

Healing and the Hmong: A Study of Cross-Cultural Issues in Healthcare Delivery

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Obtaining quality healthcare can be challenging for immigrant populations. Barriers to care affecting immigrant populations include language differences, lack of health insurance, and different cultural beliefs. A prime example visible in California is the Hmong community. Prior research on the Hmong, though limited in scope, confirm instances of these barriers at work. This leads to a lack of trust in Western medicine and lost opportunities for disease prevention and treatment. In extreme cases it has even lead to death. This Senior Research Project examines satisfaction with the healthcare system, utilization of health services, health beliefs and practices, and the medical encounters of Hmong students living in San Diego. The results demonstrate that in order to provide effective healthcare to immigrant populations, healthcare providers must be aware of and willing to work within that culture's schema in order to facilitate trust. This study includes surveys and interviews with Hmong students. The inclusion of dual control groups - students whose parents were born in the United States, and students whose parents immigrated but are not Hmong - enable distinction and separation of uniquely Hmong experiences from those of other immigrants and those of non-immigrants.

Keywords: cultural competency, Hmong, culture of biomedicine, healthcare disparities

Introduction

During the Vietnam War the Hmong in Laos fought with the United States against the communists. The reward for their efforts included being targeted for genocide by the victors. They fled Laos to refugee camps in Thailand, and from there many immigrated to the U.S. (Dibble et al, 1996: 155).

In coming to the U.S., the Hmong were not only attempting to save their lives but also to resist assimilation and preserve their ethnic identity (Fadiman, 1997: 183). This desire to maintain their traditions and familiar ways of life coupled with the vast technological differences between their native and adoptive homelands has led to an inevitable culture clash. Hmong

newcomers are known to have “poured water on electric stoves to extinguish them . . . washed rice in their toilets . . . eaten cat food . . . and hunted pigeons with crossbows in the streets of Philadelphia (Fadiman, 1997: 187-188).” Adjusting to their new homeland has not been easy for the Hmong. This is apparent in their interactions with the American medical system as well.

Traditional Hmong beliefs regarding the causation and appropriate treatment of disease differ greatly from those of the Occident. Western medicine is Cartesian, analytic, mechanistic, and reductionist. It separates the body from the mind, and regards the soul as either irrelevant or non-existent. It views disease causation at cellular and molecular level (Rose, 1982:79). It breaks down a system into component parts and studies how each operates. The emphasis is on what constitutes disease. Health is simply the absence of disease. Treatment is approached empirically, gathering data to identify what part of the whole is broken (Lindenbaum, 1993: 96-98). This model has considerable predictive value but is arguably limited when viewing complex systems as a whole.

Many Hmong on the other hand have a worldview which is animistic. Illness is commonly attributed to spiritual causes. An evil spirit is often the culprit. Or, one’s own misdeeds may offend, and provoke the departure of one’s own soul (Dibble et al, 1996: 165-166). Small wonder then, that the familiar and soothing chant of a shaman may be more reassuring than a sterile American medical hospital. Because these two views are so widely divergent, it is important for healthcare practitioners who service the Hmong to both become familiar with this worldview and to examine their own biases and beliefs in order to increase the quality of care and lessen cultural misunderstandings.

This study examines the Hmong experience with the American medical system. Surveys and interviews were employed to assess the health-related beliefs, practices, and experiences of

students and their families with the healthcare system. Inclusion of dual control groups enabled separation of immigrant from non-immigrant responses, and uniquely Hmong views from those of other immigrant populations. The study focuses on Hmong students, which is advantageous because it draws from the numerically dominant side of the age spectrum. A large proportion of the Hmong population is young: 60% of the Hmong living in the U.S. are under eighteen years of age (Foo, 2002: 150). Furthermore, this segment of the population may be presumed to have a reasonable understanding of both belief systems. The results of this study confirm the expected gulf in worldviews, and also show a different and inferior experience with the healthcare system. Heightened cultural awareness by health practitioners is needed to enhance the trust of immigrant populations in the medical system. This increased trust is prerequisite foundation for improved healthcare delivery and outcomes.

Culture and Medicine: A Literature Review

In anthropology, it is well known that one's worldview and perception of the causation of illness and disease is determined by culture. Every culture has a medical model, an assemblage of understandings and beliefs regarding sickness, health, and who can dispense healthcare under what circumstances. The increasing ethnic diversity of the general American population has sparked a growing awareness that healthcare delivery needs to be culturally competent, meaning that practitioners need to be able to "provide services that are perceived by clients as relevant to their problems and are helpful for intervention outcomes (Dana, 1993: 220)."

