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Walking in Two Worlds: Hmong End-of-Life Beliefs & Rituals

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Abstract

For over forty years, the Hmong have sought refuge in the United States; however, many Hmong elders continue to honor healthcare and end-of-life beliefs and rituals that they practiced in their home country. With little known by the general public and healthcare systems about these beliefs and rituals, healthcare professionals may struggle to provide the Hmong community with culturally-sensitive care. This study sought to address this gap by conducting in-depth face-to-face interviews with 20 Animist and Christian Hmong elders born in Southeast Asia, who now reside in the United States. Results provided insights regarding the heterogeneity among these Hmong elders concerning their end-of-life beliefs and rituals. Both Animist and Christian respondents believed family should provide care at end of life. Animist Hmong elders reported the importance of Shamanistic rituals such as soul calling or spiritual offering while Christian Hmong elders believed in the power of prayers. Healthcare providers need to assess Hmong elders' preferences for care at end of life, be open to the inclusion of traditional healers in their care and/or decision-making, and understand preferences of family and community members involvement in care at the end of life.

Keywords

Hmong; end-of-life; hospice care; healthcare; qualitative

Introduction

It has been over forty years since the first Hmong refugees arrived in the United States (U.S.) and, as the generations have sought to adjust to a new way of life, many elders have continued to honor the healthcare beliefs and practices tied to their home country, particularly with regard to dying and death. Evidence (Culhane-Pera, 2003; Gervais, 2003) exists that Hmong elders who attempt to honor their traditional beliefs may struggle in a Western society that uses a medical model of healthcare, which often lacks knowledge of Hmong beliefs and values. When using hospice care services, terminally ill Hmong elders and their families often have not had their traditional end-of-life care beliefs and practices honored or their end-of-life care decisions clearly understood by Western healthcare

professionals. One case study (Culhane-Pera, 2003) found that while hospice care practitioners reported providing a Hmong elder care that aligned with the hospice care philosophy, the elder's family reported the care as dangerous and conflicting with their cultural end-of-life care practices. Such misunderstandings experienced by both healthcare practitioners and the Hmong may be due to the lack of information available to practitioners with regard to the Hmong's end-of-life care beliefs, rituals and practices prior to death. To-date, the focus of research has been on the Hmong community's beliefs, rituals and practices that take place after death occurs (Bliatout, 1993; Davy, 1997; Falk, 2004; Her, 2005; Lee & Tapp, 2010).

The aim of this study was to garner an understanding of the Hmong community's beliefs, rituals and practices that guide their dying process. For the many Hmong who reside in the US and continue to honor their traditional beliefs, rituals and practices, it is critical that Western healthcare professionals, including social workers, have this understanding and incorporate it into their practice. In doing so, healthcare professionals may be able to better provide culturally-sensitive care to Hmong patients so that they can experience a quality dying process and death.

Literature Review

Hmong and the New World

Hmong refugees, who were involved with the U.S. Central Intelligence Agency (CIA) during the Vietnam War, began migrating to the United States in 1975. During the Vietnam War, the CIA recruited the Hmong people living in Laos to fight against the Communist regime (Hamilton-Merritt, 1999; Vang, 2010; Warner, 1995) in what became known as the Secret War. The Hmong were chosen because of their familiarity with the region between Laos and North Vietnam, and for their ability to fight "as guerrillas in the jungles and mountains and as regular troops in positional warfare" (Chan, 1994, p.11). In exchange for the Hmong's service, the CIA made a promise to supply the Hmong with armament, rice, salt, planting fields, and humanitarian aid (Hamilton-Merritt, 1999; Vang, 2010). Furthermore, if the North Vietnamese Communists were successfully prevented from entering Laos, the CIA would assist the Hmong to sustain their lives in Laos (Hamilton-Merritt, 1999). If this success remained elusive, however, the CIA agreed to locate a new home for the Hmong to live (Hamilton-Merritt, 1999; Vang, 2010).

In 1973, peace talks resulted in the withdrawal of all U.S. forces from Vietnam (Chan, 1994; Warner, 1995) and the Hmong fled Laos in order to avoid persecution. In 1975, the first few Hmong (mainly Hmong military personnel and their families), arrived in the U.S. In 1976, the Indochina Migration and Refugee Assistance Act, which was enacted by the U.S. Congress in 1975 to support refugees fleeing from Vietnam and Cambodia, extended to include Laotians and other ethnic groups in Laos, such as the Hmong (Vang, 2010). Today, approximately 300,000 Hmong live in the United States, with the majority residing in California, Minnesota and Wisconsin (United States Census Bureau, 2016).

Animism and Christianity

In order to understand the Hmong's end-of-life care beliefs and practices, it is important to first have an understanding of the two religions most practiced by the Hmong living in the U.S.: Animism and Christianity. The traditional Hmong religion is Animism (Bliatout, 1993; Culhane-Pera & Xiong, 2003; Plotnikoff, Numrich, Wu, Yang & Xiong, 2002). Animist Hmong believe the physical and spiritual worlds exist and harmonize to allow spiritual and physical beings to interact with each other (Culhane-Pera & Xiong, 2003; Plotnikoff et al., 2002). Individuals have a set number of souls that operate with their physical bodies to grant "life and health" to them (Plotnikoff et al., 2002, p. 30).

As Animist Hmong, the traditional healthcare belief is that of Shamanism. Shamanism is the belief in which a shaman, a healer, serves as an intermediary between the physical and spiritual worlds to diagnose and treat an illness thought to be caused by spiritual forces (Plotnikoff et al., 2002). For the Hmong, disease is viewed as a "disruption in balanced, dynamic interactions of souls, spirits, and persons" (p. 29). When sickness occurs, a Hmong individual will seek out a shaman to diagnose and treat the spiritual illness (Xiong, Numrich, Wu, Yang & Plotnikoff, 2005). As of 2006, 70% of the Hmong residing in the United States still practiced animism (Lee & Pfeifer, 2006).

After Animism, Christianity is the most practiced religion by the Hmong in the U.S. In the 1940's, some Hmong living in Laos converted to Christianity after having contact with missionaries (Culhane-Pera & Xiong, 2003; Winland, 1992). As the Hmong relocated to the United States, additional conversions occurred (Culhane-Pera & Xiong, 2003; Vang, 1998); therefore, healthcare providers should not assume that all Hmong are Animists who practice the traditional healthcare belief of Shamanism.

