Use of Traditional Health Practices by Southeast Asian Refugees in a Primary Care Clinic

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To determine the prevalence of use of traditional health practices among different ethnic groups of Southeast Asian refugees after their arrival in the United States, we conducted a convenience sample of 80 Cambodian, Lao, Mien, and ethnic Chinese patients (20 each) attending the University of Washington Refugee Clinic for a new or follow-up visit. Interpreters administered a questionnaire that dealt with demographics, medical complaints, traditional health practices, health beliefs, and attitudes toward Western practitioners. In all, 46 (58%) patients had used one or more traditional health practices, but the prevalence varied by ethnic group. Coining and massage were used by all groups except the Mien, whereas moxibustion and healing ceremonies were performed almost exclusively by the Mien. Traditional health practices were used for a variety of symptoms and, in 78% of reported uses, patients reported alleviation of symptoms.

The use of traditional health practices is common among Southeast Asian refugees. Clinicians who care for this population should be aware of these practices because they may supersede treatments prescribed by physicians or leave cutaneous stigmata that may be confused with disease or physical abuse. Good patient care may necessitate the use or tolerance of both Western and traditional modalities in many Southeast Asian refugees.

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Over a million Southeast Asian refugees of at least five major ethnic groups live in the United States today, and over 4,000 more arrive each month from the war-ravaged countries of Vietnam, Cambodia, and Laos (Robert Johnson, International Rescue Committee, oral communication, August 1990). In many Western countries, these distinct ethnic groups are often assumed to represent a single culture or population. Members of these groups are distinguished, however, by factors such as nationality, language, and religion. Values, practices, and norms in these cultures also may differ greatly from each other and from those in Western society. Knowledge about these differences is of particular importance in medicine, where patients' medical beliefs and health practices can result in inappropriate or inadequate treatment. We surveyed Cambodian, Lao, Mien, and ethnic Chinese refugees attending a primary care clinic to learn more about cultural differences in medical beliefs and health practices.

Patients and Methods

Setting

The University of Washington Refugee Clinic is located at Harborview Medical Center, one of the four major teaching hospitals affiliated with the University of Washington School of Medicine. This general internal medicine clinic was established in 1982 to meet the needs of the rapidly growing Southeast Asian refugee population in the Seattle area. Approximately 4,000 clinic visits are made annually, and over 70% of the patients are Cambodian. The staff employs 12 medical interpreters who speak 13 languages. All interpreters finish a one-year community health advocate program designed to train clinical assistants.

Patients

A convenience sample of 20 patients in each of four ethnic groups—Cambodian, Lao, Mien, and ethnic Chinese (10 from Vietnam and 10 from Cambodia)—were interviewed by interpreters during a routine visit. Although not representative of the clinic's population in its ethnic distribution, this sampling strategy of interviewing unselected patients ensured adequate representation of each ethnic group and enhanced our ability to detect differences among them.

The Cambodian, Vietnamese, and Lao refugees had spent time, often years, in camps on the border of Thailand waiting for permission to emigrate. Most refugees from Cambodia and Vietnam are ethnic Khmer or Vietnamese; the minority, ethnic Chinese, are generally better educated and primarily urban. Both groups, as well as the Lao, place a high value on family and adherence to Buddhist principles. Unlike the lowland Lao, the Mien are a tribal people with a distinctly separate culture; they live in scattered villages in the mountainous regions of Laos. Their religion is a mixture of ancestor worship, animism, and Buddhism.[1]

The interpreters collected information on demographics, current medical complaints, medical beliefs, use of specific traditional health practices for current and past medical problems, and attitudes toward Western practitioners. This information was collected using a questionnaire that contained both structured and open-ended questions.* After receiving individualized instruction in its administration, the inter-

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preters translated and administered the questionnaire. Patients were asked if they had used any of 21 traditional Southeast Asian health practices we could identify through a review of the literature and interviews with interpreters and a medical anthropologist. For each traditional practice reported, we collected more specific information on how it was performed and by whom, for what problem it was used, and whether it helped. The patient's physician was not present during the interview. Written informed consent was obtained from all patients. Comparisons between populations were tested with the χ^2 statistic.

