

Spring 2010

Bridging Cultures: Integrative Health Care for Hmong Refugees

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**BRIDGING CULTURES: INTEGRATIVE HEALTH CARE FOR HMONG
REFUGEES**

**A thesis submitted to
Regis College
The Honors Program
in partial fulfillment of the requirements
for Graduation with Honors**

**by
Erika Tanaka**

May 2010

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ACKNOWLEDGEMENTS

I would like to thank the Director of the Honors Program Dr. Thomas Bowie, my thesis advisor Dr. Marie-Dominique Franco, and my thesis reader Dr. Ted Zenzinger for their guidance throughout this project.

I would also like to thank Pakou Xiong for her insights into the Hmong community.

INTRODUCTION

The Hmong people have often been referred to as a people without a home. Throughout their entire history, they have been a migratory people, constantly battling oppression and fighting for the preservation of their rich culture. They traveled through the Chinese countryside, along the Yellow River learning farming techniques from the Chinese tribes they encountered. Several times during their history in China, the Hmong were able to unite and rebel against their Chinese oppressors. Finally defeated in China by the Manchu Dynasty, they traveled to the Mountains of Laos where they faced unfair taxation by the French. In 1954, the French withdrew from Laos. However, the Hmong were not left alone for long. With the escalation of the Vietnam War, the Hmong were recruited by the United States to fight against the North Vietnamese and Laotian communists. Led by General Vang Pao, these Hmong forces fought bravely. Their bravery seemed to be forgotten when the United States pulled out of Vietnam in 1974 leaving the Hmong vulnerable to retaliation by the communists. The Hmong fled to refugee camps in Thailand, and from there, about 100,000 Hmong came to the United States. Throughout their history, the Hmong have maintained their independence and preserved their culture in spite of being a migratory people. They have never had their own nation where they could establish and nurture their culture. Instead, they carry their identity with them, preserved in their complex social structure and traditions.

The Hmong people live closely with the land. They practice “slash and burn” farming and raise livestock with a unique understanding of the natural world. For the Hmong, spirits exist in all natural objects and these spirits are essential to their health and

well being. The cornerstone of the Hmong community is the shaman, or *triv neeb*.

Shamans are people called to communicate with the spiritual world and are given the gift of healing. This spiritual healing, in addition to food and herb based remedies, have maintained both spiritual and physical health of the Hmong for years.

Now, living as refugees in the United States, the Hmong are struggling to adapt to a new culture. The younger generations of Hmong are starting to learn English and are very quickly acculturating into American society while, older Hmong fear that their culture is being lost. These varying levels of acculturation have created many challenges for the Hmong including challenges involving health care. The communication gap between Hmong animistic spiritual healing and the western culture of biomedicine has made it very difficult for many Hmong to navigate the western health care system. Because traditional methods of interpretation have failed to effectively bridge the two cultures, a new profession of cultural brokerage has emerged. Cultural brokers are acculturated in both cultures and communicate important information that is conveyed by nonverbal cues and through understanding of a person's cultural background.

In order to more fully bridge the gap between traditional Hmong healing and western biomedicine, the cultural brokers need to act as mediators for teams of health care providers that include the patients, their families, traditional healers and western physicians. This team approach, taking place in an integrative health care model focuses on the whole person: mind, body, and spirit. It recognizes the need for individualized care that meets the patient at his or her comfort zone and can draw from both traditional

Hmong healing and western biomedicine to ultimately provide each Hmong patient with health and happiness.

HMONG HISTORY

The Hmong are a fiercely independent group of mountain people originating from central Siberia. From the beginning, the Hmong were organized in small tribes that were constantly on the move. Accounts suggest that in 2500 B.C. they migrated to northern China where they competed with the Chinese for territory along the banks of the Yellow River (Figure 1). This territory was dominated from 4000 B.C. to 3000 B.C. by the Yangshao Chinese. These hill tribesmen practiced “slash and burn” farming and raised pigs as their primary source of protein. The Hmong adopted many of these practices allowing them to thrive in their new environment and continue their migrant lifestyle. The practices of “slash and burn” farming and livestock raising have persisted throughout Hmong history; In the dry season, the women cut away the forest underbrush and the men chopped down the trees with axes. The men then ignited the piles of vegetation. After the massive fire subsided and the charred earth cooled, all the families worked together to clear the debris before planting crops. This soil, enriched by the wood ashes, is productive for about five years, but the nutrients would be washed away by monsoons (Vista, J. 2007). The remaining land was so exhausted by this process that it needed twenty years of recovery before it was once again productive. This process let the topsoil leach away resulting in enough erosion to alter the courses of rivers. This practice of “slash and burn” farming was tied to the migrant lifestyle of the Hmong.

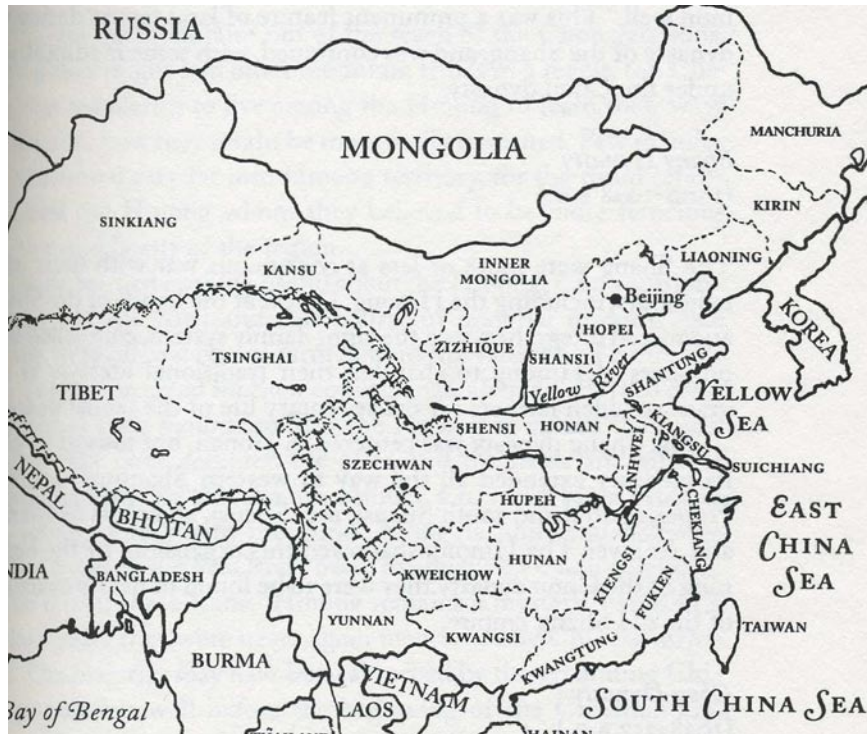


Figure 1. Map of China (Quincy, K. 1995)

The Yangshao were eventually taken over by the Lungshan Chinese. The Lungshan were rice farmers, possibly contributing to the agrarian lifestyle of the Hmong people. In 1500 B.C., the Lungshan were displaced by the Shang Chinese who established the first Chinese dynasty (Table 1). The Shang dynasty waged constant war with the tribal people, including the Hmong. This continuous violence forced some Hmong to give up their migrant farmer lifestyle and settle into the sedentary life of feudal peasants. Despite some assimilation, many Hmong held fast to their traditions and the Hmong population continued to expand (Quincy, K. 1995). During the following Chou Dynasty, (1028-257 B.C), many Hmong were banished to the mountainous region of San Wei in southern Kansu. This marked the beginning of the Hmong mountain dwelling

tradition. The Hmong enjoyed a new freedom in these isolated mountainous areas. The rulers of the Chou Dynasty tried to send Chinese scholars to live with the Hmong and govern them, but these efforts failed as the Chinese could not infiltrate the Hmong communities.

