

Indigenous healers in Southeast Asian refugee communities

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November 1982

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ACKNOWLEDGEMENT

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The Pacific Asian Mental Health Research Project (PAMHRP) is indebted to many individuals and organizations in the Southeast Asian refugee community for their part in our study, *Indigenous Healers in Southeast Asian Refugee Communities*. They provided us with valuable assistance in a variety of ways, but most importantly in identifying potential healers and by making the essential personal introduction of our staff. We are especially indebted to the healers who kindly consented to the interviews. We also wish to acknowledge the special contributions of PAMHRP staff members, Jessica Kao and Esther Wong, who developed the interview protocol and conducted the field interviews, and Anson Moon, who had an important role in the writing. Finally, we are again indebted to Alcyne Wong for her care and attention to the preparation of the manuscript and production of this report.

Kenji Murase, D.S.W. Principal Investigator

I. INTRODUCTION

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Efforts to introduce western medical technology in non-western cultures have frequently met with disappointment. One of the reasons is that differences between the new technology and indigenous ways of perceiving illness were often ignored. An example is the mother who believes that her child is afflicted by the evil eye and is told by the doctor that no such illness exists. Without efforts to bridge the gap, the mother may very likely leave the office without having gained the confidence in the doctor to return. Analogies can be drawn to the situation of the Southeast Asian refugees in the United States.

Since 1975 over 600,000 refugees from Cambodia, Laos, and Vietnam have entered the United States. For many of the refugees, the transition has not been easy, and severe mental health problems are being reported. For example, a pilot study comparing refugee clients to Caucasian Americans utilizing an outpatient community mental health center in San Francisco found that the refugees were facing far greater environmental stressors and presenting and

being diagnosed for more severe problems (Nguyen 1982). A two-year study of Vietnamese in the greater Seattle area (Lin, et al. 1979) similarly indicated problems within this community. According to the study, refugee scores on the Cornell Medical Index were much higher than the norm for the United States and about half of the Vietnamese refugees were regarded as having emotional difficulties. Higher scores persisted into the second year.

Despite indications that adjustment problems are present and are likely to worsen, the direction of policy makers has been to curtail federal refugee assistance programs. With eligibility for federal cash assistance now reduced to 18 months, the expectation, or hope, is that refugees who have not attained self-sufficiency within this period will be “mainstreamed” into local county welfare programs. Due to federal reductions in aid, states such as California have also drastically reduced or eliminated local programs that were intended to ease the transition process. In California, all mental health and social adjustment services for refugees have been eliminated and vocational training and language classes have been reduced.

p. 2 The impact of federal reduction in aid has not been fully evaluated. However, in dealing with adjustment and mental health related problems, the likelihood is that refugees will be forced to rely more on their own resources (rather than government assistance) or to begin utilizing the same services that are available to the general populace. The experience of other Asian Pacific groups has been that these public facilities have not been adequate in dealing with minority clients and their problems (Egawa and Tashima 1981). Generally, underutilization has been attributed to cultural and linguistic differences between mainstream service providers and their clients. With reduced federal support there have been reductions in refugee programs which were intended to bridge such differences and to establish culturally and linguistically appropriate services (e.g., by training and recruiting bilingual/bicultural health and mental health workers and interpreters) for the various Southeast Asian refugee communities

Purpose of the Study

The Indigenous. Healers Study was undertaken when it became evident, during the course of other research being conducted by Pacific Asian Mental Health Research Project (PAMHRP) staff, that traditional healers were being utilized by the refugees despite the existence of an advanced, highly institutionalized medical system in the United States. There was little written material that described these healers or their healing practices. However, it was felt that a description of this sort would be useful as an introduction to refugee health and mental health practices and beliefs and refugee perceptions of appropriate treatment.

The specific objectives of the study are to identify some of the healers who are well recognized in their communities and to describe their professional qualifications; current healing practices in terms of their interpretation, identification, and treatment of mental health problems; and whenever possible, characteristics of actual healing sessions and the patients' perceptions of the relative effectiveness of indigenous and western medicine in treating their problems. It was felt that the information would be useful in understanding why indigenous healing practices are continuing to be utilized as well as changes that may be occurring under the impact of the refugees' exposure to western medical practices.

Various factors can influence an individual's decision to seek help when health or mental health problems occur, including culturally based definitions of illness and beliefs about its cause. As numerous studies have indicated, indigenous concepts of illness will persist, even in countries where western medical technology has been introduced. These concepts continue to exert their influence on decisions about who is sick and in need of help as well as the choice of treatment. Where both western and indigenous medical systems are utilized, the indigenous system will generally be considered more appropriate for certain purposes and western medicine more effective for others (Lieban 1977:27).

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Perceptions of the relative effectiveness, or appropriateness, of either system are often linked to the nature of their diagnoses. Glick (1967) suggests that in western medicine illness may be explained in terms of impersonal, physiological causes or processes (e.g., a virus or hemorrhaging due to a cardiovascular disease), while the diagnosis in folk medicine is often inseparable from an identification of its "basic cause." Examples of the latter are an illness which is seen as divine retribution for moral transgressions or cases of sorcery, where another individual's wrath or jealousy is suspect. The relative effectiveness of the different systems may be seen as residing in their ability to treat such causes. For example, in a village in India, Gould (1957, 1965) found that western medicine was generally resorted to for critical incapacitating dysfunctions and the indigenous system for chronic and poorly defined complaints. However an exception occurred in the case of smallpox (a critical incapacitating dysfunction). Based on the belief that the illness was caused by one of the goddesses, villagers continued to treat the illness through religious rituals performed to expunge her influence. In a study of Guatemalan groups, Gonzales (1966) notes that, while people seek help for the same illness from both a physician and an indigenous healer, the physician may be sought for relief of symptoms and the indigenous healer for relief from the basic cause of the illness.

Therapeutic styles and the characteristics of the healer or medical practitioner may also affect the utilization of different medical systems. In another study of an Indian village, Marriott (1955) found that western medical practices were hampered by the attitudes of villagers towards its

emphasis on privacy and individual responsibility, on written prescriptions, and on the democratic style of interpersonal trust that was expected between the patient and practitioner. Similar themes are mentioned by Spiro (1978:199-202) in his analysis of Burmese exorcistic ceremonies. He suggests that part of the effectiveness of such healing ceremonies resides in the confidence the exorcist is able to instill in the patient. This confidence is based on the exorcist's professional characteristics and ability to treat basic causes (e.g., on the exorcist's recognized piety and ability to enlist the help of powerful Buddhist forces to do battle against the supernatural agents who have caused the patient's afflictions) as well as the healer's skill in conveying self-confidence and effecting a positive transference.

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Two other aspects of the ceremony, as a therapeutic setting, are the group support it often affords the patient and, in the case of exorcistic ceremonies, the opportunity for what Spiro calls an "almost massive emotional abreaction" of the patient's conflict. The ceremony induces the patient, while in a state of trance or possession, to act out the part of the afflicting spirit, sometimes identifying the spirit by name, stating the nature of its grievance, and

struggling with the exorcist to maintain its hold over the patient. The struggle ends when the possessing spirit capitulates to the greater powers of the exorcist and promises to cause the patient no further harm. The group support which Spiro and others see as an important aspect of treatment is evident in the public nature of the ceremonies. In contrast to the privacy that is often valued in western practice, during the ceremony, family and community are expected to participate in the patient's treatment (e.g., by bringing food, obtaining the ritual objects to be used, and sitting with the patient and offering advice and sympathy) and, through their presence, show their faith in the diagnosis and in the cultural resources that are at the patient's disposal.

Very little has been written on Southeast Asian mental health practices and beliefs and even less about those of the refugees after their arrival in the United States. However, some important cultural differences between indigenous and western beliefs and practices are indicated in the literature that is available. For example, it is said that much of the emotional suffering that warrants mental health assistance in the United States may be

p. 5 considered by many Southeast Asians as part of the normal vicissitudes of human life and, only in severe cases, be identified as a "problem" which requires special intervention. When intervention is sought, it is often for a physical ailment of a psychogenic nature or for various forms of hysteria, including possession by demons or spirits. Signs of possession and physical symptoms of suffering are not only more commonly recognized categories of illness than "feelings" of unhappiness or discontent, they are subject to very different treatment methods than are usually available through western health care systems. In the case of possession, the usual treatment may be ceremonies to exorcise the possessing spirit and, for physical ailments, medicines to restore the body's inner balance (Tung 1980).

The Indigenous Healers Study is only meant to provide an exploratory description of refugee healing and health-seeking practices. It was felt however that the study would provide more detailed information than is currently available. Although the emphasis is on mental health treatment, the literature indicates that the same healer will often treat illnesses of the body and mind without the distinctions that are made in western medicine.

Methodology

Ethnographic data for the study was gathered primarily through in-depth interviews with healers in the Cambodian, Vietnamese, and Lao communities in the San Francisco Bay Area. Identification and selection of the interviewees was based on a review of the literature and the recommendations of Southeast Asian refugee service providers and knowledgeable members of each of the Southeast Asian communities.

After the general purpose and objectives of the study were explained to these consultants, they provided introductions to healers either by telephone or in person. In some instances, the consultants also served as interpreters during the interviews. The criteria for selecting interviewees were that they were recognized healers in their communities, that they were

knowledgeable about traditional medical practices, and that they were available for interviews and willing to participate in the study. Interviews were conducted

from June to December of 1981 with a retired Cambodian monk, a Vietnamese Buddhist monk, two Mien families of healers, and a Hong shamaness. p. 6

An interview protocol was developed delineating areas of research interest. These areas were outlined as follows:

1. Information on the Healer

- a) Who are they? - Sociodemographic information on the healer; professional specialties; typical healing activities; personal characteristics and professional traits; healer's perception of his or her role as healer.
- b) Cultural pathways to becoming a healer: How did the interviewees choose to be healers; how were they chosen; how do they legitimize their special roles?
- c) Social and professional network: Healers as a community (professional associations, regulations and referrals); relationship between healers and the general public; linkages between healers and the larger health and mental health provider communities.

2. (Healers' Perception of Their) Patients

- a) Who are they? - Sociodemographic information on the patient.
- b) Typical problems and complaints that are brought to the healer.
- c) Patients' hierarchy of resort and health-seeking behavior
- d) Outcome of therapy.

3. Indigenous Healer's Role in Managing Mental Health and Illness

- a) Etiology of illness
- b) Classification of illness: How does the healer recognize or explain psychologically related problems?
- c) How does the healer treat different types of problems?
- d) Uniqueness and limitations of indigenous approaches.

4. Cultural Change and Adaptation

- a) Changes in healing styles since arriving in the United States.
- b) Responses or adaptations to host country.

5. Reasons Healers Continue to Attract Patients

- a) The healer's own evaluation.
- b) Other possibilities (e.g., availability and accessibility; cultural factors).

Interviews were conducted by two research assistants, both of whom were bilingual in English and Chinese (either Mandarin or Cantonese). Interpreters were used during the interviews with the Hmong shamaness and the Cambodian monk. Chinese, English, or a combination of both was used during the other interviews. Data was collected through interviews conducted at the p. 7

healer's residence and through observations of actual healing sessions. Each healer was interviewed from two to three times during sessions which lasted an average of three hours.

Information was recorded in notes taken during the interviews and written up in detail immediately after each session. When a healing ceremony was observed, details of the setting, the healing process, and the interactions among the healer, patient, and other participants were recorded.

Several limitations in the data exist. The range of healers who were identified for any one ethnic group is far from exhaustive. However, even within a small sample of healers, a fairly broad range of therapeutic approaches was evident. These include the use of physical manipulation (e.g., forms of skin cauterization and scarification), the use of medicines derived from herbs and animal parts, and various forms of supernatural intervention. Neither was there time to include healers from all of the Southeast Asian ethnic groups in the area. For example, although an ethnic Lao healer was identified, time restraints did not permit follow-up interviews.

Although an interview protocol was developed, information in all areas of the protocol outline was not obtained for each of the healers. In some cases the interviewee did not have the information on hand. For example, none kept detailed records on the number, age, or sex of patients; presenting problems; or the treatment prescribed. A great deal of the information in these areas was incomplete or anecdotal in nature. Language also put a constraint on the nature of the information which was obtained. For example, some terms and concepts were not easily translated; neither were fine distinctions always made in translating terms such as "ghost" and "deity" or "spirit" and "soul." In some instances, when the response of the interviewee or the question of the interviewer was unclear, the interpreters provided assistance and clarification.