Description of Selected Traditional Health Practices

Coining is done by lubricating the skin or a coin and then stroking the skin firmly, usually on the torso or extremities, with the edge of the coin, resulting in parallel ecchymotic streaks (Figure 1). *Pinching* uses the same principle, but pressure is applied by pinching the skin between the thumb and index finger to the point of producing a contusion. *Cupping* is performed by placing a small, heated cup on the skin, usually on the forehead or abdomen, and allowing it to cool. This results in negative pressure, which causes a circular ecchymotic area to appear (Figure 2). *Moxibustion* consists of making small, circular, superficial burns, usually on the torso, head, or neck, by touching the skin with burning incense or by igniting a combustible material placed on the skin. Moxibustion may be used with *acupuncture,* which involves placing acupuncture needles over strategic points along energy "meridians" (Figure 3). Using *medicated paper* involves placing small pieces of paper on the skin, often directly over a symptomatic area; the pieces of paper are soaked in an aromatic oil. *Healing ceremonies* are done by a shaman or traditional healer, who performs rituals that may be directed at illness sources such as spirits, ancestors, "wind," and the patient's soul.

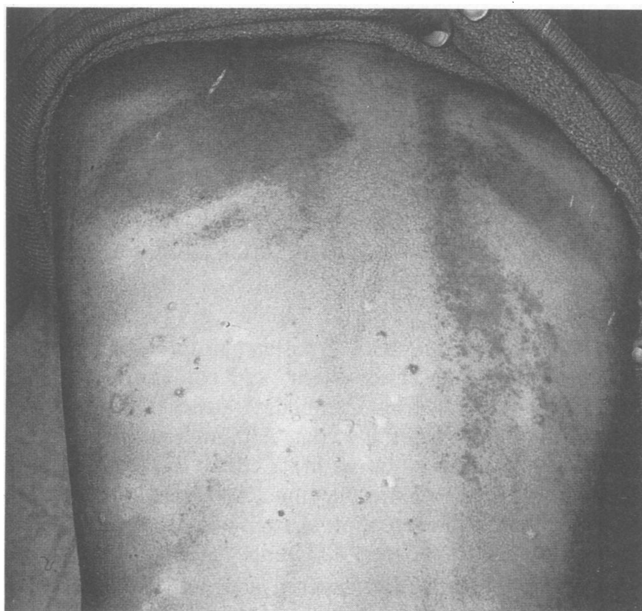


Figure 1.—Parallel ecchymoses visible on the skin are the result of coining, in which the skin is stroked firmly with the edge of a lubricated coin.

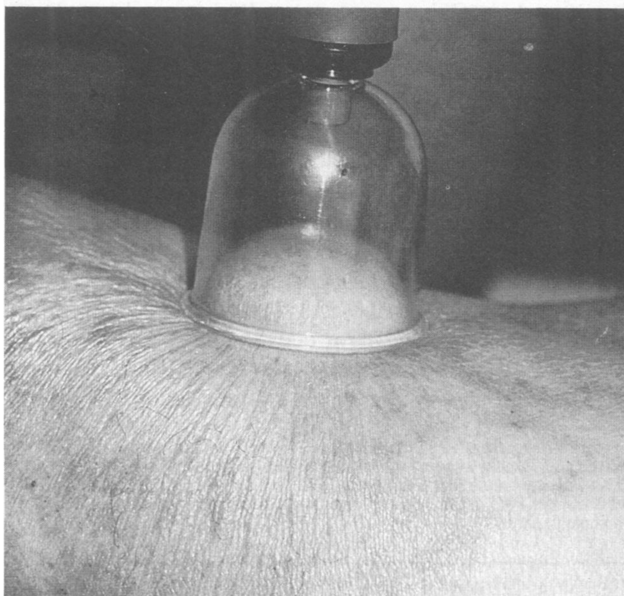
Results

Patient Characteristics

Characteristics of the study patients are shown in Table 1. The Mien patients were the oldest, and the Cambodian group had the highest proportion of females. Almost half the patients had been in the United States for more than five years, whereas 20% had resided here for less than a year. Of those surveyed, 24% of the men and 2% of the women were employed outside the home.

