in the home.” One respondent’s concern was, “Other: Outside providers utilize too much water and electricity coming into my home. They don’t pay you for utilities. I am okay if the others provide it outside of the home.” One respondent’s concern was, “No one else can provide care as well as I do.” One respondent had no concerns.

Employment status. Three respondents are employed full time. One respondent is employed part-time. This respondent chose not to respond to whether or not she does or has ever accessed FLMA. Of the three respondents who are employed full time, two indicated, “Yes.” The third respondent is unsure of FLMA, and/or has never taken off.

Paid to provide care. Of the four respondents, only one is not paid to provide care. One respondent chose not to respond to the question.

Additional non-paid persons providing care. One respondent indicated, “No.” One respondent indicated, “Husband,” and another respondent indicated, “Daughter: homemaker, and Tsev Kajsiab [name of an Adult Day Center].” One respondent declined to answer.

Highest level of education. One respondent's highest level of education is graduate school. One respondent's high level of education is a college graduate. Two respondents received their high school diploma as the highest level of education earned.

Annual household income. Two respondents made an annual income of 50,000 or more. One respondent's annual income is between 0,000-30,000. One respondent declined to answer.

Current housing situation. Three respondents own their own home. One respondent either rents an apartment or home.

Caregiver Acculturation

Languages can speak. Two respondents can speak, "mostly Asian, some English." Two respondents can speak, "Asian and English about equally well (bilingual)."

Language preferred. One respondent preferred, "Asian only." One respondent preferred, "Mostly Asian, some English." Two respondents preferred, "Asian and English equally well (bilingual)."

Identification of self. One respondent identified herself as Asian American. One respondent identified herself as Hmong American. Two respondents identified themselves as Asian.

Generation. Three of the four respondents identified as the 1st Generation (I was born in Asian or country other than the U.S). One respondent identified as 2nd Generation (I was in born in the U.S., either parent was born in Asia or country other than U.S.).

Where respondent was raised. One respondent indicated being raised in Asia only. One respondent indicated being raised mostly in Asian, some in the U.S. Two respondents indicated being raised in the U.S only.

Contacts with asia. One respondent indicated that she has had occasional visits to Asia. 3 respondents indicated occasional communications (letters, phone calls, etc.) with people in Asia.

Literacy (reading). One respondent can read only an Asian language. One respondent can read an Asian language better than English. One respondent can read Asian and English equally well. One respondent can read English better than an Asian language.

Literacy (writing). One respondent can write only an Asian language. One respondent can write an Asian language better than English. One respondent can write English better than an Asian language. One respondent can write only English.

Level of pride being a member of an asian group. One respondent felt extremely proud. Two respondents felt moderately proud. One respondent felt no pride and did not have a negative feeling towards group.

Rating of identification with self. Two respondents rated themselves as very Asian. Two respondents rated themselves as being bicultural.

Belief in asian and american values. One respondent strongly believed in Asian values and one respondent did not believe in Asian values. Two respondents did not believe or had a strong belief in both Asian values and American values. One respondent did not believe in American values. One respondent more than moderately believed in American values. See Figure 1 below.

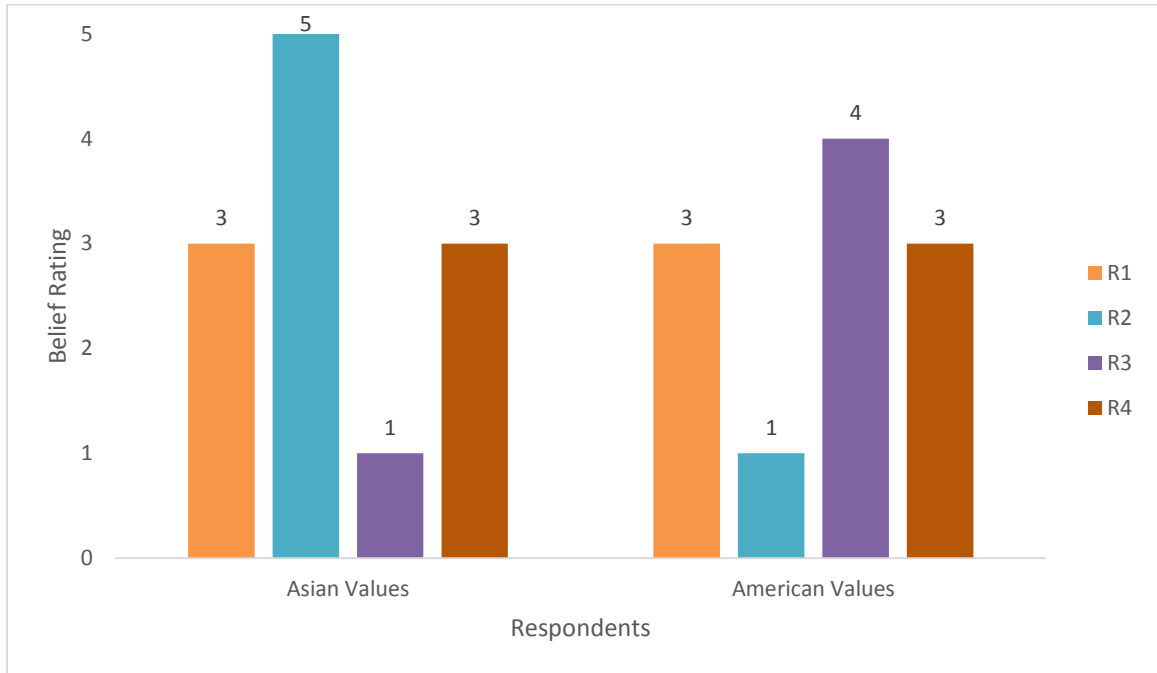


Figure 1. Respondent’s belief in Asian values and American values on a rating scale from 1-5 (do not believe to strongly believe).