Table 1. Chinese Dynasties (1600 B.C. -1922 A.D)

Shang Dynasty	1600-1028 B.C
Chou Dynasty	1028-257 B.C.
Ch'in Dynasty	256-207 B.C.
Han Dynasty	206 B.C.-220 A.D.
Hmong Kingdom	400-900 A.D.
Ming Dynasty	1368-1644 A.D
Manchu Dynasty	1644-1911 A.D.

Violence against the Hmong resumed during the Han Dynasty (206 B.C.- 220 A.D.). The Hmong were forced to migrate southwards to the mountainous Province of Guizhou, the present day region of Hupeh and Hunan Provinces (Figure 1). The Hmong villages were attacked by the Han Chinese, their homes were burned down, and their valuables were stolen. Relations between the Chinese and Hmong people remained uneasy for centuries.

Despite these violent acts, the Hmong continued to resist defeat. By the middle of the sixth century A.D., the loosely organized tribes of the Hmong people united, forming

a hereditary monarchy (Figure 2). The king of the Hmong kingdom was elected. Upon the death of the Hmong king, his successor was elected from his sons by all men capable of bearing arms. There were many sons to choose from because the king had many wives, and therefore many children. The Hmong kingdom functioned much like a republic with much of the authority divided among local villages. Villages were organized into districts, each one containing twenty villages. A district chief was elected by all men capable of bearing arms and was subject to removal if he was found to be corrupt. This district chief appointed a headman for each village under his jurisdiction. Popular assemblies were organized at both the village and district levels to make important decisions. At the village level issues such as cooperative work projects, building new fields, or construction of roads were voted on. At the district level, these popular assemblies voted on issues such as the place and time of important Hmong communal religious celebrations such as the New Year festival (Huang, H. & Sumrongthong, B. 2004). The Hmong kingdom thrived peacefully in this mountainous region averaging four thousand feet above sea level and occupied most of the Hupeh, Hunan, and Kwangsi regions of east central China. The Hmong kingdom reached the height of its power in the last half of the sixth century as China collapsed into disorganized feudalism. China began to regain its power in 617 A.D. with the establishment of the T'ang dynasty. By 907, the Chinese Sung dynasty had become so powerful that the Hmong kingdom faced certain defeat. The Chinese general Ty Ching led several expeditions against the Hmong leading to its disintegration. The united Hmong kingdom was once again separated into a tribal people, united by language and customs but separated

geographically into separate tribes. Hmong kings called *kiatongs*, or little kings, ruled tenuously over regions of Hmong tribes. The golden age of the Hmong kingdom was over (Quincy, K. 1995).



Figure 2: Map of China depicting the Hmong Kingdom of 400-900 A.D. (Quincy, K. 1995)

Dispersed throughout the mountainous lands of China, these isolated villages had become safe havens for the Hmong until the genocide by the Chinese Manchu Dynasty. The Hmong kingdoms of the lesser and greater Kin-tchuen regions led rebellions against the oppressive Manchu emperor Chi'en-lung. The Hmong refused to adopt Chinese culture. This aggravated relations with the Chinese who viewed them as a threat to the

sanctity of Chinese civilization and culture. During one of the rebellions, the Hmong closed off all mountain passes to their territory, effectively severing all Chinese travel to the southwest. With these passes closed, the Chinese were losing control over Burma and Nepal. In addition, the Hmong were able to intercept trading caravans passing through their territory, damaging a lucrative trading route. Expeditions by Chinese troops to negotiate the reopening of the passes failed miserably. The Hmong kings called the Manchu emperor's oppressive policies and military aggression towards the Hmong criminal. This statement was considered blasphemous and enraged emperor Chi'en-lung who decided to exterminate the Hmong in China and sent General Akoui into the mountains. In 1776 General Akoui ambushed the Hmong in the capital of lesser Kin-tchuen, resulting in the death of Seng-Ke-Sang, the king of lesser Kin-tchuen. The captured Hmong were disheartened by the death of their king, which they took as a bad omen. General Akoui quickly moved on to the capital of greater Kin-tchuen, Leouei. He quickly captured the city, cut off supplies, and starvation and disease spread throughout the city. General Akoui captured the king Sonom of greater Kin-tchuen, and the royal family. They were executed by Emperor Chi-en-lung, the ten thousand remaining Hmong soldiers were given to Chinese officers as slaves, and captured Hmong civilians were sent to various parts of China to work as slaves in public works projects. Small conflicts between the Hmong and the Chinese continued, but from then on, more and more of the surviving Hmong fled to Vietnam, Laos, Thailand, and Burma (Quincy, K. 1995).

After the massive military attack on the Hmong in 1776, the Hmong moved a large group of six thousand to Laos. After this initial migration, thousands of Hmong

followed. Most of the Hmong settled near a town the Laotians called Nong Het. This region, located in the mountains and high plateau, was covered in thick vegetation and had fertile soil. The Hmong stayed in the mountains of northern Laos where they lived agrarian lives, cultivating the fertile land. The Hmong lived in the mountains at altitudes of 1,000 to 2,000 meters while the Karen and the Khmu tribes, native to Laos, lived around the altitude of 50 meters. The Laotian population outnumbered the Hmong and held the economic and political power. However, as in China, the Hmong resisted assimilation. The Hmong were entirely self-sufficient. They constructed flintlock rifles and crossbows made of wood, bamboo, and hemp. They hunted rats, birds, monkeys, gibbons, deer, and wild pigs. They also gathered fruits, greens, wild mushrooms, tubers, and bamboo shoots. They collected grasshoppers from the undersides of leaves and roasted them. They even devised an ingenious way to collect honey by tying chicken feathers around the thoraxes of bees, following them back to the hive, and smoking out the bees (Fadiman, A. 1997). The Hmong lived closely and harmoniously with the land. This fertile land was also one of the world's best environments for growing opium. As a very independent population, one of their only interactions with outsiders was through the opium trade. The opium poppy was suited to the cool temperatures and alkaline soils of the highlands. The Hmong were expert farmers. Thus they found the best soil by testing it for its lime content and they planted the seeds in such a way that the young plants were protected by corn stalks. When they harvested the pods they cut the pods precisely, freeing the sap, drying it, and forming it into bricks. The Hmong became the primary suppliers for the Lao opium dens. They transported the opium on small caravans

of ponies and only accepted payment in the form of silver bars that they melted down to make jewelry. The Hmong kept less than ten percent of their opium yield for their own use. Although it was abundant in their communities, few Hmong besides the shamans, the chronically ill, and the elderly used the opium. Indeed, opium was used to facilitate the ceremonial trances of the shamans, to treat various physical and spiritual ailments such as headaches, toothaches, snakebites, and fever, and to ease the discomforts of old age.