The Hmong and the U.S. Healthcare System

To date, research regarding cross cultural competency in the delivery of healthcare services has centered mainly on Latinos and African Americans and has given little notice to Asian populations. If Asians in general are underrepresented in the literature, research on specific Asian subgroups such as the Hmong is particularly sparse. The small base of Hmong-American literature focuses largely on education in the U.S. (Walker-Moffet, 1995), (Timm, 1994)., involvement in the Vietnam War (Pfaff, 1995), or the coping process associated with immigration (Chan, 1994).

The literature that does exist regarding health and the Hmong is presented predominately from an anthropological case study point of view rather than a public health or medical perspective. For example, research on the Hmong has addressed the high incidence of sleep paralysis in the community and its folk explanations (Adler, 1995), as well as Hmong beliefs regarding illness causation for specific conditions such as epilepsy (Fadiman, 1997), and measles (Henry, 1999). From this literature one can begin to piece together the worldview of the Hmong and get a general idea of the way that Hmong culture differs from mainstream American culture and therefore what potential misunderstandings could occur in health care situations.

Anne Fadiman's *The Spirit Catches You and You Fall Down*, is a particularly valuable albeit narrow exploration of the Hmong belief system and the need for cross cultural competency in healthcare. Focusing on a particular Hmong family the Lees, living in Merced, California, Fadiman documents the misunderstandings between them and the medical community which culminate in the Lee's epileptic daughter Lia becoming brain dead. In compiling the book she interviewed scholars and members of the medical establishment as well as the Hmong community. She describes Hmong customs, such as the belief that one must bury the placenta of

a newborn baby: when a person dies he will need it in order to reenter the spirit realm. This belief is significant in the realm of healthcare. The Hmong will request the placenta after giving birth. The need for cultural competency becomes readily apparent: most doctors refuse to give the placenta, mistakenly believing that the Hmong intend to eat it. Fadiman briefly acknowledges, but otherwise ignores the Western medical model. Tacitly assuming that its implications for cross-cultural care are well known and obvious, she focuses primarily on the Hmong worldview.

In a larger, but still relatively narrow investigation of the Hmong experience with the U.S. healthcare system, Rebecca Henry investigates a 1990 measles epidemic in St. Paul, Minnesota. Hmong comprised 4.2% of the population but disproportionately accounted for 46% of the cases of measles. Henry examined Hmong folk beliefs regarding the causation of illness and how this affects treatment and prevention. She found that Hmong beliefs regarding immunizations had prevented them from immunizing their children, who subsequently were infected during the outbreak. Henry does not address the issue of conflicting medical models at all, entirely satisfied with the validity of western thought, holding that educational outreach is perhaps the most efficacious approach to addressing the cultural gap.

The Western Paradigm

Explorations of the assumptions and structure of the Western medical model itself abound. In one genre, fringe practitioners necessarily exposit the western model as background for their alternative offerings. A prime example is Andrew Weil's "Eight Weeks to Optimal Health."

A second genre takes a more overtly scholarly and philosophical approach. Kassirer's "Learning Clinical Reasoning" describes the acculturation process that medical students

undergo in pursuit of their credentials. This includes a Cartesian view of human life in which the body is seen as being separate from the mind and soul.

There are scholars who dispute the notion of a uniform biomedical worldview among doctors. “Learning Medicine: The Construction of Medical Knowledge at Harvard Medical School,” is one such example (Lindenbaum et al, 1993). The authors posit that descriptions of a unified culture of biomedicine are too simplistic, citing as evidence prior research in which medical subspecialties such as surgeons were found to be culturally distinct from other physicians. But, while specifics of the biomedical model will certainly vary between individuals and subspecialties, the empirical, reductionist, and mechanistic backdrop remains. Ironically, the author’s participant-observation report negates his very premise. He reports on both the content of medical school lectures he attends as well as student reactions to the curriculum. A representative sample: “I’ve had some real perception changes of people . . . I’m good at tennis, say, or something else . . . I can’t help thinking of us as machines . . . there’s none of this individuality . . . it’s just whether or not you synapse quickly (Lindenbaum et al, 1993:96).”

In addition, multiple sociologists (Treacher, 1982) and (Andrews, 1997) have examined medicine and the U.S. health care system as being both social and cultural constructions. However, none of these examine the western medical model in the context of cross-cultural health care delivery.

Why Study the Hmong?

The Hmong comprise only small fraction of the U.S. population, but there are many numerically minor ethnicities in the country that cumulatively constitute a sizable population. Examining how to provide culturally sensitive care is important. Its lack leads to reduced

efficacy of prevention and treatment, and potentially to public health epidemics like that described by Henry. The Hmong are of local interest because of their concentration in California. According to the U.S. Census data for 2000, there are nearly 200,000 Hmong living in the U.S., 75,000 of which reside in California. Fresno is home to a concentrated nearly 23,000 Hmong.

