Commentaries

Caring for Southeast Asian Refugee Patients in the USA

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Abstract: This paper concerns care of refugees from Southeast Asia who speak little English and are relatively unfamiliar with the formal health care system in the United States. It aims to demystify the behaviors of refugee patients and to support health practitioners who are attempting to care for them. Western medicine is discussed in terms of the expectations that refugees tend to hold of it, and of the conflicts with Southeast Asian beliefs and practices which it presents. Despite language differences, health care agents can increase the effectiveness of their communication with persons from Southeast Asia, primarily by allowing for their viewpoints. Topics discussed are: the first encounter with a refugee patient; use of interpreters; obtaining informed consent; "the passive obedient" patient; the "non-compliant" patient; body image; sources of social support for healing; use of medications; traditional self-care practices; and death and depression. (*Am J Public Health* 1983; 73:431–438.)

In the past six years, over 500,000 refugees from Southeast Asia have settled in the United States.* Some 90 per cent of them are under 45 years of age. Consequently their first contacts with our health care system are usually through obstetrics, pediatrics, and emergency rooms. Whereas the first wave of Southeast Asian refugees in 1975 was generally well educated and familiar with Western ways, most of those arriving in the past three years have had little or no formal education, and have led self-subsistent lives in rural and remote hill areas. Many of the recent arrivals have stayed in refugee camps for three to five years. Health problems such as tuberculosis, anemias, and dental and gum disease are much more prevalent among them than the first wave of refugees.[3]

*From 1975 to December 1981, 565,757 refugees from Southeast Asia entered the USA.[1] While the United States has accepted more refugees from Southeast Asia than any other country, on a per capita basis (number of Southeast Asian refugees per national population) the United States ranks third after Australia and Canada, and in terms of per capita financial contributions to international refugee aid agencies, the USA ranks twelfth.[2] The People's Republic of China and France rank second and third after the USA in terms of the total number of Southeast Asian refugees accepted for resettlement (265,588 and 71,931, respectively, as of April 30, 1981).[1]

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This paper aims to ease the frustrations which physicians, nurses, and dentists commonly report in trying to work with the less Westernized refugees and to promote refugee patients' adherence to health care plans. The focus is upon explaining behavior patterns and health care expectations that are common among Southeast Asian refugee patients. Disease conditions which are prevalent among this population are not discussed because they are treated in available literature.[3–20]

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Background

The refugees have fled from three countries of mainland Southeast Asia: Cambodia, Laos, and Vietnam. The French held suzerainty over these countries from the late nineteenth century to 1954 and grouped them together under the label *Indochina*. The French coined the term Indochina in a superficial attempt to unify the disparate groups in the area by emphasizing their heritage of Indic and Chinese influences. French control ended with the Geneva Agreements in

1954 and, with it, the political basis for the use of the term. To refer to the refugees as Southeast Asians is accurate but somewhat misleading in that the refugees have fled none of the countries of *insular* Southeast Asia, nor any of the mainland Southeast Asian countries of Burma, Malaya, Singapore, and Thailand. Nevertheless, "Southeast Asian" is used in this paper because we possess no other more accurate designation of this diverse group of refugees.

Although the refugees have only three national origins, they represent a wide variety of ethnic, language, and religious groups (Table 1). The extent of conversion to Christianity among the different groups has yet to be studied. Folk medical practices are less likely to be carried out by Christian than non-Christian refugees. Relationships among the different groups vary, and often reflect a long history of sociopolitical conflict. Refugees in the USA generally choose first to be with their own ethnic group, second with Americans, and last with refugees from other groups.

Four characteristics of refugees distinguish the Southeast Asian refugees from other Asian groups who have resettled in the United States through immigration:

- They have come to the United States by second, not first choice; their first choice was almost invariably to return to their native country if its political and economic conditions were similar to those that existed before the 1975 changes of government.
- They have come to the United States with little preparation, scant belongings, and no nest of compatriots to greet or help them.
- There is no realistic option for them ever to return to their homeland.
- They are survivors. Although statistics are not available, it is commonly estimated that for every refugee resettled, one died in flight.