The French became very involved in the opium trade, nearly establishing an opium monopoly in Laos and Vietnam. During the French colonialism in Laos from 1893 to 1954, the Hmong were once again oppressed and exploited (Lee, G. 2007). Threatened by Laos's superior military power, the Hmong were forced to pay the majority of the French imposed taxes and were also forced to work as laborers for minimal pay. They lived independently and strongly, resisting the advances of the outside world until the late 1960s and their involvement in the Vietnam War.

In 1954, Vietnam was split into North and South Vietnam by the Geneva accords. North Vietnam was ruled by a communist government under the leadership of Ho Chi Minh. Democratic South Vietnam was lead by Ngo Dinh Diem. In 1959, Ho Chi Minh launched a guerilla campaign in South Vietnam, led by Viet Cong military units. His goal was to unite Vietnam under a communist regime. The United States became involved after a U.S. Warship was attacked by the North Vietnamese in the Gulf of Tonkin. On March 2, 1965, the first U.S. troops arrived in Vietnam in support of the South Vietnamese.

The Vietnam War consisted of parts: the larger, official war in Vietnam, and a smaller CIA led secret war in Laos. The Ho Chi Minh Trail was the principal supply line for the North Vietnamese army running from North Vietnam to South Vietnam, and through the neighboring countries of Laos and Cambodia. Disruption of this supply line became a U.S. military priority. However, it was located mostly on Laotian soil and was the principal supply line to the North Vietnamese and a Geneva agreement barred the United States from sending American troops into Laos. The North Vietnamese sent forty to sixty thousand North Vietnamese soldiers along with twenty thousand Pathet Lao (Laotian communist guerillas) to defend it. The United States, fearful of a communist victory in Laos, gave military aid to the Royal Laotian Government. However, the Royal Laotian army failed many times in conflicts against the North Vietnamese and Pathet Lao due to their corrupt officers and poor training. As a result, the U.S. authorized covert CIA led operations to create an alternative indigenous army to oppose the communist forces. Led by captain Vang Pao, the Hmong became the primary opposition to the Laotian communists. When the United States pulled out of Vietnam in 1974, the Hmong were left unprotected from the communist government against which many of them had fought. In extreme danger, over 300,000 Hmong were forced to flee to refugee camps in Thailand. At these camps, the Hmong suffered from poor sanitation, malnutrition, and lack of medical services. Although these camps were meant to be temporary, some Hmong stayed there for over ten years. Those fortunate enough were relocated to host countries, including the United States.

HMONG ACCULTURATION IN THE UNITED STATES

Approximately half of the Hmong in Thailand's refugee camps chose to migrate to western countries, while the others waited for the chance to return to Laos. Several thousand Hmong resettled in France, Australia, and Canada. However, most chose to come to the United States because their military leader, Vang Pao was there. Vang Pao, the leader of the Hmong troops who fought in the Vietnam War, was granted political asylum by the United States in 1975. He settled on a 450-acre ranch in the Bitterroot Mountains of Montana. His new home in the mountains was densely forested, somewhat resembling his homeland in the mountains of Laos. Church organizations and small community groups sponsored the first wave of Hmong immigrants. These refugees became naturalized citizens. These Hmong were then able to become sponsors themselves because of the rights granted to them by the 1965 Immigration Act. This act gave them the right to bring in members of their extended families through regular immigration channels to unite their families (Immigration reform 1969). In order to assist the large immigration of Hmong refugees, Vang Pao founded the Lao Family Community which has several branches in Southern California, Wisconsin, and Minnesota. This organization offered aid in finding jobs, vocational and language training, and counseling for adjustment to life in the United States. According to the 2000 Census, there are almost 170,000 persons of Hmong origin living in the United States. Since the 1990 census, there has been a 90% increase in Hmong making them one of the fastest growing Asian-origin groups in the United States. The Hmong are on their way to being the second largest Indochinese group in the nation, second only to Vietnamese. The Midwest,

especially Minnesota and Wisconsin, is the center of the population's rapid growth. Many Hmong refugees originally settled in the Midwest because most of the sponsoring church and community organizations were located in the Midwest. They have stayed in the Midwest and expanded to parts of Southern California due to agricultural opportunities that suit their traditional lifestyle.

Suddenly exposed to a drastically different culture and environment, the Hmong have had to adapt their traditional lifestyle in the face of new surroundings. Traditionally, the Hmong lifestyle was based on farming, raising livestock, and hunting. They practiced "slash and burn" farming, which exhausted the land they were cultivating within five years. They would then migrate to a new site of land. Farms were kept at least a half-mile away from their homes and livestock so that their livestock would not graze on their farms. They used simple tools such as axes, hoes, and planting sticks.

The Hmong raised pigs, chickens, oxen, and horses. These animals were kept close to the home. Horses were used for the transport of goods. Oxen were used for transport and were sacrificed at funerals. Although pigs and chickens were the primary source of protein for the Hmong, their main purpose was sacrificial. They were sacrificed to appease ancestors, to aid the spirits of the dead at funerals, to aid shamans in curing illnesses, and to celebrate weddings, births, and the New Year Festival.

In addition to raising livestock, they were also excellent hunters. They hunted with crossbows and flintlocks, often using poison on their arrows. This poison was extracted from the sap of trees. It was slow acting and took a long time to kill a large animal. They hunted everything, including rodents, deer, and wild pigs.

In the United States, the Hmong attempted to continue their practices as best they could. However, unfamiliar with policies concerning fishing and hunting licenses, some Hmong were arrested for hunting and fishing illegally and Hmong foraging for mushrooms and other vegetables have gotten sick due to their unfamiliarity with the varieties growing in the United States (Quincy, K. 1995). It has also been difficult for them to perform traditional ceremonies involving animal sacrifices. It is often very difficult and expensive to buy live chickens and pigs. Also, many residential areas have laws against keeping livestock. The Hmong have also run into opposition by neighbors who find the animal sacrifices cruel and barbaric. In some cases they have been accused of sacrificing dogs and have been charged with animal cruelty.