General Healthcare Beliefs and Misunderstandings

Only a few studies have been conducted regarding the Hmong's overall experiences with the U.S. healthcare system, and results provided evidence that the Hmong faced misunderstanding and discrimination by the healthcare system (Johnson, 2002; Thorburn, Kue, Keon, & Lo, 2012). Respondents in the study by Thorburn et al. (2012) reported that they were treated disrespectfully, unfairly, insensitively, or rudely when they were seeking health care services. Some of the respondents shared that the providers were "dismissive" towards them when they told the providers about their conditions, the providers said "disrespectful" words to the respondents, and they had to wait longer than other patients before being seen by a provider (p.7). Some respondents felt that their mistreatment by the providers were due to their race, culture, language, education, or insurance status (Thorburn et al., 2012).

Johnson (2002) discovered similar findings with regard to Hmong's experiences with using healthcare services in the U.S. One elder woman shared that the provider who checked-in on her was "mimicking her facial expressions and crying sounds" and that she experienced feelings of humiliation (p. 129). Another situation was that of a Hmong couple, who did not understand the physician's comment regarding their daughter's terminal diagnosis and took their daughter home. The next day, the police arrived at the couple's home and took their

daughter to the hospital where she received chemotherapy by force. The physicians had obtained a court order for the child to receive treatment, even though the treatment would have only marginal effects. The parents did not understand why their daughter was forced to receive a treatment that they viewed as “torture” (Johnson, 2002, p.130).

Respondents in the study by Johnson (2002) also spoke about the issues that resulted because physicians lacked knowledge of Hmong healthcare beliefs. Hmong respondents reported thinking that Western medicine would provide immediate results, and so when it failed to do so or they felt worse, they simply stopped the medication without telling their doctors. Their doctors had no idea that to avoid being rude, Hmong patients would not tell a doctor that the medicine was not helping. Respondents felt that Western healthcare providers lacked knowledge about the Hmong belief in a collectivist approach to decision-making that involves family members talking about the risks and benefits before making a decision (Culhane-Pera & Xiong, 2003). In the traditional Hmong culture, male elders and the clan leaders of the family hold the power in decision-making, which allows the family to be responsible for the consequences rather than the patient. If an individual makes a decision independently, he or she will be solely responsible for the outcomes and could be chastised for any negative ramifications (Culhane-Pera & Xiong, 2003). In Johnson’s (2002) study, Hmong participants and their family members felt pressured by medical personnel to make a decision, even when the family was waiting for the male elders and/or clan leaders to arrive and be a part of the decision-making process. Overall, the respondents in Johnson’s (2002) study spoke about how such experiences with the Western healthcare system have led to their mistrust in it. They stated that they feared that tests, surgery and Western Medicine are not given to the Hmong people for their benefit; rather, they are given so the Hmong can be used as test subjects by medical residents (Johnson, 2002). Evidence is available that the misunderstandings reported in the Thorburn et al. (2012) and Johnson (2002) studies have also extended to care provided in the dying process.

Beliefs About the Dying Process

Although the literature is sparse regarding the provision of Western medicine and care to the Hmong at end of life, studies have been conducted more generally on their healthcare beliefs and practices (Cobb, 2010; Culhane-Pera & Xiong, 2003; Johnson, 2002; Parker & Kiatoukaysy, 1999; Rairdan & Higgs, 1992). Researchers have gained insight into the Hmong’s belief regarding etiology of illness. This belief suggests that a soul loss is one cause of illnesses (Cobb, 2010; Culhane-Pera & Xiong, 2003; Parker & Kiatoukaysy, 1999). A Hmong individual is believed to have multiple souls, one of which stays with the physical body (Bliatout, 1982; Livo & Cha, 1991). When this soul becomes frightened, sad, or lonely, it may leave the body, which Hmong believe causes the individual to become ill (Parker & Kiatoukaysy, 1999). In response to the illness, the Hmong will seek a traditional healer, such as a shaman, to attempt to cure the illness by performing multiple rituals including a soul calling or an offering. A Hmong individual may also seek western medicine in conjunction with herbal medicines and folk remedies (Rairdan & Higgs, 1992; Helsel, 2004). Despite this knowledge of traditional Hmong healthcare practices, little attention has been given to gaining an understanding of Hmong beliefs and practices regarding end of life. In terms of what is known, much of the literature has focused on beliefs and practices after death

(Bliatout, 1993; Davy, 1997; Falk, 2004; Her, 2005; Lee & Tapp, 2010) and little on the dying process.

Although a dearth of knowledge exists, two case studies (Culhane-Pera, Vawter, Xiong, Babbitt, & Solberg, 2003a, 2003b), and two research studies have focused on the Hmong's perspectives on end-of-life decision-making (Ford & Moldenhauer, 1998) and mainstream end-of-life care (Lor, 2017). The first case study was of a Hmong woman who had experienced a brain hemorrhage and was on a ventilator. A number of issues arose for the patient and her family (Culhane-Pera et al., 2003b). First, they experienced the Western medical model of a restrictive visitor policy that only allowed two visitors in the patient's room at once. Despite the hospital nurses' repeatedly reminding the family of the policy, several of the patient's immediate and extended family members practiced the Hmong tradition of having multiple family members keeping a vigil around the patient (Culhane-Pera et al., 2003b). The second issue arose when nurses asked the family about organ donations after the patient had died. Raising this topic was upsetting to the family because of their belief that organ donation would "impair [a soul's] transition to the next life" (Gervais, 2003, p. 282).

In the second case study, Culhane-Pera (2003) examined the case of a terminally ill Hmong woman with gall bladder cancer. When male family members felt no medicine would cure her, they agreed to her being transferred from the hospital to an inpatient hospice care unit. After the transfer, however, the hospice nurses told the patient she was dying and to let go, which proved extremely upsetting to the patient's family due to the Hmong community's beliefs that talking about dying and death will bring death prematurely to a person who is terminally ill (Gerdner, Xiong, & Yang, 2006; Vawter & Babbitt, 1997), and that such talk means the family does not love and respect the dying person (Vawter & Babbitt, 1997). Instead, Hmong prefer to speak about death and dying in metaphors by calling it a time to say good-bye (Gerdner, Cha, Yang, Tripp-Reimer, 2007) or saying that the terminally ill individual is not doing well (Vawter & Babbitt, 1997). Culhane-Pera (2003) notes that in the case study, the family's perspective was that their loved one's needs were not being met and the nurse's actions were dangerous. The nurses, however, misinterpreted the family's beliefs regarding talking about dying and death as the family being in denial about the patient's pending death (Culhane-Pera, 2003).

