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A Hierarchy of Medicine: Health Strategies of Elder Khmer Refugees in the United States

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Abstract

This study addresses ways Khmer refugee elders utilize traditional herbal medicine with Western biomedicine in the treatment and prevention of illnesses. Methods include semi-structured and informal interviews with elders and family members, semi-structured interviews with local health care providers and Khmer physicians, and participant observation of everyday life and actions specific to health beliefs and behaviors. Data reveal a reliance on traditional medical ideology for understanding and treating illnesses. Utilizing a traditional ideology, Khmer elders rely heavily on traditional treatments and use Western biomedicine as supplements or adjuncts to traditional preventive and curative practices. This research has important implications for health care providers who treat SEA elders, especially for diet and treatment of chronic illnesses often associated with aging populations.

Keywords

Aging, Complementary and Alternative Medicine, Diabetes, Hypertension, and Southeast Asian

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A Hierarchy of Medicine: Health Strategies of Elder Khmer Refugees in the United States

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This study addresses ways Khmer refugee elders utilize traditional herbal medicine with Western biomedicine in the treatment and prevention of illnesses. Methods include semi-structured and informal interviews with elders and family members, semi-structured interviews with local health care providers and Khmer physicians, and participant observation of everyday life and actions specific to health beliefs and behaviors. Data reveal a reliance on traditional medical ideology for understanding and treating illnesses. Utilizing a traditional ideology, Khmer elders rely heavily on traditional treatments and use Western biomedicine as supplements or adjuncts to traditional preventive and curative practices. This research has important implications for health care providers who treat SEA elders, especially for diet and treatment of chronic illnesses often associated with aging populations. Key Words: Aging, Complementary and Alternative Medicine, Diabetes, Hypertension, and Southeast Asian

Introduction

Complementary and Alternative Medicine: A Matter of Perspective

Complementary medicine and alternative medicine are defined as health therapies that are secondary to mainstream Western biomedicine. Complementary therapies, such as chiropractic or massage therapy (Eliopoulos, 1999; Lorenzi, 1999), may be used along with biomedicine whereas alternative medicines, such as acupuncture or acupressure, are thought to replace Western biomedicine (Cherniack, Senzel, & Pan, 2001; Eliopoulos; Lorenzi). Cambodian refugee elders, however, follow a reverse order of health care preferences. Traditional Khmer health strategies often are employed as a primary treatment and Western biomedicine, when it is used, is added to complement Khmer medicine or as an alternative solution when Khmer medicine is not readily available.

Since 1975 over 1.2 million Southeast Asian (Cambodian, Laotian, and Vietnamese) refugees have been resettled in the United States. Moreover, U. S. Census data indicate that the U.S. population of Asian and Pacific Island elders (of which Southeast Asians constitute approximately 22%) is projected to increase by 256% by 2020 (United States Bureau of the Census, 2000). Experiences of aging refugees and other immigrants differ significantly from elders who have not participated in international migration (Ikels, 1998; Villa, 1998); yet, little is known of health strategies aging refugees and immigrants employ. In particular, information on the prevalence of

diabetes and hypertension among Asian and Pacific Islander populations is scarce (National Heart Lung and Blood Institute, 2000; National Institute of Diabetes and Digestive and Kidney Diseases, 2002). The purpose of this paper is to describe Khmer elders' use of traditional health care practices as primary mechanisms and Western biomedicine as complementary or alternative mechanisms arranged in a hierarchy of use through an investigation into health strategies surrounding diabetes and hypertension.

Shared Health Beliefs and Behaviors

Great variation exists in caregiving beliefs and behaviors for immigrant or refugee families (Fadiman, 1997; Frye & D'Avanzo, 1994; Jenkins, Le, McPhee, Stewart, & Ha, 1996). Beliefs and behaviors are defined as ways of thinking about and putting into practice health strategies that are influenced by particular events, such as actual first-hand experiences and observations as followed in Southeast Asia versus second-hand descriptions of customs within the context of life in the United States. Individuals' and families' health statuses are a consequence of the confluence of traditional beliefs and behaviors and adaptations to life outside one's country of origin (Fadiman; Ong, 1995).