Fitting in with groups. Three respondents more than moderately, felt that they fit with other Asians of the same ethnicity. One respondent neither believed that she did not fit in or strongly believed that she did fit in with Asians of the same ethnicity. See Figure 2 below. When fitting in with other Americans who are non-Asian (Westerners), two respondents responded moderately and two respondents felt they fit a little more than moderately.

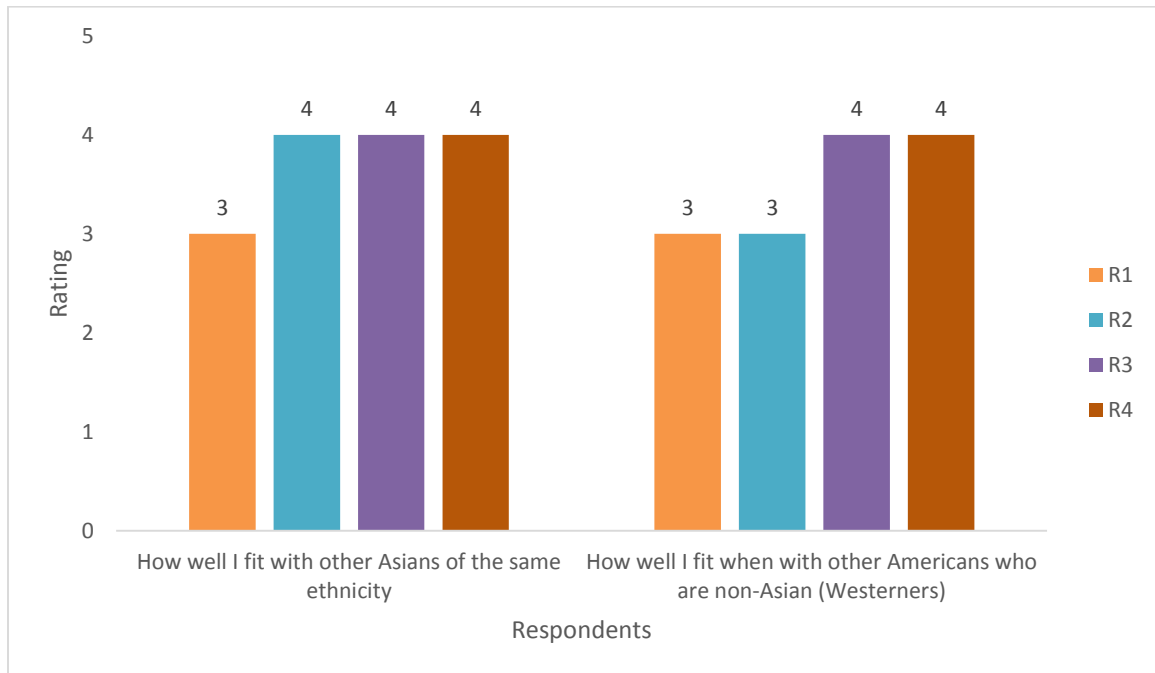


Figure 2. Respondent’s perspective on how well individual fits with other Asians of the same ethnicity and when with other Americans who are non-Asian (Westerners) on a scale from One-5 (do not fit to fit very well).

Perspective of self. One respondent viewed herself, “I consider myself basically as an Asian person. Even though I live and work in America, I still view myself as an Asian person.” One respondent viewed herself, “I consider myself as an Asian-American. I have both Asian and American characteristics, and I view myself as a blend of both.” Two respondents viewed themselves, “I consider myself as an Asian-American, although deep down I always know that I am an Asian.”

Qualitative Themes

Nine qualitative questions were asked in attempt to examine the impact of acculturation on the caregiver(s). From the transcribed interviews, three themes emerged: cultural traditions; conflict; and utilization of supports and resources.

Cultural traditions. This theme was identified when the respondents were asked about the role of being a caregiver and the length of time being in the role. All four of the respondents reported that their in-laws moved in with them after the respondents married their spouse. This is one respondent's experience:

Um, it was back in 2004. My in-laws moved in with us. They moved from Kansas City to here just because my mother in law is very mentally ill all of my husband's life. She wasn't taking her medications and no one was really monitoring it and there's more services in Minnesota so they moved here. And so we were helping my father in law take care of her and he was working but then he had a stroke, this massive stroke, and had 5% chance of living and he slowly recovered, but ever since then, we have been taking care of the both of them. So over 14 years because my oldest is 14 and she was a year when all of this happened.

For one respondent, she and her husband sponsored her mother-in-law and afterwards did not return back to Laos:

We sponsored her because her stomach was hurting. We sponsored her to heal her stomach. They took her here to get examined and they would not heal her, only if she was to stay in the United States, they would help her.