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II. HMONG AND MIEN HEALERS

The Hmong and Mien are probably the least known of the Southeast Asian refugee groups that have entered the United States since 1975. Although they are both usually categorized as "Lao refugees," in Laos, as in other countries where they have settled, they have remained ethnic minorities, with their own distinct cultures.

Background

The origins of the Hmong are unknown, but historical Chinese references place them in the basin of the Yellow River as early as the twenty-seventh century B.C. (Geddes 1976:3). From there they branched southward into the Yangtze River Basin and in relatively recent times (by some accounts no more than 400 years ago) into the mountain chains of Southeast Asia (p. 27). According to a 1959 estimate, the largest Lao-Hmong concentrations were found in northern Laos, in Xieng Khouang Province (Barney 1967:271). In the aftermath of the Indochina wars, about a third (100,000) of the Lao-Hmong fled the country to be resettled abroad, and another 60,000 await resettlement in neighboring Thai refugee camps (Dao 1982:18)

The origins of the Mien are also unclear. However, they are thought to be among the original inhabitants of southern China. Historical records indicate that they were driven into the mountains south of what is now Hunan Province during the twelfth and early thirteenth centuries and, during subsequent migrations, moved into parts of Indochina and northern Thailand (LeBar 1964:64). Probably the bulk of the Mien population resides in China, where 1965 estimates place their numbers at 740,000 (Beng 1975a:21). An accurate picture of the number of Mien in Laos is unavailable. Estimates as late as 1959 range from 5,000 (LeBar 1964:89) to 20,000 (Department of Army 1970:694). Although Mien settlements are scattered throughout Laos, like the Hmong, the heaviest concentrations were found in the province of Xieng Khouang (p.695).

Neither Hmong nor Mien, both usually classified as Sino-Tibetan languages, have indigenous scripts. However, Chinese ideographs are sometimes used for spoken Mien, and there have been attempts to provide both languages

with Lao and romanized scripts (Department of the Army 1970:699, Tou-Fou 1981:74-75). Through extensive contact with the Chinese, many Chinese loanwords appear in both languages. As the language of communication with their deities, Chinese has also played an important role in the religious ceremonies of the Mien (Kandre 1967:599). All of their religious texts are written in Chinese and the more literate, usually the “spirit doctors,” can read the language with some fluency (Beng 1975a:22).

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Often referred to as “hill tribes,” the Hmong and Mien were generally found at higher, mountain elevations where they engaged in slash and burn (swidden) agriculture. This method of crop cultivation periodically required villages to move in search of new, and more fertile, land. Hmong villages, usually found at slightly higher elevations, generally occupied the same site for five or six years; Mien settlements appear to have been somewhat more permanent, and remained in the same place for a relatively longer period (LeBar, pp.73,89). The size of these settlements varied. In Xieng Khouang Province, Hmong villages averaged eight houses, with a range from one to forty, with some structures housing as many as 34 individuals (Barney, pp.276-277).

The basic Hmong social unit was the “household” (patrilineal extended family). In villages where each house belonged to the same household, the household head also served as the village head. Where several households belonged to the same clan, the village head was usually the eldest household head. (In Hmong society, there are twelve different clans, members of the same clan tracing their descent to a common, mythical ancestor.) In cases where villages contained households from more than one clan, the eldest household head of each clan was recognized as chief. Among the Lao-Hmong, district chiefs (*tasseng*) who may have had as many as forty villages under their supervision, served as the main link between villages and officials in the Lao government (Barney, pp. 275-280).

One of the functions of these leaders was to settle disputes within their respective jurisdictions. For example, disputes within the family were settled within the household; those between households, within the villages; and those between villages, within their districts

(Barney, p. 280). According to Barney (p.292), household, village and district groupings were maintained in the refugee camps. Leadership, above the district level, was

p. 10 also recognized by the Lao government in the form of “paramount chiefs,” leaders who represented the entire Lao-Hmong population (p.281).

There are no figures on the average size of Mien settlements in Laos, but they probably ranged from small villages with as few as five houses to larger villages, subdivided into hamlets with several houses each (LeBar, p.89). In northern Thailand, the typical village consisted of fifteen houses, each with an average of 8.5 individuals per structure (Young 1966:47). Several nuclear families may have been housed under a single roof, the head of each family usually related to the house-owner (*peo tsiu*) through patrilineal descent. Members of a house shared ritual obligations with the *peo tsiu* to his common descent group and its ancestor spirits. These common descent groups were organized into sub-clans. The largest of the ritual descent groups was the clan (*fing*). According to legend, all Mien belong to one of twelve clans whose members originally set out to sea from “Nanking” and were saved during a storm by the mythical god, Pien Hung (Kandre 1967:590-591).

The secular affairs of Mien villages were usually handled by the village headman and council. In northern Thailand, the position of headman seems to have been hereditary but, under the pressure of Thai law, became an elected position (Jaafar 1975a:37-39). Headmen could also be appointed by a “big headman” (*tum tao mien*). The *tum tao mien* were high level chiefs who may have been chosen by a group of other headmen to mediate in intervillage affairs. In some cases, these high level chiefs received government titles and became mediators for the central government (Kandre, pp.611, 615-620).

Another figure of importance in Hmong and Mien villages were the individuals who acted as intermediaries between the villagers and the world of spirits. The role of many of the traditional healers that are found in Hmong and Mien societies seems to be inseparable from their function as intermediaries of this type.

p. 11 **Traditional Hmong Views on Illness**

Hmong beliefs about the cause and treatment of illness are part of a larger system of religious beliefs about the soul and the individual's relationship to ancestors, mentors, and the familiar and sometimes mysterious elements in the natural world around them. In addition to the secular world, the Hmong believe in a supernatural world where the spirits of ancestors continue to exist and, in ways mirroring the natural world, objects such as trees and rivers are given life in the form of spirit-entities. “Outside spirits” are likened to strangers, and might include the spirits of trees and forests outside the immediate precincts of the home. “Inside spirits” are more familiar and may reside in the home or in parts of the village and surrounding fields (interview notes; Scott 1982:65). Ancestral spirits usually include the worshipper's parents and paternal relatives to the generation of great-grandfathers (Geddes, p.49).

Characteristics of the Spirit World.

According to Hmong beliefs, spirits have rights and areas of specialization as well as needs that are similar to those of humans. Ancestral spirits, for example, require food and shelter, which descendants have an obligation to provide. Spirits also have feelings and may be provoked into harming individuals. Sometimes the provocation borders on the capricious, as when someone accidentally bumps a spirit on the road and angers it into an act of retaliation. While some spirits are considered malevolent, others, if properly handled, can provide protection and guidance. Ancestral spirits are among those who generally seem to have protective functions but can be angered, if not given sufficient attention or offerings of food and money which are needed to sustain them in the spirit world (interview notes). More recent ancestors are generally the most likely to be a source of trouble for the family (Geddes, p.52)

Hmong Concept of the Soul

The Hmong believe that humans have several souls (Young, p. 39; Jaafar 1975b:68; LeBar, p.76). After death, at least one of the souls goes to reside in the spirit world (Young, p.39) and one returns to be reincarnated,

either in a child about to be born (Geddes, p.5) or in the next child of the family (Barney 1981:38; Department of the Army, p.633; LeBar, p.77).

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Before a Hmong child is born, a soul must be purchased through ritual means, usually by burning "spirit-money." According to Geddes (p.98), the spirits presiding over a territory of the supernatural world inhabited by the souls of the dead then grant permission for the soul to be reincarnated. Permission is granted, somewhat like a "license," with a specified expiration date (interview notes).

Temporary "soul loss" or "soul separation" is considered a factor in the majority of the illnesses which afflict an individual (Geddes, p.98). Separation may occur because the individual's "license" has expired; because the soul may have been inadvertently dislodged by an accident or frightening incident; or because it has been taken by a spirit who has been angered or offended. Some souls are also inherently weaker than others. Soul separation is especially common among young children, perhaps because the attachments binding the soul are still weak and vulnerable to accidents and experiences of fright (interview notes).

Hmong Healers

Although the Hmong recognize both natural and supernatural causes for illness, in the majority of the cases, the cause is attributed to the supernatural—to either soul separation or the workings of an angry or malevolent spirit (LeBar, pp.71,77,78; Geddes, p.97). Most Hmong villages have traditionally had at least one person who was knowledgeable about the spirit world and able to treat supernaturally caused illnesses (LeBar, p.70). The most frequently mentioned are the village priest, the exorcist, and the shaman.

The three types of religious healers seem to differ in their areas of expertise and relative importance as healers. For example, among the Kweichow Black Hmong, healing and other religious functions are handled by either the priest or exorcist (LeBar, p.70). Geddes reports that among the Blue Hmong of Thailand, the shaman, who holds an important leadership position in village affairs, is also “their only powerful doctor” (p.99). Although the priest and shaman both deal with supernaturally caused illnesses,

p. 13 it is only the shaman who can directly see, hear, and talk with agents of the supernatural world through spirit possession (p.78).

A Hmong Shamaness in the San Francisco Bay Area

A shamaness residing in the East Bay was interviewed in order to understand more about her role and work in treating illness. The shamaness is in her mid-forties and arrived in the United States in the early part of 1981 from a refugee camp in Thailand. At least two other local Hmong shamans were identified but were not interviewed. Of the forty to fifty thousand Hmong refugees who have been resettled in the United States, approximately 300 reside in the San Francisco Bay Area (Dao 1982:18; field notes, October 1982)

Qualifications and Skills

According to the shamaness, shamans are recruited into their role after a test of their strength and character. In the case of the shamaness, the test was a three year illness. During this period, a shaman-spirit (guiding spirit) appeared to her in a dream and indicated that she had been chosen for the role. The dream was verified by other shamans whose opinions she sought. The shamaness' authority as a healer derives from her selection by the spirits as well as her efficacy in treating illnesses. Although the role is not strictly hereditary, recruits are selected from families which have shamans in their history. The interviewee's shaman ancestors were several generations removed.

The special healing skills and knowledge that the shamaness possesses ultimately depend on her ability to see, hear, and speak with her spirits. It is this ability, above all others, that distinguishes the shaman from other healers, but it is a power that the shamaness has only during ceremonies while in a “dream” or trance-like state. Outside of the ritual setting, the shamaness appears and acts very much like other Hmong refugees.

To some degree the shamaness has clairvoyant powers. In Laos, she often knew in advance whether a villager would become ill or seek her services. However, she feels that her inability to build a “home” or spirit-

p. 14 shelf for her shaman-spirits since arriving in the United States has affected her ability to foresee such events in her new environment.

The shamaness is considered exceptional in having several areas of expertise. These include skills in bonesetting; in the use of moxibustion; and in a form of “blowing” used to stop or

reduce hemorrhaging and to heal fractures and burns. There are secular practitioners who specialize in some of these same skills, but they have been taught by secular experts rather than shaman-spirits.

Major Functions of the Shamaness as Healer

The diagnostic and curative powers of the shamaness rely on her ability to act as a spirit medium between the supernatural and human worlds. The analogy was made, during the interviews, to the interpreter, who was able to bridge the language gap between the shamaness and the interviewer. Without the interpreter, she said, neither side would be able to communicate. In a similar manner, communication between the supernatural and human worlds is effected through the presence of the shaman-spirits and the shamaness, who serves as their medium. As a spirit medium, the shamaness carries out two important functions: she is able to diagnose the cause of an illness and, by negotiating a contract or bargain with the spirit world, to suggest appropriate remedial action.

The shamaness probably enagages in some preliminary diagnosis on the basis of the patient's pulse, physical symptoms, and information the patient's family may have given her about events that could have precipitated the illness. During the ceremony, she summons the shaman-spirits and with their assistance determines the exact nature of the patient's illness. In the case of "soul loss," the spirits may intervene on the patient's behalf and locate the soul or suggest ways in which it might be strengthened.

Since different illnesses are caused by different spirits, the shamaness must be able to identify the one responsible for her patient's illness. Knowledge of this sort is also obtained during healing ceremonies while she is in communication with her shaman-spirits. The shaman-spirits are able to communicate with other spirits to determine which, if any, of them was responsible for the patient's illness.