Berman, Kendall, and Bhattacharyya (1994) argue that it is important to step back from a discussion of health strategies to consider a multi-tiered analysis of macro socioeconomic systems, health care systems, and micro-level household health producing behaviors. They define household production of health as, "a dynamic behavioral process through which households combine their (internal) knowledge, resources, and behavioral norms and patterns with available (external) technologies, services, information, and skills to restore, maintain, and promote the health of their members" (p. 207). This definition encompasses the influences of elder refugees' experiences both in Cambodia and in the U.S. that can lead to a variety of strategies, whether via traditional medicine or Western biomedicine, for dealing with diabetes and hypertension. The recognition by Berman and colleagues that "health-producing behaviors are not necessarily done with explicit links to health in mind" (p. 208) is also of particular salience when considering that oftentimes health strategies are governed not only by traditional belief systems (Smith-Hefner, 1998, 1999), but also by religious tenets (Cleary & Maricar, 2000; Dinh, Kemp, & Rasbridge, 2000; Smith-Hefner, 1998, 1999) and social policies (Hendricks, Hatch, & Cutler, 1999; Wallace, Williamson, Lung, & Powell, 1991).

The decision to use traditional Khmer medicine or Western biomedicine may also be affected by financial, organizational, or cultural factors (Ahmad & Walker, 1997; Frye, 1995; Glenn, 1999; Riedel, 1998). For example, refugees bring with them the concepts, practices, expectations and constructions of health, illness, and care that may be unfamiliar to American healthcare providers (Baer, Clark, & Peterson, 1998; Buchwald, Manson, Dinges, Keane, & Kinzie, 1993; Carey, Oxtoby, Nguyen, Huynh, Morgan, & Jeffery, 1997; Fadiman, 1997; O'Connor, 1998). There exists a long-standing "legend," for example, of Southeast Asian parents' arrests for child abuse after performing traditional health practices such as coining or cupping. Coining is a practice that involves rubbing warmed oil onto the skin, followed by drawing a coin across the area in a linear pattern until a red line appears. This method is thought to release a buildup of the "bad wind" that is causing the disease. Cupping is a form of acupressure accomplished by applying a small cup to the body and creating a vacuum, either through burning a small

wad of alcohol-soaked cotton or suction, which draws blood to the surface of the skin. Cupping is thought to relieve congestion. Both techniques leave noticeable marks on the skin. Even though Khmer elders may visit American health care providers, they also may be reluctant to divulge use of traditional medicine to biomedical providers for fear of reprisals (Lewis, 2001).

In addition to differences in medical cultures, language often is cited as a major barrier to adequate health care (Elder et al., 1998; Elder et al., 2000; Flaskerud & Kim, 1999; Jenkins et al., 1996). Problems of bad phrasing, impatience, lack of linguistic equivalence, interpreters' beliefs, ethnocentrism, and role conflict are but a few problems non-English speakers encounter in clinical settings (Flaskerud & Kim; Flaskerud & Liu, 1990; Frye, 1991; Jackson, Rhodes, Inui, & Buchwald, 1997; Jenkins et al.). Any of these "problems" can cause tension and conflict between the provider, the patient, and the family and further increase elders' reliance on traditional Khmer medicine as the first option for health care.

Subjects and Methods

This research arose from a larger ethnographic study that began in 1997 with a group of 125 Cambodian refugee families who live in Alabama along the U.S. Gulf of Mexico (see Lewis, 2001). Questions for this project are an outgrowth of this ethnographic project, and are based on remarks made in previous interviews and observations regarding use of traditional Cambodian food as medicine and its use as a strategy for maintaining health. In addition, Khmer elders, when asked about specific health concerns they might have, indicated that diabetes mellitus (described by the elders in this study as "sweet blood") and hypertension (described in by the elders in this study as "high blood") were two illnesses they felt were caused by their migration to the United States. Diabetes mellitus is a disease that causes an individual to either not make sufficient quantities of insulin or to not use it properly within the body. The causes of diabetes are thought to be a combination of genetics and environment, with obesity and insufficient exercise as significant contributing factors (American Diabetes Association, 2007). Hypertension (high blood pressure) is a condition where blood pressure levels are above normal. High blood pressure can lead to stroke, heart attack, kidney failure, and other diseases. Obesity and insufficient exercise are contributing factors to hypertension (American Heart Association, 2007).

Open ended questions were used to discover elders' understandings of these illnesses both in the U. S. and in Cambodia. Questions covered four domains: causes, lifestyle factors, diet, and treatment. For example, elders were asked to tell me about their own and other elders' experiences surrounding diabetes in the U.S. and their own and other elder's experiences surrounding diabetes in Cambodia. A "tell me about" form of question was used across each domain. This study, which focuses on diabetes mellitus and hypertension, was conducted in 2002 over a period of three months.