Caring for Southeast Asian Refugee Patients

Most Southeast Asians who come to the United States are likely to know some diseases that are recognized by Western medicine. The diseases they know, however, are often ones with which American health personnel are unfamiliar because they are rarely seen in the USA, e.g., cholera, leprosy, malaria, smallpox, or tuberculosis. Complicating the poor cross-cultural correspondence of knowledge of disease, such medical basics as the germ theory and principles of anatomy and physiology are foreign to Southeast Asians who have not been educated, and there is no surgical tradition in Southeast Asia.

Nevertheless, when inconvenienced by sickness, most Southeast Asian refugees want to go to a doctor. Some common problems that they pose are that they rarely seek care when they are asymptomatic and few are familiar with our appointment system: some regard the most convenient

TABLE 1—Major Ethnic, Language and Religious Identifications of Southeast Asian Refugees, by Country of Origin and Urban, Rural or Hill Residential Background

Country of Origin	Urban, Rural, or Hill Background	Ethnic Group	Primary Language*	Religion
Cambodia	Rural	Cambodian (or Khmer)	Cambodian	Theravada Buddhism;
	Urban (Rural)	Cham	Cham	Islam (Sunni Sect)
	Urban	Chinese	Teochiu, Cantonese**	Confucian-Taoism-Mahayana Buddism; Roman Catholicism
	Urban	Vietnamese	Vietnamese	(Same as Chinese)
Laos	Rural Urban)	Lao, Lu	Lao	Theravada Buddhism
	Rural	Thai Dam	Thai Dam; Lao	Animism***
	Urban (Rural)	Chinese	Chinese**	Mahayana Buddhism
	Hill	Lao Theung	Khmu; T'in; Lamet; Lao	Animism
		Hmong (or Meo or Miaw)	Hmong	Animism; some Christianity
		Mien (or Man or Yao)	Mien	Animism
Vietnam	Urban or Rural	Vietnamese	Vietnamese	Confucian-Mahayana Buddhism-Taoism; Roman Catholicism
	Urban	Chinese	Cantonese**	(Same as Vietnamese)

*Many refugees are fluent in more than one language.
**A variety of dialects/languages are spoken by the ethnic Chinese refugees, including the following: Teochiu (from Swatow), Cantonese, Hakka, Hainanese, Fukien, Hokkien, Toi Sanese; and among the educated, Mandarin.
***Although there are myriad interpretations of animism, they all involve belief that anthropomorphic spirits may reside in organic material such as rice, trees or earth, and can influence or determine human events and well-being.

doctor as the closest one not requiring an appointment and accepting medical coupons, i.e., a hospital emergency room. To cope with these and related problems, general guidelines follow for working with partially English speaking Southeast Asian refugee patients who are in the early stages of integrating into USA culture.

The most important caveat is to seek the refugee patient's opinion whenever possible. This is necessary because cultural patterns are not predictive at the level of the individual and because the cultural orientations that the refugees brought with them are undergoing rapid change. Not only are ethnic variations in practices, beliefs, and reactions common, they are complicated by variations in rural versus urban background, sex, and educational experience of the individual, as well as by group and individual variations in patterns of adjustment to life in the USA. There is also a tendency, particularly among refugees sponsored by Americans and among converts to Christianity, to renounce traditional religious and medical beliefs and practices. This is associated with the expectation of appearing less different from, and therefore more acceptable to, Americans. As such, it is an example of Goffman's "passing" in order to hide the stigma of being a refugee.[23]

The First Encounter

A quiet, unhurried but purposeful demeanor is a part of normal professional decorum that is particularly reassuring to Southeast Asians because it symbolizes characteristics that are highly valued among them, such as wisdom, good judgment and dignity.

When the patient is accompanied by relatives, addressing at least the initial conversation to the oldest of the group shows appropriate respect for elders; this person is also usually the ultimate decision-maker for the patient.