Research Strategy: Tapping the Bi-Cultural Generation

In order to become acquainted with Hmong health beliefs and experiences with the U.S. healthcare system, I attended bi-weekly meetings and social events of the Hmong Student Association of San Diego, engaging in participant-observation. At these sessions I did not discuss healthcare issues except as explanation of my attendance. Rather, I spent time getting to know my target sample, fostering improved understanding of who they are as people, how their culture has defined their lives, what are their issues and concerns in general, and simultaneously gaining trust before probing with personal questions. Eventually, I then distributed surveys and conducted several in-depth interviews to elaborate and expand upon survey responses.

Dual control groups were used in order to determine what healthcare beliefs and experiences were distinctly the product of Hmong culture and the interaction with the U.S. healthcare system versus beliefs and experiences common across immigrant ethnicities versus what feelings and experiences regarding healthcare in the U.S. are independent of cultural origins. The control groups were comprised of students who (a) have parents who were born in the U.S., or (b) have immigrant but non-Hmong parents. All three groups were instructed to leave any questions they did not understand blank, and to put “non-applicable” for any they feel did not apply to them. In total I was able to collect thirty-one surveys: eleven surveys from the Hmong students, and ten from each control group.

Study Limitations

One limitation of the study is that sample size is small and the students were not randomly selected. Since access to Hmong students is limited, all who participated are members of the Hmong Student Association of San Diego. Likewise, students for the control groups were not chosen randomly, but rather from classes I am enrolled in. In all three groups, students were familiar with me and had seen me either at meetings or in class for at least a quarter. While this potentially yields results perhaps less generalizable than if the students were chosen at random, familiarity opened students to providing more honest and extensive answers than another type of study might permit. Another limitation to this study is that the Non-Hmong Immigrant group reported higher parental fluency in English than did the Hmong group. This may explain the higher satisfaction rate given for healthcare in group two than among the Hmong students. It also may imply more exposure to western culture before immigration generally which may not necessarily be true of all non-Hmong immigrants to the U.S. This could account for many of the response similarities between group one and group two, which the Hmong sample does not share.

Findings and Analysis

The survey began with a battery of questions intended as interpretive backdrop for the belief and health experience queries that follow. All three groups were similar in age, with Non-Hmong Immigrants and Hmong reporting similar lengths of stay in the U.S. by their immigrant families.

Table 1: Background of Participants					
Ethnicity					
Non-Immigrants n = 10		Non-Hmong Immigrants n = 10		Hmong n = 11	
Caucasian	80%	Hispanic	27%	Hmong	100%
Asian Pacific Islander	20%	Filipino	27%		
		Iranian	18%		
		Bolivian, Persian, and Indian each	9%		
Average Age					
22.4		21.5		19.4	
School Affiliation					
UCSD	90%	UCSD	80%	UCSD	41%
Miramar	10%	SDSU	10%	SDSU	41%
		CSUSM	10%	Miramar	9%
				Mesa	9%
Major					
Humanities and Fine Arts	18%	Humanities and Fine Arts	17%	Humanities and Fine Arts	36%
Natural Science, Math, and Engineering	0%	Natural Science, Math, and Engineering	25%	Natural Science, Math, and Engineering	45%
Social Sciences	73%	Social Sciences	58%	Social Sciences	9%
Undeclared	9%	Undeclared	0%	Undeclared	9%
Born in U.S.?					
Yes	90%	Yes	50%	Yes	64%
No	10%	No	50%	No	36%
(moved here at 2 wks old)		(ave age came to U.S. = 7)		(ave age came to U.S. = 3)	
Parents born in U.S.?					
Yes	100%	Yes	0%	Yes	0%
No	0%	No	100%	No	100%
		(ave. # of years in U.S. = 22)		(ave. # of years in U.S. = 19)	
Parent's level of English when first arrived?					
N/A		No English	9%	No English	67%
		Limited English	36%	Limited English	33%
		Adequate English	27%	Adequate English	0%
		Fluent English	18%	Fluent English	0%
		Blank	9%		
Is parent's view of the healthcare system different from yours?					
Yes	10%	Yes	20%	Yes	27%
No	70%	No	70%	No	64%
Unsure	20%	Unsure	10%	Unsure	9%

As noted earlier, one key difference between the Non-Hmong Immigrant group and the Hmong students is that the former reported higher English fluency rates upon arrival in the U.S. This may have some bearing on the results as it implies previous exposure to Western culture.

Also noteworthy is that a large majority of each group reported the belief that their parents viewed the healthcare system similarly to themselves. This means that for questions in which students are asked to report on their families' beliefs or experiences, the students' individual beliefs or perception of the events is plausibly representative of the viewpoint of their entire family.