A snowball sample (Bernard, 1995) of elders was selected through previously established contacts within one Khmer community. Snowball sampling is an effective method because this is a relatively small community and most families are known to each other. A group of elders (four men and two women) first met informally with me to discuss this topic. One man in that group was very familiar with herbal medicines and

had both diabetes and hypertension, and one woman had diabetes. This group identified several other elders who were known to either have one or both of these conditions or have knowledge of treatments. Once I began contacting those individuals, word spread throughout the community and introductions were facilitated either through elders placing telephone calls to other elders on my behalf or by one or more elders accompanying me to the home of other elders for face-to-face introductions. Using such a snowball technique allowed me to utilize an already-existing network of elders.

Data on causation, treatment, and dietary practices relevant to diabetes and hypertension were collected during in-depth interviews with 26 elder Khmer refugees (15 women and 11 men) from among the 35 families living in the Khmer community who were identified through the community network as having diabetes, hypertension, or knowledge of treatments for those illnesses. Because of my long-term involvement in the community, many residents knew of my research and had interacted with me in celebrations and ceremonies in homes or in the Buddhist temple.

Of the 26 individuals, two were husband and wife and two were sisters. Others were either not biologically related or were only distantly related. However, participants considered all members of the community as belonging to one “family” and often supported each other according to long-held beliefs surrounding intergenerational relations that include respect and reverence for elders (Lewis, 2005; Smith-Hefner, 1999). Individuals who self-identified as “elders” (often beginning around age 55) were included in this study. Individuals interviewed ranged in age from 54 to 86 years. Seven elders (5 women and 2 men) reported that they had been diagnosed with diabetes, nine (5 women and 4 men) reported a diagnosis of hypertension, two individuals (both men) reported diagnoses of both diabetes and hypertension, and eight individuals (5 women and 3 men) reported having neither diabetes nor hypertension.

Participant-observation (Bernard, 1995; Keith, 1986) was made possible through long-term relationships I had established in the community beginning in 1997, when I volunteered to teach English to a Khmer monk who had just arrived in Alabama. Although I did not speak Khmer in 1997, I created a system for teaching using books I purchased from my university’s English as a Second Language program. In return for my time spent teaching English, multiple members of the community volunteered to teach me about traditional customs and culture of Cambodia, about survival as refugees, and about what they called “everyday life” as Khmer in the United States. I am a Euro-American woman with no connection to the community other than my interest in their lives, my willingness to learn, and my genuine respect for the people of the community. By the time I conducted the study described here, I had begun to learn to speak Khmer and could engage in most conversations without the aid of a translator. I received Khmer language training through informal encounters with Khmer people, the efforts of several Khmer elders in the community to provide a systematic program of language acquisition (by tutoring, assisting with food preparation, and participation in ceremonies), and, in 2001, through an intensive language program offered through the Southeast Asian Summer Studies Institute (SEASSI), a consortium of 14 universities from across North America. Before attending SEASSI, I relied on a translator when the individual did not speak English or conducted interviews in English if the individual was bilingual. After completing the SEASSI language program, I conducted interviews in Khmer or English based on the participant’s preference. During these later interviews and encounters, I

often had an assistant with me to aid in translation of concepts or terms about which I was not yet familiar.

Community members were comfortable enough with my presence to allow me to engage in various activities including preparations for temple ceremonies and celebrations, everyday household chores, routine cooking, and informal visits. I gathered considerable data on patterns and practices surrounding daily self-care strategies during visits where food was prepared or offered as snacks, during family meals, meals taken during celebrations or ceremonies at the Buddhist temple, and communal meals. Multiple encounters with individuals in their homes or in the temple complex allowed the observation of individuals using traditional and Western medicines, incorporating health-giving herbs into food, and drinking teas or other infusions believed to enhance health. Daily contact with three families, who served as my hosts within the community, also provided insight into routine health strategies. I also interviewed two biomedically-trained Khmer physicians.

Institutional Review Board approval was granted for this study. Consent forms were written in Khmer and English languages. Khmer documents were reviewed and evaluated for clarity by two community elders who were bilingual in Khmer and English. I obtained written consent if the individual was literate. If the individual was not literate, I read the consent form to the individual and obtained consent verbally.

Perhaps the most significant aspect of my relationship with this particular group was my determination in learning to speak Khmer. Because very few older women and only slightly higher numbers of older men speak English, I realized early in my meetings with the community that I must develop my Khmer language skills. I found that, once I could speak even the most basic Khmer, elders were quite interested in speaking with me and telling me about their lives. For this study, I conducted all interviews in Khmer because that was the preferred language of the participants. However, my ability to speak the Khmer language was limited and my vocabulary was still developing; therefore, narratives were recorded with the aid of an assistant who could also serve as a translator when I encountered unfamiliar terms. After each interview my assistant and I discussed the interview and the content of our notes. I made additional notes or corrections where necessary.