Conflict. Conflict was an overarching theme that emerged from the data. The level of conflict varied from one respondent to the other. This theme identified different factors created or was presented as potential conflict for the caregiver. Only one respondent reported little to no conflict with her care recipient or in other areas of her life with the following statement:

No, there is no argument. We don't do that. If she doesn't do something right, then I tell her. We don't argue with each other. Since she is old, if we tell her not to do it, and since she is old, if she doesn't do it, we tell her why she shouldn't do it or why it is wrong.

There is no arguing.

This respondent who experienced little to no conflict was very traditional, or in other words, had strong beliefs in the Hmong culture. She saw that providing care to her mother-in-law was an expected role and that she was willing to do take on the duties that came along with it.

Interpersonal conflicts were found most common within the families of the other three respondents in regards to the decision making process and cultural values and demands. In one respondent's situation, she described why tension developed in her relationship with the care recipient:

I think that there are times that my mother-in-law and I, we get along very well. We are kind of like friends where we go places together. But there are times that there comes a fine line it kind of goes in a different direction. You kind of have to, for some reasons, she is not happy for some odd reason. Sometimes, you do feel that tension because I think the expectations for you as a nyab [daughter-in-law] is high. So they expect, and with her, she has a lot of kids from Laos. Her expectations of us helping them is pretty high and if we're not able to help then becomes a conflict. When it becomes the conflict then our relationship kind of goes out of whack. You can feel the tension between her, my husband, and I. We're all very tense.

In the following two statements, the respondent described what underlying feelings developed and progress through the years as she took care of her mother-in-law.

“When they are not happy, they yell at you and they do what they want. And you don’t know what to say. They cannot hear. They are old and they give you stress.”

“No, because what she is like. At the beginning, when she said stuff, you get sad and you do cry but right now, maybe you, are a little stronger, so you don’t feel sad. You just be quiet and don’t talk back.”

One respondent’s conflict involved extended family and is illustrated in this quote:

Oh, they were pretty upset. We have gone through a lot of different, um, disagreements with them and it’s gotten very heated, um. It took all these years to really prove to them that we knew what we were doing, even though we were young back then, that what we were doing was right for my in-laws and we still know what’s right for them today and no one can come in to do the things we are doing. Some of them have tried. Like they have gone to live with other relatives and oh no, they would drop them back off and, “You were right all along, and yes it’s really hard.” You’re living with someone who is very severely mentally ill so you know, it’s just hard to describe to our relatives. Even to this day, we are still judge to this day. From the beginning ‘til now and it will never end and we know that. There is someone who will come over and say something or question our intentions or um, think my mil will be cured. They will send pastors to do exorcism on her. We will tell them, ‘Um, you know the only thing that can help mom at this point is medications and God. And that’s it. Not exorcism.’ So they have tried different things.

Not only did the data illustrated what the conflict may be about, but also the ways the respondent coped or handled the situation. In terms of acculturation, there appeared to be a conflict in the

method of healing the care recipient. Hmong culture believes in shamanism, calling out for the spirits through traditional ceremonies and the use of traditional herbs. Other Hmong individuals, like this respondent, have chosen to follow Christian beliefs (which is common) and believe in the healing method of using exorcism. However, in this situation, the respondent was not placing the method of healing in the hands of god, but more so in Western medicine and following the doctor's recommendations. The respondent here identified very much as being integrated and was more open to Western methods than the other two healing methods that were mentioned.

Utilization of supports and resources. All of the participants reported a continuum of support and resources in taking care of their care recipient. Three different areas of supports were identified by the researcher from the transcribed data around the following: financial support, social supports, and health care services. Most of the respondents applied to be care recipient's personal care assistant. This theme is illustrated in the following quotes by some of the respondents:

My husband had to quit his job when my father-in-law had his stroke. Eventually came home because someone had to be home with the both of them. It definitely has strained It, but we are paid caregivers so that's definitely helped otherwise there would have been no way for us to just make it with just my income all these years.

She didn't have the paperwork or Medicaid. Once she had that, we hadn't look for organizations to take care of her. After ten years, they said that organizations can pay you. We tried and got in and then they paid us. In one day, one night, they only give two

hours and fifteen minutes. Because she isn't too old, she has a nurse who came to assess and determined the hours. If the care recipient isn't as old and is able to do things, then they don't add any more hours. If they came to see that the care recipient has some sort of illness or is not mobile, then they will decide how many hours you can do and then call to tell you.

Only one respondent utilized home healthcare support services due to the complexity of her situation and included in her perspective of healthcare services the following:

For the most part, Hmong people don't go to rehab, they don't choose the transitional care. They just want to come back home and then it's hard to get them to do the PT, the OT, and all the other therapies that they need so for him, we were like, "Nope, you're going." And he understood, he said, 'Okay, yup. That's fine.'

Many of the respondents expressed their level of social support in some way through the transcribed interview. One respondent expressed the benefit of utilizing state/community support and family support and its impact on her as she balanced work and caregiving in the following statement:

It's not hard because in the morning she goes to the adult day care. But Thursday and Friday, she stays home, but my husband stays since he works at night. He stays with her until 2:30 when he goes to work and I get home at 3:30 so she stays home for an hour by herself. It's not hard on those Two days. My husband takes her to the hospital if she is sick. It is only hard if we want to go somewhere. If you are a PCA, you cannot take her anywhere during that time.

One respondent expressed the lack of social support and the need for group support in this quote:

We haven't met a lot of people our age that have gone through the things that we have gone through. I mean I don't know if I've met older people who have gone through what we have gone through. Um but it would be good if there were support groups for people our age. Because through the years, we didn't have any. We didn't have much support. We had to figure out on our own what was going to work and what isn't going to work.