Additional studies provide insight to the Hmong's experiences with receiving end-of-life care within the Western hospice care model, two additional studies provide insight into the need to bridge the Hmong and Western approaches to illness and healthcare through communication and education. Ford & Moldenhauer (1998) found that values and beliefs about end-of-life care decisions included several components: communication, the presence of family and friends, consultation with family regarding healthcare decisions, and designated individuals can make decisions on behalf of ill family members. The presence and opinions of family is important to Hmong when it comes end of life decision-making; however, some individuals may make their own decisions despite consulting with their families (Ford & Moldenhauer, 1998). Similarly, a study of Hmong's perceptions on end-of-life care services in the U.S., revealed that some Hmong respondents preferred to provide care to their terminally ill parents and that "shaman treatment" was enough (Lor, 2017, p.

62), while some were open to using external services such as hospice care and palliative care services. For those who were open to using hospice care and palliative care services, they felt that more information about these services would be helpful for them in their decision-making. One respondent shared that Hmong elders are not familiar with the Western healthcare system and male elders still held on to what they know of in terms of talking about end-of-life care practices (Lor, 2017).

Overall, the previous studies provide some evidence of misunderstandings and mistrust between healthcare professionals and Hmong elders and families. In order to meet this need, more knowledge is required regarding the Hmong's beliefs and preferences concerning care within the dying process. This study sought to garner such knowledge by interviewing Hmong elders about their beliefs and rituals involved in caring for someone at end of life, the preferred preparations for themselves and their loved ones (e.g. financial, funeral, clothing); and the type of care family members are to provide.

Methods

Due to the paucity of literature available on Hmong beliefs and practices regarding end-of-life, this study used an exploratory, cross-sectional, and descriptive approach to understand the end-of-life care beliefs and practices preferred by Hmong elders. Questions were asked about the elders' beliefs and rituals important to them, preparations the elders would make for their families and themselves when near the end of life. Also, the types of care that a Hmong family member would provide to a loved one at end of life was examined.

Sample Recruitment and Procedures

Using purposive sampling, individuals who self-identified as Hmong and whose age was 50 years and older were recruited through flyers, written in both English and Hmong, and posted at the Hmong Mutual Assistance Associations (HMAA) throughout Wisconsin. This age range was chosen so that respondents were old enough for their place of birth to be Southeast Asia, which was an eligibility criterion, and meant they would possess first-hand knowledge of traditional end-of-life care practice and preparations. This age group would ensure that the participants have this knowledge because traditionally, Hmong people view elders not by their age but by their experience and knowledge acquired throughout life (Gerdner, 2010). This study received approval from the University of Wisconsin-Madison Institutional Review Board.

Twenty respondents were interviewed in a single-session face-to-face interview by the lead author who is fluent in both English and Hmong. Prior to beginning the interview, the interviewer asked the respondents if they consented to their interviews being audio recorded. The respondents had the options to do their interviews in Hmong or English. Seven respondents consented for their interviews to be audio recorded while 13 did not consent to be audio recorded. Of the seven respondents whose interviews were audio recorded, three chose to conduct their interviews in English while another three were in Hmong and one was in both English and Hmong. Of the remaining 13 respondents, who did not consent to be audio recorded, 11 chose to conduct the interview in the Hmong language, one chose English and one chose both English and Hmong.

Using semi-structured interviews with a question guide, both quantitative and qualitative information was gathered. Quantitative demographic questions sought information on age, country of birth, year arrived in the United States and religion. Due to the topic's sensitive nature, the qualitative questions were first reviewed by several Hmong community members to insure their cultural sensitivity and understandability. For example, the community consultants suggested that when the phrase 'end of life' was used for the first time in the survey, it be followed by "that is, when the person has an illness so big that it cannot be cured." This suggestion was incorporated into the first question posed about the respondent's beliefs concerning the way to care for someone at end of life. The remaining questions addressed Hmong rituals involved in providing care at end of life; their beliefs about end-of-life preparations to be made for themselves and their family members; and the type of care family members provide loved ones who are dying. All demographic and qualitative questions were answered by the respondents.

Data Analysis

As previously noted, some interviews were audio-recorded and some were not based on the respondent's preference. The audio-recorded interviews were transcribed verbatim. For the respondents who did not consent to be recorded, the first author carefully recorded their answers on the hard copy of the survey as close to verbatim as possible.

Due to the dearth of research and lack of theory used in prior research on this topic, the analysis was not guided by pre-established themes or patterns. An inductive method of conventional content analysis (Hsieh & Shannon, 2005) was used to identify and categorize themes and patterns that emerged from the data. Neuendorf (2002) noted the necessity of addressing reliability when human coders are used to identify themes and referred to it as inter-coder reliability. In order to ensure rigor in the data analysis process, the co-authors independently identified themes and patterns for several transcripts. A theme was created when more than one respondent reported on a topic. The co-authors then met to discuss and agree on their coding process, and then separately coded the remaining transcript. After the coding was completed, the authors met and compared their results, discussed differences and reached consensus.

The strategies used to protect trustworthiness and to meet rigor of a qualitative study included verification of the transcripts, weekly discussion of the data analysis between the authors, and member checking. The first author listened to the recordings and followed along with the transcriptions for accuracy. The two authors discussed the data analysis on a weekly basis and member checking was done to follow up with respondents for accuracy of the data.

Results

Sample Demographics

The demographic characteristics varied across the sample. Respondents had an average age of 66 years; with an age range of 50–95. Eleven (55%) respondents were female. Four (20%) respondents had earned at least a bachelor's degree, 2 (10%) had 3–4 years of education, and

14 (70%) had never attended school. Nineteen (95%) respondents were born in Laos, and one (5%) in Vietnam. All respondents had been living in the United States for an average of 27 years. When asked about their occupation, six (30%) reported being employed, 13 (65%) were unemployed or not working at the time of the interview and one (5%) was retired. Of the six who were employed, three were in service positions and three in manufacturing or factory work. Twelve respondents (60%) reported practicing animism and eight (40%) Christianity; however, Christian respondents were not asked if they converted before or after their move to the U.S.

Demographic differences did exist based on the respondents' religion. Two-thirds of the Animists self-identified as female compared to one-third of the Christian respondents. Animist respondents were slightly older on average (66 & 63 years old, respectively), less educated (2 & 9 years on average, respectively) and had been in the US for a shorter time of time (21 & 32 years on average, respectively). Concerning employment, only two (17%) out of 12 Animists reported working compared to 6 (75%) out of 8 Christians.

