

A House of Many Rooms: Healing Practice and the Ontology of Health in Hmong Tradition and the Diaspora

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Abstract: Culture – the foundation of views about health and healing – is subject to modification, translation, and adaptation as it grapples with changes in its geographic, economic, and socio-political context. For the Hmong, an Indigenous People with a millennia-long history of regional and international migration, it can be said that their cultural context has been change itself. Given the empiricist certainty that Indigenous medical systems will invariably yield to modern education and the increased availability of biomedical services, the perpetuation of various traditional elements in the medical culture of the Hmong is nothing short of remarkable. As minorities in a dominant society that rejects their ontology of health, the retention of a distinct mytho-cultural medical identity has been a choice on the part of the Hmong in Southeast Asia and the diaspora. Not only has traditional Hmong medical culture persisted in the face of (supposedly) stronger cultures of modernization, scientific rationality, and state power, but the practices and conceptualizations enshrined in traditional healing have also come to constitute a form of resistance to cultural colonization, cognitive imperialism, and social assimilation. This paper examines the ontology of health and traditional medicine among the Hmong in Southeast Asia and the United States. An analysis of the forces driving change or supporting continuity in the healing practice and the ontology of health reveals how the Hmong have managed to reconcile ‘tradition’ and ‘modernity’ – bio- and ethno-medicine – without conceptualizing these realms as mutually exclusive.

“Being Hmong is living in a house of many rooms.”

– Dr. Gary Yia Lee (1996:63)

Any work on cultural transformation must begin by acknowledging the (at least potentially) essentialist ambitions of such an endeavour. Culture is neither static nor monolithic, yet attempts to trace the translation of a people from past to present cannot help but idolize, to some extent, ‘traditions’ and a ‘traditional world’ that inevitably belong to the past. An effort must therefore be made not only to recognize, but also to apply the idea that cultural logic is subject to modification, translation, and adaptation as it grapples with changes in its social and historical context. For the Hmong – a people with a millennia-long history of migration who are today found living in dozens of countries – it can be said that their cultural context has been change itself.

Culture is the foundation of views about health and healing. “The acquisition of knowledge to prevent and treat illnesses is the ambition of all human societies,” (Santasombat, 2003:87), and a body of medical knowledge has been built up, over time, by every culture. Although “[b]iomedicine is the yardstick used in explaining illnesses,” and its rational-scientific lens is assumed to be both normative and universally valid, cultural beliefs and practices remain the foundation of local responses to illness (Santasombat, 2003:89). As migrants and minorities surrounded by a society that denies their ontology of health, the retention of a distinct mytho-cultural medical identity has been a conscious choice on the part of the Hmong in Southeast Asia and the diaspora.¹ Given the empiricist certainty that belief systems

will invariably yield in the face of modern education and the increased availability of biomedical services (Deinard & Dunnigan, 1987), the perpetuation of various elements in the medical culture of the Hmong is nothing short of remarkable. The Hmong have, in fact, deliberately nurtured cultural identity, including a unique ontology of health, as a means of resisting forces of cultural assimilation and cognitive imperialism.

Hmong History and Culture: A Brief Overview

Called Miao by the Chinese and Meo by the Thai, the Hmong prefer their self-selected name, which is said to mean “free man” (Tapp, 1998). From their original home on the central Yangtze plain the Hmong migrated southward across Mainland Southeast Asia,² arriving in Thailand – where they are identified as a minority Indigenous³ group, the second largest of the “Hill Tribes”⁴ – in the late nineteenth century (Anderson, 1993; Kundaster, Kesmanee & Pothi-art, 1987). Here, continued migration and natural increase have slowly inflated their numbers in the mountainous areas, while self-directed and imposed

² The Hmong are today found in Yunan Province (China), Burma, Laos, Cambodia, Vietnam, and Thailand.

³ For the purposes of this essay, the term “Indigenous” will be used to refer to “those [peoples] which having a historical continuity with pre-invasion and pre-colonial societies that developed on [or, over time, encroached upon] their territories, consider themselves distinct from other sectors of societies now prevailing in those territories, or parts of them. They form at present non-dominant sectors of society and are determined to preserve, develop, and transmit to future generations their ancestral territories, and their ethnic identity, as the basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal systems.” This is the definition developed by/for the United Nations, in 1984 (as cited in IPHRP, 2003:3).

⁴ In 2002, officials indicated that the Hmong constituted about 15% of a Hill Tribe population of approximately one million (TRI).

¹ A diaspora is defined as “the (imagined) condition of a ‘people’ dispersed throughout the world, by force or by choice. Diasporas are transnational, spatially and temporally sprawling sociocultural formations of people, creating imagined communities whose blurred and fluctuating boundaries are sustained by real and/or symbolic ties to some original ‘homeland’” (Ang, as cited in Julian, 2004, p. 8).

relocation has also scattered the Hmong into the Central Plains region (Kundaster, Kesmanee & Pothi-art, 1987). The Hmong traditionally practiced subsistence-oriented pioneer swidden farming, limited animal husbandry, and hunting, settling in areas suited to intercropping rice, maize, and opium⁵ (Kundaster, Kesmanee & Pothi-art, 1987). Anthropologists would describe them as an ethnic group displaying a patrilineal kinship system, practicing clan-exogamous marriage, and exhibiting a patrilocal residence pattern, who “value highly a social system with father-right as the norm”⁶ (Lee, 1994-5:4, 9; Symonds, 2004). The nuclear family and extended household together constitute the central social unit, though lineages and clans also figure strongly in both social organization and ritual performance (Lee, 1994-5:15).