Nearly half of the Hmong students are Natural Science, Math, or Engineering majors. One might suppose that an affinity for the quantitative sciences might increase the tendency to view health from a biomedical perspective. But the influence of shamanism and the worldview it entails appears to remain a strong influence in many of these students' lives.

The core of the data from the surveys and interviews has been arranged into six categories: healthcare satisfaction, utilization of health services, health beliefs, health practices, and generational differences in order to be further examined and discussed.

Healthcare Satisfaction

The literature has pointed to both language and cultural barriers as impediments to quality care for Hmong refugees and their families. Therefore, one question asked students to rate the quality of care that they and their families have received.

Table 2: Level of satisfaction with the healthcare system					
Non-Immigrants n = 10		Non-Hmong Immigrants n = 10		Hmong n = 11	
Poor	0%	Poor	20%	Poor	0%
Fair	10%	Fair	10%	Fair	73%
Good	70%	Good	40%	Good	9%
Excellent	20%	Excellent	20%	Excellent	9%
		Blank	10%	Unsure	9%
Good and Excellent = 90%		Good and Excellent = 60%		Good and Excellent = 18%	

Hmong students rated the quality of care much less favorably than the control groups. This implies heightened linguistic and/or cultural barriers for this population.

This finding was also reflected in the interviews. Several students described medical experiences that they and their families have had which were far from ideal or even adequate. A particularly moving example was given by Pa Lee. When Pa's family had been living in the U.S. for several years her younger brother became ill. Her parents, naturally concerned, took her brother to the hospital. After several tests, the doctor informed the family that he wanted to have their child sent to a specialist in San Francisco for surgery. While Pa is uncertain what the translation situation was in this encounter, she asserts that her parents came away understanding only that that the doctor wanted to have a hole drilled in their son's head for reasons unknown to them. Afraid that the surgery would hurt more than help or even possibly cause retardation, her parents took her brother from the hospital and began to drive back home. The doctor apparently thought the situation grave, and had the police chase her family home and demand that they return the child to the hospital. Her parents, under legal threat, brought the child back. He was then transferred to a hospital in San Francisco. Pa's family arrived in San Francisco feeling stressed, hopeless, and powerless. Upon arrival it was made known that they were under surveillance, and that the child was not to be taken from the premises. After several weeks of extensive testing, the doctor decided that the surgery was not required and the Lees returned home with their son. Today he is in good health, but the family remains ignorant as to why the surgery was thought necessary (Lee, 1/29/03).

Both linguistic and cultural barriers figure into this story. There was an obvious lack of communication between the doctor and Pa's family, aggravated by the fact that Pa's parents spoke limited English and by the lack of a trained translator. In addition, less obvious cultural

factors heavily influenced this encounter. Reincarnation looms large in the Hmong worldview. Both one's actions and things that happen to the body in this life may affect its physical state in the next. If one makes fun of a handicapped person, he may suffer that very affliction in his next life (Lee, 1/29/03). Likewise, things which alter the body's physique such as surgery may make the person incomplete or disfigured in the next life (Fadiman, 1997: 33) Because of this belief, parents often delay surgery if the illness is not life threatening until the child is old enough to make the decision for themselves. This point was reinforced later in the interview when Pa mentioned her parents waited until she was eighteen to have surgery done on her eardrum, which had been filling up with fluid. Her parents, concerned about repercussions in the hereafter, deferred the decision until she could make her own choice (Lee, 1/29/03). In treating Hmong patients, doctor awareness of their heightened concerns about invasive procedures can be valuable both in communicating the situation and also in selecting the most palatable treatment regime in cases where options exist.

Utilization of Health Services

In examining utilization of health services, one must consider whether choices in healthcare are being made because of financial accessibility to particular types of service. If insurance coverage is a metric of accessibility, Table 3 suggests only minor differences between the Hmong and the control groups, the Hmong being at a slight disadvantage.

Table 3: Health Insurance					
Currently have health insurance?					
Non-Immigrants n = 10		Non-Hmong Immigrants n = 10		Hmong n = 11	
Yes	100%	Yes	100%	Yes	82%
No	0%	No	0%	No	18%
Have you or a family member ever been uninsured?					
Yes	20%	Yes	30%	Yes	36%
No	80%	No	70%	No	36%
				Unsure	27%

Those interviewed reported that a lack of access based on finances had never been a problem for them personally, though it had been for others in their family. One student reported that although his family currently has health insurance, he felt that his father might see a doctor more frequently if the co-payments and additional costs were less burdensome (Vang, 1/27/03). Another felt that her immediate family, who are insured through her mother's employer's program receive better care than members of her extended family. Her grandfather, for example, is uninsured (Vue, 1/27/03). In summary then, although economic constraints do not appear to have undue impact on Hmong decisions to visit a healthcare practitioner it may still have some bearing, and is an area meriting further exploration. That said, it is important to note that access to western medical care did not necessarily result in a decreased use of herbs, blessings, or shamanic rituals (see Table 9). This implies that the Hmong use of shaman or herbs is not merely a financially imposed substitute for other forms of care.