In the following quotes, two respondents expressed barriers in receiving social support:

“My husband, he doesn't like me talking to my side of the family. It makes it complicated. I honestly don't talk to my family when I am at home.”

“Can't have open conversations with your family when they are there.”

Discussion

The findings in this study indicate that caregiving within the family home continues to be preferred method within the Hmong community. The purpose of this study was to explore if acculturation has made an impact on Hmong caregivers, who Hmong caregivers are today, and what caregiving in the Hmong community looks like today. This section will discuss the findings and the literature, limitations to the study, followed by implications for further research and social work practice.

Findings and the Literature

The demographic survey, acculturation survey and qualitative interview provided a small general picture to what the Hmong population may look like in terms of its caregiver and how much progress has been made as far as acculturation including its impact. Because all of the participants were women, daughter-in-laws, taking on the role of caregiving as a result of being married to their spouse, either completed high school or beyond and that most owned their own home; this may possibly suggest that most all of the participants are doing economically well. In addition, generally, more than half of the respondents did not care much for additional outside service providers to be the ones to help support or provide care for their care recipient(s).

The acculturation survey revealed that more participants identified as being integrated, keeping their own cultural identity while interacting with the mainstream culture (Schmitz, 2005). More than half of the respondents believed in both their cultural values and American values. These findings may help support that acculturation within the Hmong population is still continuing to progress and that others do or have acculturated successfully.

From the qualitative interviews, three themes emerged; cultural traditions, conflict, and utilization of supports and services. These themes provide an understanding to how acculturation has or has not impacted these three areas and are discussed further in the following sections.

Cultural traditions. The grounded theory process expanded the understanding of the caregiving with the Hmong community through the interview. The continuance of cultural traditions was a prominent theme expressed from all of the participants. Each participant married into their husband's family and then took on the role of providing care for their in-laws. Within the Hmong family system the literature supported this theme indicating that caregiving is provided by family members and that if the sons were married, then the wives of those sons also took on the responsibility of providing care (Lee & Tapp, 2010). Furthermore, the findings were also consistent with the literature allowing three of the four recipients to be able to get paid for providing care. The state of Minnesota allows those under Medicare access to services such as personal care assistants enabling care recipients to live out in the community alone. Although most personal care assistants can be provided through agencies, all of the participant's care recipients provided the care under this program (Vang, 2013). Continuing cultural traditions indicate that this belief within the Hmong family system is still very much alive today and that older adults still depend on their children to help them as they age. What is also revealed within this theme is that although the sons are given the responsibility, most of these women did most of the caregiving tasks such as cooking, cleaning, bathing, and transporting them to different places. The expectations that come along with marrying into their husband's family may also suggest that acculturation made no impact on continuing this tradition. Most importantly, most of the

respondent's attitudes towards caregiving revolved around feelings of obligations, duties, doing what was right for the care recipients.

Conflict. Another theme emerging from the findings was the concept of conflict. With all of the respondents, conflict varied on different levels where there was low to high conflict. In the literature, family conflict was one of the outcomes as a result of acculturation. The findings appeared to be consistent with the literature. The level of low to no conflict appeared to correlate with the one respondent whose cultural characteristics did not seem to change after being in the United States since the mid-1980s. This respondent believed strongly that not only was caregiving for an older adult was a role she required to do but that she was also willing to do without question. There appeared to be no conflict within her family nor with the care recipient. One reason that may suggest the low level of conflict is because of her strong belief in the traditional values and role she has been given. The level of high conflict appeared for those respondents whose cultural characteristics seemed to be more integrated with the Western ways. One example, significant to the findings is the one respondent who decided with her husband to utilize transitional care services when her father-in-law had a stroke. As a result of their caretaking, many extended families did not approve of their decisions and questioned their love for the care recipients. The literature indicates that caregiving for the elders are not only placed on the adult children but also the extended family members; and that if the older adults were sent away, it would be seen as a sign of abandonment (Lee & Tapp, 2010). Although this respondent did not necessarily, "abandon" the care recipient, she did send him away for a short period of time until the care recipient was able to function more independently on his own. She specifically mentioned that this was not the preferred method how Hmong people took care of

their elders. This respondent's situation suggest that collectively, extended family members want to have influence over the decision-making of the care recipient and may judge the primary adult caretakers if their opinions are not taken into consideration. This also may suggest that western beliefs of sending older adults to transitional care units still may be new to the Hmong population and that it is not a preferred method to providing care. One of the other significant finding related to the literature is the financial dependence that is placed on the caregiver (Gernder, 2013). One respondent felt, "tension," between her and the care recipient if she was not able to also take on the role of providing for other family members in Laos. In addition, this respondent felt that this, "tension" also affected her relationship with her husband negatively as well. This situation gives insight that financial dependence on adult children still continues today even if the caregiver has acculturated successfully; and in this situation, not only does it financially strain the caregiver, but also strains the family relationships.