Traditional holidays have also been adapted to fit in with American society. The most important holiday in the Hmong culture is the New Year celebration. Traditionally, it is a month long celebration that takes place during the change of the lunar calendar. They celebrate by wearing new clothes, offering gifts to the elders, visiting other members of the clan, and arranging marriages for their children. In the United States, the Hmong have adopted their New Year celebration to reflect the timing of American holidays. Fresno, California has the largest Hmong celebration in the country. Their celebration runs from Christmas to New Year on the Roman calendar (Miyares, I. 1997).

The Hmong have also struggled to maintain their traditional system of social organization. When they first arrived in the United States, the Hmong resided in the cities of their sponsors and were supported by generous federal grants for Indochinese refugees. The government enacted a “scattering policy” that attempted to scatter Hmong refugees

evenly throughout urban and rural areas of the United States to encourage more rapid acculturation (Tatman, A., 2004). However, after they began familiarizing themselves with their surroundings, the Hmong initiated secondary migrations, trying to reunite their clans that had been separated. The clan is the most important unit of social organizations. There are eighteen main clans and the people within the same clan are considered to be brothers and sisters (Xiong, P., personal communication, January 26, 2010). Clan elders have the authority to make decisions for the members of the clan and to communicate with other clans. Within the clan, there is a similar hierarchy within each family unit. The eldest man traditionally holds the utmost power and has the final say in all family decisions.

Despite their best efforts to maintain strong clan and family relationships, adapting to life in the United States has created many issues of cultural conflict. Younger generations of Hmong are slowly acculturating to the American western society while older generations are maintaining traditional customs and beliefs. This discrepancy in acculturation is creating a generational gap and causing familial stress (Tatman, A., 2004).

Hmong did not have their own written language until the mid 1950s. Many of the Hmong refugees did not attend school in their native countries and were thus illiterate in their own language as well as in English. Lack of profitable skills and literacy have made it difficult for the Hmong to find employment and left the elder Hmong dependent on the younger generations (Tatman, A. 2004). Thus, younger Hmong have taken on the

responsibilities of finding employment and providing financial support for the family to compensate for the limited English language skills of the elders.

Education has played a primary role in the acculturation of Hmong youth. Through formal education and socialization with other American youth, they have quickly learned English and have become familiar with American customs. Many young Hmong have been successful in seeking higher education and building careers. Some Hmong women have decided to postpone marriage to pursue higher education. Although these Hmong face criticism from the larger Hmong community, they attempt to make amends by continuing their involvement in Hmong traditional celebrations and traditional arts such as folk dancing and needlework. Many Hmong have become doctors, lawyers, and university professors. Hmong writers have even begun producing a growing body of literature. In 2002, a compilation of Hmong stories and poems about life in America called *Bamboo Among the Oaks* was published (Kaufman, M. 2004). Many Hmong have become very successful in America, however, this success and wealth is mostly gained by the more acculturated youth. Many Hmong elders not only rely on the youth to translate for them, they also often depend on the younger generations financially. This transfer of responsibility has disrupted the traditional generational hierarchy of Hmong culture.

Despite the successes of many Hmong, poverty is still a widespread problem facing the Hmong in the United States. In 1987, nearly sixty-three percent were dependent on welfare (Quincy, K. 1995). Traditional Hmong agricultural skills left them with few employment options. They are competing with other racial and ethnic minorities

for a limited number of unskilled jobs (McInnis, K. 1991). Many Hmong men have taken jobs as laborers in meat packing plants and other factories. Recently, as U.S. government has increased its crackdown on illegal immigrants, more Hmong workers have been recruited to replace illegal Hispanic workers (Greenhouse, S. 2007).

Hmong gender roles are also a potential source of conflict and challenge for the Hmong. Traditionally, males are expected to provide financially for the family. Females are expected to marry young and start having children. Hmong teenagers are allowed to court during the Hmong New Year Celebration. Following this celebration, courtship lasts from three to nine months. Most Hmong youth are married between the ages of fifteen and eighteen. In the United States, this tradition presents many challenges to the girls who are unable to complete their high school education due to early marriage and pregnancy. Hmong females have a much higher rate of dropping out of high school than Hmong males. Hmong parents also often have higher expectations for their sons than their daughters. These cultural barriers to females seeking higher education have resulted in an elevated risk of poverty for young Hmong females (Vang, T. & Flores, J., 1999). Some Hmong females have started to use their needle work skills to produce decorative items that can be sold to western consumers. They have modified the themes of their needlework to appeal to western tastes (Lee, S., 1997).

The generation gap has also created conflict concerning healthcare and healing. Hmong youth are more accustomed to western medicine and have started utilizing the western healthcare system. On the other hand, Hmong elders are more likely to rely on traditional healing practices and remain skeptical of western medicine. The conflict

between Hmong spiritual healing and western medicine has been and continues to be one of the most challenging aspects of the Hmong integration to the United States.

HMONG HEALING

The Hmong spiritual beliefs have remained remarkably intact despite widely dispersed settlements. In large part, this can be attributed to their common history as an agrarian people. The Hmong people have traditionally cultivated a close and harmonious relationship to the land. Evidence of this relationship can be found in their everyday expressions. For example, *lis loos* means bees buzzing, *rhuj rhuau* means birds shuffling through the leaves looking for insects, *nrhuj nrhawv* means a tree popping slowly before it falls, and *xuj xuav*, which means a long, easy, all day rain. The Hmong were keenly aware of the processes of their surroundings (Fadiman, A. 1997). This intimate knowledge is accompanied by a spiritual connection and profound respect for all of nature.

Traditional Hmong beliefs revolve around an animistic understanding of the world, meaning that they believe that spirits exist within all natural objects. Animism is characteristic of many cultures that continue to work closely with their local environments. It reflects the understanding that human life is interconnected with the spirits of all other natural beings and that humans do not exist separate of their surroundings. In the animist belief system, distinctions are not made between the spirit of a person, the spirit of an animal, and the spirit of a place. Each one of these spirits exists as a conscious life. Animists embrace the concept of relatedness between all things.

Shamans, or *triv neeb*s, are Hmong spiritual healers. Each clan usually has at least one shaman. Shamans can be male or female, but they must be called upon by the ancestors. New shamans often learn of their calling through a long and serious illness.

Quag dab peg, or epilepsy, is considered to be an illness of some distinction. It is sometimes viewed as a sign that the sufferer is called to be a *triv neeb*, or shaman. In this case, the illness is considered sacred (Viste, 2007). Shamanism can also be inherited. The offspring of shamans are often deemed to have a predisposition to becoming shamans (Helsel, D., Mochel, M., & Bauer, R. 2004). Once the chosen person is recognized as a potential shaman, he or she enters intensive two to three years of training with the master shaman of the clan to learn the intricacies of communicating with the spirit world and how to perform ceremonies. The shaman is one of the most important members of the clan. Shamans communicate with the spirit world in order to heal or to prevent disease and illness, and through traditional healing rituals they rid the body of harmful spirits (Fadiman, A., 1997).