Qualitative Analysis Results

Responses to the interview questions resulted in several themes for each group. The themes for each question are reported separately for the Animists (N=12) and Christian (N=8) respondents. The themes for the first questions about beliefs and rituals regarding care at end of life included family caring for elders, dying at home, shaman rituals and herbal medicine for Hmong Animists. For Hmong Christians, the themes were prayers, Christian beliefs and children care for parents differently. The themes for the second question regarding beliefs about preparations that need to be made at end of life for Hmong Animists included do not know what to prepare, adaptive financial preparations and clothing. For Hmong Christians, the themes for beliefs about preparations consisted of those for children's future, self, financial, funeral plans and clothing. The themes for the third question regarding beliefs about type of care given by Hmong family members included types of care and support and adaptive care practices for Hmong Animists. For the Hmong Christians, the themes for their beliefs about type of care given by Hmong family members were preference to be cared for by family, types of care and support and training to provide care.

Beliefs and Rituals Regarding Care at EOL

Animists.—With regard to beliefs and rituals concerning care at end of life, four themes were identified for respondents reporting Animism as their religion. These themes were family care for elders, dying at home, shaman rituals, and herbal medicine.

Family care for elders.: Respondents talked about their beliefs that family should care for them when they are at end of life. A 93-year-old female respondent said, "Well, I still practice shamanism, so my children will be caring for me per Hmong traditions, per the traditions that Hmong originated." Respondents also noted that it is not simply that children take care of you; it is important that the child be the same sex as the person who is dying. A 50-year-old respondent elaborated:

Hmong people are modest. They are modest, Hmong people are not like other ethnicities. So if, for example, the father is sick, then the sons will take care of him.

So for the sons and sons-in-law to provide the care. They are the males. If the wife is sick then the daughters-in-law and the daughters provide the care, because we don't want our loved one to um, have any embarrassment...And this is something that we don't like either. Hmong people, for the most part that I have seen, we desire to have children to provide care for us when we are old. So if we are sick, we believe that we should have sons and daughters, too. At least so there is, there is that person who will not have any embarrassment with us. Those are our real children so we feel comfortable.

Dying at home.: Respondents noted that according to tradition, dying should occur in either the elder's or one of their children's homes. A 73-year-old female respondent explained that, "When the elders passed away, the oldest son has the altar to spiritually hold the house together." This respondent was referring to an important Hmong custom and belief that either the elder's and/or oldest son's home have an altar. The belief is that an elder must die in a home with an altar because the altar is where the deceased elder's soul will reside and protect the living descendants (Gerdner et al., 2007; Her, 2005). Another elder, a 50-year-old male, talked about the value that Animists place on having a "home": "So we care for them that they are our mom and dad, or we do not want them to pass away in a place where it is not their home. Would prefer them to pass away in their home so they (elders) can be happy that there is a home for their children to see them pass away." Finally, a few respondents also shared that it was important for them to see their homes before passing away.

Shaman rituals.: Respondents discussed the importance of practicing shaman rituals for an elder who is terminally ill. Several explained that if the elder cannot be cured by a doctor, then the Shaman would perform rituals to see if they can do so.

The ritual discussed most by respondents was when the shaman performs a soul calling for someone at the end of life. Respondents explained that when someone is ill, the belief is that the person's soul may be sad, scared or in need of something and so has wandered away from the person's body. Soul calling would be one of the first attempts to treating an illness. An 87-year-old male respondent explained that Shamans, "Do shamanistic rituals, soul calling so the spirit (soul) is happy." A 60-year-old male respondent shared that a reason behind this ritual is the belief that if the soul is happy and has returned to the person's body, the person could be cured of the illness.

Spiritual offering was another shaman ritual deemed important for elders who are dying. Respondents shared that spiritual offering is usually done when an ill person does not become better, even after a shaman has already come to help them and especially after a soul calling. Another 50-year-old male respondent shared:

After the shaman comes to help and the sick person does not get better, then we make an offering (fiv yeem). Making an offering is offering to ask the spirits of the land to help us...sometimes...it is the bad spirits that catches the sick one's soul...so then we ask the spirits of the land, which guards the land, to come and forgive the wrongdoing of the ill individual [and]to give the individual's soul back. We believe that as living beings, there are governors, in the spiritual world there are

also governors. When we look at the sick person and his or her illness is not anything like cancer but that person suddenly falls ill, we don't know what to do so we make an offering (fiv yeem). The offering has cured many... We call the spirits of the land that...we will provide you with money and incense (as an offering). Sometimes if we see that the sick person has a very severe illness then we will make an offering of a cow or a pig in return for their effort. Yeah, the offer is what we use to give as gratitude for the spirits of the land to help us retrieve the soul back.

Herbal medicine.: Herbal medicine was also noted by respondents as a treatment to care for terminally ill elders. One 50-year-old male respondent talked about using this medicine to cure the person: "The, the, practice which is, it's, we are using like our herbal medications to cure. Like shaman, you know." Another 60-year-old male respondent said he would like to take herbal medicine so it would make his soul "happy".

Christians.—Three themes regarding providing care for someone at the end of life surfaced based on the discussion by Hmong respondents identifying as Christian. The themes include prayers, Christian beliefs and children care for parents differently.

Prayers.: Praying was another theme that emerged when the respondents talked about providing care to someone at end of life. They believed praying would help the individual and would make that person feel happy that someone else was there to pray for them. Furthermore, respondents talked about demonstrating through prayer their belief that the fate of their illnesses depended on God.

Christian beliefs.: Respondents shared that Christianity is a way of life for them and that Christian beliefs provide guidance on what to do at end of life and assurance on what would happen after life. A 70-year-old male respondent reflected on this belief: "Because you believe that when you die, you are going to be with God. So you don't die completely. Your spirit does not die, only your body dies, because your spirit is going to be with God."

Children care for parents differently.: Respondents shared that having family provide care at end of life is a Hmong tradition and they sought to adhere to that tradition. Furthermore, a 50-year-old male respondent stated that caring for his parents is not just adhering to Hmong traditions but also honoring his Christian beliefs.

So I think culture, culturally, we are still Hmong and we still like to care for our elders, we still like to see our elders, um, being taken care by us. Um, in Christianity, we al-we also like to believe that we have to honor our parents, and hon-honoring means sometimes we have to care for them at-at the old age and end of life.