Interestingly, the concept of conflict gives insight to a gap in the literature in terms of the relationship between daughter-in-laws and the in-laws. The findings indicate that there seems to be some heavy expectations for daughter-in-laws as caretakers and that the daughter-in-laws (respondents) genuinely try to care for their in-laws as if they were their own parents. Some respondents experienced stress with financial burden and the balance of work, family life, and caretaking. It also appeared that one respondent experienced emotional distress as she stated in the interview that her mother-in-law frequently yelled at her. At first the respondent, felt hurt, but eventually, she ignored the remarks. It also appeared that that half of the respondent's mother-in-laws had no trust in the daughter-in-laws in fear of not knowing where they went, who they were meeting with, or what they were doing; the fear that respondent's would be

cheating on their husbands. A possible reason for these conflicts to arise may be due to the lack of acculturation on the care recipient's part as mostly all of them were very traditional, or in other words, have strong beliefs in the Hmong culture.

Utilization of supports and resources. Lastly, the third theme to emerge from the findings was the utilization of supports and resources; financial supports, social support, and health care services. Financial support was an essential need for all of the caregivers and it seemed that acculturation made no impact to how each respondent sought out the resources, whether it was finding out through other people or applying on their own. The most popular sought out service was state based supports such as the personal care assistant program. To be able to provide in the home, receive financial help and assist the older adults, three of the respondents applied to be personal care assistants as indicated in the literature (Vang, 2013).

In regards to social support, extend family members and adult caretakers supported the care recipient as noted in the literature (Lindberg, Owen, & Ulstad, 2013). In the findings, all members within the immediate family provided support to the caregivers by taking on some of the caregiving tasks. Surprisingly, one respondent experienced a lack of support from extended family members. Some respondents experienced a lack of support from their own side of the family. It was suggested by the respondents that that the reason for this lack of support was due to the fact that the respondent's' mother-in-law did not like that the respondents' associated or spoke with their own side of the family. This response from the mother-in-law of the respondents may indicate that culture influences how respondents are able to utilize their support systems. The respondents who experienced such pressure that forbids them from speaking to

their own side of the family, seemed more integrated in terms of acculturation, but yet let the care recipient's own cultural belief override their own basic needs of social support.

There is limited research on the utilization of adult day care services within the Hmong community. In Minnesota, adult day centers are regulated by the Minnesota Department of Human Services (2017) to provide coordinated services in improving an individual's self-care capabilities. Interestingly, this study revealed a surprising find. One respondent, who was very traditional and not wanting to utilize many other services, actually noted in the interview that her care recipient attended a Hmong adult day center three days a week. This allowed the caregiver the time to work full time, while being able to come home on time take care of the care recipient in the evenings. On the other hand, one respondent, who identified to be very much integrated in terms of acculturation, did not want her care recipient to attend the Hmong adult day care service. As noted in her interview, she felt that other attendants from the facility negatively influenced her care recipient to not take her medications and also that the care facility did not know how to take care of the care recipient's high needs. This finding is a surprising, because it would probably be more highly expected that the more integrated a person is with another culture, the more accepting of the service. What this finding may also suggest is that perhaps, the reason why the traditional respondent was willingly to let the care recipient attend the adult day center was because it only consisted of Hmong older adults as noted in the interview.

Lastly, healthcare services was another identified support or resource. All of the respondents utilized the healthcare system to take their care recipients only in cases if they were ill or injured. One respondent, perhaps in her special situation, identified utilizing transitional care units and home health care to help provide support service to not only her but also ensuring

that the care recipient was receiving the best care possible. This respondent, again very much identified as integrated in terms of acculturation. This may indicate that the healthcare system has a large influence in factoring how the respondent and her husband decide on what's best for the care recipient, and which was also noted in the interview; that western values have impacted her greatly in terms of following the doctor's orders. The other three have not been in a situation that requires additional services from the hospital so this may suggest that transitional care units and home health care it is still new for the Hmong population in terms of care and support.

Limitations of this Study

This study has several limitations. First, the study aimed for Hmong caregivers within the Twin Cities region, however the participants who responded represented were all females. The sample size was also small, therefore with these limitations, the findings cannot generalize the experience of the Twin Cities Hmong caregiving population. Secondly, because of limited responses from participants, the methodology was amended to allow the researcher to contact the interested participants which decreased the time that the study was conducted. The methodology also did not allow much for random samples which may or may not have allowed for a different outcome in findings. Thirdly, language may have compromised the findings. Often times, words in the English language do not translate in Hmong. During the qualitative interview and both quantitative surveys, the English word would have to be explained in different ways so that the participant understood.

Implications for Further Research

This study suggests implications for future research in three key areas. First of all, more research should be conducted within the community and other communities to target families,

couples, and older adults since this study is limited to only female caregivers located within the twin cities region. The research should also continue to focus on the areas of concerns and needs for the caregivers as social and emotional support appeared to be strong need that was not being met in this study's findings. Furthermore, additional research needs to be conducted on how to effectively reach out to support these caregivers and meet their needs. Most of the caregivers in the study relied on their own social networks. Lastly, more research needs to be conducted on best practices to support the needs and work cross-culturally with Hmong caregivers.

Implications for Social Work Practice

This study's findings suggest some implications for social work practice. When working with the Hmong population, it is important for social workers to understand the culture of caregiving through their lenses and be aware of the implications it may have on how care is provided. The qualitative interview suggest that providing caregiver support groups may help as one respondent was unaware of others who were in the same situation, specifically for Hmong caregivers who are living in dual worlds within the Hmong culture and the American culture; and figuring out how they can navigate and find the support they need. Furthermore, social workers should continue to work on reaching out to the Hmong population and providing additional caregiver support resources to those who need it and ensure that they are aware how these resources can benefit them.