Also of interest were the varieties of health practitioners consulted. Respondents were asked to circle all that apply.

Table 4: What types of healthcare practitioners do you and your family visit?					
Non-Immigrants n = 10		Non-Hmong Immigrants n = 10		Hmong n = 11	
Acupuncturist	10%	Acupuncturist	10%	Acupuncturist	0%
Chiropractor	10%	Chiropractor	20%	Chiropractor	45%
Dentist	100%	Dentist	100%	Dentist	100%
Doctor	100%	Doctor	100%	Doctor	100%
Herbalist	0%	Herbalist	10%	Herbalist	18%
Masseuse	20%	Masseuse	20%	Masseuse	0%
Nurse – Practitioner	50%	Nurse – Practitioner	50%	Nurse – Practitioner	18%
Nutritionist	10%	Nutritionist	0%	Nutritionist	9%
Optometrist	70%	Optometrist	80%	Optometrist	54%
Psychologist	50%	Psychologist	10%	Psychologist	0%
Shaman	0%	Shaman	0%	Shaman	82%
Other: Physical Therapist	10%	Other: None Listed		Other: Orthodontist	9%

The use of doctors and dentists was universal. Psychological treatment was common among Non-Immigrants, rare among Non-Hmong Immigrants, and entirely absent among the Hmong, suggesting a cultural rift between immigrants generally and non-immigrants on the acceptability and/or merit of such treatments. Also noteworthy is that a large majority of Hmong students reported that they and their families visit shamans, a practice entirely absent in the other groups, and a clear indicator that the majority of these students and their families have a more spiritual view of illness. This was confirmed in the interviews: “shamanism is our religion and our beliefs have a lot to do with the spirit” (Vue, 1/27/03).

Table 5: Treatment of chronic illness					
Has anyone in your family been diagnosed with a chronic illness?					
Non-Immigrants n = 10		Non-Hmong Immigrants n = 10		Hmong n = 11	
Yes	60%	Yes	60%	Yes	55%
No	40%	No	40%	No	45%
Is anyone else besides a doctor consulted to cure or manage the disease or its symptoms?					
Yes	33%	Yes		Yes	67%
No	67%	No	66%	No	17%
		Blank	34%	Blank	17%
Who?					
Acupuncturist (1) Herbalist (1)				Shaman (3) Herbalist (2)	

In the treatment of chronic illness, over two thirds of the Hmong reported seeking treatment beyond and in addition to a doctor's services. Only half of the Non-Immigrant group sought additional help and none from the Non-Hmong Immigrant group. This suggests a form of medical pluralism in the Hmong community, on the one hand recognizing that there are occasions where it is important to see a doctor, but at the same time believing that treatment to be insufficient or incomplete. One interviewee described an instance when her aunt had been diagnosed with breast cancer. While both the aunt and her family felt that it was necessary to undergo the prescribed surgery, she also elicited the help and guidance of a shaman in Minnesota for post-op treatment. She had contacted the shaman because she had prolonged swelling around the scar tissue. He blessed some water and sent it to her to apply to the area (Lee, 1/29/03). Thus, use of one medical system does not necessarily preclude the use of the other, and many of the Hmong adhere to a mix of Western medicine and shamanism.

Health Beliefs

One key objective of the survey was to assess and compare beliefs regarding disease causation by students in the various groups. Students were given a list of potential causes and asked to circle all that they or their family felt could lead to disease and were further instructed to add any other causes not included on the list. From this measure one can gauge the sources and frequency of misunderstandings between health practitioners and their patients.

Table 6: According to your family background what types of things can cause illness or disease?					
Non-Immigrants n = 10		Non-Hmong Immigrants n = 10		Hmong n = 11	
Being out of Balance	30%	Being out of Balance	10%	Being out of Balance	9%
Character Flaws	20%	Character Flaws	20%	Character Flaws	0%
Exposure to Chemicals	50%	Exposure to Chemicals	30%	Exposure to Chemicals	27%
Fright	20%	Fright	0%	Fright	27%
Genetic Predisposition	70%	Genetic Predisposition	40%	Genetic Predisposition	9%
Germs	60%	Germs	70%	Germs	36%
Lack of Exercise	70%	Lack of Exercise	40%	Lack of Exercise	36%
Poor Nutrition	80%	Poor Nutrition	80%	Poor Nutrition	82%
Spirits	10%	Spirits	10%	Spirits	72%
Stress	80%	Stress	60%	Stress	54%
Strong Emotions	30%	Strong Emotions	20%	Strong Emotions	18%
Causes not listed on survey but written in:					
Depression	10%	None written in		Bad actions towards others	9%
				Having too much	9%
				Headaches	9%
				Karma	9%
				Loss of Energy	9%
				Unbalanced appetite	9%

Poor nutrition ascribed as a cause of disease was cited most often and to the same degree by all groups. Germs also ranked high for Non-Immigrants and Non-Hmong Immigrants, but surprisingly only half as high among the science-major dominated Hmong. Conversely, spirits were cited by a strong majority of Hmong, but rarely mentioned by the others. This tendency to see disease and illness as having a spiritual component again demonstrates the influence of shamanism.