Although Christian respondents noted they preferred to care for a loved one who is dying and do so in the person's own home, they reported having to sometimes adapt this tradition to the demands of western society. Respondents talked about the need to sometimes place elders in a nursing care facility where they will die. A 50-year-old male respondent provided insight for this adaptation:

But again, believing sometimes is challenging because this society-the children need to go to work so sometimes I think it is okay to have other people like assisted living or nursing home or hospice facility to care for your parents. But by honoring them, you visit them every day and talk to them, make sure that you are with them....

Beliefs About Preparations that Need to be Made at End of Life

Animists.—Three themes emerged about the Animist respondents' beliefs regarding preparations that need to be made for their children or themselves at end of life. The themes include: do not know what to prepare, financial preparations and clothing.

Do not know what to prepare. Many respondents shared that they were not sure what to prepare during this stage of life. Although they did not know what to prepare, some trusted their children would make preparations for them.

Adaptive financial preparations. In terms of financial preparations, the respondents spoke of money and life insurance, a change to their traditional approach. This change was explained by a 50-year-old male respondent:

We are safe that there is insurance in this country to purchase as protection. In case if we don't have anything, at least our children will not be impoverished...It's a bit different in this country than overseas. Overseas, we raise livestock and save money for our children in case they do not have any. But since we have arrived here in this country, it is a little different; we don't have homes, we don't have land but we are safe that there is insurance in this country to purchase as protection. In case if we don't have anything, at least our children will not be impoverished.

In terms of money, the respondents shared that they would leave some money for their children. Three (24%) of the Animist elders shared that they wanted to make sure their children received equal amount of inheritances regardless of whether they were daughters or sons. A 60-year-old male respondent shared: "If there is enough money, divide equally between girls and boys."

Clothing. Clothing was another theme that emerged when talking about preparations for end of life. Respondents were concerned with the type of clothing they would wear upon death because a traditional Hmong belief is that the deceased is going to live among their ancestors in the afterlife (Culhane-Pera, 2003; Gerdner, 2010) and this traditional clothing is symbolic of this next step (Culhane-Pera, 2003). The individual would need to be clothed upon death, which would signify that the individual is wearing clothes when meeting their ancestors. Not being clothed would result in ramifications for the deceased person and the living descendants. A 71-year-old female respondent provided insight into the ritual that must take place when the person who dies is not clothed:

Hmong's tradition is like that so that person dies it is required to clothe that person so when that person goes to heaven that person, um, will have clothes to wear. So that person will not come back and look for the living relatives. If you do not put clothes on that person then when that person goes, that person is naked. So when

that person goes, that person will come back in your dreams and that person will come find the living relatives...that person does not have clothes to wear so then Hmong have to gather clothes and ask a shaman to come and do a ritual. So Hmong gather the clothes in a pile even if the clothes are brand new, Hmong people still burn them. The shaman then does a ritual and Hmong burn them then the shaman will send it off...

Christians.—Five themes emerged regarding Christian respondents' preparations at end of life. The themes included making preparations for children's future, preparations for self, financial preparations, funeral planning, and clothing.

Preparations for children's future. In terms of preparations at end of life, respondents talked about making them with regard to their children's future. These preparations included marriage for their children to insure they have a family to support them as well as an equal distribution of property. For example, a 61-year-old female respondent said, "I prepare my children so they have relatives, make sure they are married." Another respondent, a 95-year-old female, spoke of the concern she had for her children's future and wanted to make sure that what she had would go to them: "I will prepare things for my children. Divide equally to the sons and daughters."

Preparations for self. Two respondents also spoke about making preparations for themselves. For one 70-year-old male respondent, his self-preparations involved making sure his family knew that praying for him was important. The other respondent, a 50-year-old male, shared that he wanted to his family to know what his wishes were for when he was at the end of his life and to make sure they knew that he loved them.

Financial preparations. Financial preparations at end of life were also talked about by respondents. One reason for respondents to make financial preparations was security for their children. A 63-year-old respondent spoke about the preparations Hmong Christians make and described the differences between preparing in her home country and in the United States.

I do believe so. Just like today how we want to buy life insurance, right? We do want to prepare for our family; we want to help ourselves so when we pass away, we have them (the money) to help, so we are able to complete it (funeral), and because currently, living in this country is different from when living back then where you can live at home, and want to be buried anywhere. For this, you must have money to make it happen. Therefore, we prepare like that, prepare for our family, prepare for ourselves.

Funeral plans. One preparation that the Christian Hmong respondents talked about was that of funeral planning. A 70-year-old male respondent spoke about how funeral planning was related to his Christian belief: "For this, when I know that my life is going to end...and um when I have died then for them to um do a nice funeral, send my spirit to God." Another 50-year-old male respondent spoke about funeral planning but shared that he wanted his children and relatives to make the decisions together.

Christian respondents spoke directly about the adaptation they have made in regard to funeral planning. They noted that traditional Hmong funerals are known to last several days with many rituals for the deceased. For example, a 53-year-old male respondent shared:

I know Hmong, Hmong people like to make it very complicate and elaborate....Like, all the Hmong uh, funerals that I've gone to, and that we're all seeing, it just takes so many days and so many people come. And just the, the rituals can go on and on, and you know, it costs a lot of money.

These Christian respondents, however, felt that although there was value to the traditions, the elaborateness of the Hmong funeral was no longer necessary. They noted that after they die, it would be easier on their family if the funeral arrangements were not so complicated and time-consuming. A 50-year-old male respondent noted that as a Christian having the traditional Hmong funeral does not matter, particularly since they may live where few Hmong reside.

Clothing. Respondents shared that clothing preparations were necessary for them; however, they had made an adaptation in what attire was needed at end of life, such as that shared by a 63-year-old female respondent:

We do prepare some clothing for ourselves. Saying okay, when I pass away I want to do this, want to wear that, like that. The clothes so in back in the days, we Hmong, when we have not converted to Christianity yet, we do have some. They do sew some special ones for you when you die, right? But now we live in the United States so we think oh, I want to wear something very white, very long, and very beautiful or I want to wear however, then you, you think like that. But back in the days, we do have some special ones for when the ones who have passed away. For example some grandmas, they do have them. For me, my parents do have them for me too, but those are not my interests and I don't like them. I don't, I have some but I think that when I pass away, I don't, I don't want those.

This elder continued and said she would still consider the traditional Hmong outfit at end of life, but would not wear it. She stated, "You can just fold it or just put it nicely on the side or by the feet or somewhere."