Conclusion

This research study suggests that acculturation does impact Hmong caregivers within the community on a continuum of conflict and utilization of supports and resources. However, this study was limited as all respondents who participated were female and the methodology required

the researcher to contact the respondents limiting the random sampling. Additionally, the Hmong language also limited the research as there were certain terminology that did not translate into Hmong which required the researcher to describe the word. Within the Hmong community, the practice of older adults depending on their children or the spouse of their children continue remain an important cultural practice and expectation. In order to do this, caregivers may find themselves in varies levels of conflict within the family based on expectations from the caregiver, decision-making in the caretaking process, and financial burdens. Additional supports and resources to help these caregivers mostly are limited to PCA services where they receive some limited financial means to keep their care recipients in the home and in the community. Caregiver group supports should be initiated and promoted to Hmong caregivers in order to improve their access to additional resources, provide emotional support, and improve conflict within the family.

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Appendix A



Consent Form

[977188-1] *Impact of Acculturation among Hmong Caregivers*

You are invited to participate in a research study exploring the impact of acculturation among Hmong caregivers. I invite you to participate in this research. You were selected as a possible participant because you identify as a Hmong caregiver taking care of an older adult either in or out of the home and live within the Twin Cities region. You are eligible to participate in this study because you have met these requirements. The following information is provided in order to help you make an informed decision whether or not you would like to participate. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Mai Ia Vue, a graduate student at St. Thomas University under the supervision of Dr. Renee Hepperlen. This study was approved by the Institutional Review Board at the University of St. Thomas.

Background Information

The purpose of this study is to explore the impact of acculturation on Hmong Caregivers. This study is also aimed to examine the demographics of Hmong Caregivers within the Twin Cities Region.

Procedures

If you agree to participate in this study, I will ask you to do the following things: Choosing a location that you feel is safe and confidential for me to conduct the interview and surveys. The time commitment that I am asking will take an hour. You will be taking a brief demographic survey first, followed with the interview, and then another survey on acculturation. I will ask for your permission that only the interview be recorded if you so choose. You can choose to terminate the interview or surveys at any time without any consequences

Risks and Benefits of Being in the Study

The study has risks. The risk of emotional distress may occur during the interview process for the participant when he or she has to recall how caregiving has impacted their financial situation, job, relationships, and social life. In addition, these questions may also lead the participant to recall traumatic or distressing events and/or risk of mental fatigue or embarrassment. There is a risk of asking for personal or sensitive information in both the survey and the interview as it relates to the

participant's socioeconomic status. Prior to the interview, the participant will be informed of these risks when discussing the informed consent form. The participant will be reminded that the data will be transcribed and deleted within 24 hours of the interview. The participant will be reminded that they can skip any questions they like.

There are no direct benefits for participating in this study.

Privacy

Your privacy will be protected while you participate in this study. The location in which the interview will take place is controlled by you. The information from the interview will be transcribed and uploaded into Onedrive which is password protected and requires encryption.

Confidentiality

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you. The types of records I will create include notes during the interview, surveys, transcripts, and audio recording. I will be the only one to have access to these records. The audio record will be recorded using an iphone which is password protected. The recording will be deleted 24 hours after the interview is transcribed and uploaded into Onedrive. The survey and other paper documents will be scanned and shredded 24 hours after the interview once they are uploaded into One Drive. Prior to, the researcher will keep these documents in a travel safe binder while traveling. One Drive which is password protected and encrypted. The researcher will ensure that the computer will need a password every thirty minutes that it is idle. All signed consent forms will be kept for a minimum of three years upon completion of the study. Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

Voluntary Nature of the Study

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of St. Thomas. There are no penalties or consequences if you choose not to participate. If you decide to participate, you are free to withdraw at any time without penalty or loss of any benefits to which you are otherwise entitled. Should you decide to withdraw, data collected about you, will be discarded. You can withdraw by letting me know that you would like discontinue with the survey or interview. You are also free to skip any questions I may ask.

Contacts and Questions

My name is Mai Ia Vue. You may ask any questions you have now and any time during or after the research procedures. If you have questions later, you may contact me at (715)203-6206 or vue02021@stthomas.edu. You may also contact Dr. Renee Hepperlen at (651)-968-5802 or hepp1989@stthomas.edu. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 or muen0526@stthomas.edu with any questions or concerns.

Statement of Consent

I have had a conversation with the researcher about this study and have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I give permission to be audio recorded during this interview.

You will be given a copy of this form to keep for your records.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix B



Ntawv Tso Cai

[977188-1] *Impact of Acculturation Thaum Cov Tu Neeg Laus*

Thov caw koj tuaj piav txog kev tu cov neeg laus pub rau kuv thiab txog acculturation. Koj yog tu kuv xaiv tuaj piav vim koj yog tus muaj tus laus tus thiab vim tias koj yog tus nyob hauv peb lub zos Twin Cities no. Koj nyem kuv cov lus kuv saw nram qab no kom tas seb koj tuaj koom puas tau yog koj tuaj tau no koj sau npe rau. Ua ntej koj sau npe yog koj muaj lus noog no koj nug kuv tau.

Qhov kev khaum no yog los ntawm Mai la Vue, ib tus ntxhais kawm graduate tom St. Thomas University nrog kev pab los ntawm Dr. Renee Hepperlen. Qhov kev khaum no tso cai los thaum lus Institutional Review Board tom University of St. Thomas.