Once the responsible spirit has been identified, the shamaness begins negotiating on her patient's behalf. For example, she may bargain with the responsible spirit, promising that certain offerings will be made if the patient recovers. If the patient fails to recover within the time promised, she may approach the spirit again. Once patients have regained their health, they must carry out their part of the bargain, offering whatever spiritmoney, foods, or animals (usually a chicken or pig) were initially promised or the illness recurs. Propitiatory action of this type appears to be common. In some cases, the shamaness may also exorcise an illness by calling on her shaman-spirits to "push back" an afflicting spirit.

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When a patient's illness and death are inevitable, the shamaness will tell the patient, and no bargaining will occur. However, even in the case of an "expired license," the shamaness is sometimes able to negotiate a longer term.

The Patient

Very little sociodemographic information on the shamaness' patients was obtained. Case examples indicate that she is seeing both male and female patients and young children as well as adults. She has worked with patients in communities within a radius of 140 miles from her home (i.e., in addition to the San Francisco Bay Area, patients from communities such as Stockton, Santa Rosa, and Merced)

Ethnicity of Patients

The majority of the shamaness' patients are Hmong refugees. She has also treated a few ethnic Lao and Cambodians as well as an American teaching English to the refugees at a local Indochinese resettlement center. The shamaness offered to examine the American when he appeared in class, on crutches, after having fallen and injured his ankle.

The fact that the shamaness is treating non-Hmong patients may be indicative of changes that have been occurring since her arrival and might be seen as the result of resettlement patterns which find refugees from different ethnic groups in the same classrooms and often in the same apartment buildings and low-income neighborhoods. One or two of the shamaness'

p. 16 recent cases have been the result of her participation in classes at the resettlement center, where news of her skills seems to spread by word-of-mouth and she is able to meet other refugees who may be having problems.

Number of Patients

Since her arrival in the United States, the shamaness has been attending English language classes during the day and, with the exception of emergencies, has been seeing the majority of her patients on weekends. In Laos, in addition to her part-time functions as a shaman, she would probably have been engaged in other activities such as farming. In the United States, weekend appointments probably reflect the convenience of the patient as well as her own, since ceremonies may require a full day or longer for preparation and completion and involve the participation of family members who are working or attending classes during the week.

The shamaness was unable to provide the exact number of patients who were seeking her services. She did indicate, however, that she might not see any patients for a week or more but, then, at other times be "very busy." During the period of the interviews, she received requests from patients almost every weekend and may have been seeing from two to three patients each week. While at a refugee camp in Thailand, she performed ceremonies for four or five patients a day.

Major Complaints/Problems Treated

Since arriving in the United States, the shamaness has treated a variety of complaints. Three major types of problems, or illnesses, are illustrated by the following examples.

Children's Problems

Several cases involve children. In the case of a Santa Rosa family, the child was described as weak and suffering from both a loss of weight and appetite. In a second case, involving a refugee family in Merced, the child had similar symptoms and a recurrent fever. They symptoms began about two weeks after the child accidentally fell into a river near his home. The third case involved a young child who was feeling feverish and had had diarrhea for about a month and a half.

In the case of the Merced child, it was believed that the patient's soul had been dislodged by the accident and had sunk to the river-bottom. The shaman-spirit was asked to retrieve the soul. The third case was also diagnosed as a weakness in the child's soul. The shamaness believed it could be strengthened by sacrificing a pig and bartering its soul for that of the child. A similar idea might be seen in Geddes' description of "counterpart souls" (pp.98-99). In the case he relates, a Meto (Thailand). child's illness is linked to events occurring in the spirit world. Through a shamanistic ceremony, it was determined that the child's counterpart was a pig who was being slaughtered for a festival. In order to spare the child's life, a replacement for the counterpart's soul was needed, and a village pig was subsequently sacrificed for this purpose.

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A point to note in these cases is that the shamaness' services are often being sought despite geographic distances and economic hardship. In several cases, ceremonies were postponed until the family had sufficient funds on hand. Since the shamaness does not charge for her services, expenses may involve the purchase of food, offerings for the spirits (such as spirit-money, incense, and a live pig or chicken) and perhaps a token donation to the shamaness as well as arrangements for her transportation.

Another point of interest is the position held by indigenous healers vis-a-vis western practitioners. In the third case cited above, the child had been hospitalized, but when the diarrhea and fever continued, the family summoned the shamaness. According to the interpreter, western medicine is considered effective in treating "diseases" but not illnesses caused by indigenous agents, such as a Hmong spirit, or for treating cases of weak souls. When the child's illness persisted, even after hospitalization, the family began to think of these more traditional causes for the illness. The interpreter explained that the shamaness might not know much about "diseases" but was very knowledgeable about "inside" and "outside" spirits.

Women's Problems

Another type of problem is specific to women. In one case, a San Francisco Hmong woman sought the shamaness' help with complaints of muscle pains and menstrual difficulties. The woman, who was twenty-five years old and the mother of five or six children, had stopped menstruating two years

earlier. When the problem continued after seeing a western doctor, she turned to the shamaness and requested medicinal herbs.

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In Laos, these problems seem to have been fairly common. Women went to the shamaness when feeling tired during menses, when having difficulty conceiving, and when suffering from complications related to delivery. One of the more severe cases involved a young woman who continued to hemorrhage after childbirth. When she was seen by the shamaness, she was barely conscious. Although specific information on the treatment was not obtained, the case seemed to involve initial pulse diagnosis to determine whether the cause of the illness was due to “inside” or “outside” spirits.

In Southeast Asia, the Hmong had access to a fairly extensive pharmacopoeia, including Chinese medicines obtained from traders (LeBar, p.81; Department of the Army, p.600). The case of the San Francisco patient indicates that the shamaness' medical knowledge includes the use of herbs. However, many of the traditional herbs and medicines she once prescribed can not be obtained in the United States or are sold in dried or altered forms that are difficult for the shamaness to identify. The medicine she gave her patient was one of the few herbs grown in her own backyard.

Psychological and Behavioral Problems

A third type of problems includes depression, excessively aggressive behavior, and withdrawal. Although specific labels were not used to identify patients or their symptoms, one case was presented to the interviewer as an example of someone who was considered *veu* (“crazy”). The case involved a Cambodian refugee woman who had insisted that her family change residence because she was afraid someone would kill her. Initially, it was felt that the woman's behavior might be due to the side-effects of medication prescribed for the woman when she had gone to a western doctor. When her behavior became more violent, family members tied her down with cords to prevent her from kicking and fighting. After the shamaness arrived, she burned incense; prayed to the spirits for about thirty minutes; and then had two chickens sacrificed on the patient's behalf. Apparently, the patient had been unaware of the proceedings during this time. When she regained consciousness, she immediately asked why she had been tied down and seemed to be extremely embarrassed.

p. 19 Another case concerned a young man in his early twenties. From his family's description, it appears that the young man had been suffering from bouts of depression for several years, even when he was in Laos. According to his family, the young man's mood was unpredictable, and he sometimes became very hostile, even to friends and members of the family. He might also become physically violent and begin throwing and hitting objects within reach. At these times, his family described him as being “very, very angry.” The young man described himself, during the weeks preceding the shamaness' visit, as being “very unhappy.”

A ceremony was held for the young man several weeks earlier, during which his condition was diagnosed as possession by a tree spirit. On the occasion when he and his family met with the interviewer, they were meeting with the shamaness for the second ceremony, this time to offer their thanks to the spirits for their assistance and to elicit their continuing support.

Healing Ceremony

The ceremony for the young man was the second of two performed on his behalf and took place in the patient's home in South San Francisco. Friends and relatives had been invited.

A low table had been set up in the living room and prepared with lighted candles, joss sticks, and bowls of wine and other offerings to the spirits. A small pig which had been purchased in Santa Rosa lay behind the chair facing the table.

During the first part of the ceremony, the young man sat facing the table. The shamaness donned the black cloth which would later serve as a mask and stood behind the young man, chanting and striking a plate-shaped metal gong which she held in her hand. The chanting and beating were probably to invite the spirits to partake of the offerings on the table.

During the latter half of the ceremony, the shamaness took the young man's place in front of the altar, and covered her face with the black cloth. The black cloth, and finger bells to simulate the sound of horses, may have symbolized her departure for the spirit world, where she would thank the spirits for their assistance and also elicit their continuing support and cooperation. Although a few reports (see, for example, Cadet 1962) describe

the shaman as entering a trance at this point, the shamaness appeared to be conscious, though her voice sometimes reflected the spirits speaking through her. During this period, the pig had been taken from the room and prepared as an offering to the spirits. It was placed behind the chair, and spiritmoney was burned in a tray beside it. The young man's case was considered difficult since it took several attempts on the shamaness' part to gain the spirit's cooperation. The ceremony which lasted for about two hours, ended when it was finally elicited, and the shamaness removed the mask from her face.

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Throughout the ceremony, guests and family milled in and out of the main area, talking with friends, observing the ceremony, assisting the shamaness, and preparing for the banquet which followed. Sections of pork were later given to the shamaness for her services.

Traditional Mien Healers

Like the Hmong, the Mien believe in a spirit world which can exert its influence over secular events and the health and well-being of individuals. The main elements of the supernatural world are a central spirit government, ancestral spirits, and a host of minor spirits, often of malevolent tendencies. The latter include the spirits of animals, such as tigers, and natural phenomena, such as the wind and the leaves in the forest (LeBar, p.91; Umemoto 1981:33). While the spirit world can protect individuals from harm, it can also be a major source of affliction. The Mien believe that there are evil spirits for every category of illness and accident that occurs (Kandre 1967:588-589).

Mien Beliefs about the Supernatural World

Spirit Government

The Mien spirit world is governed by a group of eighteen functionaries. Often depicted in ritual scrolls used during religious ceremonies, these officials, and their assistants, show a strong Chinese influence. According to LeMoine (1982), they are often similar in name and appearance to those in the Chinese Taoist pantheon. The Mien believe that the spirit government controls events in the spirit world as well as the human world and that an

p. 21 individual's ultimate well-being depends on relations with these high officials (Beng 1975a:25; Kandre 1967:588).

The spirit government has many functions of immediate and long term interest to the Mien. Of long-term interest is the individual's fate after death. The spirit government determines this fate—and the status or position of the individual's spirit in the spirit world—on the basis of the merits individuals have accumulated during their lifetime. Status is gained through a series of merit-making ceremonies. A Mien's first “official” title, or rank, in the spirit hierarchy is granted after he has passed the *kwa tang* ceremony (see p.23; LeMoine, pp.24-27; Kandre 1967:588). For those who have accumulated little merit, the fate may be punishments for past sins or a return to the world of the living, where they are destined to wander the earth as hungry ghosts (LeMoine, p.106).

Of more immediate interest to the Mien perhaps is the spirit government's ability to lend individuals its expertise and protection. The spirit government includes divine warriors (or “spirit soldiers”) who may lend their help to worthy humans and provide protection from illnesses and the influence of evil spirits (LeMoine, pp.50, 115-124, 147-152). It also includes notables who are reputed to have learned the secrets of healing from Lao-tzu. The secrets have been handed down to Taoist priests in the form of registers of helpful spirits, liturgical books, mudras, and other sacred tools that are used in ritual ceremonies (LeMoine, pp.75-76).

Ancestral Spirits

Another class of helpful spirits are the Mien ancestors. The Mien believe that these ancestral spirits can provide the family with protection and assistance in its dealings with the spirit world. For example, ancestors may petition the spirit government on behalf of descendants, asking for offspring to carry on the family line (LeMoine, p.134). The higher the ancestors rank, or status, the greater its influence in the spirit world. As indicated earlier, the Mien believe that rank, or status, in the spirit hierarchy is granted by the spirit government on the basis of merit-making ceremonies that the individual carries out during his lifetime or that are carried out on his behalf by later descendants.

p. 22 Ancestral spirits also have the capacity for causing illness. When obligations which individuals have incurred toward ancestral spirits—obligations, for example, to keep them fed with “spirit food”—are not carried out, forebears can apparently be the source of a variety of afflictions.