It is evident from Table 6 that while the Hmong attribute illness to a wide range of causes, the most common are poor nutrition and spirits. A subtlety that emerged during the interviews is that “poor nutrition” was being interpreted in multiple ways, some familiar to the American notion of good nutrition, and some entirely foreign. Of the former, one subject was suffering from a cold, and mentioned eating more fruits and vegetables than usual as a countermeasure (Vue, 1/27/03). Of the latter, another explained that there are special diets one must follow when menstruating, after giving birth, during pregnancy, or after an injury to prevent scars. A menstruating woman

should avoid the ingestion of cold liquids and foods. After giving birth a woman should consume only warm foods: chicken, rice, warm water. During pregnancy she should avoid ginger lest her child be born deformed. Meat should be avoided while cuts are healing as it is thought to promote scarring (1/29/03).

Soul loss or the actions of one’s spirit are also seen as a primary cause of sickness. “If your spirit is unhappy with things you are doing than it can leave your body – soul loss” (Vue, 1/27/02). According to shamanic belief, most sickness is due to soul loss. Souls can depart in response to overt behaviors and also can be driven out by stress (Vue, 1/27/03) or fright (Vang, 1/27/03). This condition will not heal on its own and if untreated may lead to death (Vue, 1/27/03). Treatment entails a soul calling ceremony. The shaman goes into a trance, and inquires of the spirits why the soul left or why the soul is causing this illness (Lee, 1/29/03).

Cultural beliefs are also a factor in the decision to not utilize a specific type of practitioner or different health services as seen in Table 7.

Table 7: Have family’s beliefs ever prevented anyone from seeing a health practitioner?					
Group 1 – Parents Born in U.S. n = 10		Group 2 – Parents Immigrated n = 10		Group 3 – Hmong n = 11	
Yes	0%	Yes	30%	Yes	27%
No	100%	No	70%	No	73%
Table 7 cont:					
Why?					
		Listed: Parents didn’t want her to see a psychologist (1), Didn’t think that families problems were serious enough to go (1)		Listed: Feel best way to deal with mental illness is through shamanic rituals (1), Heal through shaman if feel doctor won’t be effective (1)	

Both Hmong and Non-Hmong Immigrant survey respondents reported a belief system distrustful of psychology. The interview results, in fact, suggest a larger distrust than the survey results indicate. Those I interviewed had stated on the survey that family beliefs had not

prevented anyone in their families from visiting any type of health practitioner. When questioned in person, all said that either their parents were not aware of the existence of mental disorders or that going to a psychologist was looked down upon and discouraged because it implied that you were insane. One confided in regards to depression that “. . . in our culture it’s not acceptable to be that way or to have that in your life. And so you don’t talk to your parents about it and sometimes it doesn’t get healed” (Vue, 1/27/03). The Hmong surveys and interviews added that shamanic rituals were the treatment of choice for mental illness and even stress. Since Non-Hmong Immigrants were not interviewed, it remains unclear what sort of treatment they might utilize instead of psychologists, and if that bears any similarity to the Hmong.

Previous studies on the Hmong have noted that immunizations are an aspect of health delivery which has been fraught with cultural misunderstandings, with devastating impact on public health.

Table 8: Immunizations					
Were you immunized as a child?					
Group 1 – Parents Born in U.S. n = 10		Group 2 – Parents Immigrated n = 10		Group 3 – Hmong n = 11	
Yes	90%	Yes	90%	Yes	100%
Unsure	10%	Blank	10%		
How did your parents feel about this?					
Didn’t want to	0%	Didn’t want to	0%	Didn’t want to	9%
Uneasy	0%	Uneasy	0%	Uneasy	18%
Neutral	0%	Neutral	0%	Neutral	18%
Felt positively	50%	Felt positively	45%	Felt positively	18%
Felt it was very important	30%	Felt it was very important	55%	Felt it was very important	27%
Unsure	20%	Unsure	0%	Unsure	9%
Totals					
Felt positively or that it was important = 80%		Felt positively or that it was important = 100%		Felt positively or that it was important = 45%	
Didn’t want to or felt uneasy = 0%		Didn’t want to or felt uneasy = 0%		Didn’t want to or felt uneasy = 27%	