Beliefs About Type of Care Given by Hmong Family Members

Animists.—Two themes emerged regarding the type of care given to elders at end of life and the gender differences related to the types of care and support.

Types of care and support. In discussing the types of care and support that are important, respondents talked about the number of people necessary to provide care, the types of care needed, the roles women and men play, and how doctors can teach them about how to provide care. Respondents spoke about how it can take seven to eight individuals to provide the care needed at the end of life. In terms of the type of care given, it was noted by a 55-year-old female respondent: "If they are able to provide the care, to help each other, do shamanistic rituals, find medicines for me to make me feel better, call relatives to help provide care." The differences between the male and female caregivers' roles was also

important. A 73-year-old female respondent shared that, “The men (male relatives) discuss regarding what rituals to do...the women (female relatives) help care for the ill person and cook.” Lastly, a 50-year-old male respondent shared that western doctors will teach one on how to care for someone at end of life. He talked about the type of care that the doctors will teach such as using briefs, turning the sick individual, and using medications.

Providing the care is probably, doctor will most likely teach how to provide the care, right. If a person is sick and know that he or she cannot go anywhere then there is a way to help. Some people, they provide with briefs to change so there are no odors, and for the ones who can't go to the bathroom, for them to help so there are no rashes or skin breakdowns. And turn the individual so he or she does not lay too much on one side, which can be bad for that side. I think providing care like this. If there are medications, give enough so the pain goes away. Other than that, there isn't anything else.

Adaptive care practices.: Respondents shared their belief concerning the need to be flexible and integrate the Hmong and mainstream cultural end-of-life care practices. A couple of respondents reported that they believed in using western medicine, as well as traditional spiritual treatments. A 50-year-old male respondent explained this need:

I believe that in this country, I would like to be more um, more um, independent, and I would like to be more like, what the majority is like to do or see. Because it's like I said, if we're really strict on, on the way we believe, and practice the way we believe, then it's really hard for, for us to do something like when a person is in hospice care or is in hospital, you know. We are unable to, to full-fill what we, what our uh, tradition or practices, you know, so we can't do everything. So now, I think that I would like to (pauses) see something we can do, the things we cannot do, we cannot do, and we be, we be more flexible. That's what I, I would like to, to see for myself, and, and my family. I think that, again, it's based on what you believe, and what you think is good for you.

Christians.—Three themes emerged regarding Christian beliefs about types of care given to their Hmong family members. The themes include preference to be cared for by family, types of care and support, and training to provide care.

Preference to be cared for by family.: The respondents shared that one type of care for a terminally ill elder is family providing the care, as the Hmong traditionally have done. A 53-year-old male respondent said: “I think uh for Hmong uh families, or Hmong community members, you know, they would like uh prefer to care for their loved ones at the end of life... they would still like to take care of their loved ones in the home.”

Types of care and support.: In terms of the types of care that Hmong family members would give, the respondents talked about physical and emotional care. One 63-year-old female respondent shared, “I don't know but I think that cooking for them, bathing them, wiping them with towels, hold them.” While a 50-year-old male respondent added, “You know comfort and understanding...”

Training to provide care.: Similar to the adaptations that respondents shared about funerals and clothing preparation, they also talked about being open to receiving caregiving training from western providers. A 50-year-old male respondent reflected that the Hmong lack the training and knowledge to take care of their elders who are at the end of life and “don’t have the mental capacity to understand things anymore”. He continued:

We invited the community members to come here...to be trained... and one of the things that we were taught is that at the end of life, particularly for elder parents, they may suffer from memory lost, and other mental capacity...as a caregiver, family caregiver, or children, we need to understand that they are not the same person, but how to respect them? They may act like childish nowadays, physically, and mentally, and how do you still honor and respect them...don’t get angry, no yelling, and don’t do anything that would consider to be dishonorable uh and you would feel bad when they die. Uh, not that you are a bad child, but because it is just so overwhelmed within uh 24 hours a day, and ...you are just so exhausted and even you don’t understand this stage that uh, when you are old, your brain is not the same anymore...and then you don’t um, treat your parents that way.

Discussion

The results of this study provide a deeper understanding of the beliefs and rituals related to the end-of-life care practiced by Hmong elders residing in the U.S. The 20 Hmong respondents who participated in this study provided information about the Animist and Christian beliefs and rituals related to end-of-life care, preparations they would make, and types of care Hmong family members would provide. Several key findings emerged but perhaps most salient for healthcare providers was the heterogeneity found among these respondents. Some respondents reported adhering very closely to the Hmong Animist traditions, some reported adhering to Christian beliefs and a few traditional Hmong practices, and both groups talked about having made adaptations to the Western healthcare practices. Understanding this diversity is key to providing the Hmong community with culturally sensitive care at the end of life.

Beliefs and Rituals Regarding Care at End of Life

Responses about their preferred beliefs and rituals concerning the way to care for someone at end of life provided insight into the heterogeneity that exists within the Hmong community. Animist and Christian Hmong respondents reported similarities and differences regarding the beliefs and rituals they practiced. The similarities between the two groups surrounded who the caregivers were and the location of care. As previously found (Culhane-Pera, 2003), the Hmong Animists and Christians in this study believed their family should provide the care and that being at home was important. They differed, however, in regard to the reason for doing so. The Christian respondents shared that being at home afforded them the opportunity to receive care from their loved ones. It also enabled them to have family and friends visit, and their pastor pray for them at home. The Animist respondents reported that home is where the altar is located. Gerdner et al., (2007) reported that an altar serves as a way for the living descendants to appease the spirits of the deceased ancestors, who are responsible for the living descendants’ well-being.

Although Animist and Christian respondents both reported believing in the tradition of children caring for elders, differences again surfaced. The Animist respondents stressed the need for same-sex caregivers due to the value placed by Hmong on modesty and intimacy. Parker & Kiatoukaysay (1999) found that this value of modesty extended to healthcare providers as well and that Hmong women were more likely to prefer female physicians, especially for in-depth physical exams. The Christian respondents, however, reported that the U.S. economic demands have resulted in their children needing to work outside the home and such that they cannot always care for their elders. As a result, they stated that using facilities to provide such care was acceptable if children and family visited the elder daily. Overall, respondents' discussion of their beliefs and values provide insight into care differences based on religion but also the need to adapt due to living in the U.S.