The Mien Concept of Soul

Like the Hmong, who believe that illness may be caused by the temporary departure of the soul, the Mien believe that health is dependent on a “life force” (*hwen*) (Kandre 1967:596n; Crystal 1981). When the life force departs the body for some reason, the priest or ritual expert may call upon the assistance of the spirits to search the universe to locate it and to induce it to return. Miles (1978:432) argues that every human possesses twelve *hwen* (*uari*, “soul”), each corresponding to one of the twelve divisions of the body (eyes, ears, mouth-and-nose, neck, arms, chest-and-upper back, abdomen-and-lower-back, legs, left side of the head, right side of the head, feet and hands). Illness is effected in one or more parts of the body by malevolent ancestors who can instigate the loss of the *hwen* corresponding to these parts (Miles 1973:81; 1978:434).

Mien Healers

The Mien have two major methods of dealing with sickness. *Dia* (“medicine”) seems to be resorted to in cases of illness attributed to hereditary factors (e.g., an individual's hereditary predisposition to ill health), and *tsiang* (“ceremonies”) to illnesses attributed to supernatural causes (Miles 1973:77-78). At least three types of healers are mentioned in relation to the latter: high level nonmonastic Taoist priests, or grand masters, who are called *tum sai kung* (Kandre 1976, 1967) or *tom sai chia* (LeMoine 1982); lower level priests called *sib mien mien*; and spirit mediums called *bogwa* or *bothung*. Although all three can communicate with the spirit world, there seem to be differences among them in terms of their training, the level or type of spirits they have access to, and their methods of dealing with the spirits.

Taoist Priest Hierarchy

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According to LeMoine, under the master (*sai chia*) and grand masters (*tom sai chia*), there are four main levels of priesthood, each with increasing influence over the spirits of the supernatural world. LeMoine lists these levels, corresponding to levels of ordination, as: (1) *kwa tang*, (2) *tou sai*, (3) *chia tse*, (4) *pwang ko*. Ideally, Mien males will have undergone at least the first level of ordination (*kwa tang*) during their lifetime, since initiation into the Taoist priesthood confers the individual (and his family and forebears) with benefits, including spiritual rank after death and control over harmful and malevolent forces during his lifetime (Umemoto 1981:35; MeLoine, p.33). For example, those who have gone through the *kwa tang* or *tou sai* ceremonies are rewarded with “spirit soldiers” who can protect the family against evil spirits, diseases, and misfortunes of various kinds. *Kwa tang* receive 36 to 72 soldiers and *tou sai* 60 to 120. During emergencies, these soldiers can be enjoined, along with other spirits in the Taoist pantheon, to exorcise evil influences and to restore order (LeMoine, p.28). A vivid description of these soldiers is provided by Miles (1978:443) during a ceremony to retrieve a villager's “lost soul.” Villagers, enacting the part of the spirit soldiers and armed with weapons, ran through the town, beating on doors, in search of the soul and the spirit responsible for having taken it.

Difference among Healers.

Falling somewhat below the four levels of priesthood are the *sip mien* (LeBar 1964:91; LeMoine, p.24), individuals who are able to perform simple oral rituals (called *sip mien*, “to deal with spirits”) but unable to undertake advanced studies under qualified ritualists such as the masters or grand masters because they are only semi-literate in Chinese. Chinese, as mentioned earlier, is the language of all Mien religious texts. Under the direction of a master, an initiate is expected to learn about rituals and to copy from his master's books matters pertaining to sacred chants and written documents such as petitions and memorials to the spirits (LeMoine, p.29).

p. 24 The difference between *sip mien* priests and higher level priests is that the former are only able to deal with “smaller spirits.” The grand masters and higher level experts such as the *tou sai* are able to deal with all levels of the spirit world, including the Spirit Government (LeBar, p.91; Kandre 1967:599n). These higher level priests are also able to petition the spirits through written documents.

One of the basic differences between spirit mediums and priests is that mediums communicate with the supernatural world through possession, while the priests do not (Miles 1976:14; Beng 1975a:27). In a case involving “soul loss,” Miles (1978:442-443) describes the function of the priest as exorcising the supernatural agent responsible for the patient's illness. The medium on the other hand becomes possessed by one of the patient's dead ancestors, the only ones who can see the lost soul and thus facilitate its return.

Mien Healing Practices in the San Francisco Bay Area

In order to understand more about Mien healing practices in the United States, two families of healers in the Bay Area were interviewed, along with a refugee service provider who is a leader in the Mien community. The latter was interviewed primarily for supplementary information. There are approximately 15,000 Mien refugees in the United States and 2,000 in the San Francisco Bay Area (interview notes; Crystal 1981).

One of the families interviewed resides in an industrial section of West Oakland where approximately 200 Mien refugees are clustered within a five-block area. Family members include the father, a ritual expert in his early sixties; the mother, an herbalist in her late fifties; and one of their sons, a young religious healer in his early thirties. Although the father is retired, he is able to offer his assistance and advice to the younger healer for special cases requiring the father's expertise and experience. At the time of the interview, the family had been in the United States for a little over a year.

The second family resides in San Francisco, in a downtown area that has absorbed a considerable number of Southeast Asian refugees in recent years. Household members include a ritual expert in his late forties; his wife, a

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former mid-wife in Laos; and adult children and their families. Although two of the sons are active in the refugee community as social service providers, neither is currently following in his father's footsteps. However, the father expressed the hope that one of his sons would learn about Mien healing practices and rituals in the future. The extended family includes the father's elder brother, an herbalist in his sixties.

Ritual Experts

Training of Ritual Experts

The term which emerged during the interviews to refer to religious or ritual experts was *sai kung*. Eight or nine such experts reside in the Bay Area. The ritual experts in West Oakland and San Francisco were both considered among the most knowledgeable of this group. The latter's training began at the age of eighteen. Although he is now in his late forties, he continues to study and learn. Religious knowledge and training may be transmitted from teachers to pupils through hand-written texts that have been passed down through the ages. In his own case, this knowledge was part of the family tradition, handed down from father to son for generations. Since the texts contain the key to religious knowledge, an important part of one's ability to deal with the spirits derives from the ability to read and to understand these texts, which are written in an archaic form of Chinese. The interviewee's third son, to whom he hopes to teach the family texts, began learning Chinese at a refugee camp in Thailand during his midteens and is continuing his studies in the United States.

The young healer in West Oakland has been studying under the tutelage of his father since his early twenties, when he first began learning Chinese incantations and other skills to diagnose and treat illnesses. His father is currently teaching several other pupils as well, and continues to provide his son with consultation and assistance as needed.

Ceremonial Functions of Ritual Experts

Although there are many types of spirits who are potentially harmful, the examples given during the interviews pertained to ancestral spirits who might be angered if descendants failed to provide offerings of spirit-food or to perform appropriate ceremonies on their behalf. The ancestors most

likely to cause trouble are the patient's deceased parents and grandparents.

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Loss of *hwen* was also mentioned as a cause of illness. *Hwen* can be dislodged or separated from their owners by a sudden fright, a car accident, a change of residence, or the owner's physical and emotional state (e.g., by periods of unhappiness or fatigue). Without the protection of *hwen*, individuals might suffer from "weakness," "tiredness," "bad brains" (learning disabilities), "mental illness," or from further accidents.

Therapeutic ceremonies for those afflicted by supernaturally caused illnesses seem to be performed primarily by priests, or religious healers, who are able to communicate with the spirit

world and invoke the presence and assistance of spirits such as those of the healer's masters and the patient's ancestors. The latter appear to play an important role in the ceremony, since ancestral spirits can often tell the patient the specific cause of the illness and the steps which must be taken in order to alleviate or remedy the condition. Sometimes an offering (of a pig or chicken) will be indicate. Ceremonies also involve the burning of "spirit-money," often special papers imported from Thailand. Money (whether in the form of silver or "spirit-paper") seems to be an important currency of exchange in negotiations and dealings with the spirit world. Kandre points out its importance in merit-making ceremonies and also in healing rituals ("bridge ceremonies"), where its function is to form a symbolic bridge between the human and supernatural worlds so that communication between the two can be effected (1967: 588-589; 596n).

"Bridge ceremonies" have been variously described in the literature (see, for example, Kandre; Miles 1978:442-443; and Beng 1975b:41-45). An important element in the ceremonies, for cases of *hwen* loss, seems to reside in what the interviewees refer to as "binding." Once the lost *hwen* has been retrieved, the priest symbolically binds it to the patient by winding ritual threads around the patient's wrists. The threads may be worn for as long as a year.

In addition to its therapeutic functions, "binding" ceremonies may also be performed to prevent illness and to strengthen the patient's *hwen* ("life force"). A ceremony of this sort was conducted during a birthday celebration for the wife of one of the religious experts who was approaching her forty-seventh birthday. While male guests and relatives sat around the family

p. 27 dining table, white threads of differing lengths were placed before them. A long thread circled the table top and each guest had a shorter thread in front of him. After an interval of chanting, during which white paper money was passed out by the guests and then burned, one of the older men at the table began wrapping a thread around the left wrist of the celebrant. The action was then followed by each of the guests in turn. Apparently the Mien believe that once individuals have passed their mid-thirties, they stand a greater chance of having weaker *hwen*, and the ceremony was an attempt to bolster its strength.

Patients

According to one of the healers, ceremonies to prevent or cure illnesses are performed on behalf of individuals once or twice each year. The ceremonies are performed in the homes of patients, who include both sexes and cover the age spectrum from young children to the elderly. The West Oakland religious healer and his father see at least two patients each month and sometimes as many as two individuals a week. Patients reside in Oakland as well as nearby cities such as San Francisco, San Jose, and Richmond. Transportation is provided by the patient's family.

Mien Herbalists

Several members of the families who were interviewed are herbalists (*dia sai*), knowledgeable about the use of medicines derived from plants and animals. These include both male and

female members of the two families. In the case of the women, herbal remedies have been passed on from mother to daughter. This tradition continues in the West Oakland family, where knowledge of herbs is being transmitted from the mother to her daughter-in-law, the wife of the younger religious healer. The mother is also experienced in “burning” (moxibustion) parts of the body for various complaints such as headaches and stomach upsets. The elder brother of the religious expert in San Francisco is also considered quite knowledgeable about indigenous herbs. In his sixties, this brother learned the religious incantations which can be used in administering the various medicines from a “master” while in Laos.

Problems Treated

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In Laos, nearly every Mien family seems to have had access to herbs which were used as home remedies or prescribed by specialists. The problems for which these medicines were used ranged from simple body aches, fevers, stomach upsets and “tiredness” to major illnesses which were common in Laos but have not occurred in the United States. For example, one such illness—afflicting the neck area and causing difficulties in breathing and swallowing—could result in death if not quickly treated. Herbs were also used in pre-natal and post-natal care. For example, during pregnancies, women were put on dietary regimes that included herbs mixed with rice and other foods. Special bathing water, prepared with herbs, was also used for three days immediately after childbirth in order to prevent complications with later pregnancies and to facilitate the woman's recuperation and early return to the fields.

Religious Aspects of Treatment

Although a variety of problems can be treated with herbs, it takes a specialist to treat certain types of illness. For certain illnesses, the herbalist must also know “special words” or incantations to invoke the appropriate spirits, including those of the healer's master, for assistance. These incantations are learned from the healer's masters.

Patients

Healers in the two families were asked about their use of herbs in treating patients in the United States. The West Oakland herbalist indicated that many people continue to seek her services; and, as mentioned earlier, she is now teaching her daughter-in-law about the uses of various traditional medicines. The herbs are used for complaints such as headaches, stomach upsets, fever, body aches, and tiredness.

By contrast, members of the San Francisco family indicated that they are seeing very few refugees and are largely confining their use of traditional herbs to situations within the family. For example, the mother currently has no students and gave, as the primary reason, the unavailability of traditional medicines. Apparently the demand for the services of herbalists

continues. However, because few herbs are available, the elder male herbalist indicated that he might often have no recourse but to refer refugees to a hospital or western doctors for treatment.