The traditional Hmong experience of the world divides the seen and unseen into different realms: that of man, that of nature, and that of supernatural entities (Santasombat, 2003; Helsel, Mochel & Bauer, 2004), all of which contain threats to fortune and health. Unseen forces inhabit all three realms, existing as spirits of persons (khwan), spirits of nature, and ancestor spirits. A balance between these worlds is critical; indeed, “[h]umanity can live happily only by living harmoniously with these myriad spirits” (Adler, 1991:59). The interplay between entities across and within these three intersecting worlds is characterized as a social relationship, controlled by a “local conception of power [which is] the basis of thought regarding production systems, livelihood, fertility, illness, and traditional beliefs that conform with cosmology and make [one] able to interpret the meaning, arrive at an understanding with, and explain the phenomena that occur” (Santasombat, 2003:106). This power is culturally determined and socially controlled.

Some historians assert that the Vietnam War cost one-third of Laotian Hmong their lives⁷ (Quincy, as cited in Adler, 1991:62), while untold numbers died from hunger, disease, and accident during the subsequent exodus of individuals, families, and entire villages in the face of Communist Vietnamese advancement into Laos (Dao, as cited in Adler, 1991:62; Julian, 2004). After decades of life in the refugee camps of Thailand,⁸ initial resettlement in the United States saw the Hmong scattered throughout various urban centres (Kaufman, 2004; Helsel, Mochel & Bauer, 2004), in which they found that their skills, experiences, language, and cultural logic “seemed irrelevant” (Adler, 1991:62). In this new physical and social geography, traditional support systems and resources, including the clan affiliations that “form the social backbone of the Hmong community,” were crippled (Kaufman, 2004:24). Today there are approximately 187,000-200,000⁹ Hmong living in the United States, more than the approximately 152,000 that today remain in Thailand – in fact the largest urban concentration of Hmong in the world is found in the American city of St. Paul (Julian, 2004; Her & Culhane-Pera, 2004; Kaufman, 2004).

5 Such areas are typically found at elevations above 1,000 metres, explaining the major Hmong settlement patterns in the Thai highlands.

6 Despite gendered, unequal power relations in physical and earthbound spiritual life, all Hmong souls are equal in the afterlife (Symonds, 2004).

7 This includes both civilian and military deaths, as during the Vietnam War Hmong were recruited by the United States’ Central Intelligence Agency (CIA), as fighters whose familiarity with the local geography could help to advance American ambitions in Laos (Warner and Mochel, 1998).

8 The last Hmong refugee camp on the Thai border closed in the mid-1990s (Peters, 2005).

9 These are official figures; Hmong leaders estimate that the number is closer to 300,000 (Helsel, Mochel, and Bauer, 2004).

Healing Practice and the Ontology of Health in Hmong ‘Tradition’

The biology of illness is intimately connected to cultural meanings; these, in turn, are based on social processes and relationships. Sickness is the crucible of community, for it is in times of misfortune that the group must coalesce to maximize social and economic support (Capps, 1994). Hmong views of illness include a plethora of local customs and taboos that protect biodiversity, guide agricultural production, and inform resource management systems. In the realm of the psychological and social, healing rituals restore proper interpersonal relations; reinforce cultural symbols; and legitimize mutually understood interpretations of the world. The whole person – body, mind, and spirit – is the target of medical strategies, which minister at the same time to the individual, family, and community (Santasombat, 2003). “The Hmong have a holistic approach to healing; they heal the soul and then the flesh” (Yang, 1998:7).

Their geographical origins and migration have resulted in the presence of Chinese and Buddhist elements in traditional Hmong medical culture (Tapp, 2001). The influence of Chinese medicine can be seen in the ideas of soul loss; humoral balance (including the idea that excessive emotion can cause illness); a balance of elements (earth, water, wind, and fire) in the body; in so-called “hot/cold reasoning,”¹⁰ by which foods and physical conditions are given characteristic temperatures that must be set in harmony; and in the practices of herbalism and therapeutic massage (Capps, 1994).¹¹ Buddhism lends the view of illness as a result of karma and the use of astrology for diagnosis and prophylaxis (Santasombat, 2003).¹² Despite these influences, Hmong Animism remains the core belief in health and healing, giving rise to the view that an individual has many souls,¹³ at least one of which is responsible for health and happiness (Fadiman, 1997). For the Hmong, Animism provides a culturally relevant form of social control, giving healing an extra-physical role in addressing disputes, releasing tensions, and in preserving and transmitting traditional practices and understandings. “Viewed this way, illness is not the sole problem of a single person but the joint responsibility of the family, friends, and community” (Santasombat, 2003:112). Fadiman (1997) contends that, for the Hmong, “[m]edicine was religion. Religion was society. Society was medicine” (61-2).

In Hmong medical culture, illness may be caused by natural or supernatural influences¹⁴ on the body and spirit; with both of these categories of causation encircled by the social aspects of health and illness (see figure 1). In assessing and treating illness, the mind and the body are considered part of a continuum of physical, emotional, and spiritual health (Santasombat, 2003). The Hmong, in fact, “often may link somatic responses to psychic experience”

10 Hot/cold reasoning comes into play in Hmong medical practice largely in the context of fertility and childbearing. The importance of such reasoning should not, therefore, be overemphasized (Capps, 1994).

11 Note that, despite persistent misunderstanding on the part of certain authors, there is no Hmong concept that correlates with the Chinese ch’i (Capps, 1994).

12 Buddhist monks occasionally come into play as medical practitioners in this regard.

13 Different sources report a different number of total souls (ntsuj or plig) recognized by the Hmong as inhabiting a human body. Capps (1994) cites Bernatzik, Bliatout, and Chindarsi in acknowledging anywhere between three and twelve such souls.

14 Though some authors contend that the natural, supernatural, and social constitute separate realms of illness causation for the Hmong, this is a modern conceptualization and not one that would be recognized as ‘traditional’.