The interconnectedness of the spiritual and material worlds is paramount for the shaman's understanding of illnesses. Shamans heal their patients by reestablishing spiritual and physical balance. During healing ceremonies, the shamans cover their faces with a black cloth to protect them from bad spirits. They then enter a trance state in order to communicate with the spirit world. In this trance, the shaman can request that certain animals be sacrificed to appease the angry spirits. An important part of shaman healing work is searching for wandering souls. When the shaman successfully finds and returns a lost soul, health is restored. Shamanic healing is believed not only to heal the individual; it also restores the connectedness between the patient, the family, and the community. After the ceremonies, the shaman is offered a meal, paid for his or her services, and is

often given some of the meat from the sacrificed animal (Helsel, D., Mochel, M., & Bauer, R. 2004).

Hmong understanding of illnesses can be organized into two categories: non-spiritual and spiritual. The shaman plays an important role in the categorization of illnesses. Hmong families will often treat minor illnesses as non-spiritual first. However, if home remedies do not work, they will call on the help of the shaman. When the shaman comes to see the patient, he or she will determine if the illness is spiritual in nature (Helsel, D., Mochel, M., & Bauer, R. 2004). An egg is one of the tools the shaman can use to determine the cause of the illness. The shaman boils the egg and then peels it slowly examining the various bumps on the surface of the egg. These bumps tell the shaman what caused the illness (Xiong, P., personal communication, January 26 2010).

Minor illnesses such as fevers, weakness, poor vision, broken bones, stomach aches, and constipation are usually considered non-spiritual (Fadiman, A. 1997). Eating the wrong food, changing weather, unbalanced forces of hot and cold, and exposure to environmental elements are often to blame. These illnesses are most often treated with herbal remedies (McInnis, K. 1991). Herbs can be crushed, dried, infused with water, mixed with egg or chicken, and mixed with ashes. Measles is often considered a seasonal illness brought about by strong winds. In addition to using herbal medicines, the patient is also kept away from the wind and covered to conserve body heat.

Dabs, or malevolent spirits, may also be the cause of illnesses. *Dabs* can cause illness when they are scared or angry or by stealing souls. Illnesses can also be caused by bumping into a *dab*, having a *dab* sit on one's chest while sleeping, or digging a well in a

dab's living place (Fadiman, A. 1997). Illnesses caused by bad spirits can be treated with "cupping" and "coining". "Cupping" involves creating a vacuum on the skin's surface to draw out the bad spirits and pain. "Coining" involves scraping the skin with a coin to draw out the malevolent spirits (McInnis, K. 1991).

In addition to being a seasonal illness, some Hmong also believe that measles is caused by *dabs* that were frightened by or offended by strong odors produced by cooking. In this case, frying foods and cooking with odorous substances such as garlic and onion are restricted. Cooking was limited to foods that produce mild odors such as boiled rice and vegetables. A shaman may also be called upon to perform a ceremony called *Ua Neeb*. During this ceremony, the shaman communicates with the *dab* asking it to come out of the affected body (Jintrawet, U., & Harrigan, R. 2003).

The most severe type of illness is one caused by soul loss. Some Hmong believe that each person has only one soul, while others believe in as many as thirty two souls. The most common cause of severe illness is the loss of the life soul, which is essential for health and happiness. The soul can be lost as a result of anger, grief, fear, or curiosity. One of the most common indications of soul loss is paleness in the face (Xiong, P., personal communication, January 26 2010). The life souls of babies are especially vulnerable because they were so recently called from the spirit realm. The soul can be drawn away from a baby by bright colors or fragrant smells. It may also leave if the baby is not sufficiently loved and feels lonely (Fadiman, A. 1997). Parents take many precautions to protect their baby's soul from being stolen by a *dab*. Hmong babies are dressed in intricately embroidered hats to deceive *dabs* into thinking that the babies are

actually flowers. The mothers carry them swaddled against their backs in cloth carriers called *nyias* to protect them. Some babies also wear silver necklaces fastened with locks meant to lock their soul in.

The soul is an essential part of each person. On the third day after a new baby is born, he or she is given a name during a ceremony called *hu plig*, or soul calling. It is only after this ceremony and the baby has received its soul, that the baby is considered a full member of the human race. Although babies are the most vulnerable to soul loss, adults also take precautions to keep their souls intact as well. After an outing, many Hmong call out to their souls so that they come home with them and are not left behind (Xiong, P., personal communication, January 26 2010).

The illnesses caused by soul loss are regarded with much more severity because if the soul does not return, the body will die. Animal sacrifices are often involved in healing ceremonies because the souls of animals are believed to be connected to human souls. The bonding between the animal and the human soul helps bring the lost soul back. If the soul has only left recently and the family believes it to be nearby, the family can perform simple ceremonies to return it to the body. Most often, a chicken is placed outside the house to scratch at the ground to search for the missing soul. When the soul is found, then it is tucked under the chicken's wing. The chicken is then sacrificed and the soul is reunited with the body (Quincy, K. 1995). After the chicken is sacrificed, it is cooked and the shaman examines the feet and the tongue. If the feet and tongue are curled tightly, this indicates how strongly the soul was reunited with the body (Xiong, P., personal communication, January 26 2010).

Hmong healing is firmly grounded in their close, spiritual relationship to the natural world. On the other hand, western biomedicine is guided by biological and physiological principles and is based on a culture driven by technology. The differences between these two methods of healing extend deep into the cultural identity of the people that practice them. Mutual understanding and respect between the two cultures is necessary to facilitate effective communication between Hmong healing and western biomedicine.

A CASE STUDY

As discussed previously, epilepsy, or *quag dab* peg, is considered to be a blessing. It is a sign that the affected person is called to be a shaman. On the other hand, some illnesses such as birth defects are viewed by the Hmong as curses or punishment from the ancestors. According to traditional Hmong beliefs, birth defects are based in the spiritual realm and are predetermined in a past life. When birth defects run in the family they are often attributed to ancient curses. Birth defects can also be caused by the sins the baby or the parents committed in a past life. Some Hmong believe that the spirits are collecting a debt either from a past life by giving the baby a defect. Because of this, preventing birth defects or agreeing to outside help or intervention can be seen as an act of disrespect towards the spirits and ancestors. If the parents intervene, they believe that they are interfering in the work of the spirits thereby offending them (Viste, J. 2007).