Puab Ntxiv Txog Qhov Kev Khaum

Qhov hom phiaj ntawm txog kev khuam yog saib seb lub neej hauv America hloov tau los ua rau koj lub neej pauv lis cas vim koj tu cov neeg laus hauv tebchaws America. Thiaj siab seb leej twg yog tus tu cov neeg laus hauv peb lub zos Twin Cities.

Ua Raws Lis Cov Lus No

Yog koj pom zoo koom tes, kuv yuav nug koj ua raws li cov tom qab no: Koj xiav ib qhov chaw seb kuv tauj tsib tau koj es koj pom zoo. Kuv siv ib teev rau lawm. Kuv yuav muaj ib cov survey rau koj koj mus teb tauj rau kuv. Tom qab ntawd kuv yuav muaj lus nug koj. Kuv thov sev koj puas kam kuv kaw cov lus. Yog koj tsis teb cov survey los kuv tsoj lus noob no lawm los tau.

Risks thiab Benefits Txos Qhov Kev Kaum

Qhov kaum nov mauj risks los yoj phom sij mus xws li nrau qab nos. Mauj risk txog emotional distress rau tus neeg teb tham nug txog lub neej pauv li cas lis vim nus tu tus neeg laus thiab cov lus nug yuav ua tus neeg teb nco txog tej yam nyuab nyuab rau yus lub hlwb, los yog ua rau yus txaij muag. Mauj risk txog cov lus nug txog personal (tus kheej) los sensitive information txog socioeconomic status ntawm tus neeg teb. Ua ntej kuv yuav muaj qhov survey cov los noog, kuv yuav qhia tus neeg teb hai tias yuav mauj tej risk (tej yam phov sij) thaum tham txog tsab ntawv tso cai ntawm no. Nco ntsoom qhia tus neeg teb hai tias cov lus kaw tsev yuav muab saw rau ib daim ntawv tom qab 24 xuab moo yuav luv pom tseg thiab yog muaj ib cov lus nug teb tsis tau los kom hla mus tau, hais skip.

Tsis muaj benefit yog koj koom qhov kev khaum.

Txog Kev Tsis Cia Lawv Tu Pau

Yuav tsis cia lawv tu pau txog ko. Qhov chaw sib ntsib xaiv los ntaum koj. Koj cov lus teb yuav muab suab rau ib daim ntawm thiab tso hauv Onedrive, mauj ib qho password tim thaiv thia yuav encryption.

Cov Lus Npog Cia

Koj Cov ntaub ntawv ntawm no yuav tsis pub leej twg saib. Tsab ntawv kuv sau tom ntej txog qhov kev khaum no kuv tsis tso cov information tawm hais tias yog koj. Thaum koj hais lus kuv yuav sau cov ntsiab lug tseem ceeb tseg. Tsis pub leeg tug saib cov ntaub ntawv no. Tsuas yog kuv xws. Kuv yuav ib lub iphone kaw cov lus tseg. Nus mauj password tiv thaiv. Cov survey thiab cov ntaub ntawv yuav tso rau lub computer tom qab 24 xuab moo yuav muab cov survey thiab ntaub ntawv pom tseg. Kuv yuav mauj cov ntaub ntawv tso rau ib lub napiv daum tom qab interview. Lub computer los yuav ib qho password tom qab 30 minutes tsis muaj neeg siv. Cov ntaub ntawv sign npe koj kam no yuav khaws tseg tom qab 3 xyoo. Institutional Review Board officials tom University of St. Thomas yuav saib cov ntaub ntawv kom raus li lawv txoj cai.

Txuas Siab Pab Dawb Txog Qhov Kev Khawm

Yog koom tev tuaj piav txhais tias koj txuas siab pab dawb. Yog koj koom tes los tsis koom los tsis ua lis cas rau lub tsev kawm, University of St. Thomas. Tsis koom tes los tsis mauj teeb meem. Yog koj koom tes koj tawm thaum twg los tau, tsis mauj teeb meem los tsis poob benefits. Yog koj taum ces yuav mauj cov ntaub ntawv pov tseg. Thaum twg koj xav hais tiag koj yuav twam ces koj qhia kuv paub xwb. Thiaj koj hlas ib cov los lus noog los tau.

Hu Rau Yog Mauj Los Lus Noog

Kuv lus npe yog Mai Ia Vue. Koj mauj los lus noog kuv tamsim no los tau los yog tom qab koj piav tag. Yog koj mauj los lus nug, koj hu kuv thaum (715)203-6206 or vue02021@stthomas.edu. Koj hu rau Dr. Renee Hepperlen thaum (651)-968-5802 or hepp1989@stthomas.edu. Koj hu rau lus University of St. Thomas Institutional Review Board tom 651-962-6035 or muen0526@stthomas.edu yog koj mauj los lus nug los teeb meem.

Lus Tso Cai

Kuv tam nrog tus neeg txog qhov kev khaum thiab nyeem daim ntawv no. Kuv cov los lus nug yeem teb rau kuv siab xav. Kuv tso cai koom tes txog qhov kev khaum no. Kuv yog 18 xyoo los tsaj. Kuv tso cai koj kaw kuv cov los lus teb.

Mauj ib daim theej rau koj khaws tesg

Tus Koom Tes Sign Nep

Hnub Tim

Tus Koom Tes Print Npe

Tus Researcher Sign Npe

Hnub Tim

Appendix C

Caregiver Acculturation. 15 questions are selected from the Suinn-Lew Asian Self-Identity Acculturation to help measure caregiver acculturation. Circle the one answer which best describes you.