Ethnographic research involves a constant analysis of data to uncover trends, patterns, issues, and themes as they unfold (Bernard, 1995). Data gathered as fieldnotes were recorded with careful attention to detail and context and were matched with semi-structured interviews, unstructured interviews, and participant observations (Bernard). For example, it was important to consider specific individual actions such as the purposeful inclusion of health-giving herbs in one's food remedies, as well as words that informed a person's experiences within collective actions (i.e., consuming traditional herbs for their taste) such as those found in community meals. By observing individual actions within a community context, then matching notes about those behaviors to the words spoken, it becomes possible to gain a fuller understanding of health beliefs and exhibited behaviors surrounding diabetes and hypertension.

An initial analysis in the field allowed me to identify emergent themes. These emergent themes (use of herbal medicine, sharing of knowledge, and understandings of changes in diet and exercise patterns) were discussed with participants and community elders. Because my relationship with the Khmer community was ongoing, I was able to

check back with participants to confirm my interpretations both during data collection and during the entire analytic process. After returning from the field, data were coded by systematically reading and rereading the entire set of narratives and fieldnotes (Emerson, Fretz, & Shaw, 1995), while keeping in mind the context in which these events occurred.

Collected data were analyzed line by line to categorize multiple ideas and issues using an “open coding” process (Emerson et al., 1995, p. 143). The identification of ideas and issues led to more focused coding whereby more finely nuanced topics and themes were identified. Notations and memos were written to correspond with fieldnotes and the themes were identified through this multi-stepped process of sifting and sorting themes. Ethnographic analysis is an iterative process of general reading, close reading and writing, followed by general reading that directs the researcher’s attention more deeply into the data. Fieldnotes and written notations read as a whole after coding facilitated my recognition of significant themes. In addition to my own review of the data, I continually verified information and concepts with a group of six community elders (four men and two women) who have served as my mentors throughout my relationship with the community. Of these six individuals, one man and one woman were included in my interviews. Both engage in traditional health care practices. The following table contains an excerpt from fieldnotes and shows how codes were progressively narrowed to generate themes (Table 1).

Table 1

Coding and Thematic Generation Matrix: Engagement in Traditional Health Care Practices

Raw Data/Fieldnotes	Open Coding	Focused Coding & Pattern Development	Thematic Coding
I began talking to the FL woman again as we moved about the yard. When we came to the fig tree she began telling me about making tea from the old leaves to control blood sugar. She said she didn’t really know how to make it but that sometimes the old people would come to her house to get the old leaves and make the drink. She stressed that the new leaves (i.e., this year’s growth) would not do, that only the oldest leaves on the tree would work. I asked if she knew how	<ul style="list-style-type: none"> ▪ Visitor ▪ Herbal tea ▪ Cultural knowledge ▪ Health properties ▪ Health maintenance ▪ Diabetes ▪ Lost knowledge ▪ Age-specific usage ▪ Shared herbs ▪ Formula ▪ Herbal tea ▪ Shared knowledge ▪ Intergenerational transfer 	<ul style="list-style-type: none"> ▪ Knowledge of specific plants used in traditional medicine ▪ Treatment of diabetes ▪ Intergenerational transmission of cultural knowledge ▪ Differential usage according to age 	<ul style="list-style-type: none"> ▪ Traditional medicine ▪ Diabetes (Illness category) ▪ Age-specific usage

<p>many leaves and she said that the old people knew but that she thought just enough to make a good, strong tea. She explained that the old people take enough leaves to dry and keep a supply. She said that they drink the tea everyday.</p>	<p>of knowledge</p> <ul style="list-style-type: none"> ▪ Cultural knowledge ▪ Age-specific knowledge ▪ Formula ▪ Age-specific knowledge ▪ Formula ▪ Herbal tea ▪ Age-specific knowledge ▪ Shared knowledge ▪ Age-specific usage ▪ Health maintenance ▪ Daily/routine consumption 	<ul style="list-style-type: none"> ▪ Health 	
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An iterative process of open coding is followed by progressively more focused coding. Patterns are identified throughout this process and are collected into major, overarching themes.