While the Hmong etiology of birth defects is mainly spiritual, western biomedicine seeks to explain the causation of birth defects through molecular and developmental mechanisms. During the 1990s, research indicated a strong correlation between the consumption of the B-vitamin folic acid and the prevention of the neural tube defect in infants (Katan, M. *et al.*, 2009). Although the method by which dietary folic acid supplementation prevents neural tube defects is poorly understood, it has been determined that folic acid derivatives act as coenzymes and are essential for the synthesis of DNA, cell division, tissue growth, and DNA methylation. DNA methylation enables proper gene expression and chromosome structure maintenance, which are essential for normal development of an embryo. Low folic acid levels limit the ability of cells to

metabolize methionine, increasing the concentration of homocysteine in the maternal serum. This disruption of proper metabolism negatively affects folic acid receptor function and methionine-homocysteine regulatory genes resulting in various neural tube defects (Boyles, A. *et al.* 2006). In order to prevent neural tube defects, sufficient folic acid levels have to be established before pregnancy occurs because the neural tube forms and closes during the first month of pregnancy. Without sufficient folic acid levels, defects can be caused by a defective closure of the neural tube in the first month of gestation. A defect in the closure of the neural tube can result in malformations of the brain, skull, and spinal cord that in some cases are fatal. Spina bifida (malformation of the spinal cord) and anencephaly (malformation of the brain) are two examples of neural tube defects. Spina bifida is often fatal, but if the infant survives the complications are severe and lifelong. Infants born with anencephaly cannot live more than a few hours after birth (Viste, J., 2007).

As they begin to assimilate into western culture, the Hmong living in the United States are starting to eat fewer folic acid rich fruits and vegetables, which is more typical of western diets (Viste, J., 2007). Traditional Hmong diets are rich in dark greens and fruits rich in folic acid. The change in diet is putting the acculturating Hmong women at a higher risk of delivering babies with birth defects. In the United States, folic acid deficiency is being addressed through the fortification of grains and through public education programs on the importance of folic acid and good food sources such as dark green leafy vegetables, broccoli, spinach, asparagus, corn, nuts, dried beans, egg yolks, oranges, and strawberries. However, the Hmong's nutritional needs are not being met by

government efforts to fortify foods with folic acid. Packaged cereals, citrus fruit juices, and yeast breads are the top sources of folic acid for the general population. However, these items are not commonly found in traditional Hmong households.

Another strategy for addressing folic acid deficiency is through supplements. The Center for Disease Control recommends that all women of childbearing age take a multivitamin containing 0.4mg of folic acid per day to prevent the neural tube defects in case a pregnancy should occur (Centers for Disease Control, 1992). The recommendation to take a folic acid supplement presents many practical and spiritual issues for the Hmong. At the most practical level, many Hmong are unable to speak or read English and would not be able to understand instructions for taking supplements. Also, as mentioned earlier, prevention is a difficult concept for Hmong to accept especially in regards to health issues. They may not see the reasons for taking a pill everyday for a problem they cannot see and when they are otherwise healthy. They may also hesitate to take these supplements because the words folic acid sounds threatening and harsh. Pills are foreign to the Hmong who rely on food based and spiritual remedies. In order to promote folic acid supplementation for Hmong women, an education campaign needs to be specifically designed for the Hmong to help them understand why folic acid is beneficial.

In order to address the growing Hmong population in Wisconsin, the Wisconsin Folic Acid Council decided to create an educational campaign designed specifically for the Hmong community. Originally, the council intended to translate existing brochures

into Hmong. However, they quickly realized that many cultural considerations were needed to communicate within a Hmong context.

The committee decided to write the pamphlets in both English and Hmong at low literacy levels to be accessible to as many women as possible. Three bilingual translators translated the English text into the White Hmong dialect, which is the most commonly used dialect. Next, a Hmong registered dietician refined the translated material to ensure its cultural relevancy and checked it with several Hmong bilingual nutrition educators. This team translation approach was much more effective than traditional word for word translations. In addition to making the material more culturally sensitive, this method was necessary due to the fact that some terms do not translate literally into Hmong. For example the words spinal cord, fortified cereal, birth defect, and multivitamin were especially difficult to translate. Thus, the members of the Wisconsin Folic Acid Council also decided to incorporate other visual, non-print communications such as videos, small group classes, radio, and picture boards (Viste, J., 2007). In addition to addressing the needs of the illiterate, these alternative approaches also appeal to the visual and oral nature of the Hmong culture. As mentioned earlier, they did not have a written language until the 1950s. They have communicated through the art of storytelling, drawings, needlework, music, and song writing. For example, the elaborate needlework seen in traditional Hmong clothing records their history, tells stories, and communicates information (Xiong, P., Personal Communication January 26, 2010). The primary use of written text is a mistake. It considers only the preferred methods of communication of the

United States. The use of drawings and illustrations is more effective because it is more accessible and relevant to the Hmong community.

Hmong community events and health fairs attract large numbers of Hmong and are the primary venues of education. In addition to distributing pamphlets, Hmong educators are also there presenting displays with visuals and information. As mentioned earlier, Hmong social organization is based on a system of hierarchy within clans. Clan and family elders are trusted with the authority to make decisions and to give instructions. Therefore, the involvement of trusted Hmong leaders as educators is essential to the community's acceptance and compliance with recommendations. In order to make the displays more appealing, the presenters used bright pink and blue colors to imitate the colors often found in Hmong needlework and clothing. Neural tube defects are illustrated using medical illustrations. Often, there is an aversion to using such graphic illustrations in a presentation to a western audience. Presenters often fear that these pictures would be considered offensive by a western audience. However, the use of illustrations here shows a shift and sensitivity to the Hmong culture. It more closely follows the traditional use of story cloths to relay important information (Xiong, P., Personal Communication January 26, 2010). In addition, there is no exact translation for "birth defect" in Hmong and the illustrations serve to clearly show the problem. The illustrations prompted discussion among the attendees. At one fair, an educator noted that a conversation began with a memory of seeing such defects at a refugee camp. By engaging in these conversations and offering more information, the educator effectively relayed the message that folic acid can help prevent these problems. These conversations

among trusted members of the Hmong community are the primary sites of education. The pamphlets became secondary, acting as reminders of the information obtained through conversation (Viste, J. 2007).

CULTURAL BROKERS AND INTEGRATIVE MEDICINE

Culture is defined as a dynamic process through which ordinary activities and conditions take on emotional tone and moral meaning for the members of that culture (Kleinman, A., & Benson, P. 2006). Culture is not simply about differences in dress code, religion, and cuisine; culture ultimately shapes what really matters to people in a most profound way. The previous case study of folic acid education illustrates how the clash of cultures can inhibit the achievement of health and thus happiness.

The most complex issue revealed by the case study is the effect of acculturation on the relationship between the two cultures. Different levels of acculturation affect diet, literacy, and adherence to traditional beliefs. The younger generations of Hmong have become more familiar with western culture through education and greater proficiency with English. The elder Hmong have held more firmly to their traditional culture and fear that acculturation will lead to the loss of the Hmong culture. This struggle underscores the importance of considering culture as a dynamic phenomenon. Individuals identify with their culture and adapt to new ones in different ways. Effective communication must be able to mediate cultures in their dynamic and complex state.

The Hmong conception of illness comes from a culture based on a spiritual relationship with the natural world. As previously discussed, birth defects can be caused by sins committed in a past life; thus the physical pathology of the birth defect is wrapped in a much bigger spiritual context. Western biomedicine, on the other hand, comes from an individualistic culture driven by technology. Diseases are viewed as physical phenomena and birth defects are the result of developmental irregularities caused by

aberrant molecular mechanisms. The understanding of birth defects is based on a biological and physiological context.