The Hmong sample here differs from that reported by Henry: in this sample all have been immunized. Yet less than half felt positively about it or that it was important while the control

groups unanimously felt it important. The interviews reconfirmed this result: several of the Hmong students mentioned that their parents worried that immunization would hurt them. One confided that her parents had that view, and this was confirmed in their eyes when after being given the tuberculosis skin test her younger brother had an adverse reaction. In a TB test, a person's skin becomes red and swollen at the spot administered in the case of a positive (tuberculosis present) result. This occurred with her brother. When the worried parents returned with the boy, the doctor the doctor announced that "there is something wrong with your son," and prescribed a large amount of medicine. Neither the doctor nor the person who had administered the test had adequately explained the purpose of the test and ways in which their son might respond. So, while Henry points to cultural explanations for avoiding immunizations, in this particular instance at least it seems as though a general lack of communication and understanding is the larger issue.

Health Practices

Students were asked if their families used home remedies or practices instead of or in addition to consulting a healthcare practitioner or using pharmaceuticals. They were given examples which included prayer/blessings, use of special foods, and use of objects to heal. Students were asked to specifically describe any home remedies or practices they or their family used and what those listed were used for. High percentages of all groups acknowledged the use of home remedies and practices. However, the type of home remedies and practices utilized by the Hmong sample differed substantially from that of the other two. Hmong were more inclined to make use of objects such as stones or silver bars, use herbal remedies in addition to pharmaceuticals, and engage in a shamanic ritual in order to treat illness.

Table 9: Home Remedies and Practices					
Group 1 – Parents Born in US n = 10		Group 2 – Parents Immigrated n = 10		Group 3 – Hmong n = 11	
Does your family ever use home remedies or practices instead or in addition to consulting a healthcare practitioner or using pharmaceuticals?					
Yes	80%	Yes	80%	Yes	100%
No	20%	No	10%	No	0%
		Blank	10%		
What Types?					
Herbs	30%	Herbal Oils	10%	Herbs	45%
Objects	10%	Objects	0%	Objects	45%
Prayer/Blessings	20%	Prayer/Blessings	20%	Prayer/Blessings	36%
Rest	10%	Rest	10%	Rest	0%
Shamanic Ritual	0%	Shamanic Ritual	0%	Shamanic Ritual	45%
Special Foods/Diet	10%	Special Foods/Diet	30%	Special Foods/Diet	27%
Listed: blessings, chicken soup, cold rags, Echinacea, ginger ale, hot pads, jell-o, prayer, rest, vitamins		Listed: chicken soup, egg-milk-henna mixture, herbal oils, porridge, powder, prayer, rest, sugar water, white rice with yogurt		Listed: acupuncture, animal sacrifice, call spirits, egg with coin, herbs, incense, prayer/blessings, rice pudding, shamanic rituals, silver bars, special diet, stones, suction techniques, sweat rooms	

For a variety of ailments, Hmong students cited greater confidence in the efficacy of home remedies than in western medicine. Most of the herbs used are shipped from Laos and Thailand, but some are bought from Mexico, found locally, or are available in Chinese medicine shops (Vue, 1/27/03), (Lee, 1/29/03). The herb lore itself is apparently the domain of the parents: all students questioned reported ignorance of types of herbs used, but confidence that they really worked. One version: “My mom just makes them and we drink them. All I know is that they smell really bad, I have to cover my nose and drink them like that . . . but they work really well, they really do” (Vue, 1/27/03). Home remedies appear to be the first line of defense. Failing there, a doctor and possibly a shaman would be contacted.

Generational Differences in Health Beliefs and Utilization of Health Services

From both the surveys and the interview data it becomes clear that there is a difference between the generations on the necessity and efficacy of western medicine. Although the majority of Hmong students felt that they and their parents view the healthcare system in the same way (see Table 1), those who did not stated that they had more faith in the U.S. medical system than did their parents. Parents and grandparents of the students were more likely to view western medicine as supplemental, possibly helpful but not sufficient to the cure of disease. To rid the body of illness it was first necessary to address the spiritual issues. Visiting a doctor is the avenue of last resort.

The students' view towards western medicine appears to be more complicated. In the survey, half of the students reported feeling most comfortable with a doctor and a third said they felt most comfortable with a shaman. On the one hand a majority of the students were science majors and are therefore are likely to be as versed in western ideas regarding disease causation as any of the others included in the sample. One remarked "I just totally believe in the healthcare system, because you know, biology – who can doubt that, right?" (Lee, 1/29/03). However shamanism and cultural beliefs have also had an influence on their lives and understanding of illness as is evidenced by the fact that they listed germs and genetic predisposition significantly less often than the control groups and listed spirits much more often (see Table 6).