Preparations to be Made at End of Life

In terms of understanding about the Hmong respondents' end-of-life preparations, the heterogeneity of the Hmong community with regard to their beliefs and practices was again evident. When asked, Hmong Christians reported several types of preparations whereas Hmong Animists reported being unsure of what preparations to make. This uncertainty is likely due to their adherence to the traditional belief that their children and family make these decisions. On the other hand, however, the Hmong Animist discussions around finances and funerals indicated some shifting away from traditional practices. Concerning financial preparations, some respondents had purchased life insurance and were equally splitting financial resources between daughters and sons, which is a shift from the traditional Hmong patrilineal practices of financial resources going to the sons. With regard to funerals, some of the Animist and Christian respondents reported that a complicated and expensive traditional Hmong funeral (see Bliatout, 1993) was no longer necessary now that they were living in the U.S. and that they preferred a simpler funeral.

This heterogeneity among the respondents also extended to the belief in being clothed at end of life. Although a belief shared between the Animists and the Christians, how this belief is practiced is different between the two groups. The Hmong Christians viewed non-traditional clothes as an option but still considered having their traditional Hmong outfit inside their casket while the Hmong Animists adhered to traditional clothing only. These findings with regard to preparations suggest that the respondents, both Animist and Christians, may be straddling the traditions they practiced in their home country and those practiced in the U.S.

Types of End-of-life Care Given by Hmong Family Members

When respondents spoke about the types of care family members should provide to their loved ones who were dying, Animists and Christians had different answers. Animist respondents spoke about types of care within the framework of gender. They stated that women were responsible for domestic duties and men were assigned to decision-making, supporting previous findings by Culhane-Pera (2003). Christian respondents did not associate certain tasks with a particular gender.

As in previous studies (Culhane-Pera, 2003; Gervais, 2003; Ford & Moldenhauer, 1998; Johnson, 2002), Animist respondents kept with their traditional collectivist approach to

health decision-making and care. On the other hand, Christian respondents practiced individualism, which is the dominate approach in the U.S.

Overall, the similarities, differences, and shifts from traditions found in this study suggest that the Hmong community is quite heterogeneous with regard to beliefs, rituals and practices related to end of life. Some Animist respondents appeared to hold steadfastly to their traditional practices while other Animist respondents believed in being flexible with these traditions. Similarly, some Christian respondents highly valued their religious beliefs while other Christian respondents appeared to have not completely let go of some traditional Hmong beliefs. These findings have important implications for healthcare providers.

Study Limitations

It is important to acknowledge the limitations of this study. First, the sample size was small and geographically limited to one area of a Midwest state. Second, due to the sensitive nature of the study's topic and to the rarity of dying and death being spoken about in the Hmong culture, some self-selection bias will likely have occurred. Additional research with larger sample sizes and multiple geographic sampling areas is called for, as is involving the community in methodological design to insure that interviews, surveys, focus groups, etc. are conducted sensitively and respectfully. This future research could help further understand the Hmong community's beliefs, rituals and practices that guide their dying process.

Implications

The study results also have practice implications for healthcare professionals seeking to provide culturally sensitive care to Hmong elders at end of life. The heterogeneity of the 20 Hmong respondents with regard to their religion and adaptation to western healthcare practices indicates the importance of not making assumptions that all Hmong individuals are traditional or fully acculturated with regard to their end-of-life care beliefs and rituals. Therefore, assessments performed with each Hmong client should include questions regarding not only their religion but also their end-of-life care practices and preferences.

It is possible, too, that some Hmong elders would wish to have a Shaman involved in their end-of-life care, thus requiring healthcare providers to prepare to be open to collaborating with these traditional healers. In such cases, a Shaman would not be addressing the physical aspect of the patient's care (Lemoine, 1986); rather, they would focus on the patient's spiritual needs by performing rituals, such as soul calling. Healthcare providers need to remain nonjudgmental as to the effectiveness of the Shaman or the spiritual care provided.

Additionally, providers must develop an understanding regarding the concept of collectivism and a Hmong elder's preferences regarding the level of family and community member involvement in decisions about medical care and treatment. Providers can honor the U.S. healthcare system's practice of patient autonomy and Hmong elders' preferences for collectivism by asking an elder if they prefer to make all their healthcare decisions (autonomy). When an elder states a preference for family and community involvement (collectivism), the providers can honor this preference by ensuring that designated individuals are included in the elder's healthcare decision-making. The consideration of

these implications may likely begin the process to building the trust necessary for the Hmong to receive the care they desire at end of life.

Conclusion

This study sought to garner an understanding of the Hmong community's beliefs, rituals, and practices that guide their dying process. Interviews with Hmong elders revealed heterogeneity with regard to their end-of-life care beliefs, the influence of religion on their practices, and the adaptations made regarding the provision of care as a result of living in the U.S. Although more research is needed on this topic, the study's findings provide guidance to healthcare professionals caring for Hmong elders and their families at end of life. Recognition of Hmong's varying beliefs and practices, openness to working with traditional healers, and honoring an elder's preference for collectivist decision-making can help to ensure that these elders and their families experience a quality dying process.

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References

- Bliatout BT (1982). Hmong sudden unexpected nocturnal death syndrome: A cultural study. Sparkle Pub.
- Bliatout B (1993). "Hmong Death Customs: Traditional and Acculturated" In Irish DK, Lundquist KF, & Nelsen VJ (Eds.), *Ethnic variations in dying, death, and grief: Diversity in universality* (pp.79–100). Washington, D.C.: Taylor and Francis.
- Cha D (2003). *Hmong American Concepts of health, healing, and conventional medicine*. New York: Routledge.
- Chan S (1994). *Hmong means free: Life in Laos and America*. Philadelphia: Temple University Press.
- Cobb TG (2010). Strategies for providing cultural competent health care for Hmong Americans. *Journal of Cultural Diversity*, 17(3).
- Culhane-Pera KA (2003). Cultural complications in end-of-life care for a Hmong woman with gallbladder cancer In Culhane-Pera KA, Vawter DE, Xiong P, Babbitt B, & Solberg MM (Eds.), *Healing by heart: Clinical and ethical case stories of Hmong families and Western providers* (pp. 258–264). Nashville, TN: Vanderbilt University Press.
- Culhane-Pera KA, Vawter DE, Xiong P, Babbitt B, & Solberg MM (2003a). Hospice patient with gallbladder cancer: A case story In Culhane-Pera KA, Vawter DE, Xiong P, Babbitt B, & Solberg MM (Eds.), *Healing by heart: Clinical and ethical case stories of Hmong families and Western providers* (pp.255–257). Nashville, TN: Vanderbilt University Press.
- Culhane-Pera KA, Vawter DE, Xiong P, Babbitt B, & Solberg MM (2003b). Pregnant women with a brain hemorrhage: A case story In Culhane-Pera KA, Vawter DE, Xiong P, Babbitt B, & Solberg MM (Eds.), *Healing by heart: Clinical and ethical case stories of Hmong families and Western providers* (pp.269–272). Nashville, TN: Vanderbilt University Press.
- Culhane-Pera KA & Xiong P (2003). Hmong culture: Traditions and changes In Culhane-Pera KA, Vawter DE, Xiong P, Babbitt B, & Solberg MM (Eds.), *Healing by heart: Clinical and ethical case stories of Hmong families and Western providers* (pp.11–68). Nashville, TN: Vanderbilt University Press.
- Davy J (1997). Por Thao's funeral. *Hmong Studies Journal*, 2(1), 1–5.
- Falk. C. (2004). Hmong instructions to the dead: What the mouth organ qeej says (Part One). *Asian Folklore Studies*, 63, 1–29.