Naming systems vary by ethnic group and can be very different from the Western system, fomenting consternation among record-keepers. The surname is often placed first, and may be a clan name (Hmong, Mien) or dynasty name (Vietnamese) rather than a family name (Table 2). Among most groups except the Lao, the woman does not change her family (clan or dynasty) name at marriage. Among some groups, an individual may take additional names at certain

TABLE 2—Selected Common Characteristics of Southeast Asian Naming Systems by Ethnic Group

Ethnic Group	Usual # Of Names/ Person	Common Surnames	Husband and Wife Share Surname	Example of a Name 1 = given name 2 = middle name 3 = surname
Cambodian	2	Chak, Chep, Samroul, San, Sok, Som, Vuthy	no	3 1 Sovann Loeung
Chinese*	3	Chan, Chau, Ha, Lau, Lee, Lieng, Ly, Ong, Pho, Tang, Vuong	no	3 2 1 Wang Din Wah
Hmong	2–4	Chang, Fang, Hang, Khang, Lee, Lor, Ly, Moua, Thao, Xiong, Vang, Vue, Yang	no	3 1 Vang Koua
Lao	2	(varied: usually 3–5 syllables)	yes	1 3 Thongsouk Vongkhamkaew
Mien	2–4	Saechan, Saechao, Saelau, Saelee, Saelui, Saephan, Saetau, Saetang, Saetern, Saezulai	no	3 1 Saeteun MuiChua
Vietnamese	3–4	Cao, Dinh, Hoang, Le, Luu, Ly, Ngo, Nguyen, Phan, Pho, Tran	no	3 2 1 Nguyen thi Canh

*In Chinese publications the family name precedes the given name (usually hyphenated): Chen Tai-chien or Chen, Tai-Chien. But in American and British journals a Chinese name is usually anglicized and transposed: Tai Chien Chen or Chen, T. C. (See Council of Biology Editors Style Manual, 3d Ed., 1972, p 156.)

points of the life cycle. Many refugees, however, are changing their names to conform to American practice. Because of this and the wide ethnic variation in name systems, it is best to ask the patient what he or she wants to be called. To initiate contact it is usually appropriate to address adults by title (Mrs., Mr., Dr.) plus first (given) name (see Table 2).

Provider attempts to obtain information through medical, health, and fertility histories of the less well educated Southeast Asian patient tend to be unproductive. This is because in Southeast Asia medical patients are rarely told the names of their illnesses, of the medicines given, or of the diagnostic procedures performed on them; consequently they rarely know what was done for them or why. Furthermore, refugee patients from rural or hill areas or with little formal education are not accustomed to the Gregorian calendar used in the West. Their methods for calculating ages may vary by up to two years from our method of starting day 1 at birth. In addition, fertility histories are likely to underreport pregnancies and fetal losses because many people in Southeast Asia do not consider the fetus human, and some do not consider the newborn human until the baby is three days old (Hmong, Lao) or even older.

Interpreters

If the patient does not speak English easily, trained bilingual interpreters should be sought to assure accurate two-way flow of information at the key decision-making points in the health care process, i.e., for history taking, when prescribing and evaluating diagnostic or therapeutic procedures which are new to the patient, and before any change in management, as from the ICU to the medical floor in a hospital, or from parenteral to oral medication. Without a trained bilingual interpreter at such points, intentions to provide for the patient's informed consent are thwarted, patient safety is jeopardized, and patient's non-compliance to medical regimen is likely.[24] Ideally, the interpreter should be bilingual and bicultural, treated as a colleague, and chosen both for competence in the language foreign to the health care professional and for familiarity with biomedicine.

When speaking through an interpreter, watching the patient (rather than the interpreter) will enable you to pick up behavioral cues. If the patient's responses do not fit your comment, check that you have made your meaning clear to the interpreter. Sometimes it will take an interpreter much longer to say in a Southeast Asian language what has just been said in English; this is often the sign that a cultural as well as a linguistic translation is being made. Sometimes the interpreter may appear to answer for the patient; this may be because he or she knows the information sought from having been that patient's interpreter on previous occasions.