Reported Symptoms, Beliefs, and Behaviors

Patients reported a variety of symptoms, health beliefs, and behaviors. The most common chief complaints at the study visit were joint pain (15%), headache (13%), gastrointestinal complaints (11%), back pain (10%), and chest pain (9%). There was no correlation between specific symptoms and ethnic background. The cause of their illness was not known by 64% of the patients. In all, 20% of Chinese, 30% of Lao, 40% of Cambodian, and 45% of Mien patients had previously seen other physicians outside the refugee clinic for their chief complaint. Western medicines not prescribed



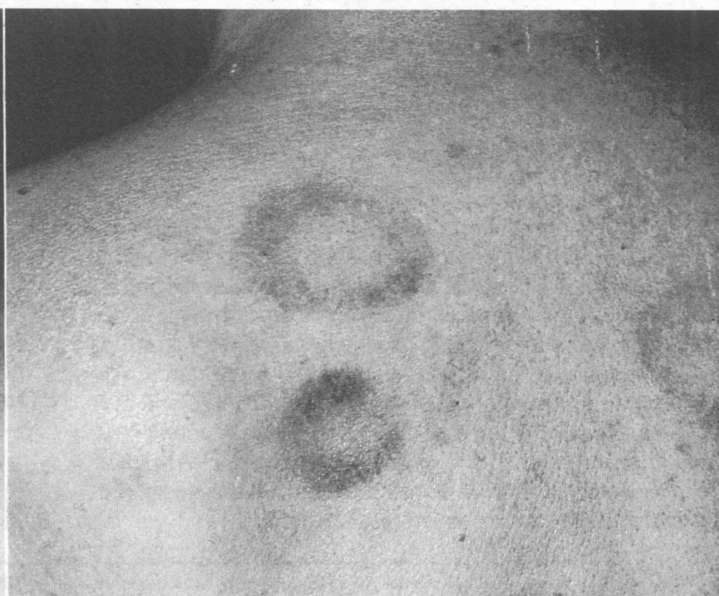


Figure 2.—In cupping, a small cup is heated and applied to the skin, causing negative pressure as it cools **(left)** that results in circular ecchymoses on the skin **(right)**.

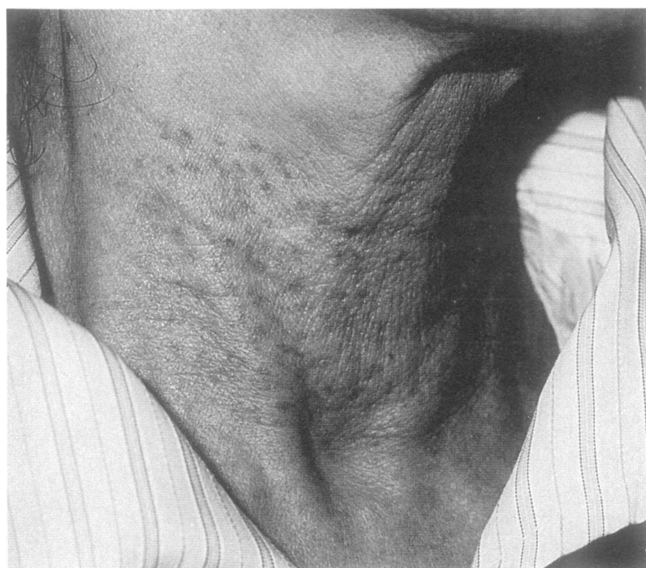


Figure 3.—Acupuncture involves inserting needles into the skin at strategic points, called energy meridians, in this patient leaving small, pinpoint-sized marks on the skin.

by a clinic physician were being taken by 10% of Cambodian, 15% of Chinese, 20% of Lao, and 30% of Mien patients. In addition, 80% of Mien, 60% of Lao, 40% of Chinese, and 25% of Cambodian patients stated a belief that they would be cured by a refugee clinic physician.

Use of Traditional Health Practices

Of the 80 patients, 46 (58%) had used one or more traditional health practices since arriving in the United States, but the prevalence of use varied greatly among the ethnic groups (Table 2). Women were more likely to report using traditional health practices than men overall (69% compared with 39%, $P<.01$) and within each ethnic group (Lao 18% versus 0%, Cambodian 96% versus 50%, Chinese 64% versus 44%, and Mien 91% versus 67%). The use of these practices was greater in patients from rural areas than in those from towns or cities (81% versus 36%, $P<.001$). The prevalence of use of traditional health practices was not associated with the duration of residence in the United States.

