In Search of Healers—Southeast Asian Refugees in the American Health Care System

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Healing is the alleviation of sickness, which includes both medically defined problems of pathophysiology (disease) and personal definitions of not being well (illness). Refugees from Southeast Asia now have a special need for healing because their health problems are changing from those of concern to public health, which are well documented and for which there are known effective treatments, to those that are primarily a personal concern and that are difficult to diagnose and treat effectively because of their chronic nature and their cultural and emotional components. The finding among refugees of physical complaints for which there is no identifiable medical cause is explained by cultural tendencies in Southeast Asia that promote focusing on somatic symptomatology, and by a delayed somatic response to refugee trauma. To prevent escalation of medical intervention, physicians need to be sensitive to Southeast Asians' attitudes toward health and their expectations and apprehensions regarding Western medicine.

Large numbers of refugees from Southeast Asia were first admitted to the United States in 1975. That year of tumult alone brought some 130,000, who were mostly Vietnamese and predominantly professionals, government officials and military personnel who had some close affiliation with the United States and the collapsed Thieu regime. These first refugees were generally well educated (more than 25% were college graduates), young (88% younger than 45 years of age) urban dwellers (75%) of Catholic background (55%) who were in good health and in the company of family (62% arrived in family groups of at least five persons).[1] They were kept in make-shift relocation centers at US military bases where they were given physical examinations[2] and studied English until they found sponsors to assist in their resettlement. Whereas this group of refugees has had to deal with immense psychologic trauma and stress,[3-11] it has not baffled the American health care system to the extent that the subsequent wave of refugees from Southeast Asia has.

The next burst of refugees from Southeast Asia began arriving in the United States in 1979. It reflected the Vietnamese invasion of Cambodia in January 1979 and a new anti-Sinitic policy of the government in Vietnam, as well as new military offenses against the hill peoples of Laos. From January 1, 1979, through February 28, 1983, there were 455,255 refugees from Southeast Asia resettled in the United States, constituting 72% of the total of 631,554 who have arrived since April 1975.[12] This group is so different from the first group and from the general US population that it is usually referred to as "the second wave" of refugees from Southeast Asia. It is heterogeneous in national origin, ethnic identity, religion, language facility, literacy, urban-rural-hill background and health status.[13,14] However, "second wave" refugees are generally less well educated, less literate, less familiar with Western thought and institutions, less facile in English and less healthy than those in the first wave. Escape attempts from the countries of origin were typically long, harrowing and fatal for up to 50% of the displaced; their temporary refuge in camps in Southeast Asia was generally long, even up to seven years, and resources for survival were sparse. Comments in this article generally

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TABLE 1.—*Distribution of Refugees From Southeast Asia in 13 Western States**

State	Estimated Total 28 Feb '83	Percent of Total in United States	Percent of Total in 13 Western States
Alaska	296	0.05	0.10
Arizona	4,045	0.64	1.29
California	228,946	36.25	73.20
Colorado	10,620	1.68	3.40
Hawaii	5,743	0.91	1.84
Idaho	1,297	0.21	0.42
Montana	997	0.16	0.32
Nevada	1,841	0.29	0.59
New Mexico	2,779	0.44	0.89
Oregon	18,113	2.87	5.79
Utah	7,367	1.17	2.36
Washington	30,475	4.83	9.74
Wyoming	266	0.04	0.09
TOTAL	312,785	49.54	100.03†

*From Refugee Reports, 1983.[12]
†Total exceeds 100.00% due to rounding.

refer to this second wave of refugees because of the greater cultural and socioeconomic disparity between them and physicians than between the first wave and physicians.

Half of the refugees from Southeast Asia in the United States have settled in the Western states and a third have become residents of California (Table 1). Four Western states—California, Colorado, Oregon and Washington—have refugee populations that exceed 10,000 in size. Other Western states, particularly Hawaii and Utah, have high refugee-to-general population ratios.