The development of the Hmong folic acid education campaign showed a two part problem to communicating effectively between cultures: a language barrier and a cultural barrier. The creators of the Hmong pamphlet encountered linguistic barriers when attempting to translate from English to Hmong. English words such as “birth defect” and “folic acid” did not have equivalents in the Hmong language. In addition, many differences exist within the Hmong language between the White and Green dialects. Cultural barriers also made it difficult to make information culturally relevant. For example, prevention as defined by western biomedicine is a foreign concept in the Hmong culture. The idea of taking medicine while apparently well, does not make sense in their culture. There is also a distinct difference in the manner through which information is distributed. Western culture is largely text based. Literacy is the cornerstone of western educated culture. The Hmong, on the other hand, did not have a written language until the mid 1950s. New shamans learn the art of shamanism through mentorship. Stories are passed down through story cloths.

Research has shown that three communication processes are directly correlated with improved health outcomes. These include the amount of information exchanged between the individual and the physician, the individual’s control of the dialogue, and rapport between the individual and the physician (Singh, N., McKay, J., & Singh, A., 1999). Individuals with limited English proficiency and cultural differences have deficient amounts of success in all three of these communication processes. These people

have less access to health care services and lower rates of physician visits. Even when these people do have access to care, they experience decreased satisfaction and increased medication complications. This usually results from a lack of comprehension of the diagnosis and treatment instructions (Karliner, L., Jacobs, E., Chen, A., & Mutha, S., 2006).

Traditionally, an interpreter has been used to overcome the language barrier. In an effort to ensure the quality and accessibility of interpreting services, the U.S. Office of Minority Health released national standards for culturally and linguistically appropriate services (CLAS) in health care in December 2000. Standard 4 states that “Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation”. In addition, standard 6 requires that “Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer)” (U.S. Department of Health and Human Services 2000). These standards are considered mandates and are federal requirements for all health care organizations receiving federal funds. In practice however, the kind of interpreter used can range from a highly trained medical interpreter to any available bilingual person. The lack of availability for trained medical interpreters often results in the improvised arrangement of interpreters. Therefore, in most cases, Hmong patients depend on family members to interpret for them. These family members

are usually the younger members of the family, because, as mentioned earlier, the Hmong youth are quickly learning English, while elders are not. This transfer of responsibility from the Hmong elders to the Hmong youth disrupts the hierarchical nature of Hmong society. The youth may hesitate to ask elders probing or potentially embarrassing questions to avoid disrespecting the elders. In turn, the elders may hesitate to disclose sensitive information to younger Hmong. In addition, family members are not qualified to act as medical interpreters because they may not be able to provide accurate translations due to unfamiliarity with medical terms used by the physician. Finally, family members who are not trained in interpreting tend to give polite and brief summary translations of what the patient actually said. This could leave out potentially important information necessary for accurate diagnosis.

Professional interpreters have been shown to make fewer errors and result in improved patient outcomes (Karliner, L., Jacobs, E., Chen, A., & Mutha, S., 2006). Standardized proficiency training that is specialized for medical setting is necessary to ensure quality care and to comply with CLAS Standard 6. A good model for such training is the PALS for Health Training. It includes 40 hours of classroom education for medical interpreting, a spoken and written proficiency test, shadowing a trained interpreter, and demonstration of abilities under supervision. Although this type of rigorous and standardized training will raise standards of interpreting, it will also have to be supplemented with cultural familiarity. Cultural barriers also impede complete understanding between the patient and physician.

Despite the interpreter's proficiency in language, their ability to translate does not necessarily remove cultural barriers. Interpreters may not be aware of equivalent medical terms in the patient's culture hindering them from facilitating the needed interaction between the patient and physician. In some cases, equivalent terms for western medical words and concepts do not even exist in the patient's language. For example, some terms critical to the folic acid campaign such as multivitamin and folic acid do not translate literally into Hmong. In addition, the concept of pills is foreign to the Hmong who rely on food-based remedies. Many languages also have multiple dialects that individual interpreters may not be familiar with. In Hmong, there are two main dialects- White Hmong and Green Hmong (Allen, M., *et al.* 2004). Since White Hmong is the most prevalent dialect, those speaking Green Hmong may be at a disadvantage. Also, some Hmong may also speak and read multiple other languages such as French, Laotian, and Vietnamese.

Due to the difficulty of navigating various languages and cultures and the need to bridge cultures, a new profession, cultural brokerage, developed. Cultural brokers not only translate the spoken word, but also give very important information that is conveyed by nonverbal cues and through understanding of the person's cultural background. Cultural brokers are people who are acculturated in both the minority culture and the mainstream culture (Singh, N., McKay, J., & Singh, A., 1999). They act as bridges between cultures, informing both the western physician and the minority patient. With their unique knowledge of both cultures they are able to communicate the nuances and values of the minority culture to the mainstream culture. They recognize that as powerful

as the culture of the Hmong has on health care, the culture of biomedicine is equally powerful. The cultural broker facilitates mutual understanding between the two cultures, laying the foundation for an effective communicating relationship.

One of the most important tasks of a cultural broker is to reconcile the expectations of the patient and the physician. In western medicine, physicians have certain expectations of the role of their patients. They view their patients as autonomous, physical individuals. They expect patients to take an active role in making the diagnosis and discussing possible treatment plans. In the Hmong culture, patients are viewed as spiritual and physical beings who do not exist autonomously, but rather as members of a complex and hierarchal social structure. When offering treatment plans to a Hmong patient the physician often focuses too much on the patient's physical body and on choices as an individual. Since the Hmong believe their health is a result of both physical and spiritual causes and that their health is connected to that of their family, they consider decisions concerning their health as family decisions and will not make them without the input and approval of the family and a shaman. It is especially important to explain the patient's situation to the elders of the family so that they can be a part of the decision making process. Without mutual understanding of these expectations, the physician and patient will not be able to effectively approach the tasks of diagnosing and treating the illness.

The western and traditional Hmong expectations of the healer also differ markedly. In western medicine, the physician is recognized as a highly educated person, but an ordinary person nevertheless. Western patients are accustomed to the use of tests

to facilitate diagnoses. They also recognize that treatments are not guaranteed to be perfect and that treatment plans often have to be tried and adjusted to give the best outcome. In the Hmong culture, the shaman is a person of great distinction. The shaman is called to the vocation by the spiritual world. As mediators between the physical and spiritual world, shamans have a divine quality. Many of these attitudes carry over to the Hmong expectations of physicians. They expect the doctor to know for sure what is wrong with them and that the treatment prescribed will have immediate curative properties (Xiong, P., personal communication January 26, 2010). Elder Hmong are especially disconcerted when the physician runs multiple tests to eliminate possible illnesses. They are often exhausted and frustrated by tests. Seeing the doctor deliberate about the source of their illness makes Hmong elders feel uneasy. They expect the doctor to be authoritative and absolute about the cause of the disease and the treatment.