Credibility was strengthened by comparisons of narratives across participants. Furthermore, an initial analysis in the field was discussed with participants and with community elders to verify my understandings and interpretations of their narratives and practices. Data were further contextualized by additional review of cross-cultural and complementary and alternative medicine literature. Gathering and recording interviews, narratives, and interactions using the above described methods and analyzing and understanding each particular action, behavior, or belief combine to create a collective ethnography of actions, behaviors, or beliefs of the group (Abu-Lughod, 1991). Interviews complement data gathered through participant observation and provide a broader view of beliefs and behaviors. It is the combination of these techniques that allow a richness and depth toward understanding the social, cultural, and political processes that created the lived experiences of Khmer elders and their families that would not otherwise have been possible. For example, the fieldnotes shown in Table 1 were matched to the following narrative of one elderly woman who, in addition to growing traditional herbs, often gathered leaves from a neighbor's garden for tea to treat her husband's diabetes. "...when I young I never used the [French bio-] medicine. I only use the plants...I learned from my grandmother...from my grandfather... [they] used a lot of kinds. Now, we grow some here... they good for the health." Her statements correspond with the fieldnotes associated with the tour where I was shown the tree from which the leaves are taken. Within the above statement, the broader themes of knowledge of specific plants

used in traditional medicine, intergenerational transfer of cultural knowledge, health, treatment of diabetes, differential usage according to age, and health are present. In addition, this excerpt was coded for hierarchy of use based on her statement about use of plants instead of French bio-medicine.

Integration of fieldnotes and narratives form a more comprehensive view of elders' beliefs and behaviors. Fieldnotes gathered throughout the three month period of the study provided more data than did narratives. This project involved daily opportunities for participant observation (e.g., tours of herb gardens, demonstrations of herbal preparations, meal preparation, shopping, and events at the local Buddhist temple). Much of the time, I was involved in the actual preparation and labor: Therefore, fieldnotes were my main form of recording the encounter. Narratives from the 26 people were used to make the fieldnotes "come alive" through the voices of the elders as demonstrated in the linking of fieldnotes and narrative (above) that both correspond to one afternoon's visit. Both fieldnotes and narratives were subjected to the same type of coding and analysis. That is, they each were read as a whole then open coding was applied followed by focused coding to arrive at themes.

Results

Causes of Diabetes and Hypertension

Diabetes and hypertension were the two illnesses about which this particular group of Khmer elders was most concerned. Almost invariably they reported that diabetes and hypertension were illnesses they encountered here in the United States that they had not known in Cambodia. Communications with Dr. Nal, a Khmer physician, who escaped Cambodia shortly after Pol Pot's regime gained control in 1975 and now lives in California, supported elders' assertions of the absence of diabetes and hypertension in Cambodia. Healthier lifestyles, less stress, fresh food, and an ideology that encouraged moderation contributed to elders' health in Cambodia. Dr. Nal cautioned, however, that a lack of knowledge of these illnesses did not offer proof that they did not exist in Cambodia (personal communication, April 13, 2002).

Changes in Lifestyle

The Khmer community in Alabama is quite rural and only other Khmers live within its boundaries (approximately 180 acres of forest land). The community consists of homes that range from elaborate brick buildings to tattered and repaired mobile homes. Some homes are filled with American-style furnishing; others are more sparsely furnished to allow greater facility for crowds to sit on the floors. Often, cooking is done outdoors over wood fires or with propane burners. Banana trees line fence rows and Khmer-style gardens greatly outnumber American-style gardens. Khmer elders and families with whom I interacted, at first consideration, appeared to adhere to a lifestyle more like the one they followed in Cambodia. Elders cared for grandchildren, most maintained small vegetable and herb gardens, and they devoted considerable time to the Buddhist temple. Most elders lived with other family members in multi-generation housing.

However, the landholdings were relative small, usually around 3 acres per family, far less than would be needed to raise rice or livestock for families' consumption. The temple complex was centrally located, less than a three minute walk from most homes. The climate in Alabama is somewhat similar to the climate in Cambodia. However, elders in Cambodia would have relied on natural breezes for cooling because of the unavailability of mechanical cooling and would have been more acclimated to the heat and humidity of Cambodia. In the U.S., the ubiquitous use of central air conditioning units that offered welcome comfort against the humid, oppressive Alabama heat, and automobiles (with teen-aged drivers) that sat ready for even the shortest trips, have changed elders' notions of a "comfortable" outside environment. These factors diminished elders' incentives to engage in physical activity. Thus, stress associated with refugee status, changing family roles, changes in diet, and changes in exercise patterns all were likely contributors to the noticeable increase in diabetes and hypertension among Khmers in the U. S. All these factors point to the need to understand what strategies Khmer elders use to deal with diabetes and hypertension as "new" illnesses.