The refugees in the second wave were screened for major public health problems (tuberculosis, syphilis, leprosy and drug addiction) in refugee camps in Southeast Asia. Many were screened again after their arrival in this country, generally by health departments concerned with protection of the public's health. In consequence, a high prevalence of certain infectious diseases has been well documented (hepatitis B, intestinal parasitism, malaria and tuberculosis).[13-28]

Turning Point

We are now at a turning point in the health care needs of refugees from Southeast Asia. The infectious diseases that have been highly prevalent among them are generally under control, if not eliminated. Now refugees are seeking help for more chronic illnesses that are a personal, rather than a public, threat to health and that are not as easily identified or controlled as the infectious diseases. And now, sufficient time has elapsed for signs and symptoms of the post-traumatic stress disorder[29] to emerge.[10,30,31] The chronic personal and emotional problems that are now surfacing demand effective physician-patient communication and a far greater degree of mutual understanding than is necessary for the diagnosis and treatment of infectious diseases.

A large proportion of the adults in the second wave of refugees, however, speak only minimal English, know very little about our health care system and continue to take care of their health as they did in Southeast Asia where few had access to biomedical health care. At the same time, they are so widely dispersed in the United States that in many areas they do not compose a critical mass necessary for inauguration of special services such as modified hospital diets, language banks of trained bicultural interpreters and English language training. This means that caring for them takes time and can be fraught with the frustrations of noncomprehension and "noncompliance."[32] It also means that healing must replace curing in the care of refugees from Southeast Asia.

The Need for Healing

What is the difference between curing and healing? In making a distinction, medical anthropologists differentiate between the terms disease, illness and sickness. *Disease* is defined as abnormalities in the structure or function (or both) of bodily organs and organ systems. *Illness* refers to a person's perceptions of disease and other debilitating conditions. *Sickness* is often used as a cover term for both disease and illness,[33-35] though there is some debate about its meaning.[36-38] *Curing* refers to the treatment of disease and consequently to the practice of biomedicine. *Healing,* in contrast, refers to the alleviation of illness or sickness, and may or may not refer to a diagnosed disease. The extent to which healing occurs in the practice of biomedicine depends largely on the behavior of a practitioner-physician. That is, physicians may believe they are successfully managing the progress of a disease but may still be unsuccessful in dealing with the debility and feelings of illness that persist for a patient. We now understand that this seeming paradox is often related to differing concepts of health, sickness and appropriate health care among members of strikingly different sociocultural groups.

Major Nonbiomedical Concepts of Sickness and Health Among the Refugees From Southeast Asia

Religion and Medicine

While the underlying major traditions are not directly related, there are parallels between paradigmatic schools of thought in the history of Western medicine and medicine as practiced in Southeast Asia. Just as in ancient Egyptian and Mesopotamian medicine, the practice of medicine for some refugees, particularly the non-Christian Mien (sometimes called Yao) and H'mong (sometimes called Miaw or Meo) who come from the hills of Laos, is inseparable from religion. Sickness is believed to come from the wrath or wiles of gods. A physician, then, is a priest who negotiates with the gods (note: not with the patient) to remove or alleviate sickness. A physician-priest is believed to have superhuman powers because of her or his capacity for influencing the gods, whereas the gods are blamed in the event that a patient fails to recover, thereby preserving the reputation of and need for a priest-healer.[39-42]

There are few Mien or H'mong shamans in practice

in this country, which is a radical change not only from the life-style in the hills of Laos, but also from coping strategies used in the refugee camps in Thailand. Conversion to Christianity has eradicated some of the practice, and urban apartment living in heterogeneous neighborhoods has suppressed most of the rest, as calling the gods in H'mong or Mien style involves noise-making that could bring untoward attention to the presence of the refugees and their alien behavior.

Although shamans are rare in the United States, the heritage of belief in external causes of health and sickness persists. It is manifested in the Lao hill people's mistrust, fear and incomprehension of biomedical invasive procedures, whether they be for diagnostic, palliative or curative purposes. Often the best physician is defined as the one who intrudes on the body the least. For example, when given the choice, pregnant H'mong and Mien women almost invariably ask *not* to be given anesthesia during labor and delivery, or they simply avoid hospitals that have a reputation for using anesthesia indiscriminately. There is variation by ethnic group in the degree to which medicine is associated with religion and to which medical intrusion in the body is shunned. Vietnamese women, for example, usually ask for anesthesia during labor and delivery.