1. What language can you speak?

1. Asian only (for example, Chinese, Japanese, Korean, Vietnamese, etc.)
2. Mostly Asian, some English
3. Asian and English about equally well (bilingual)
4. Mostly English, some Asian
5. Only English

2. What language do you prefer?

1. Asian only (for example, Chinese, Japanese, Korean, Vietnamese, etc.)
2. Mostly Asian, some English
3. Asian and English about equally well (bilingual)
4. Mostly English, some Asian
5. Only English

3. How do you identify yourself?

1. Oriental
2. Asian
3. Asian-American
4. Chinese-American, Japanese-American, Korean-American, etc.
5. American

4. What generation are you? (circle the generation that best applies to you:)

1. 1st Generation = I was born in Asia or country other than U.S.
2. 2nd Generation = I was born in U.S., either parent was born in Asia or country other than U.S.
3. 3rd Generation = I was born in U.S., both parents were born in U.S, and all grandparents born in Asia or country other than U.S.
4. 4th Generation = I was born in U.S., both parents were born in U.S, and at least one grandparent born in Asia or country other than U.S. and one grandparent born in U.S.
5. 5th Generation = I was born in U.S., both parents were born in U.S., and all grandparents also born in U.S.
6. Don't know what generation best fits since I lack some information.

5. Where were you raised?

1. In Asia only
2. Mostly in Asia, some in U.S.
3. Equally in Asia and U.S.
4. Mostly in U.S., some in Asia
5. In U.S. only

6. What contact have you had with Asia?

1. Raised one year or more in Asia
2. Lived for less than one year in Asia
3. Occasional visits to Asia
4. Occasional communications (letters, phone calls, etc.) with people in Asia
5. No exposure or communications with people in Asia

7. Do you

1. Read only an Asian language?
2. Read an Asian language better than English?
3. Read both Asian and English equally well?
4. Read English better than an Asian language?
5. Read only English?

8. Do you

1. Write only an Asian language?
2. Write an Asian language better than English?
3. Write both Asian and English equally well?
4. Write English better than an Asian language?
5. Write only English?

9. If you consider yourself a member of the Asian group (Oriental, Asian, Asian-American, Chinese-American, etc., whatever term you prefer), how much pride do you have in this group?

1. Extremely proud
2. Moderately proud
3. Little pride
4. No pride but do not feel negative toward group
5. No pride but do feel negative toward group

10. How would you rate yourself?

1. Very Asian
2. Mostly Asian
3. Bicultural
4. Mostly Westernized
5. Very Westernized

11. Rate yourself on how much you believe in Asian values (e.g., about marriage, families, education, work):

1	2	3	4	5
(do not believe)			(strongly believe in Asian values)	

12. Rate yourself on how much you believe in American (Western) values:

1	2	3	4	5
(do not believe)			(strongly believe in Asian values)	

Appendix D

Hmong Caregiver Interview Questions

1. Please explain to me how you took on the role of being a caregiver and the length of time you have been in this role?
2. What kinds of caregiving tasks do you provide?
3. Are you employed? If yes, how has caregiving impacted your life in terms of your job?
4. How has caregiving impacted your financial situation?
5. How has caregiving impacted your life in terms of your relationship with your care recipient?
6. How has caregiving impacted your social life?
7. In what ways does your culture influence the way that you provide caregiving?
8. In what ways do your American values influence the way that you provide caregiving?
9. Is there anything else that you would like for me to know?

Appendix E**Additional Demographic Information**

1. What is your relationship to the care recipient?
 1. Child
 2. Friend
 3. Grandchild
 4. Grandparent
 5. Life Partner
 6. Neighbor
 7. Other Relative
 8. Other Non-Relative
 9. Sibling
 10. Son/Daughter-in-Law
 11. Spouse
 12. Refused to Answer

2. Are you aware of caregiver support resources?
 1. Yes
 2. No

3. What kind of services do you currently have and please rank them in order. Use to the most to the least 1-10.

4. What kinds of services would you like to learn about?
 1. Access/obtaining healthcare options
 2. English translation
 3. Transportation
 4. Job
 5. Additional family support
 6. Financial Support
 7. Emotional Support
 8. Housing Support
 9. Additional information on respite, nursing or hospice care in out of home care/in home care.
 10. Other. Please list _____.

5. What concerns do you have about receiving caregiver support?
 1. Care recipient reluctant to accept outside help
 2. No one else can provide care as well as I do
 3. Do not trust service providers in the home
 4. None
 5. Other: Please describe _____.

6. What is your employment status?
 1. Employed full-time
 2. Employed part-time
 3. Employed seasonally
 4. Unemployed

If yes to employment,
Do you or have you accessed FLMA?

7. Are you paid to provide care?

1. Yes
2. No

8. Are you the only non-paid person providing care?

1. Yes. If yes, please include other members _____.
2. No

9. What is your highest level of education?

1. Less than high school
2. High school graduate
3. Some college
4. Technical school College graduate
5. Graduate school

10. What is your annual household income?

1. 10,000-30,000
2. 30,000-50,000
3. 50,000+
4. Decline to answer

11. What is your current housing situation?

1. Own home
2. Rent apartment/home
3. Subsidized housing/public housing
4. Other _____.