(Capps, 1999:3), as intense emotional states are seen to affect physical health. Traditional etiology acknowledges a wide range of possible interpretations of symptoms, while diagnostic techniques also serve to reveal the appropriate therapy (Her & Culhane-Pera, 2004). In the arena of naturally-caused illness, exposure to environmental toxins, spoiled or unsuitable food; travel to new locations; an imbalance of elements; and the effects of changes in weather¹⁵ are the principal culprits (Jintrawet & Harrigan, 2003). In several of these categories, “no earthly medicines can cure those afflicted” (Tapp, 2001:165). The various supernatural causes of ill health give evidence of the Hmong belief in spirits, demons or gods; witchcraft; magic; and astrology (Santasombat, 2003). Diagnosis here often involves divination, with various rituals employed to isolate the specific supernatural cause. Spirits may be benevolent or malevolent, but the boundary is easily blurred by human action, as beneficial and neutral spirits may be angered by the violation of social taboos or religious norms (Santasombat, 2003). Ancestor and guardian spirits may demonstrate that anger by inflicting illness directly, or by abandoning a neglectful or errant individual to the will of other, more malicious or capricious spirits (Adler, 1991:59; Capps, 1994; Helsel, Mochel & Bauer, 2004). Minor forms of possession are also noted, in which spirits may enter the body and manifest as illness (Adler, 1991).

Traditional health practitioners include the spirit doctor (txiv neeb), ‘spirit-chosen’ shaman (txiv neeb thawj or txiv neeb muag dub), ‘learned’ spirit doctor (txiv neeb kawm or txiv neeb muang dawb),¹⁶ sorcerer or magician (tus ua khaaw koob), soul caller (tus hu plig),¹⁷ fortune teller (saib yaig), herbalist (kws tshuaj), and bone-setter, though there is some overlap in each of these sets of specializations, and many therapies (for example, massage, or tus ua zaws hno) are employed by several different kinds of practitioners (Capps, 1994; Her & Culhane-Pera, 2004; Kundaster, Kesmanee & Pothi-art, 1987). Helping or healing spirits (dab) work with all practitioners but the herbalist, whose jurisdiction is principally that of naturally-caused illness. Shamans – arguably the most significant medical figures in Hmong culture – bridge the corporeal and spirit worlds, executing diagnoses and treatments through trance and animal sacrifice (Fadiman, 1997; Helsel, Mochel & Bauer, 2004). They minister to both genders, to all age groups, and treat illnesses stemming from both natural and supernatural causes (Her & Culhane-Pera, 2004). Historically, every village would have at least one shaman, who could be male or female; often, each clan had its own, though there could only be one shaman in each generation in any one lineage (Tapp, 2001; Chindarsi, 1983; Helsel, Mochel & Bauer, 2004). The Hmong shaman is a vessel for inherited wisdom, a seeker and adapter of outside knowledge, and a devotee of the spirits, who have specifically chosen him or her for a shamanic role. In unresponsive cases a shaman will refer a patient to other practitioners; in others, a shaman will find nothing spiritually amiss, or that the spiritual

15 For example, measles are said to be caused by seasonal (cyclical) weather changes, specifically strong winds (Henry, as cited in Jintrawet and Harrigan, 2003, p. 81).

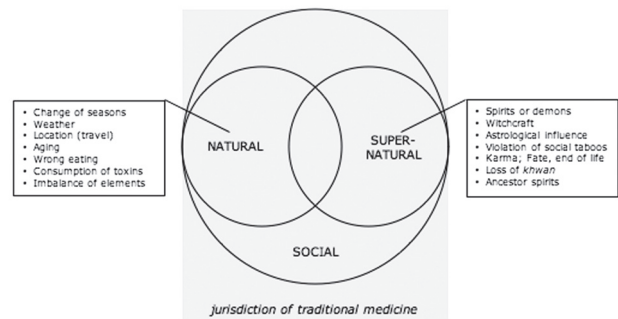
16 The difference between txiv neeb kawm and txiv neeb thawj lies in the method of passage into being a ‘spirit doctor’. The txiv neeb thawj is chosen by spirits, a process that manifests itself as a protracted illness, and this kind of practitioner executes diagnoses and treatments through possession. The txiv neeb kawm apprentices him- or herself to another doctor, and although incantations are employed, he or she does not experience possession.

17 Soul calling can be performed “by an ordinary householder,” and needn’t involve the services of a shaman (Tapp, 2001, p. 161).

cause is not reparable¹⁸ (Helsel, Mochel & Bauer, 2004; Her & Culhane-Pera, 2004).

Traditionally, a Hmong health practitioner is selected on the basis of his or her skill and integrity – an assessment made via a kind of ‘professional referral system’ that includes consultations with the patient, family, and clan, and the performance of ritual intended to promote empathetic understanding within the healing relationship (Santasombat, 2003; Deinard & Dunnigan, 1987). Experimentation and borrowing are included in the practitioner’s repertoire, as medical knowledge was historically sought within other clans and communities, as well as from other healers (Santasombat, 2003). In fact, traditionally a shaman had to be trained by a master practitioner from outside his or her own clan, creating cooperation and borrowing as fundamental tenets of traditional medical practice. Hmong medical knowledge is transmitted only to pupils who have been tested for both moral and intellectual strength, while payment for services rendered is traditionally accomplished through ritual offerings of food and liquor. The result is a social, outwardly-oriented role for the healer who, while possessed of specialized knowledge, is not socially superior to his or her patients (Santasombat, 2003).

Figure 1: ‘Traditional’ Medical Culture of the Hmong



Treatment for naturally and supernaturally caused illnesses is performed through one or a combination of: administering plant compounds, propitiating spirits, performing incantations or exorcisms, and the enactment of rites that dispel bad luck (Santasombat, 2003:112). Herbalism (tshuaj ntsuab) involves the preparation and delivery of one or a combination of plants, in conjunction with other therapies¹⁹ to produce synergistic effects (Santasombat, 2003; Capps, 1994; Hein, 1998; Kundaster, Kesmanee & Pothi-art, 1987). The plants employed are typically native to the practitioner’s territory, as knowledge of herbalism is always adapted to the specific natural environment. Propitiating spirits may involve ameliorating the behaviour that initially offended the entity;²⁰ or calling back a soul that has become separated from its bodily vessel.²¹ Spells – magic performed by one living person

18 For example, if a soul has wandered for too long it cannot be brought back.

19 These may include such as massage, bloodletting or needling (nkaug), cupping, and ‘blowing magic incantations’.

20 Typically an ancestor, the ghost of a person who died traumatically, or a spirit of the natural world. The identity and desires of the spirit in question must be determined by ritual performance.