Natural Medicine

Southeast Asian refugees, even those in the second wave, are culturally diverse. The Mien and H'mong just described are tribal people from the hills of Laos with predominantly shamanistic systems of belief, though aspects of other systems, such as the use of herbal remedies, may be incorporated. Other refugees come from peasant agricultural villages where medical belief systems are somewhat different, and fewer shamanistic elements are present.

The primary system prevailing among these peasant people is here called *natural medicine,* in contrast to the supernatural medicine of the hill people. The peasant medicine of Southeast Asia is similar to Hippocratic medicine of the first five centuries BC in that both are grounded in a belief in the healing power of nature. Human anatomy, according to Hippocratic-peasant medicine, is composed of bodily humors, and their natural environment, not the gods, determines the extent to which they are in harmonious equilibrium—that is, healthy. Diagnosis in this framework involves observation of the physical and social environments of a patient, and treatment consists of either surveillance while natural recuperative powers are at work, or support for natural vegetative processes such as digestion and sleep.[42]

The Hippocratic-peasant framework is evident in the daily behavior of many of the refugees from Southeast Asia. Growing herb gardens for making herbal medicines is common practice among the H'mong, and massage, tonics and avoidance of excesses are common health maintenance behaviors throughout lowland Southeast Asia (that is, among the Chinese, Khmer, Lao and Vietnamese). An expectation that nature will cure and a fear of invasive procedures may explain the lateness with which refugees tend to present themselves for medical care of blatantly pathologic disorders.

'Hot-Cold' Theory

The tenets of Aristotelian medicine also have parallels in Southeast Asian concepts of health and sickness. The belief that living matter is composed of four elements, air, fire, water and earth, and that each has an associated characteristic—cold, hot, wet and dry, respectively—is common to both Aristotelian and Southeast Asian metaphysical systems and underlies much of Southeast Asian self-care behavior. For example, refugee women who give birth in the United States usually refuse to take baths, wash their heads or drink juices or water in the postpartum period from fear of upsetting the balance of "hot" and "cold" in their bodies. The underlying logic (which might not be as widely known as the practice it generates) is that blood, which is the fire element that is characteristically "hot," has just been lost through delivery; consequently, the body is at risk of becoming too "cold" or getting too much "air," so the above exposures to cold things that are associated with air are avoided.[43] Similarly, when a person is febrile, fluid intake is commonly restricted, the body is dressed warmly and fresh vegetables and fruit are avoided. The underlying logic here is that the body is already losing too much heat, so every effort must be made to retain it: foods that are classified as "cold" (most vegetables and fruits) must be avoided, in favor of foods classified as "neutral" (rice, eggs, chicken broth, teas and sweets).

Resistance to venipuncture is common among refugees from Southeast Asia for a complex of reasons besides the fear of upsetting the "hot-cold" balance of the body. These include the lack of a tradition of blood drawing for medicinal purposes, coupled with its recent association with the military's need for blood: some refugees think that blood is taken from them to give to American troops. Also, although blood is viewed as a vital element of the body, less well-educated refugees may not be aware that the body can compensate for the amount lost and produce more blood.

The fundamental position of the "hot-cold" belief system is shown in self-care behaviors common among refugees from Southeast Asia, be they educated elite or preliterate hill farmers. Western or biomedical medicines are generally classified as "hot" and are perceived as very potent, often too potent for Southeast Asian physiology. Although refugees from Southeast Asia expect to receive medicine whenever they visit a physician, many will adjust the dosage downward to protect themselves from untoward effects, or stop taking it altogether if there has been no relief of symptoms within a few days.[44]

Another common manifestation of the "hot-cold" belief system in refugee self-care behaviors is the dermabrasive procedures.[45-47] These are important self-care practices that are widely used, particularly among the Khmer from Cambodia (now Kampuchea) and

Vietnamese, to alleviate a wide variety of symptoms (headache, myalgia, nausea, cough, backache, motion sickness and so forth). Although they abrade the skin, such minor scrapes are rarely harmful and help persons gain a sense of control over their ailment. Cutaneous hematomas are sometimes purposefully created over the affected area (of the face, neck and anterior or posterior torso, excepting the genitals) to release the excessive "air" that is associated with certain ailments. The hematomas are made in several ways: by firmly pinching the epidermis and the dermis between two fingers while pulling on the skin; by rubbing an oiled skin with the edge of a coin, spoon or piece of bamboo, or by placing a cup from which the oxygen has been burnt out over the affected area for 15 to 30 minutes; as the air in the cup cools, it contracts and draws the skin and "air" up and out, leaving an ecchymotic area on the skin. Some care must be taken when the patient is a child to differentiate these signs of home treatment from evidence of child battering.[47]