If trained interpreters or bilingual health care providers are not made available for work with non- or partially-English-speaking patients, the health care agency may be failing to meet the requirement of Title VI of The Civil Rights Act of 1964 for the provision of equal access to care, regardless of national origin.** Resettlement agencies (commonly called "VOLAGS" for Voluntary Agencies) can provide information on the availability of interpreters in local areas. Each refugee's initial resettlement in the USA is organized by a VOLAG so the refugee should know the name of his/her VOLAG.***

Whether speaking through an interpreter or directly with a patient who is not sufficiently functional in English, ambiguity of meaning can be minimized in the following ways:[25]

- using basic words and simple sentences, and using nouns rather than pronouns;
- paraphrasing words that carry much meaning (e.g., "workup") in order to be precise about the specific meaning intended;
- avoiding use of metaphors, colloquialisms, and idiomatic expressions;
- learning and using basic words and sentences in the patient's language: this induces the patient or interpreter to take greater care in making their use of language accurate;
- inviting correction of your understanding of the matter at hand ("Am I understanding you correctly that . . .?").

Informed Consent

Obtaining a Southeast Asian refugee patient's informed consent prior to undertaking a medical procedure is difficult because cultural differences in health-related concepts often cannot be simply translated linguistically, and because values of biomedicine might conflict with those of the patient's culture.[26] From an uninformed Southeast Asian perspective, diagnostic tests are baffling, inconvenient, and often unnecessary. Procedures such as circumcision or tonsillectomy, which biomedicine considers simple, are generally unknown. Any invasive procedure is frightening, and may be believed to have long-lasting and multiple effects. The prospect of surgery can be terrorizing. There is a great fear of mutilation that stems from widespread beliefs (among non-Christians) that souls are attached to different parts of the body and can leave the body, causing illness or death. This fear of mutilation extends through death, so that few Southeast Asians consent to autopsy unless they know and agree with the reasons for it in their own case.

Assuring that a patient gives or withholds adequately informed consent to procedures guards his or her legal and ethical rights, and can also prevent iatrogenic psychological distress and promote patient adherence to the medical regimen.[27] However, a belief that verbal statements in and of themselves can cause the event described to occur lingers among some peoples from Southeast Asia. As a result there is a tendency to avoid discussing problems, risks, and

**All agency recipients of federal funds, including Medicare are subject to the stipulations of Title VI.

***The VOLAGS are: American Council for Nationalities; American Fund for Czechoslovak Refugees; Buddhist Council for Refugee Rescue and Resettlement; Church World Service; International Rescue Committee; Iowa Refugee Service Center; Lutheran Immigration and Refugee Service; Tolstoy Foundation, Inc.; United Hias Service, Inc.; US Catholic Conference; World Relief Refugee Service; and Young Men's Christian Association. All but USCC are headquartered in New York.

dangers. Explanations about why necessary procedures are recommended should be made routinely. For example, once the patient understands that the body continuously produces its own blood, that red blood cells live only 120 days, and that blood drawn from patients is used to help assess their physical status, he or she will usually consent to blood drawings for laboratory analysis.

However, the difficulties in achieving truly informed consent can be large. Reducing the number of procedures performed to a minimum is desirable. In some cases, cultural considerations may have to supercede usual policy for obtaining informed consent. For example, if the group to which the patient belongs believes that at death grandparents and parents become ancestors who should be worshipped and obeyed, and who shape the well-being of living descendants, the children of the patient for whom a decision about terminating active intervention needs to be made may have difficulty consenting to terminate care. Such consent would be equivalent to contributing to the death of an ancestor, that is, of one who would shape the survivors' fates.

The "Passive Obedient Patient"

Southeast Asians generally expect health professionals to be experts in diagnosis, treatments, and medications. Consequently they tend not to contribute as much information as health care professionals want or consider essential.[28] According to many Southeast Asian cultural traditions, authority figures should not be questioned or opposed directly so as not to offend or embarrass them openly; they may, however, be discreetly disobeyed "behind their backs." That is, the passive obedience may be a culturally adaptive and sanctioned illusion of conformity. However, among some refugees in the United States, the tendency to passivity around authority figures is compounded by fear and ignorance of our legal system: suspicion that divulging personal information, as for a medical history, could jeopardize their legal rights is common. When the health problem is severe or complex it may be useful to ask an intermediary who is close to the patient (e.g., VOLAG caseworker or the sponsor) to assist. Sometimes a refugee patient considers the doctor or nurse of such exalted status that the patient could do nothing other than obey.