21 Soul loss, or poob plig, is in fact quite common, as spirits will wander (for example, during dream states) or flee the body (usually as a result of fright or shock) quite frequently – the souls of children being more prone to do so, due to their weaker attachment to the physical form (Santasombat, 2003; Capps, 1999; Capps, 1994). For the retrieval of a wandering soul, calling back and the

against another – cause psycho-neurosis as well as physical illness, and can only be overcome by a counter-spell of equal or greater power, typically in the form of incantations, healing magic (khawv koob), and exorcism (Santasombat, 2003; Hein, 1998). Also in the realm of ‘magic’ are objects imbued with healing power, for example the scarves worn by elderly women or new mothers, which are used to prevent headaches and osteoporosis (Capps, 1994). The final traditional treatment method – dispelling of bad luck – includes the performance of rituals aimed at extension of one’s “life visa” by ancestors, the expiry of which brings illness and death (Helsel, Mochel & Bauer, 2004:934-5; Santasombat, 2003).²² All of these therapies considered, traditional healing is preventative as well as curative, and examples of shamanic prophylaxis (caiv) include: annual curing ceremonies for families (in which their souls are gathered and tied in, as a group); soul calling; extensions of a life visa; naming rituals for three-day-old infants; and ‘soul-splitting ceremonies,’ in which the souls of a pregnant woman and her unborn child are uncoupled so that the death of one will not demand that of the other (Helsel, Mochel & Bauer, 2004).

A key feature of traditional Indigenous health systems in Northern Thailand is the fact that medical knowledge belongs not only to specially trained practitioners, but also to the patient and wider community. Historically, knowledge of the use of herbs and lifestyle-related therapies²³ in treating simple ailments was widespread, often held by mothers, and reinforced by daily practice (Santasombat, 2003; Capps, 1999). Local medical knowledge is holistic and relational, arising from local contexts and linking with outside influences in a creative, energetic process of adaptation. Ultimately, Hmong traditional knowledge flows from, and is held by, the group; it is a collective form of knowing. The power of medical knowledge is therefore regulated by moral codes and behavioural norms circumscribed by local traditions and belief systems (Santasombat, 2003).

Healing Practice and the Ontology of Health in the Hmong Diaspora²⁴

International migration and government programmes of relocation and infrastructure construction have brought the Hmong physically closer to mainstream medical facilities (Capps, 1994). In response, Hmong healers have actually incorporated aspects of biomedicine into their own practices²⁵ (Santasombat, 2003). Just as traditionally a Hmong shaman would refer the patient to other practitioners, today those ‘others’ may include a biomedical doctor (Her & Culhane-Pera, 2004). Within this dual or bicultural medical context, illness causation is explained by the stitching together of outsider and traditional beliefs and experiences building of a soul bridge are the usual treatments, followed by a ritual to fasten (with string or metal rings about the wrist, ankle, or neck, or even a safety pin attached to clothing) the soul (Helsel, Mochel, and Bauer, 2004). For more dire soul loss, involving the wresting of the spirit from the body, shaman, “whose eyes are hooded to symbolize their inner vision” (Tapp, 2001:151), pass into the spirit world to track and retrieve the lost soul; do battle with the forces in the unseen realm; offer an animal’s soul in exchange; and/or ransom the soul from its captors with paper money (Her and Culhane-Pera, 2004).

²² Animal sacrifice is common in most treatment methodologies (see, for example, Boyes and Phaban, 1990).

²³ For example, dietary changes.

²⁴ There is considerable variation of belief and practice in the Hmong diaspora (Capps, 1999), and the following discussion – though limited to two country contexts – should not be read as an effort to restrict the Hmong to a narrow cultural identity.

²⁵ For example, the use of antiseptics, surgical instruments, x-ray imaging; and the suturing of wounds.

without this resulting in cognitive or cultural dislocation, since new concepts and procedures are “link[ed] up with the group’s age old cosmological meaning, applied to come to an understanding, explanation and interpretation with their cultural meaning” (Santasombat, 2003:105). Increasingly, local or ‘ethno-medical’ practitioners specialize in diagnosing and treating diseases that elude biomedical attention or expertise, creating parallel systems in which traditional therapies are seen as more effective for what patients perceive as “Hmong-specific illnesses” (Capps, 1994:173), as well as in those cases in which biomedicine fails to produce a diagnosis or effective treatment (Santasombat, 2003).²⁶ Ultimately, many Hmong do not perceive ‘traditional’ and ‘modern’ medical paradigms as either competitive or mutually exclusive (Kundaster, Kesmanee & Pothi-art, 1987).

Unfortunately, the interaction of these two paradigms has not always been productive, and obstacles persist. Coming from a location (either the village or the refugee camp) in which biomedical exposure was minimal, an initial lack of familiarity was compounded by post-relocation linguistic and cultural barriers (Warner & Mochel, 1998; Deinard & Dunnigan, 1987). Faulty interpretation and lack of cultural sensitivity has allowed biomedical tests and procedures to go ill- or unexplained, while a dismissal of traditional healing as “backward” often leaves Hmong unable to share their beliefs, fears, and expectations with mainstream practitioners (Warner & Mochel, 1998). Hospitals in Hmong-settled areas, as a result, report that the community makes “so-called unusual medical requests” (Chiu, 2004:3), while medical personnel find the criteria Hmong employ in selecting a physician – including interest, respect, and a positive outlook – biomedically incomprehensible (Her & Culhane-Pera, 2004). During clinical encounters, doctors and nurses typically fail to take the patient’s relatives into account, viewing the individual as an autonomous decision-maker, yet the Hmong patient’s clan has a duty to provide support during times of illness, and his or her family members take part in all medical decision-making (Her & Culhane-Pera, 2004; Warner & Mochel, 1998; Yang, 1998). Unfortunately, simple semantics have also led to confrontations between mainstream and traditional medicine – for example, Hmong healers in the north of Thailand have been accused of making unfounded medical claims because “to cure” means “to improve a given condition” in their local language (Santasombat, 2003).