The cultural broker also has the responsibility to protect the patients by making sure that they understand their rights. Due to their hierarchical culture, the Hmong do not question or challenge anyone of higher prestige. They view physicians as authority figures who deserve respect. Hmong seldom question the physician even if they did not understand the diagnosis or treatment. Paperwork and contracts are also a foreign concept for the Hmong. It is very important that the cultural broker explain the binding nature of signing forms. Many times, these forms are rushed and the physician takes advantage of the patient's trust and gets them to sign them without explaining them first. Another western concept that the Hmong are not familiar with is confidentiality (Xiong, P., personal communication, January 26, 2010). This is very important to explain to the

Hmong who may withhold important information for fear of embarrassment. Confidence in their understanding of the western medical system increases the likelihood that the Hmong patient will be open to trusting and communicating with the physician.

The work of cultural brokers is to build a bridge of understanding between Hmong patients and western physicians. Hmong patients who can trust their physicians will be more open to western biomedicine and western treatments of illnesses. While cultural brokers make great strides in bridging cultures, they cannot replace professional health care providers and their expertise in healing. Cultural brokers need to function as part of a health care team. They act as mediators for teams that includes patients, their families, traditional healers, as well as western physicians. An integrative approach to medicine will more fully bridge the gap between traditional Hmong healing and western medicine by bringing the two approaches together.

Integrative medicine focuses on the patient as an individual and seeks to treat the whole person: mind, body, and spirit. It recognizes the potential benefits of alternative healing practices in addition to western biomedicine. Biomedicine focuses on pharmaceutical treatments derived from understanding of the biological causes of disease. It is the product of a society driven by technological advances. Alternative medicine has a very broad definition that includes acupuncture, nutritional modifications, herbal remedies, and meditation. Many of these treatments originate from traditional methods of healing used by different cultures throughout the world. Many of these cultures live closely with the land in areas where technology is completely foreign. Their medical treatments have been designed to fit their lifestyles and to make use of their

resources. Integrative medicine seeks to complement the use of biomedicine with alternative techniques that focus not only on the symptoms of the illness itself, but on the overall well being of each individual. The goal of integrative medicine is not necessarily to blend biomedicine and alternative medicine. It recognizes the merits and weaknesses of both approaches. In the integrative medicine framework, biomedicine and alternative medicine both maintain their unique attributes while working together (Willison, K. 2008).

Research has shown that integrative medicine contributes to high levels of patient satisfaction especially in the management of chronic conditions. Chronically ill patients often require the services of a wide range of care givers including multiple specialized physicians, nutritionists, nurses, and psychotherapists. This is especially true for those individuals whose condition fluctuates between acute and chronic care phases. An integrative care model brings these caregivers together as a team, which fosters more effective use of health resources.

Improved communication between health team members is one of the most beneficial characteristics of an integrative care model. Research has shown that the integrative care model helps reduce clinical error by improving communication among staff. One study showed that this team approach helped lower clinical error rates in the emergency room from 30.9 to 4.4 percent. Moreover, an additional study showed that the implementation of caregiver teams in a 300 bed hospital reduced the incidence of unexpected cardiac arrest by fifty percent. These teams were able to intervene earlier, reducing the incidence and mortality from unexpected cardiac arrest (Willison, K. 2008).

Patients treated with integrative medicine also reported an improvement in emotional well-being and increased communication with physicians. They felt that the integrative medicine approach supported their beliefs that health is a combination of physical, spiritual, and emotional well being (Myklebust, M., Pradhan, E., & Gorenflo, D. 2008).

Integrative health care also reduces the use of medication and invasive treatments by considering alternative treatments alongside biomedical treatments. For example, Dr. Lawrence Taw, a physician at the Center for East-West Medicine, developed a clinical and educational program that focuses on patients with inflammatory diseases. This program targets patients with osteoarthritis, rheumatoid arthritis, and other autoimmune conditions such as lupus, multiple sclerosis, and inflammatory bowel disease. He creates individualized treatment plans that include dietary modifications in order to control inflammation and reduce medications. For example, he may suggest increased intake of Omega-3 fatty acids by eating more fish and flaxseed. This dietary modification can often aid in the reduction of anti-inflammatory medication (CEWM 2010).

An integrative approach to medicine views traditional Hmong healing techniques and western medicine as complementary practices, combining the best of both, and balancing their use. This type of approach suits the unique background and culture of the Hmong people. Based on the animistic roots of their beliefs, the well being of the mind, body, and soul is essential for health. They are also more comfortable with herbal and food based remedies and would prefer exploring these options and leaving pharmaceutical and invasive interventions as last resorts (McCaffrey, A., Pugh, G., & O'Connor, B. 2007).

Within the Hmong community, some herbalists have already shown their willingness to incorporate western medicine into their practices. Hmong herbalists are experts in traditional herbal remedies. Knowledge of herbal medicine is passed down from generation to generation through apprenticeships. Those herbalists exposed to western medicine have begun to blend medicines with their herbs. For example, they mix antibiotics with herbal creams to treat wounds. There are also existing resources that are working towards bridging the gap between western and Hmong medicine. For example, the Hmong Health website (www.hmonghealth.org) includes a traditional healing section that includes pictures and descriptions of Hmong herbs (Allen, M., Matthew, S., & Boland, M. 2004). Information about these herbs is written in both English and Hmong. With this information available, Hmong patients are able to tell the providers what herbs they are using and the physician will be able to understand them as part of the treatment plan.

Western physicians can be trained in traditional Hmong herbal medicine while working alongside shamans and Hmong herbalists. Dietary, herbal, spiritual, and biomedical treatments can be combined in individualized treatment plans. This combination of techniques can result in a reduction of medication and invasive treatment. This outcome is especially favorable for the Hmong who often resist the use of medicines and see invasive treatment as a last resort.

Since the level of acculturation varies greatly across generation, the level of comfort with western and traditional healing will too. The spectrum of care needs to be adjusted to meet the needs of each specific individual remembering that each patient is a

person first, and a patient second. The United States can be viewed as the latest stop on the migratory journey of the Hmong. The Hmong have the remarkable ability to maintain their identity while learning from the people they encounter. As they traveled through China, they learned “slash and burn” farming and how to raise livestock among many other things. Now, as their journey has brought them to the United States, an integrative approach to medicine will bring Hmong healing and biomedicine together in a collaborative and fruitful relationship that brings health and happiness to the Hmong.

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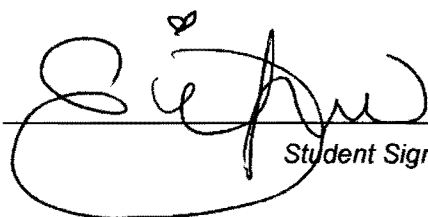
Date of Submission 5/6/10 Degree Program B.S. Biology, Honors

Title of Submission Bridging Cultures: Integrative Health Care for Among Refugees

Submitted To Regis College Honors Program

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