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Indigenous Healing Practices and Western Medicine

Hierarchy of Health-Seeking Behavior

The Mien in Southeast Asia seem to have had access to a range of remedies and specialists, including herbal and religious experts, to whom they could turn for the prevention and treatment of illness. For example, Miles (1973) lists under the *dia*, or “medicine,” available to a North Thailand Mien village procedures such as skin scarification, cauterization, massage, forms of acupuncture, home-made herbal medicines, inhalations and ointments. The medicinal repertoire for the villagers also included patented drugs and pharmaceutical goods obtained on the market and through contacts with other settlements (p.78). In addition to these, *tsiang*, or “ceremonies,” could be resorted to by the villagers as a prophylactic against illnesses caused by malevolent ancestor spirits. In a survey of the villagers, Miles found that 53% relied exclusively on medicine (*dial*), 4% exclusively on ceremonies, and 35% on the combined efficacy of both in order to protect themselves from various illnesses (p.79).

Initially, Miles hypothesized that the majority of the villagers in his survey no longer believed in the power of supernatural agents, since a larger percentage would have otherwise resorted to ceremonies rather than the protection of various forms of *dia* (p. 78). Later findings, however, suggested that all of the villagers acknowledged the importance of ancestors as agents of illness. Whether villagers sought protection through *dia* or *tsiang* was determined by whether or not their ancestors were considered malevolent. *Tsiang* were resorted to by those who had malevolent ancestors and *dia* by those who considered themselves protected by ancestral benevolence but still physically susceptible to illness by genetic inheritance (p.81). The factor which accounted for the relatively less frequent use of *tsiang* was the recourse commonly open to villagers with malevolent ancestors; namely, that of taking a spouse who enjoyed ancestral grace and joining the latter's dwelling group. It was believed that, by shifting residence in this manner, the villager was able to escape the malicious influences of his own ancestors.

p. 30 From the interviews that were conducted in the Bay Area, a similar distinction between *dia* and *tsiang*, and the occasions when one would be preferred over the other, did not emerge. However, *tsiang* were consistently referred to in the context of illnesses where a supernatural cause was suspect. The two most commonly referred to causes were ancestors and *hwen* separation or loss. According to one of the healers, in the event of an illness, a Mien might typically have gone first to a herbal doctor but, if the problem persisted, might next have consulted the spirits (“ghosts”) as to its source. Those who had the ability to communicate with the spirits were the religious healers.

In the United States, parallel to an indigenous system of treatment, comprised of healers such as herbalists and religious experts, is the system of medical care provided by western doctors and hospital personnel. The refugees seem to be using both of these systems concurrently or alternately, switching from one system to the other if treatment is dissatisfactory or ineffective. For example, if a problem persists for a refugee after going to a western doctor, the patient may seek one of the indigenous healers as an alternative. Even when the healer is not actively seeing patients, as in the case of the San Francisco herbalist who was interviewed, some attempt is

usually made to help the refugee. While going to a western medical doctor, the refugee may also supplement the care with a more traditional form of treatment.

In addition to the relative effectiveness of different treatments, the suspected cause of an illness is another factor which determines whose help the refugee seeks. If “ghosts” or spirits are suspected, the refugee is likely to seek the services of a religious healer. This is especially true if an illness persists even after a western doctor has been seen. The failure of western medicine to cure the condition seems to raise the likelihood, in the refugee's mind, that the illness is of a supernatural rather than natural cause. A third factor which influences the health-seeking behavior of the refugees is the availability of traditional remedies. As indicated earlier, many of the traditional herbs and medicines that were used in Laos are unavailable in the United States.

Patient and Healer Attitudes Toward Western Medicine

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Although the refugees are utilizing the western medical system, there seems to be some reluctance in doing so. For example, a refugee service provider who was interviewed indicated that many of the refugees were “afraid” because they neither spoke nor understood English. Some were afraid of being hospitalized or “being cut” and subjected to surgery. According to the interviewee, most of the refugees would go to a hospital or doctor if the need to do so were clearly explained to them. However, among the older Mien, there were many who would “stay at home and suffer,” rather than see a western medical doctor.

The refugees have also encountered resistance to their use of traditional treatment methods. For example, the service provider was able to cite several cases where traditional Mien curing methods which left bruises or scars on the body were mistaken by hospital and medical personnel as forms of physical abuse, and the police and courts were informed. For certain illnesses, the Mien traditionally “scratch” the skin with a bowl, “pinch” areas of the body, or apply “suction” cups to stimulate and improve circulation. Because of the adverse reaction of hospital personnel, many of the Mien are afraid to consult a western doctor until the marks left by these methods have faded away.

Although the healers who were interviewed seem to be encountering residual cases—where refugees seek their help after having been to a western doctor without having found relief for their problems—these healers also seem to be aware of the effectiveness of western medicine and indicated that they would refer a refugee to a hospital or doctor if they were themselves unable to handle the case. As one of the healers indicated, a referral of this sort may occur when a herbalist lacks the traditional medicines to treat a patient. For illnesses where a supernatural agent is the suspected cause, western medicine may be considered ineffective, and what may be needed are the services of a religious expert, or “someone knowledgeable about religion.”

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III. CAMBODIAN HEALERS

According to 1981 estimates, there are approximately 20,000 Cambodian refugees in the United States and another 100,000 to 187,000 awaiting resettlement in camps of first asylum (U.S. DHHS 1981:8; Nordland 1981; Refugee Reports 1982:8; White 1982:598). Approximately 4,000 of the Cambodian refugees have been resettled in the San Francisco Bay Area (field notes, November 1982).

Historical/Cultural Background of the Refugees

Modern day Cambodia occupies an area of approximately 66,000 square miles, bordered on the east by Vietnam, on the north by Laos, and on the northwest by Thailand. In 1967, it had a population of approximately 6.25 million. Ethnic Khmer comprised about 85 percent of this total. The origins of the Khmer are unknown, but it is believed that they moved into the Mekong Delta from the Northwest sometime before 2,000 B.C. (Munson 1968:1, 47-56).

Khmer history is usually divided into three main periods. The earliest period, which extends to the middle of the fifteenth century, witnessed the Khmer's rise to political dominance in the area and the flowering of Cambodia's classic culture. During the Angkor Period (803-1432), there was a rapid growth in the arts and the introduction of Mahayana and Theravada (Hinayana) Buddhism. Theravada Buddhism, brought to Cambodia by way of Ceylon sometime during the middle of the thirteenth century, was later adopted as the state religion (Zadrozny 1955:16-20). The Period of Transition (1432-1864), which marks the second major division in Cambodian history, witnessed a decline in the Khmer's economic and political power and continual struggles with neighboring countries to retain autonomy and dominance. This decline led to the establishment of Cambodia as a French Protectorate in 1864, a status which it was to hold for nearly a century. It was not until 1953 that Cambodia finally regained its independence.

The culture of the Khmer is said to derive from three principal sources—India, France, and an indigenous folk tradition which is shared through much of Southeast Asia (Zadrozny, p.3). As a result of Cambodia's extensive

p. 33 indianization during its early history, many loanwords from Sanskrit and Pali are reflected in the Khmer language. Both Pali and Sanskrit remain the languages of the Buddhist clergy (pp. 107-109).

Religion and Folk Beliefs

The majority of the Cambodians are adherents of Theravada Buddhism, the state religion since the fourteenth century. Traditionally, the official hierarchy was headed by the king and supervised by sectarian chiefs (*sangneayuk*) who were the king's appointees. Religious matters on the provincial level were delegated to *me-kon* (provincial chiefs) and on the district level to *anouckon*. On the village level, pagodas were usually headed by a *chau-athikar*, assisted by two deputies (Zadrozny, pp. 128-130). At least one pagoda was located in every village and served as the social nucleus of the community (p. 310). Cambodia is predominantly rural, with about

ninety percent of its population residing in small, scattered settlements or villages averaging from 300 to 400 inhabitants (pp. 89-90).

Traditionally, every Khmer male entered the village pagoda, where he spent several months as a novice giving witness to the virtues of his parents. Except for those who chose to remain monks, the vow of monkhood was not considered a lifetime pledge. In a study of a Cambodian hamlet, conducted in 1966, Kalab (1976) estimates that the majority of the males were or had been monks at one time. The numbers ranged from sixty percent for the younger men (26-30 years of age) to 100 percent for the older males (56-85). According to another estimate (Zadrozny, p. 126), the ratio of monks to the total Cambodian population was one to sixty.

Until the early 1900's, when a public educational system was instituted under French rule, pagoda schools were virtually the only centers for secular and religious instruction. The schools continued to exist along side of the state primary schools, although their enrollment was limited to male students and instruction usually covered only the first three years of education (Zadrozny, p.131). In addition to providing secular and religious training, the pagoda also served as a meeting place where all community-wide affairs were discussed and decided on (p.126). Village monks not only taught in the pagoda schools but were considered trusted advisers

in a variety of secular matters as well (Kalab, p.160)

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The folk religion which coexists alongside of Theravada Buddhism centers on beliefs about a variety of spirits. These include the *neak taa* spirits which are thought to reside in mountains and rivers and other natural habitats; ancestral spirits called *arak*; and less important, though dangerous, spirits such as the *kmoch long* ("ghosts"), *beisac* ("hungry ghost"), and *ap* ("ghoul") (Department of the Army 1970:277-279; Zadrozny, pp. 345-346; LeBar, p. 105). Belief in these spirits is considered widespread, though confined largely to the rural and less educated classes (Zadrozny, p. 344). Monks apparently find no contradiction between Buddhism and the folk religion since they participate in many of the spirit rituals that are performed (Department of the Army, p. 272). While some of the spirits are inherently evil, others are considered benevolent. However, even the latter may become the source of misfortune if angered or improperly treated. Illness is one of the principal punishments that is meted out by an angered or malevolent spirit (p. 277).

Medical Practices in Cambodia

Western medical services were introduced to Indochina by the French in the 1860's. Initially for the benefit of the French troops stationed in Southeast Asia, the services were soon extended to the general populace. The first Cambodian medical school, staffed by French doctors and equipped by the United States, was established in 1956. By 1967, it is estimated that, for a population of about 6.25 million, there were 337 physicians and 2,214 nurses in Cambodia. An additional corps of about 400 health officers worked in the provincial capitals, in larger villages, and with mobile health units. Since entire provinces may have had no more than one or two physicians, these health officials were considered essential for the delivery of health services to the general population. One psychiatric hospital, staffed by nine psychiatrists, was located

in Takhmau. (Munson, pp.86-69.) Of the 600 Cambodian doctors who were practicing in Cambodia before the Khmer Rouge came to power, less than sixty were known to be alive and in the country in 1979 (White, p. 605).

Despite government efforts to introduce western medicine, it appears that indigenous practices were never supplanted by those adopted from the

- p. 35 French. When illness occurred, indigenous practitioners continued to be resorted to first and western doctors, usually only in cases when the illness persisted (Steinberg 1959:239). According to one estimate, the treatment of pain and disease in Southeast Asia falls within the province of traditional therapy for more than three quarters of the population; in many areas of Cambodia, no direct or continuous contact with western trained medical doctors or medical services has existed since the Japanese occupation (Jaspan 1969:11).

In Cambodia, traditional prevention and treatment methods have included the use of herbal medicines and forms of physical therapy such as moxibustion, “coining,” and “cupping.” Cupping (e.g., inverting a cup of alcohol over an affected area) is used to create suction, and leaves a bruise on the body. Coining (rubbing a metallic object such as a coin over the skin) also leaves a bruise. According to a traditional view, coining uncovers, or releases, harmful “wind” which may have accumulated in the body (Tung 1980:24-25). A western theory is that it may stimulate adrenalin action (interview notes). Along with these treatment methods, the patient may also have resorted to rituals conducted by priests and other indigenous practitioners. In addition to physical disorders that might be remedied by western or indigenous medicines, the Cambodians believed that certain illnesses had an underlying “spiritual” or “moral” cause that required ritual treatment (LeBar, p.105).

There appear to be several types of indigenous practitioners to whom the Cambodian may have turned when illness occurred. In cases where sorcery was suspected, a *kru* (“he who knows”) may have been summoned to neutralize an evil spell. *Bangbot* were sorcerers who were able to inflict punishment on thieves; read omens; and make philters to provide protection or to arouse amorous desires. The latter were considered potentially dangerous to their recipients. *Thmup*, another type of sorcerer, were believed to be capable of killing people at a distance. In addition to neutralizing harmful spells, the *kru* were summoned to exorcise evil spirits from the sick and to make amulets to prevent or cure illness. The *achar*, Buddhist laymen attached to village pagodas, were able to prevent evil spirits from acting but were unable to exorcise them once they had afflicted the patient. The *achar* were also summoned to diagnose illnesses through divination. (Zadrozny, pp. 311, 344-46; Department of the Army, p.279; Steinberg, p. 239.)