The better a refugee patient understands reasons for a health professional's inquiries, the more direct and complete his/her responses tend to be. However, gaps in cross-cultural meaning may preclude refugees' understanding of medical rationales. The interpretation of organic signs and symptoms is not isomorphic across cultures:[29,30] points of major concern to health professionals may be irrelevant (exact age, medical or fertility history, causes of relatives' deaths) or unfamiliar (allergy, depression, virus, names of medications) to refugee patients. Values between two cultures may conflict (prolong life versus relieve suffering). The Southeast Asian refugee patient often copes with uncertainty and authority in a way—passive obedience—that is consonant with his cultural heritage but frustrating to the norms of biomedicine. He can protect his self-esteem by concealing, through passivity, his own ignorance, and he believes he can protect the health professional's status by concealing disagreements or incomplete understandings from him, that is by appearing obedient or compliant. Asking the patient to explain the issue at hand as he sees it can reduce the illusional aspect of his passive-obedient behaviors.

The "Non-Compliant Patient"

Two common causes of failure to adhere to the medical or nursing regimen reiterate the need for bilingual and bicultural trained interpreters, or for the assistance of refugee advocates or caseworkers: 1) the patient's misunderstanding of the medical regimen (e.g., taking the antimalarials Chloroquin or Fancidar for a fever, as fevers in hill areas were commonly associated with malaria); and 2) the patient's inability to carry out behaviors that are prerequisite to observance of the medical regimen, such as locating and getting to the referral site, or using the telephone to report new medical or nursing problems.

Ethnographic and clinical evidence suggest that noncompliance among Southeast Asian refugee patients is associated with the following patient perceptions: 1) cessation of symptoms; 2) inconvenience of observing the regimen; and 3) lack of cultural precedent for the regimen. Therefore, to help prevent noncompliance, the rationale(s) for continuing treatment after cessation of symptoms (or despite the absence of symptoms, as in prophylactic INH treatment or antihypertensive therapy) should be made explicit to the patient. S/he should also be asked if s/he knows of a cultural precedent for the proposed prescription, and what there is about carrying it out that would be difficult for him/her. If the patient identifies no cultural precedent for it or identifies one that s/he values negatively, or identifies barriers to its implementation, the necessity for the regimen should be reconsidered. If still indicated, special efforts should be made to assist the patient to adhere to the regimen.

Constraints of Body Image

Notions of body image that are widespread among Southeast Asians but uncommon among Americans include reverence for the head, dispassionate acceptance of the female breast as the natural means for infant sustenance, and extreme privacy of the lower torso. The human head is regarded as the seat of life and therefore as highly personal, vulnerable, honorable, and untouchable except by close intimates. Procedures that invade the surface or an orifice of the head tend to frighten Southeast Asians with the thought that the procedures could provide exits for one's life essence. This is particularly true for infants on whom a scalp vein is used for IV lines because infants are considered at high risk for loss of life and because the lines are close to the soft fontanel from where it is believed that the soul may take easy exit. Explanation of the rationales for the procedures in question is necessary to allay undue anxiety.

Although breastfeeding in public is commonplace among rural and hill populations of Southeast Asia, the refugees quickly observe that it is unusual in the USA. Most refugee women prefer to bottle-feed their infants in the United States because of its perceived convenience and conformity to American norms.

The area of the body between the waist and knees is almost never exposed, even in privacy, by anyone other than young children. The loose hospital gown, or physical examination of the genital area consequently can be deeply humiliating and unnerving to the Southeast Asian patient. Pelvic examinations of unmarried Southeast Asian women should not be undertaken routinely. When there is medical indication for a pelvic examination, the woman may want her husband to be present; if possible, the practitioner, and interpreter if one is needed, should both be female.

Social Supports

To be alone is frightening to many Southeast Asians. Offering to involve the patient's family as much as possible during the diagnostic and treatment program can help put them at ease; scheduling an entire family for care simultaneously can promote understanding and adherence as well. Different cultures dictate that different persons accompany the patient, e.g., at childbirth, a Chinese woman should have her mother-in-law in attendance, and a Hmong woman, her husband to bathe the newborn; for infants and children, either parent may assume what Americans term a mothering role.

Adult Southeast Asians are generally more comfortable with health care providers of their own sex rather than the opposite sex. This is particularly true for young and unmarried women.