For their part, Hmong have been uncertain of biomedicine’s motives, occasionally expressing a fear that doctors may actually be experimenting on patients, and it does not help matters that patients can be forced to undergo procedures through the use of court orders and child protective agencies (Chiu, 2004; Fadiman, 1997; Deinard & Dunnigan, 1987; Warner & Mochel, 1998). As a result, a “fragmented rather than unified health care program [has] emerged,” with Hmong establishing networks of traditional, alternative, and mainstream practitioners from which they could choose culturally appropriate diagnoses and therapies (Deinard & Dunnigan, 1987:861). “[I]n many cases, [traditional] ways of healing are seen as superior, enhancing [the] sense of membership in a distinct ethnic group,” (Capps, 1994:163) and Hmong in both America and Thailand have been reticent to undergo procedures that contravene beliefs about health and healing (Her & Culhane-Pera, 2004). For example, since surgery opens up and scars the

²⁶ From the Hmong perspective, chronic, especially biomedically unresponsive illnesses may be a sign that the patient has been chosen to be a shaman, in which case the assistance of a ‘master’ shaman is especially appropriate.

body, it may cause the soul to flee in fright, or else deny it reincarnation after death²⁷ (Deinard & Dunnigan, 1987; Her & Culhane-Pera, 2004; Lampert Smith, 2004). Hmong also display a reluctance to follow medical regimens prescribed for symptomless diseases,²⁸ as seeming well is not culturally consistent with being ill, particularly when the illness is not one from which Hmong traditionally suffered (Deinard & Dunnigan, 1987; Helsel, Mochel & Bauer, 2004). Routine preventative measures, such as check-ups, are therefore not the norm (Capps, 1994). Similarly, a course of medication is often discontinued after the alleviation of symptoms, regardless of whether or not the underlying cause has been medically addressed, while if a medication causes symptoms worse than those of the illness for which it was prescribed, other community members will abandon or avoid the same regimen (Deinard & Dunnigan, 1987; Underwood & Adler, 2005). Hmong also shun long treatment regimens, expecting cure in a relatively short period of time, perhaps because in the past chronic symptoms were unknown, and those who did not recover from an illness would most likely pass away (Her & Culhane-Pera, 2004). Often, a language barrier, lack of medical insurance, and lack of familiarity with the procedures for obtaining and taking prescriptions present significant barriers to patient compliance (Deinard & Dunnigan, 1987; Capps, 1994). In the end, Hmong are painted as difficult patients who actually “threaten accepted, routine operations [of] health care” (Chiu, 2004:4).

A high percentage of the Hmong in America are Christian (Julian, 2004), yet traditional views still exert influence. Individual and group prayer may have supplanted shamanism, but the underlying belief in supernatural causes and healing modalities has not yielded to the concept of illness as purely biological, since “ideological dichotomies of illness, namely illnesses “of God” and illnesses “of man,” determine the therapies” (Janzen, as cited in Capps, 1994:162). Moral and spiritual aspects of illness are underscored in both Animist and Christian Hmong communities, though the latter asserts that the power of ancestor and nature spirits has been supplanted by the power of the Holy Spirit (Capps, 1994). In the same way that protective spirits may withdraw if social taboos are violated, God may vacate his protection if sins are committed (Capps, 1994). In this context, the Hmong priest (tus txiv plig) or minister (tus xwb fwb) takes up the role of the shaman, acting as a mediator between the earthly and unseen realms. Additionally, although pagan practices are forbidden, Christian Hmong continue to visit traditional herbalists and massage therapists (Her & Culhane-Pera, 2004). New illnesses have also emerged among the Hmong, their occurrence and growth paralleling the introduction of modern medicine. Among the lifestyle-related diseases that often accompany transition to a sedentary urban life²⁹ are found conditions that baffle even the foremost medical researchers, including nightmare and fear-related illness (ceeb), and Sudden Unexpected Nocturnal Death Syndrome (Adler, 1991; Capps, 1999). Such phenomena challenge not only the medical establishment, but also the uniformity of belief in Christian Hmong communities, who see in them an enigma that is somehow related to the Animistic notion of soul loss.³⁰ This

27 The Hmong believe that the body must be intact at the time of death in order for the soul to be reincarnated (Lampert Smith, 2004).

28 These would include, for example, diabetes and hypertension.

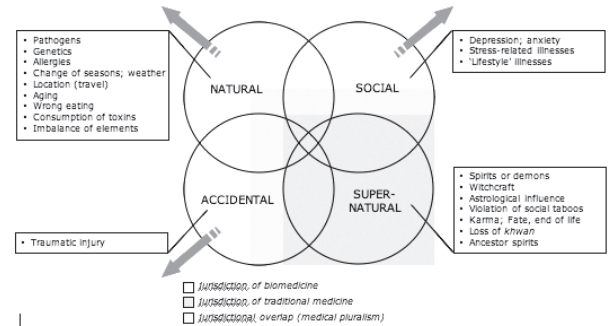
29 These include hypertension, diabetes, dyslipidemia, obesity, metabolic syndrome, heart attack, stroke, and kidney failure – all of which were unheard of prior to emigration from Laos (Her and Culhane-Pera, 2004; Helsel, Mochel, and Bauer, 2004).

30 As was discussed above, fright illness is also noted in the wake of

equivocation remains unresolved, and different communities grapple with it in different ways (Capps, 1994).