- p. 36 *Rup-arak* served as spirit mediums who were able to communicate with family *arak*. *Arak* were usually the spirits of distant ancestors of the patient and generally considered benevolent. However, on occasion these spirits could also be the source of affliction. Through communication with one of the family *arak*, the medium was able to elicit information on whether or not a spirit was responsible for the illness, what the nature of the spirit's grievance was, and what measures could be taken to make amends. If the illness was caused by an evil

spirit, rather than an *arak*, a *kru* was usually summoned to remedy the situation. (Zadrozny, p.346; Department of the Army, p.278.)

Another practitioner who is often mentioned is the Buddhist monk, or bonze. Although the Buddhist clergy was not obligated to perform any duties with regard to the lay community, in practice, monks were active in many aspects of village life: they gave advice on village affairs, participated in various ceremonies, and expounded the scriptures on holy days. They were also teachers in the pagoda schools and consoled the sick. According to one source, their medical services ranged from “magic to genuine scientific therapy” (Munson, p.145).

Cambodian Healing Practices in the Bay Area

The Cambodian healer who was interviewed for the study is a retired Buddhist monk in his late sixties. He entered the Buddhist priesthood at the age of thirteen and, in Cambodia, held the title of Chief District Monk. Most of his medical knowledge derives from Buddhist texts, written in Pali, the sacred script of Theravada Buddhism. Some of his medical knowledge was also obtained from a doctor who treated him when he was a child and suffering from partial paralysis.

The interviewee arrived in the United States in December of 1979, and resides in a hotel in the downtown area of San Francisco. Both the hotel and the general area around it have become the home of a number of Southeast Asian refugees. In his own building, there are five other Cambodian families. Although retired, the interviewee continues to perform ceremonies for Cambodians on request and maintains contact with refugees directly, through correspondence or by phone. Among the refugees with whom he maintains active

contact are the one hundred or so Cambodians whom he led into Thailand during the Pol Pot era. Most of these refugees now reside in different parts of the United States. p. 37

During the period of the interviews, the monk attended English as a Second Language classes and enjoyed jogging and exploring the San Francisco Chinatown area. In the future, when a temple for Cambodians is established, he hopes to be re-ordained.

Views on the Cause of Illness

According to the interviewee, illnesses can have a variety of causes. Among the supernatural causes that were mentioned are “black magic” and spirits and among the “natural” causes, humoral imbalances.

Spirit-Induced Illnesses

The interviewee said that there were nineteen different types of spirits which are recognized as potential sources of illness. Among these are ancestral spirits, which may take harmful action against a descendent if not properly handled. Failure to provide food for an ancestor may be

one source of spirit grievance. In such cases, the monk may recite prayers in Pali to invoke the offended spirit in order to present offerings of food.

Spirits can figuratively blind patients, clouding their eyes to reality and making them see only what the spirit wants them to see. In addition to ceremonies to propitiate an offended spirit, exorcistic rites may also be performed by the monk to “chase the spirit away” through the power of incantations recited in Pali. Ritual in such cases may be combined with the use of herbs.

One of the ways in which spirits cause illness is by entering the body, where they combine with the patient's food. Once in the body, they are carried to the head of the patient by “wind,” one of the three vital humors. “Bad” wind, entering the head or other vital organs, can cause a variety of problems, including sudden seizures and blackouts.

“Black Magic”

Cambodians also believe that harm can be caused as well as prevented by practitioners of magic. Moslems, who constitute a small (approx. 73,000 in

p. 38 1963) ethnic minority in Cambodia, were often thought to be responsible for the practice of black magic. It was believed that magic could be used to cause a young woman to fall in love with a man or be responsible for ailments such as tumors or ovarian cysts. When magic was suspected, patients resorted to another practitioner of magic in order to neutralize the original spell. According to the interviewee, monks were unable to neutralize spells cast by practitioners of magic.

Humoral Imbalance

The imbalance of humors in the body is another source of illness. Similar to the three vital humors which appear in Ayurvedic medicine, the three humors in Cambodian medicine are: wind, water, and fire.¹

¹ The influence of Ayurvedic medicine in Southeast Asia has been noted by a number of sources (see, for example, Leslie 1976:3; Filliozat 1964:xviii; and Hart 1969), but none of these sources suggests a direct influence on Cambodian humoral theories.

In Ayurvedic medicine the universe is composed of five basic elements (*bhutas*): ether, wind, water, earth, and fire. Three of these elements enter the body as humors which regulate the bodily functions: wind enters as wind, fire as bile, and water as phlegm. Each of the humors carries out a number of different functions that are vital to the body. Bile, for example, is thought to be responsible for digestion and the secretion of chyle, urine and excreta. It also colors the chyle and turns it to blood (Jolly 1951:59-60).

According to Ayurvedic thought, illness occurs when the homeostatic condition of the three humors is upset. Thus, a patient with a severe headache may complain that “wind has struck the top,” meaning an excess of wind has moved from the stomach to the head (Obeyesekere 1976:225). The balance of the three *dosas*, or humors, can be upset by a variety of factors. For example, bile may be deranged by emotions such as anger, grief, and anxiety; phlegm, by want of activity, inertia, and sleeping by day.

According to the interviewee, most, if not all, diseases can be traced to the diet and nutritional deficiencies. Food is the matter that humors act upon or that can affect the normal functioning of the humors. In order to maintain its health, the body must maintain a balance of the three humors.

The various functions of the three humors were not clarified during the interviews, but individual humors seem to be associated more with certain vital organs than others. Water, for example, is associated with the gall bladder, wind with the stomach, and fire with the stomach and liver. Energy derives from fire. Using the analogy of a pot of boiling water, the interviewee pointed out that water can derive enough power from fire to blow the lid off a pot. Again, fire was likened to the fuel in a ship; without it, the ship would lose its locomotive power. The power of the wind, derived from fire, carries blood to the brain, which controls the functions of sight, hearing, smell, taste, and eating. In extreme cases, an excess of fire, caused by a deficiency of water, might cause death. p. 39

Diagnostic Methods

Pulse diagnosis was used to indicate the condition of the humors and vital organs. To illustrate the method, the interviewee traced the outline of the interviewer's hands on a piece of paper. The outline located the different organs with respect to one another and indicated the size of the liver. Then, while feeling a forearm pulse, the interviewee drew in lines representing the flow of blood from the heart to parts of the liver. The pulse indicated the strength of the flow and whether or not it lacked sufficient energy. A pulse can be described as "strong" (normal), "weak," or "shaky."

There appear to be some similarities between the interviewee's explanations and Chinese pulse diagnosis, which was probably borrowed at one time from the Ayurveda (Hart, p.59). Chinese physicians can reveal the condition of the various organs by placing their fingers on the pulse of the artery in either the left or right forearm and varying the pressure that is applied. Lighter pressure on the left forearm can indicate the condition of the small intestine, gall bladder and bladder. Stronger pressure on the same arm reveals the condition of the heart, liver, and kidney.

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Phlegm is also considered particularly vulnerable to derangement in winter and spring. One of the chief causes of imbalance is an unsuitable diet (Jolly, p.70).

Therapy is based on ideas about the soothing or exciting action of drugs, aliments, diet, and place of habitation on the mind and the humors. Once the role of a particular humor in relation to an illness has been determined, the physician prescribes a medicine which is known to have an antagonistic effect on the humor concerned (Filliozat, p.29). The binary distinction between hot and cold foods, often used in popular culture, is based on ideas about their soothing or exciting effects (Obeyesekere, p.224).

According to the interviewee, diagnosis can also be made on the basis of abdominal palpation, by feeling the pulse along the sides of the neck, and by measuring the strength, or weakness, of a person's breath. The strength or weakness of one's breathing can indicate such things as the situation of wind in the body.

Treatment

The interviewee seems to be knowledgeable about various forms of treatment, including the use of herbal medicines, moxibustion, and ritual. Detailed information on when different treatment methods were used or to what degree they were used in combination was not obtained during the interviews.

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Ritual Treatment

Ritual includes the use of prayers or incantation, sometimes to invoke spirits who are then propitiated with offerings and sometimes to exorcise the spirit from the patient. "Sprinkling" was also mentioned. In rituals of this sort, incantations are recited in Pali by a Buddhist monk who is summoned to sprinkle holy water over the affected part of the patient's body, for example, over the forehead in the case of fever. According to the interviewee, this method is used for illnesses where spirits are the suspected cause. In one case which he treated, it was used for a young woman who was thought to be suffering from some type of mental disorder. In Northern Thailand, there are practitioners who are specifically referred to as "holy water doctors" (Cunningham 1970:155). The holy water, fortified by means of incantation, prayer, or plant medicines, is applied by blowing or sprinkling or is sometimes fed to the patient.

Moxibustion Treatment

A small wad or ball of cotton may be applied to various parts of the body, and burnt, for illnesses involving convulsions, epilepsy, or different forms of mental disorder. The sites which are chosen vary according to the type of disorder. If applied to the wrong site, the stream of energy which is emitted during the burning can cause serious injury. The interviewee said he had learned the procedure from the doctor who treated him when he was ill in Cambodia. As a child, when he was suffering from partial paralysis in one of his arms, the procedure was applied to the injured arm and wrist. The interpreter mentioned that he was once treated for hernia by the same method.

Herbal Medicines

During the first hour of interviews, a bag with animal and plants parts, used for medicinal purposes, was shown to the interviewer. These included a section of crocodile gall bladder, the teeth and jaws of a small deer, hardened insect secretion, the horns of different types of buffalo, elephant bone, and plant roots. Some of the medicine was meant to be taken internally, after having been ground or prepared for drinking, and others were applied to the skin. The purposes for which they were used included snake bites,

broken bones, fungus infections, constipation, fever, and blood clots. One of the bones was considered effective for any type of post-partum illness that occurred within a year after delivery. Although most of the ingredients are native to Cambodia, and were brought with the interviewee when he fled the country, some are available in Chinatown herb shops.

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Patients and Presenting Problems

A clear picture of the number or type of patients the interviewee treated in Cambodia or sees in this country was not obtained. Since arriving in the United States, it appears that he has treated three cases, all females, whom he considered “mentally disturbed.” Generally, this category of illness seems to include symptoms such as seizures and sudden black-outs and unusual or bizarre behavior such as running away from home or talking incoherently. In one case, a young refugee woman was unable to open her jaws after childbirth. Cases involving these symptoms were explained in terms of humoral imbalances which, in some instances, may have been precipitated by the violation of a taboo or custom or by a spirit entering the body by way of the food that was eaten. For example, in the case of the young woman who was unable to open her jaws, the diagnosis was that impure blood had risen to the patient's head because she had engaged in intercourse too soon after childbirth. Traditionally, couples refrained from intercourse until the fourth month after delivery. The explanation for sudden black-outs was wind in the head due to an excess of heat, or energy, in the body. Treatment seemed to involve moxibustion or ritual.

In the United States, the interviewee appears to be seeing fewer patients but continues to perform ceremonies and, for minor ailments such as constipation, to prescribe medicines quite frequently. He said he would help Cambodians if they sought his services or if western medicine proved ineffective for some reason in dealing with their problems. However, he also indicated that Cambodians should attempt to adapt to the ways of their host country.

IV VIETNAMESE HEALERS

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The Vietnamese represent sixty-seven percent of the nearly 550,000 Southeast Asian refugees who had been resettled in the United States as of September 1981 (U.S. DHHS 1982:15). The San Francisco Bay Area currently has a Vietnamese refugee population of approximately 30,000. About one-half of the Vietnamese refugees are ethnic Chinese (field notes, November 1982).

Background

A large percentage of the Vietnamese refugees in the United States (about 145,000) fled Vietnam within weeks of the fall of Saigon in April 1975 and represent some of the earliest arrivals to the United States. From ten to fifteen thousand left within a few days prior to the collapse of the Thieu government; another 68,000 Vietnamese and Americans were evacuated by way of massive airlifts during the last days of April; and an additional 40,000 to 60,000 fled in commandeered aircraft and in ships and small boats (Liu. 1979:1, 13-14). A second large wave of refugees, comprised of more than 85,000 “boat people,” fled Vietnam during the last months

of 1978; the majority (about sixty percent) of these boat people were Chinese Vietnamese (Montero 1979:70-71).