If the option exists when making staff assignments or referrals for a Southeast Asian patient, ask if s/he would prefer an Asian service provider; often s/he would prefer a Filipino, Korean, or Japanese to an American even if she or he cannot speak a Southeast Asian language. However, because of political differences, persons from Laos and Cambodia might prefer not to have a Vietnamese nurse or physician.

Many non-Christian and non-Muslim Southeast Asians wear strings around their wrists, and amulets on necklaces, ankle bands, or clothes. Although simple in appearance, such accoutrements can carry deep sacred and social meanings for the sick person and his or her family. The wrist strings are believed to prevent soul loss, which in Laos and Cambodia is thought to cause illness. In a commonly practiced ritual, a soul-caller, respected elders and kin symbolically bind the sick person's soul in his or her body by tying strings around his or her wrists (and, for infants, the neck, ankles, or waist). The strings thus signify both the spiritual wholeness and social support of the sick person. The soul-calling, wrist-tying ritual is also performed to bolster the strength of the ritualee in the face of major change, as at marriage or leaving home. If the strings or amulets must be removed for medical purposes, an explanation of the need to do so usually brings the patient's consent; some might want to keep the removed item.

Medication

Southeast Asians tend to define their health problems in terms of physical symptoms and to seek symptomatic treatment. They also tend to express emotional disturbances somatically; doing so enables them to avoid the heavy stigma that mental illness carries among Southeast Asians.[23,31]

The main reason most refugees from Southeast Asia go to a doctor is to get medicine for a symptom. They usually believe that Western medicine is very powerful and cures quickly. If they go to a doctor when sick and do *not* receive medicine, they are likely to feel cheated. Once given medicine which they find effective, however, they might reason, "Since I forgot to take one yesterday, I'll take two today," or, "If one pill is good, two are better." While most are familiar with the beneficial effects of Western medicine, few understand the risks of over- or under-dosages.[28,32] This is related to the fact that all kinds of medicines were imported from the West and were widely available over the counter in Southeast Asian cities and towns. They were popular for quick relief of acute symptoms, and usually self-administered by a people who could not read the foreign language in which the package instructions were written.

Underlying this conviction about the powerfulness of Western medicine to cure, however, is an anxiety that Western medicine might not be appropriate for Eastern people. Not only is the belief widespread that Asian bodies, diets, and behaviors are different from American, but also there is the, at times, perplexing knowledge that according to the Chinese "hot-cold" theory most Western medicines are classified as "hot," while most Southeast Asian herbal medicines are "cool." Such contradictions and uncertainties tend to heighten the Southeast Asian patient's concern about drug-induced idiosyncratic and side effects. Their concern often results in self-management of prescribed as well as over-the-counter (OTC) medication. Prescriber efforts to explain the reason(s) for set dosages will increase the safety of the patient's tendency to self-medicate.

Traditional Self-Care Practices

Southeast Asians have traditionally dealt with illness through self-care and self-medication. When illness occurs in the USA, they practice self-care longer before seeking professional care than do Americans. This is related to their having had access to most drugs OTC at low cost in Southeast Asia, to having had few hospitals and physicians, and to the high cost of Western medical care. Four major forms of self-care that are commonly performed by refugee patients in the USA are offerings to spirits, dermabrasive techniques, maintenance of hot-cold balance, and use of herbal medicines.

Theories of supernatural etiology and cures of illness are widespread among non-Christian Southeast Asians. Traditional treatment of illness includes a focus upon the supernatural agent as well as upon the body of the sick person. For example, among non-Christian Hmong, illness is interpreted as a visitation by spirits. It is commonly believed that a child becomes sick when its spiritual parents try to take it back; treatment consequently involves placation of the spiritual parents, and this may be done by offering them chicken at an altar in the home.[33] When sickness occurs in other persons, the head of household administers herbal remedies, having grown the herbs in a home garden. If sickness persists, a shaman may be called to enter a trance in

order to communicate directly with offended spirits and to negotiate for the return of the sick person's soul; the negotiation is usually accompanied by a sacrifice of a pig or a chicken.