Although Khmer elders understood that diabetes and hypertension were two separate and distinct illnesses, most often they attributed the same causes, poor exercise habits and poor food quality, to both. For example, limited outdoor activities were thought to lead to both diabetes and hypertension. Although the majority of those interviewed stated that neither diabetes nor hypertension were found in Cambodia, two men described "sweet urine" as a problem experienced by a few individuals, mostly men, who had violated sexual norms. One 62-year-old man explained,

When the man [in Cambodia] see the ants come to the pee pee, he know something wrong. He don't know what to do so he go to the old people and they make tea from some leaves so he can drink. But here [in the U.S.], anybody can get sick [with diabetes], they don't have to do nothing wrong. It just come from the food.

All individuals interviewed agreed that elders in Cambodia stayed healthy through farming or caring for family. They acknowledged that work shifted away from heavy manual labor as elders advanced in age. One 72-year-old woman described the role of elders in Cambodia as one consisting of pleasures such as "taking care of grandkids, tending a small garden, feeding chickens, and visiting neighbors." Even in large cities, such as Phnom Penh or Battambang, one walked to markets, to work, or to visit relatives and friends.

Life in the United States presented a very different picture. One 69-year-old man commented,

Here [in the U.S.], we stay inside with the air conditioning; there is no need to work so hard. We can buy rice easily... It is too hot and there are too many mosquitoes outside to walk. So, we just sit...

Dr. Nal (personal communication, April 13, 2002) also attributes increases in illnesses such as diabetes and hypertension to "a new lifestyle made-up of comfort, felicity, and abundance" whereby elders can scarcely resist sweetened sodas and the

temptation to eat more than the body needs. Dr. Sokkun, a biomedically trained Khmer physician associated with Khmer communities in Alabama and Florida, argues that, after living through the harsh conditions of Cambodia during the Pol Pot era, elders have little resistance to the comforts of life in the U.S. She explained that she had great difficulty convincing elders to adhere to a more austere diet and to engage in routine exercise (personal communication, April 14, 2002). “They [elders] are quick to embrace the pleasures of American life and I completely understand their position,” she remarked, “but they are equally reluctant to trust American medicine when they do become ill.”

One of the most significant factors involving elders’ distrust in biomedicine is the perception that biomedicine does not treat holistically, nor does it consider that Khmer “bodies are just different” and that “American doctors just don’t understand how we [Khmers] work.” Dr. Sokkun added that it was not unusual for Khmer families to visit American doctors but, once back home; they rarely followed the doctor’s advice. Reluctance to follow Western biomedical advice and directives often is attributed to differences in health beliefs (Hsu, Davies, & Hansen, 2004; Jenkins et al., 1996; Li, 2004), language barriers (Stephenson, 1995), and differences in medical systems (Fadiman, 1997; Ong, 1995).

When asked what she might recommend to American doctors, Dr. Sokkun replied that they simply needed more patience and understanding of Khmers’ experiences with Western powers. Her description of Khmer elders’ attitudes toward the power associated with American doctors reflects, in part, the ordeal of becoming refugees; an ordeal that included early encounters with aid agencies’ bureaucratic inflexibility during processing through various refugee camps where an identity as weak and helpless refugee was also imposed (Knudsen, 1995; Ong, 1995). With no sensitivity to previous identities, family hierarchies, or previous interrogations by communist forces, which often elicited personal and family information later used against one or one’s family, refugees were routinely subjected to multiple interviews regarding their identities (Lewis, 2001; Muecke, 1995). Distrust permeated such encounters. Interviewers distrusted refugees’ stories and refugees distrusted interviewers’ motives (Lewis, 2001). Through these and other practices encountered early in the process of escape and resettlement, many refugees internalized a deep distrust and uneasiness that has permeated encounters with persons or agencies holding positions of power (Kingfisher & Millard, 1998; Ong, 1995). This distrust has continued for many refugee elders and has created a reluctance to follow the advice of physicians and other medical practitioners in the U.S. Such distrust, according to Dr. Sokkun (personal communication, April 14, 2002), also has created an environment that leads many older refugees to follow practices that involve use of traditional herbs and other foods as their first mode of health maintenance or treatment.

Properties of Food

Elders also reported that the quality of food in the United States contributed to diabetes and hypertension. When a family did not have access to a large garden, vegetables were purchased from local Asian or American markets. Many elders reported that vegetables were “old” and that meat was not healthy because it was not fresh. American processed foods, such as potato chips and sodas, were also viewed with great suspicion as foods that could undermine health. However, they were often found in

Khmer kitchens, especially with those who had young children. When asked about dietary preferences, most elders responded that they continued to eat lots of rice and vegetables. One 79-year-old woman commented that she missed the fish in Cambodia because the fish in the United States tasted like grass. She added that food in the U.S. might have looked the same, but it did not have the same flavor, it had lost its fresh properties, and was not likely to provide healthful benefits. “It just makes me fat.” She continued, “that is why old people here get so sick...the food is not good for the body.”