Types of Traditional Health Practices

Coining was the most commonly used traditional health practice among the Cambodians (70%), the Chinese (35%), and the Lao (10%); however, this practice was not reported by the Mien (Table 2). Similarly, massage was used by all groups except the Mien. Coining and massage were the only practices reported by the Lao. Cupping was used commonly by the Cambodians and the Mien but not the other two groups. Moxibustion and healing ceremonies were used almost exclusively by the Mien.

Each of the commonly used traditional health practices was used for a wide variety of symptoms (Table 3). Practices identified by our staff or described in the literature but not reported by our patients included the use of tattoos, holy water, hair cutting, talismans, and steam inhalation.[2-4]

Patients reported that a traditional health practice definitely alleviated their problem in 62 (78%) of 83 reported uses. In only four reported uses were practices entirely unsuccessful in providing relief, and in 14 they were helpful only under certain conditions, such as if the problem was perceived as spiritual. Moxibustion, healing ceremonies, and cupping were least likely to be reported as unqualified successes; only 5 of 11 uses of moxibustion, 3 of 14 uses of healing ceremonies, and 1 of 9 uses of cupping were reported to be entirely successful.

Discussion

Traditional health practices are used commonly by Southeast Asian refugees, including those who have resided in the United States for many years. We documented substantial differences in the prevalence of use of these practices among ethnic groups and between sexes within these groups. The reasons for these differences remain unclear but probably reflect differences in the sophistication of medical knowledge. Populations with a low prevalence of use of traditional health practices may have greater exposure to, and therefore greater acceptance of, Western medical principles. In the case of the Mien, the higher use, particularly for healing ceremonies, may reflect the older age of this population.

There have been few studies examining the use of traditional health practices among Southeast Asian refugees in the United States. Our results are consistent with earlier obser-

TABLE 1.—*Patient Characteristics by Ethnic Group*

Characteristic	*Cambodian*	*Lao*	*Mien*	*Ethnic Chinese*	*Total*
No. enrolled	20	20	20	20	80
Mean age, yr	46	45	57	47	49
Age, %					
18-39 yrs	40	45	10	30	31
40-59 yrs	50	40	40	60	48
>60 yrs	10	15	50	10	21
Female, %	80	55	55	55	61
Residence in native country, %					
Large city	10	70	5	80	41
Town	20	10	5	15	13
Village	70	20	90	5	46
Buddhist, %	84	85	90	88	87
Years resided in US, %					
<1	5	15	21	35	20
1-3	17	20	26	15	19
>3-5	28	5	11	15	14
>5	50	60	42	35	47
Males employed, %	25	44	11	33	24

TABLE 2.—*Patients Using Specific Traditional Health Practices Since Arrival in the United States**

Practice	Cambodian, n=20	Lao, n=20	Mien, n=20	Ethnic Chinese, n=20	Total, n=80
Acupuncture	--	--	1	1	2
Coining	14	2	--	7	23
Cupping	4	--	5	--	9
Hair pulling	3	--	--	1	4
Healing ceremonies	--	--	14	--	14
Massage	5	1	--	2	8
Use of medicated paper	--	--	1	1	2
Moxibustion	1	--	10	--	11
Use of oils and balms	--	--	--	2	2
Pinching	1	--	2	1	4
Use of teas	1	--	2	--	3
Other	--	--	1	2	3
Any practice (not specified)	17	2	16	11	46

*Many patients used more than one traditional health practice, so the number of practice uses reported may exceed the number of patients for a particular ethnic group.