Because it proved relevant and effective for millennia, many Hmong pursue traditional healing prior to, or even to the exclusion of, seeking out Western medicine (Warner & Mochel, 1998). Consulting with a shaman involves a long, unhurried conversation which provides an opportunity to vent anxiety in a safe and culturally-reinforcing atmosphere. Regardless of physiological outcomes, this constitutes remarkably effective psychotherapy,³¹ particularly since shaman tend to operate in small communities and therefore have an intimate knowledge of the personalities of their patients (Chindarsi, 1983; Yang, 1998). Despite strong claims to the contrary,³² “the significance of [...] beliefs in disease causation and cure is the same as that of micro-organisms and medicinals; given certain conditions of host and environment, pathology or healing consistently follows belief” (Hahn & Kleinman, as cited in Adler, 1991:67). Yet the Hmong attitude toward the biomedicine/traditional medicine schism remains ambiguous, and fluctuations occur both across and within groups. In Doi Pui, a Hmong village of 1,200 in Thailand’s northern Chiang Mai province, almost 70 percent of the village residents practice Animism, yet only about half of the community reports visiting a shaman (McCaskill, 2005). Village herbalist Amnuay Fuangfookitchakarn (2005), who is not only traditionally trained but also university-educated and certified by the Ministry of Health, asserts that “you cannot get away without ritual; the healing won’t work.” Health campaigning in Doi Pui takes place in conjunction with government-sponsored biomedical initiatives, but traditions play a strong role in mediating collaboration between the two healing paradigms. Describing adaptation over the past decades, the village headman says “[o]f course we have changed, but we have not changed totally; within change we have our own culture set aside.” In modern Thailand, it is noteworthy that Hmong spirit mediums and shaman are often women, which represents a significant shift from the traditional gender balance in professional healing; in fact, women in ethno-medicine have gained a measure of power and status often unparalleled in other areas of ‘modern’ life (Santasombat, 2003).

Figure 2: Medical Culture of the Hmong Diaspora



The medical culture of the Hmong diaspora (see figure 2) is characterized by those elements that mark it as distinct from the traditional Hmong ontology of health. The most striking change

Hmong patients’ experience with biomedicine (Capps, 1999), adding to the consternation felt concerning Western diagnosis and treatment.

31 It is important, however, not to portray the psychological effect of traditional healing as the only benefit; such a stance contradicts assertions emanating from the Hmong themselves, among others.

32 See, for example, Dao, 1993; and Bhikkhu and Bhikkhu, 1973/4

is that healing itself has become disembedded from the norms which historically circumscribed Hmong life, as disease etiology and symptomatology have been slotted into more numerous and clearly defined (but less interrelated) spheres. Here, 'social' factors are segregated into their own group of causes and symptoms; 'accidents' become another discrete cause of ill health; and genetic factors and pathogens join the roster of 'natural' disease triggers. The overlap between various spheres is lesser or greater, and may be either growing or shrinking, depending on the specific community. Such changes are a direct result of the meeting of bio- and traditional medicine. Where the jurisdictions of these two healing paradigms overlap – producing medical pluralism³³ – the influence of biomedicine applies certain stresses to the system, further isolating certain explanatory and therapeutic models.

As parts of a tradition that has always been adaptive, Hmong views of health and healing have found a unique purpose in the modern world: mediating the stress of rapid, often uncontrollable social change. Santasombat (2003) refers to local medical knowledge as ideally suited to pressure of "development imbalance" (123), a thought that Mueggler (1997) echoes when he states that "healing rituals can express an epistemology of origins which counters the dismissal of origin by the state modernization project (as cited in Tapp, 2001:167-8).

Forces Driving Change – and Resistance – in the Medical Culture of the Hmong

Several theorists have attempted to clarify the disharmonies between Hmong and mainstream cultures in both the West and East.³⁴ Warner and Mochel (1998), for example, assert that these cultural regions exhibit different temporal orientations, and under their classification system the Hmong have a "past-oriented culture," in which history provides "a prologue for the present," and certain kinds of change are actively resisted (6). Although the Hmong identity narrative here "acknowledges the future (through, for example, the value of educational achievement) [...], it does so in the context of a trajectory emanating from the past" (Julian, 2004:11). By way of contrast, Hmong in the West and in Western-influenced societies are surrounded by a "future-oriented society," in which the "present is just a road to a better future," the novel is valued above the historical, and change is sought as synonymous with momentum and opportunity (Julian, 2004:11). Deploying another theoretical model, Helsel, Mochel, and Bauer (2004) assert that the real cultural conflict is found in the incongruity between the Hmong orientation toward the family and group, and the Western emphasis on the individual; in fact, Hmong characterize strong individualism as evidence of a "sick society" (937). Whatever the conceptual framework, and regardless of the geographical or political context, it is a fact that the Hmong have found themselves literally and figuratively encircled by a society with strikingly different – even antithetical – values and norms.

Change, for every culture, is inevitable. Hmong do not view internal change with trepidation, as it takes place within the context of continuity in social relationships and structures. Similarly, material changes³⁵ are perceived as relatively benign, since these

do not directly intersect with deeper ethical and identity issues. Mode of thought and spiritual practice, however, do not easily enter into flux, and changes to these areas of culture are viewed as dangerous. Negative effects here are amplified by the myriad psychological consequences of drastic relocation, particularly in the wake of violent conflict, including "posttraumatic stress syndrome, depression, loss of purpose in life, loss of individual and cultural identity, loss of friends and families, new styles of houses, the everyday battle to use a grocery store, and above all, the bureaucratic nightmare of all forms of government" (Warner & Mochel, 1998:9). A profound cultural disorientation in such cases is inevitable, during which tradition becomes a lens through new experiences are focused. George de Vos (1978) calls this 'selective permeability,' an unconscious coping or defensive mechanism that permits the inflow of only those new influences that are consonant with traditional cultural values. Because it is essential to societal integrity and identity, "in times of disruptive change, religion, as an explanatory system, may be relied on to a greater extent" (Warner & Mochel, 1998:9), and it is in such times that the traditional healer acts as "an advocate of conservative beliefs," mediating change so that new influences resonate with pre-existing systems (Landy, as cited in Deinard & Dunnigan, 1987:863; Santasombat, 2003). For the Hmong, their traditional belief system is the foundation of their medical culture.