It was very common for elders to share traditional herbs and health knowledge during celebrations or ceremonies at the Buddhist temple. For example, one middle-aged woman, who was visiting from another state, gathered several hands-full of a variety of herbs brought to the temple by a local elder. She explained her dismay that she could not routinely use traditional medicine.

In Cambodia, the old people know trees and told me what to use. But [in the city where she lives], the old people don't know trees so I don't use the medicine...I like to use the herbs, the mint, in food...It tastes good, like real Cambodian [food]...I know it's good for the health...

A clear distinction arose between Khmer food that was “good for the body” or “good for the health” and American food that had “lost its freshness” and “had no more health in it.” Even food traditionally associated with a “healthful” diet, such as rice, noodles, and fish, were seen as no longer providing adequate protection against illnesses.

Khmer Medicine Comes First for Khmers: American Medicine Comes Second

Traditional Southeast Asian medicine evolved and was adapted from the 1000-year-rule of the Chinese (Chandler, 2000; Jenkins, et al., 1996; Lovell, Tran, & Nguyen, 1987) and was combined with a strong Indian influence in Cambodia (Kulig, 1995; Lovell et al.). A modification of Chinese and Indian remedies and practices, which took into account the different climate and vegetation of Southeast Asia, developed in the 14th century (Chandler, 1991, 2000; Jenkins et al.). Modified Indo-Chinese medicines became the traditional medical practices throughout Southeast Asia until the 19th century when the French occupied Cambodia. Although the French introduced Western medical practices, or biomedicine, to Cambodia during the initial occupation and colonization, there was no widespread use of biomedicine until the 20th century (Jenkins et al.). Khmer refugees brought to the U. S. their traditional medical preferences, beliefs, and practices along with a familiarity of Western biomedicines.

Products associated with “traditional” Cambodian medicine are used by Khmers living in Alabama as their first defense against illnesses such as diabetes or hypertension. Plants (leaves, roots, bark, fruits, flowers, and seeds) contribute to the pharmacopoeia found in many Khmer homes I have visited over the past several years. Plant products may be included in food to correct or prevent an illness, or as a way to maintain general good health. Plants also are manipulated to create health restoring medications in a variety of ways, including drying leaves for teas, grinding various parts of plants to make poultices, or infusing strong wine with bark and roots. Manipulations such as those described above create “medicines” that are more recognizable in Western cultures as

curative items rather than as food additives. In addition, Chinese medicines and practices (such as cupping, acupuncture, and acupressure) often are used as intermediary steps between traditional Khmer medicine and Western biomedicine.

Perhaps the strongest encouragement for use of Cambodian traditional medicine is the availability of plants known for their medicinal or health-giving properties and the availability of elders who know the various health-related properties of such plants. Gardens throughout the community overflow with traditional plants currently used by the elders of the community as medicine and by most all ages as healthy additives in food. Herbs (including leaves, plants, roots, or bark) known by many Cambodian refugees to have healing properties may be used as specific remedies or may be incorporated into food to prevent the onset of a specific illness.

My host, Prahm, also explained that “the old people know about a lot of medicines...for old people Khmer medicine is first and American medicine is second.” He introduced me to one elderly couple, 67-year-old Kan and 64-year-old Kara Nai, who grew traditional herbs for use as medicine and as flavorings for foods. Kara Nai explained how she learned about traditional medicine. “...when I young I never used the [French bio-] medicine. I only use the plants...I learned from my grandmother...from my grandfather... [they] used a lot of kinds. Now, we grow some here... they good for the health.” Kan was diagnosed with diabetes and hypertension more than four years ago. He had medicines stored in a cabinet that were prescribed by his American doctor but, most often, he relied on teas made from herbs he and Kara Nai grew. He had no intention of taking the American-physician prescribed tablets, and had recently received French medicines from a brother who was resettled there. “I think the French [doctors] maybe understand Khmer bodies better” he explained as he placed the unopened bottle back into the cabinet.

Kan’s behavior was echoed by other members of the community. A hierarchy of medical preferences was apparent throughout interviews and observations. First, there was a strong reliance on teas made from locally available herbs and roots. Next, Khmer elders might add Chinese medicines available over-the-counter at larger Asian markets, and, finally, when symptoms such as thirst or “being tired” (for diabetes) or headaches and dizziness (for hypertension) became too great, American medicines were added. The alleviation of symptoms, however, also meant that American medicines were relegated back to the cabinets where they were stored.