TABLE 3.—*Patients With Symptoms for Which Selected Traditional Health Practices Were Used*

Symptom	Coining	Cupping	Moxibustion	Massage	Healing Ceremonies
Body aches	2	--	1	1	--
Dizziness	4	2	--	--	--
Joint pain	1	--	3	--	--
Fever	--	1	1	--	--
Gastrointestinal problems	3	2	4	--	1
Headache	6	1	--	2	--
Myalgias	--	--	--	2	--
Shaking	2	--	--	--	--
Other	2	2	2	2	--
Unspecified health problem	3	1	--	1	13
Total	23	9	11	8	14

vations, which found that Southeast Asian refugees frequently diagnosed and treated themselves and that those from rural areas were more likely to continue practices used in their native country.[5] In one study, root medicines were found in 27% of Lao and 7% of Vietnamese households, and tiger balm was found in 80% of Lao and 54% of Vietnamese households.[6] In another study, 49 of 50 Vietnamese interviewed, including a nursing student and a medical assistant, still performed coining four years after arriving in the United States for a wide variety of symptoms.[7]

Traditional health practices may reflect different beliefs about the causes of illness that have evolved in Southeast Asian cultures.[2-4] Perhaps the prevailing belief is the naturalistic theory, in which diagnosis and treatment involve integrating physical and social factors. "Wind" is thought to cause many minor and major illnesses. Certain foods, such as beef, may carry "wind" and so are avoided. Treatment consists of special diets, medicinal herbs, or coining, which is commonly used to "rub out the wind." A second belief is that certain illnesses are a punishment resulting from the influence of gods, demons, spirits, or malevolent or magical spells. These illnesses are treated by healers or shamans, who negotiate with supernatural forces to remove or alleviate the sickness. A metaphysical explanation (also known as the "hot and cold" or yin-yang theory) is also used to explain illness. In this case, illness is caused by an alteration in the natural balance between hot and cold elements in the universe. To restore balance and harmony, intake of drugs and foods is adjusted. Coining, pinching, or cupping may be done to restore balance by releasing excessive "air"; in cupping, as the cup cools, it is believed to draw the skin and air up and out. Western medicines are generally considered hot, whereas herbal remedies possess cooling properties. Thus, depending on the nature of the illness, Western medicines may be avoided or reduced in dosage.

Little is known about users' perceptions regarding the mechanisms of action of traditional health practices. In our study, a mechanism of action was given in only 26% of reported uses. This is consistent with a survey on coining in which only about half of the respondents were able to cite a mechanism, such as increased circulation or body warmth, facilitation of respiration, or a spiritual connection.[7] Patterns of use in our patients suggest that different traditional health practices may serve the same function because various practices were reported for the same symptom.

In traditional, rural Southeast Asian cultures, herbal remedies, dermal techniques, and exorcistic rituals are the principal forms of medical treatment.[8] More than one treatment is often used for the same illness, either simultaneously or in succession. The aid of a health practitioner is sought if home remedies are not successful, and Western medicine, if available, may be used only when all else has failed. The same

pattern of health care behavior is practiced in urban populations, but healers are used less often and Western medicine more commonly.[8]

The potential benefits of traditional health practices depend on the patient's condition and the type of practice used. For example, their use may provide the sufferer, who may feel helpless, with a sense of partial control. The attention given to patients by those administering these practices is comforting and may itself be therapeutic. In addition, a placebo effect may have a beneficial effect on minor or self-limiting disorders. These practices also may be harmful, however, because further feelings of hopelessness may result if the treatment fails to resolve the condition. This may be exacerbated by the belief that the failure of a given practice is the fault of the patient. More important, using traditional health practices may be detrimental if patients delay seeking medical care for treatable conditions or if the practices include harmful ingredients. Traditional health practices may also involve considerable expense, especially when a healer or shaman is consulted.

Using traditional health practices has resulted in scarring, cosmetically undesirable lesions, spurious accusations of physical abuse, and unnecessary medical evaluations. Clinicians unfamiliar with these practices may suspect abuse when a patient, particularly a woman or child, presents with cutaneous lesions resulting from a traditional health practice (pseudobattering).[9-11] In one such instance, a false accusation of child abuse resulted in the suicide of the Vietnamese father.[11] In our clinic, a Cambodian woman underwent an extensive evaluation for alopecia, including laboratory tests and a dermatology consultation, before it became evident that her hair loss was the result of pulling hair at the crown and top of the head to treat headaches.

Conclusion

Increasing awareness and knowledge of traditional health practices should help physicians appreciate a patient's perception of Western medicine. Physicians should maintain a nonjudgmental attitude toward such practices while seeking information from patients about which traditional health practices and Western medications are being used. Good patient care may necessitate the use or tolerance of both modalities in many Southeast Asian refugees.

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