Mental Illness

Any of the above concepts of sickness may pertain to emotional as well as to physical sickness. Unmistakable emotional disturbance, however, is usually attributed to possession by spirits of malicious intent; to the bad luck of familial inheritance, or, for Buddhists, to bad karma accumulated by misdeeds in past lives. Partly because of its attribution to immoral causes, mental illness is commonly feared and denied. Disturbed persons are usually harbored within their family unless they become destructive, at which point they may be admitted to hospital (and "forgotten") or otherwise restrained, but at the great cost of bringing shame to the family. Perhaps in consequence, refugees from Southeast Asia who are having emotional problems tend to present themselves for care with physical problems[31] and to avoid referrals to mental health clinics, psychotherapists or psychiatrists.[30] The tendency to somatize has, however, been documented for other groups of refugees as well.[48,49] Generally, a label that does not suggest mental illness such as "family counselor" is more acceptable to Southeast Asians than terms such as therapist, and they will feel most comfortable if given some tangible treatment such as a prescription for medicine. Placebos are widely used by practitioners in Southeast Asia in recognition of patients' expectation of receiving medicine and their usefulness in establishing rapport with a patient.

Nevertheless, an apparently increasing number of refugees are being diagnosed as having psychiatric or psychosomatic problems. The prevalence of appreciable psychiatric problems among adults was reported as 10% in 1980[14] and as 17% in 1983 (for different and unmatched populations).[50] Depression and anxiety were the most common diagnoses, but psychosomatic disorders, tension headaches and psychosis were also found. The prevalence of depression among Vietnamese refugee patients of one medical outpatient clinic was found to be 40%.[51] In a study of refugee (89% Vietnamese or Chinese-Vietnamese) psychiatric patients in Ottawa, more than two thirds were diagnosed as having anxiety or depression (or both), 16% as having a psychosis and another 16% as having adjustment reactions. The difference between the diagnoses and the presenting problems is pronounced: only 12.5% presented with anxiety or depression, whereas 30% were seen because of somatic complaints and 11% for suicide attempts; other presenting problems included hallucinations, school problems, aggressive behavior including wife and child abuse and agitation.[31] Agencies working closely with refugees of any ethnic group from Southeast Asia uniformly report depression as the most pressing problem.[30] While a depression rating scale has been developed for use in clinical practice with Vietnamese clients,[51] there are as yet no such instruments for assessing the mental state of other Southeast Asian refugees.

Somatic Response to Stress

An increase in the prevalence of depression can be expected to continue for at least two reasons: the actual occurrence of depression is probably increasing due to the latency effect of posttraumatic stress disorder among refugees,[52-54] and to an increase in reporting due to greater refugee familiarity with and use of the American health care system. The rising prevalence of depression can be expected to be associated with an increase in refugee health care-seeking behavior that is focused on somatic symptoms. However, the physical phenomena through which the refugees manifest sickness do not necessarily have biomedical equivalents. Examples that are likely to be encountered include the complaint of being "hot": it usually does not refer to a febrile condition and can occur in the absence of fever. Instead, it might refer to a variety of problems, such as flatulence, constipation or dark urine. Other examples are syndromes associated with specific organs: a "weak heart" refers to palpitations, dizziness, fainting or panicky feelings; a "weak kidney" refers to impotence or sexual dysfunction; a "weak nervous system" refers to headaches, malaise or inability to concentrate, and a "weak stomach or liver" refers to indigestion.[44]

What appears to be occurring is a delayed somatization of response to the experience of being a refugee. Because this experience is cumulative, each new experience can complicate and postpone resolution of previous experiences. The refugee experience of trauma can be classified according to stages in the refugee life history (Figure 1).[55] The actual or threatened experiences of persecution and the witnessing of atrocities that occur in a refugee's country of origin are related to the emergence of the posttraumatic stress disorder in the country of refuge or later in the country of resettlement. Meanwhile, a refugee often has been separated from or has lost family members, but might not have been able to mourn their loss because of uncertainty about their fate, uncertainty about his or her own fate, preoccupation with survival or denial. Losses