Western biomedicine, too, has a culture of its own, into which practitioners are socialized during their medical education, and regular clinical encounters train patients to assume their roles. The Western healing paradigm has a colonizing aspect, parallel to its socializing one, which comes into play when those outside the culture are cast as 'patients.' Indeed, outsiders have little chance to express themselves in a medical context in which "ordinary people tend to be underestimated and [whose] knowledge tends to be discredited by authorities" (Hufford, as cited in Adler, 1991:55). Kleinman claims that biomedicine strips 'illness' of its social context, recreating it as 'disease' (as cited in Warner & Mochel, 1998). The patient here is a collection of symptoms; his or her obligation is to be prompt, compliant, and subordinate to the clinician (Warner & Mochel, 1998). This model – deploying a "germ theory" of disease that focuses on hygiene, anatomy, and pathogens, and adhering to the Cartesian dualism that sets mind and body in opposition – recognizes "no alternative forms of healing; [...] no other healers" (Warner & Mochel, 1998:15). Indeed, among the Hmong in America, "Western health care was promoted according to the principle that there should be no double standard" (Deinard & Dunnigan, 1987:859).

By way of contrast, traditional Hmong practitioners "fuse the dichotomy of illness and disease" (Yang, 1998:8). While biomedicine functions optimally in the social context from which it initially arose, "so, too, has shamanism proven effective in certain historical and social conditions," where it reinforces the patient's perceptions of health, validates his or her concerns, and "provid[es] comforting explanations of terrifying behaviour and offer[s] community-based mechanisms for healing" (Chiu, 2004:15). Similarly, Helsel, Mochel, and Bauer (2004) explain that shamanic healing "restores the connectedness between patient, family, and community" (934). Traditional medical consultation itself provides a disincentive to seek out biomedical approaches, since the diagnostic and therapeutic modalities employed by the various txiv neeb are dialogical, socially embedded, and familiar (Yang, 1998). For the Hmong, connectedness, comfort, and the alleviation of feelings of

33 Medical pluralism is defined as "the presence of differently designed as conceived medical systems in a single society" (Janzen, as cited in Capps, 1994, p. 162).

34 Further, with the forces of globalization, the influence of the West has burst geographical borders and can now be found to have effect in every corner of the world.

35 For example, economic and technological changes.

isolation are sought alongside amelioration of physiological discomfort, so that the psycho-social and physiological jurisdictions blur (Helsel, Mochel & Bauer, 2004). Mind-body separation is altogether rejected, even in those Hmong communities where shamanism and Animism play no role in health and healing.

Helsel, Mochel, and Bauer (2004) claim that mutual misunderstanding has been the defining feature of encounters between Hmong patients, shaman, and biomedical doctors, while Warner and Mochel (1998) assert that the bulk of responsibility for this failure rests with Western medical staff. Through clinical procedures and scientific discourses, biomedicine “legitimizes its own narrative” at the expense of alternative modes of thought, translating, reordering, and retelling illness stories that erase the patient as the subject in order to recreate him or her as the object of a case study or clinical intervention (Chiu, 2004:3-6). The logocentric biomedical model of health involves the deployment of “a rational theory of the world made up of knowable things and subjects, including the body, which can be ordered and controlled” (Bhattacharya, 2002:1). Patients’ bodies are framed as objects of intervention, yet since “medical ‘cases’ are socially as well as biologically constructed, case histories participate in producing as well as recording what they observe” (Epstein, 1995:29). Critical medical anthropologists therefore speak of health as a socio-political issue, and illness as one expression of non-physiological suffering that is “mystified as [disease], medicalized, and brought under the power of the state” (Santasombat, 2003:96). Similarly, Chiu (2004) likens medical power to colonial power, particularly in the control or deployment of knowledge, stressing “the urgency of negotiating cross-cultural solutions in an increasingly multicultural [field] that, unfortunately, practices varying types of subtle but powerful and devastating colonialism” (5).

Whatever the reason, effective communication has been lacking between biomedicine and traditional forms of healing. It is certainly possible that amelioration of this situation was never a priority because of the perceived inevitability of assimilation into the rational-scientific paradigm. Assimilation is, indeed, one possible choice for refugees and minority groups; one way of dealing with the sensation of being both out of time and out of place, described by a former headman of a Hmong village as feeling “like a thing which drops in the fire but won’t burn and drops in the river but won’t flow” (Whitham, as cited in Adler, 1991:62). Yet although adaptation has been posited as a zero-sum phenomenon, entailing the loss of one culture commensurate with the adoption of another, current thought on the persistence of group identity offers that certain foundational elements of culture will not yield, even in the face of significant pressure to conform. As a result, Isajiw offers that the process that has been labelled ‘assimilation’ might better be termed ‘acculturation’ (as cited in Helsel, Mochel & Bauer, 2004:934).

There have, however, been some positive developments in the dialogue between Hmong patients, traditional healers, and Western doctors. One physician – himself Hmong, and one of only a dozen or so such physicians in the U.S. – has tackled the health effects of sedentary urban life by developing and teaching a set of tai ch’i movements based on traditional Hmong chores (such as pounding rice), thereby combining Chinese martial arts, elements of traditional village life, and Western ideas about the benefits of formal exercise (Lampert Smith, 2004:11). In California, Hmong shaman are extended privileges similar to those provided to members of the clergy,³⁶ and these healers have expressed their

desire to work cooperatively with biomedical practitioners (Helsel, Mochel & Bauer, 2004). The practice of using shamanic healing as prophylaxis before and after hospitalization is another example of positive pluralism (Helsel, Mochel & Bauer, 2004); similarly, “many Hmong who see physicians also rely on shamans for restoring health and balance to their body and soul (Plotnikoff et al., as cited in Helsel, Mochel & Bauer, 2004:936-937, emphasis added).