- Ford C & Moldenhauer S (1998). Living in two worlds: A phenomenological study of health care and end of life decisions of the Hmong (Master's thesis, Winona State University).
- Gerdner L (2010). Health and health care of Hmong American older adults In Periyakoil VS, eds., eCampus Geriatrics. Stanford, CA Retrieved from <http://geriatrics.stanford.edu/ethnomed/hmong/>.
- Gerdner LA, Xiong XX, & Yang D (2006). Working with the Hmong American Families. In G. Yeo and D. Gallagher-Thompson (2nd ed.), *Ethnicity and the dementias* (pp.209–230). New York, NY: Taylor & Francis Group.
- Gerdner LA, Cha D, Yang D, & Tripp-Reimer T (2007). The circle of life: End-of-life care and death rituals for Hmong-American elders. *Journal of Gerontological Nursing*, 33(5), 20–29.
- Gerdner LA, Tripp-Reimer T, Yang D (2008). Perception and care of elder Hmong Americans with chronic confusion or *tem toob*. *Hallym International Journal of Aging*, 10(2), 111–138.
- Gervais KG (2003). Accommodation of cultural differences in end-of-life care In Culhane-Pera KA, Vawter DE, Xiong P, Babbitt B, & Solberg MM (Eds), *Healing by heart: Clinical and ethical case stories of Hmong families and Western providers* (pp.280–283). Nashville, TN: Vanderbilt University Press.
- Hamilton-Merritt J (1999). *Tragic mountains: The Hmong, the Americans, and the secret wars for Laos, 1942–1992*. Bloomington: Indiana University Press.
- Her VK (2005). Hmong cosmology: Proposed model, preliminary insights. *Hmong Studies Journal*, 6, 1–25.
- Helsel DG, Mochel M, & Bauer R (2004). Shamans in a Hmong American community. *Journal of Alternative & Complementary Medicine*, 10(6), 933–938. [PubMed: 15673986]
- Hsieh HF, & Shannon SE (2005). Three approaches to qualitative content analysis. *Qualitative health research*, 15(9), 1277–1288. [PubMed: 16204405]
- Johnson SK (2002). Hmong health beliefs and experiences in the western health care system. *Journal of Transcultural Nursing*, 13(2), 126–132. [PubMed: 11951715]
- Lee TP & Pfeifer ME (2006). Building bridges: Teaching about the Hmong in our communities. Retrieved from <http://www.hmongstudies.org/BuildingBridgesGeneralPresentation2006Version.pdf>
- Lee GY, & Tapp N (2010). *Culture and Customs of the Hmong*. Santa Barbara, CA: ABC-CLIO.
- Lemoine J (1986). Shamanism in the context of Hmong resettlement In Hendricks GL, Downing BT, & Deinard AS (Eds), *The Hmong in Transition* (pp.337–348). Staten Island, NY: Center for Migration Studies.
- Livo NJ, & Cha D (1991). *Folk Stories of the Hmong: Peoples of Laos, Thailand, and Vietnam*. Libraries Unlimited.
- Lor MG (2017). *Hmong Community Perceptions on End of Life Care* (Master's thesis, California State University, Sacramento).
- Neuendorf KA (2002). *Content analysis guidebook*. Newbury Park, CA: Sage.
- Parker M, & Kiatoukaysy LN (1999). Culturally responsive health care: The example of the Hmong in America. *Journal of the American Association of Nurse Practitioners*, 11(12), 511–518.
- Patton M (1990). *Qualitative evaluation and research methods* (2nd ed.). Thousand Oaks, CA: Sage.
- Plotnikoff GA, Numrich C, Wu C, Yang D, & Xiong P (2002) Hmong Shamanism: Animist spiritual healing in Minnesota. *Minnesota Medicine*, 85(6), 29–34.
- Rairdan B, & Higgs ZR (1992). When your patient is a Hmong refugee. *The American Journal of Nursing*, 92(3), 52–55.
- Thorburn S, Kue J, Keon KL, Lo P (2012). Medical mistrust and discrimination in health care: A qualitative study of Hmong women and men. *Journal of Community Health*, 37(4), 822–829. doi: 10.1007/s10900-011-9516-x. [PubMed: 22116737]
- United States Census Bureau. (2016). 2015 American Community Survey 1-year estimates. Retrieved from <http://www.hmongstudiesjournal.org/uploads/4/5/8/7/4587788/2015hmongacsus.pdf>.
- Vang CY (2010). *Hmong America: reconstructing community in diaspora*. Urbana, IL: University of Illinois Press.

- Vang T (1998). Coming a full circle: Historical analysis of the Hmong church growth 1950–1998. Retrieved from ProQuest Dissertations and Thesis. 9918782.
- Vang T & Flores J (1999). The Hmong Americans: Identity, conflict, and opportunity. *Multicultural Perspectives*, 1(4), 9–14.
- Vawter DE, & Babbitt B (1997). Hospice care for terminally ill Hmong patients: A good cultural fit? *Minnesota Medicine*, 80(11), 42–44.
- Warner R (1995). *Backfire: The CIA's secret war in Laos and its links to the war in Vietnam*. New York: Simon & Schuster.
- Winland D (1992). The role of religious affiliation in refugee resettlement: The case of the Hmong. *Canadian Ethnic Studies*, 24(1), 96–120.
- Xiong P, Numrich C, Wu CY, Yang D, & Plotnikoff G (2005). Hmong shamanism: Animist spiritual healing in America's urban heartland. *Religion and healing in America*, 439–454.