Components of Refugee Trauma by Stage of Refugee Life History	Emotional Response	Somatic Response
Country of Origin		
Persecution; forced migrations; witness to human-perpetrated atrocities; separation from or loss of family members		
Country of Refuge		
Limbo experience of finding asylum and of refugee camp life; separation from or loss of family members; hasty marriages and affiliations with new families in refugee camps		
Country of Resettlement		
Resettlement in an alien culture (USA) where religion, language and skills may no longer be relevant and previous social support system may not exist	Anxiety Delayed grief Depression Posttraumatic stress disorder	Psychosomatic conditions Somatic problems with no identifiable cause
Frequent isolation from compatriots		
Low English-speaking ability		
Wrong skills for American economy: cannot find jobs; welfare dependency		
Children more skilled than parents: parent-child role reversal and tension		
Marital conflict; single parent-headed households		

Figure 1.—Model of delayed somatic response to refugee trauma.

that require grieving can accumulate overwhelmingly fast in the life of a refugee. Complicating these experiences is the risk of mismatch in new alliances that are hastily formed in refugee camps to gain companionship. Subsequently there may be myriad incongruities between a refugee's knowledge, skills and expectations and the expectations of the new environment in the country of resettlement to wound a battered psyche even more.

It should be remembered that the origins of some emotional responses and some sicknesses of refugees predate or are otherwise unrelated to refugee trauma. Refugee trauma, however, increases the likelihood of specific emotional responses such as anxiety, depression, delayed grief and posttraumatic stress disorder.[53,54] Cultural heritage and the social environment then shape the nature and extent of somatization of the emotional response. We do not yet have data that identify variation in the type of somatic response to stress among the different ethnic groups of refugees from Southeast Asia, but we do have reports of somatic complaints that have no medically identifiable cause.[31]

Implications for the Physician-Patient Relationship

When the above model of delayed somatization of refugee trauma pertains to a refugee patient's sickness, the cause of the sickness—refugee trauma—cannot be cured or mitigated by medical ministration alone. Consequently, the sickness might persist despite expert symptomatic treatment, or it might disappear, reappear or metamorphose for no apparent medical reason. This can be exceedingly frustrating for a physician and can be guilt-provoking when, with the best of intentions, the physician pursues an intractable symptom with progressively intrusive measures, only to have it persist with stunning recalcitrance.

The danger of escalating intervention beyond what proves, in retrospect, to be medically indicated and the danger of misdiagnosing signs of chronic disease as delayed somatic response of refugee trauma can be prevented by assiduous attention to a refugee patient's point of view. This means, for example, respecting a Southeast Asian's fear of bodily intrusive measures by keeping them to a minimum. It also means probing beyond the smiling "yes yes" response that is, for Southeast Asians, the proper way to show respect for another person, to determine a patient's understanding of the matter at hand. This might require the assistance of a trained bilingual interpreter.[32] It does require that the physician or nurse ask a patient to repeat what has been said about the nature of the problem, about what should be done for it, how long it will take, what specific medications the patient took, what measures the patient has considered taking to deal with the problem and so forth in order to validate a communication. It also might require authoritative suggestions of hope, prescriptions for benign medicines when others are not medically indicated, encouragement to continue taking home remedies such as herbal teas and poultices or to continue consultation with an ethnic healer,* and it might require allowing a patient to return for consultation even when medical remedies have been exhausted.

The risk of fostering medical dependency probably will fall over time as an increasing number of Southeast Asians become health care professionals, able to minister directly to the illnesses and diseases of fellow refugees by virtue of their common cultural background and history as refugees. Meanwhile, the risk of medical dependency can be therapeutically justified because somewhat extended health care provides an arena where a refugee can feel validated as a patient and secure in the repetitive care of an authority figure—the physician—whom she or he perceives as having the power to heal.

*In a study of biomedically trained physicians in northern Thailand, two thirds estimated that more than half of their patients were using herbal medicines or receiving treatment from practitioners of indigenous medicine (or both): "They also estimated that approx. 90% of their patients had sought medical care only after trying herbal medicines and/or attempting self treatment with the aid of drugs and medications purchased from drug sellers."[55]

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