Conversely, abandonment of shamanistic healing, discontinuation of ancestor rites, and conversion to more ‘mainstream’ religions are characteristic of many contemporary Hmong communities in both America and Thailand. Such changes in belief may satisfy needs other than the spiritual, however, including the desire for community; access to the resource pools that mainstream religious institutions command; and an avoidance of the stigma and cost associated with traditional practice (Desan, as cited in Adler, 1991:63; Capps, 1994). Capps (1994) has observed that some Hmong in Kansas City “choose among different therapeutic ideologies to alter social relationships and to create access to secondary social and economic resources” (163). Sometimes, purely practical impediments encourage conversion to Buddhism or Christianity; for example, the animals required for ritual sacrifice were simply not available in the Thai refugee camps (Capps, 1994). Relatedly, Kundaster, Kesmanee & Pothi-art (1987) observe that “[c]hanges in economic and settlement patterns implies changes in behaviour which may have medical or demographic significance” (69). The economic landscape of the Hmong in Thailand has shifted rapidly in the past several decades, particularly with the eradication of traditional poppy crops during the government’s “war on drugs.” Other changes, both negative and positive, have included: the building of roads, improving access to biomedical facilities; the adoption of labour-reducing machinery, reducing accidents but also exercise; and the introduction of Western foods which, supplanting those in the traditional diet, often lead to malnutrition (Kundaster, Kesmanee & Pothi-art, 1987; Leeja, 2003). Resulting impacts on the Hmong medical culture have been profound, ranging from the loss of medicinal opium to the sloughing off of the dietary aspect of traditional healing as the availability of traditional foods has waned. The low socio-economic status of Hill Tribes in Thailand also contributes to chronic undernutrition (Leeja, 2003). Traditional medical relationships have also been significantly damaged by the market, in terms of the enclosure, degradation, and commodification of medical resources;³⁷ declining terms of trade for cash crops, which reduces and renders unreliable a family’s income; and in the increasing acceptability of remuneration for healing, which weakens the moral authority and social control that formerly regulated medical knowledge (Santasombat, 2003).

To a certain extent the scientific-rational and mytho-cultural paradigms construct the various actors struggling for validity and dominance, setting “medical authority and cultural adherence” (Chiu, 2004:5) at odds. Faced with a system that denies their ontology of health and wellness, Hmong often abandon biomedical practitioners, use Western medicine as a last resort, or see mainstream doctors only to satisfy social obligation or resource maximization within the host state (Chiu, 2004; Warner & Mochel, 1998; Helsel, Mochel & Bauer, 2004). Distrust, bred by persistent marginalization and exclusion, leads Hmong patients to “strategically deliver only “acceptable” cultural information to

shamanic practice, relegating it to the realm of “belief”, and is thus arguably a token gesture.

37 Such as plants for herbal treatment, and the forests that hold them.

36 It is interesting to note that this entirely circumvents the medical aspect of

their Western counterparts” (Chiu, 2004:5). Koltyk calls this behaviour “collective impression management,” through which Hmong “negotiate their public images in order to avoid disapproval” (as cited in Chiu, 2004:7). In such cases, identity itself is a resource – one that can (or must) be nurtured, manipulated, and maximized for the sake of the survival and prosperity of the group.

Conclusion

Regardless of the society or culture under discussion, and despite scientific-rational claims to the contrary, views of illness and healing are socially embedded. For the Hmong, as in other cultures, “issues of health, illness, disease and death are closely interlinked with social relations and processes; that is the biological dimension and medical understandings of these phenomena cannot be extricated from the socio-cultural context in which they are learned and experienced” (Santasombat, 2003:104).

Not only has traditional Hmong medical culture persisted in the face of (supposedly) stronger cultures of modernization, scientific rationality, and state power,³⁸ but the practices and conceptualizations enshrined in traditional healing have also come to constitute a form of resistance to cultural colonization, cognitive imperialism, and social assimilation. The illnesses associated with the stress of cultural change, the gap in medical knowledge about culture-specific physiological or psychological conditions, and the persistence of certain chronic conditions that are unresponsive to biomedical intervention have together enabled a resurgence of traditional knowledge in health and healing. Further, the flexible and creative nature of Hmong traditional medicine allows a remarkable situational responsiveness in both health care practices and the overarching ontology of health. Far from belonging to a moribund ‘traditional world,’ then, Hmong healers have “retained, revised, and adapted local medical knowledge and practices to meet the changing medical needs of modern times” (Santasombat, 2003:). Further, as biomedicine begins to not only acknowledge, but also actively seek out alternative diagnostic and therapeutic modalities, the Hmong have taken the opportunity to educate ‘outsiders’ in their traditional medical paradigm. In this they are asserting bi-directional acculturation as an alternative to uni-directional assimilation (Deinard & Dunnigan, 1987).

As a group with a history of near- ceaseless migration and adaptation, portraying the Hmong as a single cultural group with an identity that has changed over time from original/traditional to modern/diasporic may be entirely inappropriate; they are effectively a diaspora-within-a-diaspora, influenced over millennia by migration through Southeast Asia and out across the world. As Tapp (1998) relates, the Hmong “were used to taking their kinship relations with them, and recreating their society wherever they went” (23).

Kunstadter (1978) writes that “[i]n the face of uncertainty and tension, plural systems of thought and action will coexist” (as cited in Capps, 1994:173). The medical pluralism practiced in Thailand and America provides a means by which the Hmong may fit in to mainstream society while simultaneously articulating their own distinct identity (Capps, 1994). In this they reconcile ‘tradition’ and ‘modernity’ without conceptualizing the two as mutually exclusive. Ultimately, today as in the past, the cultural context of the Hmong

can be said to be change itself. They are, as Gary Yia Lee has asserted, the occupants of a house of many rooms, in which their adaptability and vision continue to forge keys to those doors yet unopened.

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38 Though only two case studies were presented in this report, others are available for interpretation, and add to the argument (of simultaneous flexibility and integrity) presented. For example, Tapp (2001) reports that the Hmong in China have incorporated Daoist elements into their medical culture while “resist[ing] the incursions of the Socialist state” (146).

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