The earliest Vietnamese arrivals were relatively well-educated and predominantly from urban backgrounds. According to early reports (Liu 1979), nearly a third of the household heads surveyed indicated that they had been in the medical profession or in professional, technical, or managerial positions in Vietnam. Seventy percent had also lived in Saigon prior to their evacuation. Only five percent indicated rural backgrounds or occupations in farming, fishing, or forestry. According to these same reports, the earliest arrivals were also predominantly Catholic (55%). The Vietnamese who indicated that they practiced ancestor worship were mainly confined to the Buddhists and Confucians, who together comprised about a third (39%) of those surveyed. About two-thirds also spoke English and over forty percent spoke French.

Subsequent reports on later refugees (i.e., those who arrived after 1975-76) suggest that the Vietnamese refugee population is somewhat more

p. 44 diverse and less “westernized” than the earlier studies may have indicated. For example, the “boat people” and later refugees are reportedly less educated, less proficient in English, and include a larger percentage from rural fishing and farming villages. The group also includes a substantial number of ethnic Chinese. (Aylesworth 1980:66-67; Carlin, n.d.; Starr, 1981; Center for Applied Linguistics, n.d.)

Medical Practices in Vietnam

Several medical traditions co-existed in Vietnam. These include western medicine, traditional Chinese medicine (*ong lang*), and folk medicine and health concepts centering on the ill effects of *phong* (“wind”). As elsewhere in Southeast Asia, there were also religious views which linked illness to supernatural intervention.

Western Medicine and Psychiatry

Western medical services were first introduced in Vietnam prior to the 1800's by European and American missionaries and later expanded during the French colonial rule (1883-1946). During this period, the French established public health services, hospitals and clinics, and a school of medicine at the University of Hanoi. In South Vietnam, faculties of medicine were subsequently added to the University of Saigon and, in 1961, to the University of Hue (Smith 1967:129-131). By the fall of the Thieu government in 1975, South Vietnam reportedly had 2,000 registered physicians. For a population of 18 million, this theoretically meant a ratio of physicians to patients of 1 to 9,000. Because three-quarters of the physicians served in the army, there were probably even fewer available for the civilian population (Tung 1980:32-33). By contrast, there was a fairly large number of practitioners trained in traditional Chinese medicine. According to one estimate, there were 4,600 such practitioners in 1965, six hundred of whom resided in Saigon (Smith, pp.129,132). According to Rieu (n.d.), fifty percent of the rural and urban population continued to resort to these doctors of Chinese medicine.

The shortage of western-trained medical personnel also applied to the field of psychiatry. According to Tung (p.75), the medical personnel in this field included three clinical psychologists; three psychiatric social workers;

psychiatric nurses who were trained on the job; and eight full-time psychiatrists, who were responsible for two in-patient facilities and about 2,000 hospital beds. It was not unusual for patients to have tried some form of traditional treatment before entering a psychiatric facility or consulting a western-style physician (McKinley 1966:423; Tung, p.74). Often these physicians were the final choice, resorted to only after traditional cures proved ineffective and the patient was no longer manageable in the home or the community.

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Traditional Medical Practices

Traditional avenues for the treatment of mental disorders can be categorized according to one of three disease models. Tung (1980) describes these as the “Am Duong Model,” the “Organic Model,” and a collection of beliefs centering on supernatural beings. The latter reflects a mixture of folk religion, Buddhism, Confuciansim, and Taoism.

Am-Duong Model

The Vietnamese concepts of *am* and *duong* are based to a large extent on Chinese traditional medicine and the belief that illnesses are caused by im-balances in a complex system of correspondences. All phenomena in the universe (including the organs of the human body, the seasons and cardinal points, and the emotions) are incorporated into this classificatory system. The basic categories are *yin* (*am*) and *yang* (*duong*). Associated with *yin* are foods characterized by their sour or pungent taste; the seasons of winter and autumn; the hours between noon midnight; cold and coolness; and human organs such as the liver, heart, and spleen (Lock 1980:32; Porket 1974:23-29).

Illnesses, depending on their properties or symptoms, can also be classified in terms of a deficiency or excess of *yin* or *yang*. The system applies to both physiological and mental illnesses. For example, pimples are thought to come from an excessive amount of heat which erupts through the skin (Tung, p.13). Delirium and agitated psychoses are thought to be caused by a preponderance of *yin* (p.56). Physiological imbalances (i.e., excesses or deficiencies of *yin* or *yang*) can be caused by internal influences (e.g., one's emotional state) or external influences (e.g., sudden climatic or seasonal changes), which work within the body to obstruct the circulation of *ch'i* (vital energy) or one of

its variants (e.g., blood or *hsüeh*). One method of clearing obstructions is the application of acupuncture to strategic points of the body. Another way of remedying the imbalance is to prescribe herbs or aliments which can offset the imbalance by virtue of their *yin* or *yang* attributes (Lock, pp.35-37).

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Organic Model

The Organic Model sees mental illness as a function of the nervous system. According to Tung (p.55), the Vietnamese, like the Chinese, describe neuroses as a “weakness of the nerves” (*than kinh suy nhuoc*) and psychoses as a “turmoil of the nerves” (*than kinh thac loan*). In practice, “weak nerves” seems to be a common complaint, signifying minor mental disorders ranging from anxiety to depression and sometimes including mental retardation and mental deterioration. Medicine (e.g., an appropriate nerve tonic or tranquilizer) is usually prescribed to treat such conditions.

Supernatural Model

According to Tung (p.74), supernatural intervention has been the most persistently held cause of mental illness as well as its most popular form of treatment, regardless of the patient's level of education and sophistication. In Vietnam, folk beliefs are similar to other Southeast Asian groups such as the Hmong and Mien in that they encompass a body of spirits with both harmful and protective tendencies. The malevolent spirits are capable of inflicting illness, insanity, or even death by taking one of the souls or “vital spirits” which the Vietnamese believe sustain and give life to the human body (Hickey 1964:76).

Two opposing types of supernatural beings, or spirits, are the *tien*, deities who are believed to have the power to protect individuals, and errant spirits. The latter are the spirits of individuals who have died without benefit of an ancestral cult in their honor (p.76). The importance of the cults resides in the belief that individuals can attain happiness in the after-life only if they are properly venerated by their descendants (p.88). Cult maintenance is the responsibility of members of the same patrilineage (*toc*) and involve appropriate ceremonies and offering in honor of deceased ancestors, usually up to three generations in ascent from the patrilineal head. *Ma troi* are a type of errant spirit, normally the ghosts of people who

p. 47 have drowned but whose bodies have not been recovered. Like others who have died violent deaths or have no families to carry on observances in their behalf, *ma troi* are destined to wander the earth, causing harm to the living, until they can be restored to the family tomb or to the ancestral altar (p.78).

Vietnamese communities had several types of religious healers who were able to prevent or treat supernaturally caused illnesses. These include spirit mediums, “sorcerers,” and Buddhist priests and lay monks. Hickey describes two such healers in a small village located outside of Saigon. The *ong thay phap* (“Masters of Sorcery”) were healers who derived their special powers to invoke and exorcise evil spirits from patron deities who were the center of cult worship. According to Hickey (pp.78-80), one of the village *ong thay phap* specialized in curing mental disorders. The usual procedure was to obtain a sample of blood from the patient and use it to write a special formula which had the power to frighten away the afflicting spirit.

Hickey (pp.64-66) also describes two village lay monks (*cu si*) who served as healers. The elder *cu si*, who had learned his healing arts from monks in southern Cambodia, employed amulets

and medicines for physical ailments and exorcism for cases of “insanity.” The younger *cu si* specialized in disorders associated with childbirth.

Ong dong and *ba dong* are spirit mediums associated with the popular cult, *chu vi*, which honors the spirits related to the goddess Lieu Hanh and the fourteenth century cultural hero, General Tran Hung Dao. Cult rituals focus on communication with either the spirits or with the souls of ancestors. *Ong ho*, usually associated with a particular pagoda, derive their powers to protect individuals against misfortunes and disease from the deity Quan De or by his acolytes, Quan Chau and Linh Hau (LeBar, p.170).

A Vietnamese Religious Healer in the Bay Area

The Vietnamese healer who was interviewed for the study is a Buddhist priest attached to a large temple in San Francisco. The temple was founded in 1978 by four Vietnamese refugees and has a congregation of from 500 to 1,000 members, representing all age groups. About fifty percent of the congregation has been in the United States for five years or longer. Both ethnic

Vietnamese (who comprise about 60% of the congregation) and Chinese Vietnamese (40%) attend the temple, along with a small number of Caucasian Americans.

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Setting

The temple is open from 9 a.m. to 11 p.m. on weekends and from 5 to 11 p.m. on weekday evenings. In addition to the interviewee, three other monks reside on the premises of the three-story building which serves as the temple. The second floor has been converted into a worship hall; the third floor into the monks' residence; and the ground floor, into a general activities and dining area. The temple is located on a busy thoroughfare, within walking distance or easily accessible by public transportation for the majority of the congregation. Elderly Vietnamese and minors who live outside of San Francisco rely on family members for transportation. The temple is one of several fairly large Vietnamese Buddhist churches that have developed in San Francisco. A number of smaller temples have also been formed within the last few years. The temples are seen as major forces in the rebuilding of Vietnamese communities in the United States.

The temple which provides the setting for many of the interviewee's activities performs a broad range of functions within the Vietnamese community. In addition to weekly Vietnamese language classes, the temple offers lectures on child-rearing and parenting skills; for younger members, lectures on how to get along with parents; and for couples and those contemplating marriage, lectures on marital relations and roles. The priest sees these lectures as ways of bridging the cultural and generational gaps that are developing within Vietnamese families. Meditation is also taught as a way of acquiring spiritual strength and discipline.

On a typical Sunday, sixty to eighty members are likely to be at the temple. The younger children may be playing in the building, while adults stand in conversation or prepare Sunday lunch. Other members may be sitting in prayer or making offerings at the altar. Several people may be

sitting in the monks' quarters on the third floor, waiting to talk with the priest. On one visit, a man who had received a telegram from Vietnam informing him of his brother's death waited to discuss funeral arrangements and to share his sorrow with the priest. Another woman waited to discuss her worries about relatives still in Vietnam. During one of the interview sessions, a Vietnamese

p. 49 herbalist dropped by with medicine for one of the members of the congregation. For individuals who are depressed or more severely disturbed, the interviewee offers assistance that ranges from social casework to spiritual counseling and rituals to exorcise possessing spirits.

The Vietnamese Priest

The interviewee has been in the United States for about six years and speaks English as well as Vietnamese. He is also fairly fluent in Mandarin. Now in his early forties, he began studying Buddhist doctrine from the time he was a young child. It was in Vietnam that he also learned special Buddhist rituals for those who were possessed by spirits or ghots. Curious whether some of the principles of western psychology could be applied to his own work, he recently enrolled in a psychology course at a local university.

The priest speaks with deference about his position in Vietnam and this country. As a monk in Vietnam, he feels that he was surrounded by a number of teachers who were older and more experienced in helping people. In the United States, he feels reluctant to be called a "spiritual leader" and prefers to consider himself a friend to those who seek his help. In addition to its other functions, he sees the temple as a "place where people can come to talk about their problems."

Role in the Treatment of Mental Illness

The priest recognizes many factors which may contribute to mental illness among the Vietnamese refugees. Generally, these are related to changes in the economic and material status of the refugees and to changes that threaten their "spiritual" life. Among the changes are the loss of traditional forms of support. For believers, this might be the lack of Buddhist temples in their new environment and, for many of the refugees, regardless of faith, the loss of family members, who may have died or been left behind in Vietnam. Once settled in the United States, he believes that generational and cultural gaps may develop which further divide families. For example, a growing source of tension may be the wife's newly gained status as a wage-earner. The lectures (on child-raising, marital roles, etc.) are a way of strengthening the family by increasing each of the members understanding

p. 50 standing of the changes that may be occurring. In terms of the medical model, much of what the priest does (e.g., by way of lectures and services for the spirits of deceased relatives in Vietnam) might be seen as preventative mental health.