This discrepancy resurfaced in interviews. One student had indicated on the survey that she felt comfortable with doctors yet in the interview remarked that she was "anti-hospital and anti-doctor" (Vue, 1/27/03). The medical beliefs of the younger generation then appear to be conflicted at times. Home remedies before seeing any sort of practitioner, and then visiting a doctor or shaman or both depending on the situation seems to be the norm. The students

definitely feel that shamanic rituals can heal – but unlike their parents they do not feel that it applies to every illness (Lee, 1/27/03). The students also believe that western medicine has something to offer but this is mixed with a feeling of distrust that practitioners do not share all necessary information with them and may treat them differently based on their economic status or cultural beliefs.

A Trust Deficit

A lingering legacy of these miscommunications is a culture of mistrust passed down through the generations. One student described how her family felt about the care her grandmother had received in the hospital before passing away. “My mom just thought that for some reason they don’t want to help Asian people because we are poor. And she said that the doctors could have helped my grandmother more, but they didn’t and that’s why she died. My mother blames the doctors and she says that if someone else in our family is sick, like my grandfather, she will not take them to the hospital. She doesn’t want them to do to him what they did to my grandma” (Vue, 1/27/03). She goes on to say that “I think that that’s just the impression that our parents have put upon us and that we are going to put upon our kids. You know, to be anti-hospital.” This response was more typical than unique. Another remarked of her grandfather’s death “I think the doctors knew he was diabetic, but they never really treated him . . . I don’t really understand why they didn’t treat him” (Lee, 1/29/03). The cultural, linguistic, and economic barriers to care faced by these students family’s as refugees to the U.S. have had and will continue to have an impact on multiple generations to come. Essential to establishing future trust is to actively work to dissipate these barriers by providing better care to early generation immigrant populations.

Conclusion

Hmong students and their families views of health and illness must be viewed in the context of shamanic beliefs and practice. Their worldview is one which gives primacy to the spiritual world in disease causation, although also stressing the importance of proper nutrition. Many Hmong use home remedies and/or shamanic rituals in addition to or instead of visiting a doctor or using pharmaceuticals. This is a group of immigrants who have made great strides in overcoming cultural barriers in their new homeland but unfortunately disparities in healthcare delivery still exist for this population. Whereas the majority of both Non-Immigrants and Non-Hmong Immigrants felt that the quality of healthcare they have received has been good or excellent, three fourths of the Hmong rate the quality of care they have received only as fair. Very few rate it as good or excellent. Broad extrapolation from such a small sample is precarious, but the clear suggestion here is that healthcare in California is not culturally competent.

As previously noted, western physicians and surgeons have a distinct set of shared models about the nature and causes of disease, and aspiring doctors must first pass through the intense medical school curriculum acculturation process to gain their credentials. This fundamentally shapes the way that the body and disease are viewed, i.e., the pathology-based anatomical tradition which sees disease as an incursion of competing foreign life forms (bacteria, viruses) or biochemical imbalance or malfunction. Judged by overall results, the merit and potency of this approach is undeniable. However, psychology and psychiatry have also clearly established that mechanistic reductionist medicine is neither the sole nor universally superior approach to health dysfunctions. People are more than “hardware.” We include complex “software” as well and to perform their duties optimally, our “technicians” need to consider the whole. Numerous medical

and psychological studies have established the efficacy of a strong social support system, positive attitude, faith, laughter, and the like as complements to established medical practice. In the case of the Hmong, physicians need to be aware of and accommodating of the fact that those supporting health benefits derive from profoundly different cultural practices: shamanism and the like. Moreover, a lack of cultural sensitivity in physicians is likely to repulse Hmong clients, and lead them to seek treatment elsewhere even for conditions for which traditional western medicine is optimally effective.

While it is impractical to expect physicians to understand the cultural nuances of the many possible immigrant nationalities they may be called upon to serve, it is important that they be aware of just how deep and profound the gaps can be. The Hmong serve as a prime example, illustrating important deviations from western biomedicine in their views on disease causation, medicinal remedies, nutrition, and the roles of practitioners of healing arts. Understanding even just the possible kinds of gaps in worldviews is a big first step in delivering culturally competent care.

Avenues for Future Research

The results of this small probe of the Hmong in Occidental healthcare systems suggest the need for further research on multiple vectors. Deeper investigations of actual treatment outcomes when Hmong shamanistic ritual is/is not employed in tandem with western medicine would be useful in motivating and guiding specific approaches to culturally sensitive treatment. On a different vein, studies similar to this work for other by passed minority groups would help in developing general multicultural approaches to health delivery. In modern American society, the

rapid technological advance of medicine juxtaposed with the similarly rapid ethnic diversification of the population makes cross-cultural medicine a field ripe for research.

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