Because of the pervasive influence of China on the development of the peoples of Southeast Asia, Chinese medical tenets and practices have influenced the belief systems of most people from the area—the medical texts of Mien shaman were even written in Chinese. Chinese folk remedies that are widely practiced among the Vietnamese, Khmer, Hmong, and Mien (but not significantly among the Lao) include modifications of acupuncture, massage, herbal concoctions and poultices, and the dermabrasive practices of cupping, pinching, rubbing, and burning.

The dermal practices are the most common among the refugees (regardless of religion) but the least known by Americans. The dermal methods are perceived as ways to relieve headaches, muscle pains, sinusitis, colds, sore throat, coughs, difficulty breathing, diarrhea, or fever. In *cupping,* a cup is heated and then placed on the skin; as it cools, it contracts, drawing the skin and what is believed to be excess energy or "wind" or toxicity into the cup; a circular ecchymosis is left on the skin. *Pinching* and rubbing produce bruises or welts on the site of treatment; pinching may be the base of the nose, between the eyes, or, like rubbing, on the neck, chest, or back. *Rubbing* involves an insistent rubbing of lubricated skin with a spoon or a coin, in order to bring toxic "wind" to the body surface.[34,35] A similar remedy is *burning,* touching a burning cigarette or piece of cotton to the skin, usually the abdomen, in order to compensate for "heat" lost through diarrhea. These measures all produce changes in the skin, and can be misread as signs of physical abuse by persons who are not sufficiently informed to make the differential diagnosis of cultural self-care.[36] The practices rarely, if ever, present a threat to the physical integrity of the person, and almost always nurture the person's sense of being cared for and his or her sense of security in being able to do something actively about disturbing symptoms. There is no medical reason to discourage the practices, but sound psycho-socio-cultural reason to allow, or even support, these practices among the Indochinese.[35]

The above remedies are related to Chinese theories of health as a state of balance among the different components of the body and of the body with its environment. Illness prevention and treatment involves modification of food intake in order to maintain or restore equilibrium by rebalancing the body's component parts. Therapeutic adjustment of the diet requires consideration of the "hot" or "cold" natures of foods, cooking methods, and the person's ailment. The qualities "hot" and "cold," like the polarities of energy called *yin* and *yang,* must be kept in balance to ensure health. Although the rules for classifying foods as "hot" or "cold" are difficult to decipher and seem to vary by informant,[37,38] most fruits and vegetables, along with fish, duck, and other things which grow in water are "cold," and most meats, sweets, coffee, and spicy condiments such as garlic, ginger, and onion, are "hot." "Hot" foods and beverages are thought to replace and strengthen one's blood; consequently, after surgery, and childbirth, "hot" drinks are preferred, and cold drinks, jello and juices are avoided. Many refugees in the USA have organic medicines for a wide variety of problems from impotence to mental illness, and may take them simultaneously with prescribed medications. The Hmong and Chinese are particularly skilled herbalists.

Death and Depression

Southeast Asian and biomedical reactions to death often differ in two ways. First, the biomedical drive to prolong life conflicts with the general Southeast Asian preference for quality of life over length of life because of the expectation of less suffering in one's next reincarnation. Because of this expectation, they may seem to "give up" on relatives who are severely injured but survive an accident, or on infants requiring intensive care because they were born prematurely. Secondly, almost all Southeast Asians want themselves and their relatives to die at home rather than in the hospital. At home they know they can give or receive the comfort of loved ones, comfort which they do not expect in the hospital. Furthermore, most believe that the spirit of a person who dies away from home is unhappy, and so will cause trouble to the survivors long afterward.

Perhaps the greatest threat to refugee health is depression. It is related to the pervasive and overwhelming losses and changes that refugees have experienced in a relatively short time. These may leave the refugee confused and disoriented for years afterward.[39,40] Compounded with the sorrow and homesickness is the insecurity of isolation from their past and present environments. And on top of these are the role reversals, intergenerational conflicts, and reduced social status that commonly occur within each refugee ethnic group in the USA. Refugees, in general, are vulnerable and afraid in the USA. Because the health care system is one of the few culturally sanctioned sources of institutional support for them (the other sources—church and school—are not available for all refugees), and because their access to non-formal American social life is very limited, many adult refugees can be expected to seek care and attention on a long-term basis from health care providers.

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