A clear picture of how often the priest works with individuals whom he might consider "mentally disturbed" was not obtained, but three recent cases are described below. Treatment in such

cases seems to involve several phases. The first is to relieve the immediate symptoms; for example, in instances of spirit possession, to release or exorcise the possessing spirit. The next phase is directed toward placing the individual back in the community. In some cases, this may temporarily be the “sheltered community” of the temple. A third step is to provide individuals with a philosophic, or religious, framework that will sustain and help them deal with further problems. However, attempts to teach individuals Buddhist doctrine or meditation are postponed until they are in a suitably stable, or balanced, state of mind. According to the priest, individuals who are upset or distraught quickly forget. His approach to people who are in need of help is first to establish himself as a friend or someone with whom the individual can easily speak.

Case Examples

Each of the individuals in the cases described below was referred to the priest, or brought to his attention, by a friend, relative, or social service agency because of what was considered unusual or unacceptable behavior. When asked how he himself might determine whether a person was in need of help or what treatment plan to follow, the priest said he follows a few simple procedures. For example, he observes the person's eyes, facial expressions, and behavior; he listens to the way the person talks; and he asks about their background, family situation, and social environment.

Case of a Fifteen Year Old Girl

A Chinese Vietnamese mother recently brought her fifteen year old daughter to see the priest after the girl began exhibiting what her mother considered “unusual” behavior. Both had come to the United States seven years earlier, and the daughter spoke fluent English as well as some Chinese, which was used at home and with friends. Although she knew Vietnamese, she

had never felt comfortable in the language and, until recently, seldom used it.

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When the daughter and mother first visited the priest, the girl conversed in Vietnamese, saying she had forgotten how to speak English. The priest said her hands were trembling and her eyes had a listless look to them. On the girl's second visit, she brought a friend. This time, whenever she mentioned her mother, she spoke in a man's voice. Her mother was referred to by her given name, a sign of disrespect to the Vietnamese. The priest noticed that she often blinked her eyes during the meeting. She complained that she could not sleep well and that neither she nor her mother got along. She often recalled her father who had died in Vietnam two years after she and her mother left for the United States.

Neither the girl nor her mother were members of the temple. The mother had remarried but, with the death of her second husband, began to feel she would bring bad luck to anyone she married.

The priest diagnosed the immediate problem as a case of spirit possession. He felt that the soul of the girl's father had not been able to find peace and was lingering on earth, near his wife and

daughter, in order to protect and watch over them. The priest's first step in treatment was to offer a special ceremony for the father's soul so it might find its way to the Buddhist Pure Land. During the ceremony, temple monks offered prayers and incense on behalf of the father's soul. When the chanting ended, a memorial tablet with the father's picture, name, and dates of birth and death was placed beside the main altar, alongside other memorial tablets, so that prayers might be offered in his honor from that time forth. The ceremony was performed about two weeks after the case was first presented and lasted approximately two hours.

From information provided by the young girl, the priest then began contacting people in her social environment who might be able to shed light on the girl's background and present living conditions. The hope was to begin a treatment plan that could draw on this information. In the meantime, he believed it was important to maintain an understanding relationship and to spend time with the young girl and develop her trust. The priest indicated that he does not use "mental illness" when helping those who come to him.

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Case of the Ghost-Possessed Woman

The second case, also involving spirit possession, concerned a Vietnamese refugee in her early sixties. She had been in the United States for about three months and had been resettled, with her husband, north of San Francisco. During her first meeting with the priest, she spoke in the voice of the possessing spirit (a young woman who had drowned at the age of nineteen), saying that she was in Hell suffering and needed help. Before a social worker at a local resettlement agency referred her to the priest, the woman had been sent to a western medical doctor for an examination and told she was in good health.

During her first visit to the temple, the woman frequently broke into tears and wept. She complained that she had been unable to eat or sleep properly for nearly two weeks. For about a month, a woman had been appearing in her dreams, saying that she wanted to take the patient's life. Fearful of leaving her home, the patient agreed to see the priest only because of her husband's steady insistence. Although she had no recollection of some of her actions during this time, later interviews indicated that she had been told she was acting very strangely ("crazily"). At the temple, she apparently took food from the altar but, when questioned about her behavior, only answered that in Hell she was poor and hungry. She referred to herself by the name of the young woman who had drowned.

Treatment consisted of a ceremony which lasted about an hour. While the patient kneeled before the altar, offerings of paper money, paper clothes, and incense were made, along with requests by the priest that the possessing spirit no longer torment the patient. Monks at the temple and other worshippers participated, offering prayers for the deceased woman's release and her spirit's passage to the Pure Land. After the ceremony, witnesses indicated that the woman became calmer and was able to give her own name.

At one time, because there were few Vietnamese where she lived, the woman asked that she and her husband be allowed to stay at the temple. The woman now attends every Sunday and, depending on the priest's schedule, may spend several hours in conversation with him. She

indicated that she was grateful for the priest's friendship and the support she receives at the temple. She also said that, since the ceremony, she has been feeling much better.

Case of an Alcoholic Young Man

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The third case concerns a young Vietnamese refugee who had been in the United States for six years and lived in the neighborhood of the temple. According to the priest, the young man lacked the incentive to work or to earn money because he had no responsibilities for a wife or family in the United States or in Vietnam. When his case was brought to the attention of the priest, through the intervention of a friend, the young man was receiving welfare assistance, drinking up to twenty cans of beer a day and smoking heavily, sometimes as much as ten packs of cigarettes daily. He also refused to talk with anyone and was isolating himself in his small apartment.

The priest's first step in intervention was to break the young man's isolation by encouraging him to accompany the priest on walks to the beach and nearby parks. During this time, the priest said he never directly questioned the young man but used their walks to begin building their relationship. In time, the priest asked the young man to move into the temple, where he could be monitored and observed more closely. On the young man's bedroom wall, the priest posted several reminders. The goal was: "One can of beer and two cigarettes a day." The third step was to encourage the young man's participation in other activities: he took the man to work at a local factory during the day and also had him help out with work in the temple. Apparently the young man has been following the new regimen and has cut down on his drinking and smoking. He says he feels much happier.

V. CONCLUSION

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The purpose of the Indigenous Healers Study was to provide a preliminary description of traditional healing practices in Southeast Asian refugee communities. It was felt that interviews with indigenous healers and other ethnographic material would provide a basic orientation to refugee concepts of illness, their expectations of appropriate treatment, and factors which might influence their utilization of traditional or western medical services in the United States.

The study indicates that traditional healers are being utilized in refugee communities for both physical and mental health problems. It also indicates that indigenous healing systems are being utilized less than they were in Southeast Asia and often in conjunction with western medicine. One area where western medicine seems to be unsatisfactory is in the treatment of supernaturally caused illnesses. For such illnesses, refugees are likely to feel that traditional healers, knowledgeable about indigenous spirits and concepts of illness, are the most effective. Information on how prevalent supernatural interpretations of illness are among the refugees was not obtained. However, the literature indicates that such interpretations are quite prevalent in Southeast Asian countries.

There are a number of similarities between the healers and western health practitioners. Both have diagnostic tools that help them identify the nature of the problem; both are able to provide

interpretations of the illness that are culturally acceptable and understandable to their respective patients; and both have culturally accepted methods of treating the problems presented to them. The diagnosis and treatment have an internal logic given certain premises about the basic cause of illness. The premises of Southeast Asian refugees derive from indigenous traditions and, in some cases, the larger traditions of India and China. Both the indigenous healer and western health practitioner also gain their authority and credibility in the eyes of their patients through culturally sanctioned routes.

Beyond these similarities, there are important areas of difference. One of the most prominent is found in their methods of categorizing health problems. The primary distinctions that traditional healers are likely to make in the diagnosis and treatment of illnesses are in terms of their basic

p. 55 cause: illnesses are regarded as of either natural or supernatural origin. The latter includes illnesses that westerners might dichotomize as either a physical or mental health problem and encompasses symptoms that range from stomach upsets and tiredness to unusual or bizarre behavior.

Common to the treatment of problems that are supernaturally induced are religious rituals to propitiate or exorcise the spirits responsible. These spirits are often rooted in animistic beliefs about the natural world but may frequently include the dissatisfied spirits of the patient's ancestors. In the forward to a collection of studies on indigenous healing practices (Kiev 1964), Frank cites the example of a devout Catholic divorcee who married a Protestant and was convinced that a subsequent miscarriage was the result of her having violated a religious taboo. Although the woman was admitted to the psychiatric outpatient unit of a large hospital, Frank suggests that a priest might be more appropriate for such patients than a western psychiatrist. Once natural causes have been ruled out, there are probably a number of refugees who would be equally convinced that their misfortunes were the result of an unsatisfactory relationship to the non-secular, spirit world. One of the major functions of indigenous healers is to correct this relationship and to intercede with the spirit world on the patient's behalf. Although the treatment of naturally caused illnesses seems to be shifting to western medical practitioners, religious healers are still being resorted to for illnesses of a supernatural nature.

A number of factors may account for the less frequent use of indigenous healing systems, especially for naturally caused illnesses, including competition from western medicine. In a number of instances, traditional healers indicated that they were seeing patients after the refugee had been to a western medical doctor. In Southeast Asia, the first choice of healer may have been the secular healer and then, only after natural causes had been ruled out, the healers who were knowledgeable about the spirit world. In the United States, it appears that the pattern is to see a western doctor first and, if the problem persists, to then try an indigenous cure. To some degree, indigenous healers appear to be treating residual cases that have not been satisfactorily treated within the western medical system.

p. 56 Another factor which may be influencing refugee utilization of indigenous healers is the availability of traditional medicines. Several healers indicated that they were unable to obtain herbs and medicines traditionally used in treatment and were therefore referring their patients

to western doctors. Information on the degree to which medicines were used in conjunction with ritual ceremonies to cure supernaturally induced illnesses was not obtained. However, since the ceremonies seem to be the most important element in treatment, the unavailability of medicinal cures may not affect the utilization of healers for this type of illness as strongly as illnesses that are thought to be of natural origin.

A third factor may be the geographic dispersion of the refugees in the United States. In some cases, refugee groups are just beginning to reestablish the networks and communities that are necessary for traditional customs and practices to thrive. The Vietnamese temples, herb shops, stores and media organizations that have developed in San Francisco are examples of this type of community-building. By contrast, the Hmong population in the San Francisco Bay Area is relatively small and fairly well dispersed throughout sections of San Francisco and the East Bay. There are few visible signs of a community that can cater to their special ethnic interests and needs. It is probably an indication of the strength of traditional beliefs that many of the Hmong patients who seek the services of indigenous healers are doing so despite formidable geographic and informational barriers.

It was not the Pacific Asian Mental Health Research Project's (PAMHRP) intention to promote any particular healing approach, whether traditional or western. However there are clear instances when an understanding of the refugee's interpretation of a problem and traditional coping methods can be helpful to western service providers whether they subscribe to the interpretation or not. An actual case, cited in a refugee mental health training manual (Friedman 1981:14-16), illustrates the point. The case involved a Hmong couple who were anxious to move from an apartment their caseworker had found after a number of "spirits" began to appear in their dreams. Learning that one of the spirits was that of an American woman, the couple's sponsor began to think that the spirit was a projection of herself and avoided any contact with the couple for fear they would harm her. Although the case-worker believed that the couple's anxieties were symptoms of "culture shock,"

he also understood the importance of the spirits to the Hmong couple. After consulting with community leaders, he had a woman who was able to communicate with the spirit world perform a ceremony for the couple's benefit. During the ceremony, the woman was not only able to identify the spirit to the couple's satisfaction but also exorcise it from their apartment. Apparently the spirit belonged to a previous tenant of the apartment who moved without giving it notice.

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Although healers were treating both physical and mental health problems, they rarely spoke of illnesses in terms of these two categories. Future studies might attempt to obtain a clearer picture of the range and types of mental health (as opposed to physical health) problems the different healers are treating and whether these problems are diagnosed primarily as supernatural or natural illnesses. Future studies might also obtain more information on the patient: sociodemographic information that would indicate the type of refugee who is most likely to utilize indigenous healers; specific conditions that refugees are likely to consider "problematic" and within the purview of traditional medicine; the patient and community's role

in the prevention and early stages of the illness as well as its treatment under the supervision of the healer; and finally, the patient's evaluation of the treatment and its outcome.

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