Most Khmer elders recognized the connection between adequate exercise, good diets, and good health. Those with hypertension often cited the need to limit salt and MSG, reported that they had lowered their consumption of red meat, and carefully self-monitored blood pressure with sphygmomanometers owned by several elders in the community. By the end of my research period, three elder women, two of whom had diabetes, and one couple (both with hypertension), had adopted a walking routine around the temple grounds.

The connection between diet and diabetes, however, was not as clear. Most elders understood that they should limit their intake of “sugar,” but did not equate sweetened soy milk, fruit drinks, or other simple carbohydrates with control of blood glucose levels. There was little understanding of dietary information supplied by health care providers; all documents were in English, instructions included foods not usually eaten by Khmers, and only a few elders could read English. Most elders relied on teas made from dried fig

leaves or other herbs to maintain “good sugar” in their blood and only sporadically took Western biomedicine. Of the nine individuals who had received diagnoses of diabetes, only one 63-year-old man followed an American-style regime to control his blood sugar. When asked about his routine, he replied that his daughter, who worked as a teacher’s aide in a local elementary school, came by his house everyday to see his chart (showing his fasting blood sugar each morning) and check his bottles of medicine. He added that he followed the American doctor’s orders to keep his daughter happy, but that he drank Khmer tea to make sure that the American medicine would work properly.

Discussion

A study of this size and type can provide important insights into the lives of elderly refugees. However, the same factors that create rich data can also serve as limitations. Methodological limitations include the relatively small sample size of 26 individuals. All participants lived in a very rural community that was exclusively Khmer. All individuals either had intensive gardens themselves or had access to family gardens that were used to grow traditional herbs and vegetables. As is common in qualitative research, it is difficult to generalize beyond the group studied.

Using a convenience sample also limited my interactions with Khmer elders who do not remain engaged with this small tight-knit community and its Buddhist temple. There are likely to be other Khmer elders whose experiences in the United States have created different types and meanings surrounding health and treatments. Those elders were not reached by me, perhaps because of their desires to live apart from other Khmers. It is likely that, should I have been able to include elders who do not live in close proximity to other Khmers, I would have found different understandings of these diseases and the attitudes toward their origin and treatments that are described in this report.

In addition, my language skills can only be classified as a beginner. Although I was able to conduct interviews in Khmer, and usually had an assistant present, because of my limited vocabulary, it is very likely that more finely nuanced meanings may not have been fully understood by me. I attempted to overcome this limitation through use of an assistant and through returning to participants to confirm my initial understandings. Khmer people, in general, are extremely polite. It is possible that, even when I misunderstood some word or concept, they did not reveal to me my mistakes because of their politeness. A humorous example of their tolerance and polite acceptance was my mispronunciation of the complimentary phrase “this is delicious.” For several weeks, the women who provided me with food were, instead, told by me that the food “tastes like a cooking pot,” a mistake I made by using the wrong consonant on the end of one word (a “g” sound instead of an “ng” sound). My host’s young son finally told me of my mistake and helped me correct my pronunciation. I am certain that other words and phrases, both spoken and heard by me, were similarly misunderstood. An additional language limitation is my inability to read French. Much of the historical literature on life in Cambodia is written in French, as a consequence of 19th and early 20th century France holding Cambodia as a protectorate, and has not been translated into English. Therefore, my understanding of the history of Cambodia has been limited to a small collection of translated works (e.g., Coedès, 1968; Groslier, 1967) and reports from archaeologists (e.g., Higham, 1989; Janse, 1947) and journalists such as Chandler (1991, 2000). Because

history informs both social and individual behaviors (Mills, 1959), it was important to understand the political and social history of Cambodia to gain a better understanding of current beliefs and behaviors held by the elders in this study. A fuller understanding might have been possible through an exploration of a broader body of historical literature.

Another limitation is my status as an outsider. Although Khmer people in this study welcomed me into their homes and shared their narratives with me, there is little doubt that I only learned part of their stories. I had not experienced the massive trauma through which they had lived, so could not always identify with their plight. Because of my long-term engagement in the community, at times I recognized the more “public” version of their stories; however, there are likely to have been several times that I did not recognize their narratives as tempered by what they thought were the “correct” answers to my questions.

Finally, this study was conducted within a defined geographic region and, as previously mentioned, is focused on a small group of rural dwelling elders. Future research that includes comparative groups, either urban versus rural groups or across cultures, could further enhance our understanding of types, meanings, and actions surrounding health beliefs and behaviors of refugee elders. In spite of these limitations, this study adds to our knowledge of ways refugees adapt to life in an unfamiliar environment.

There was widespread agreement in Khmer elders’ understandings of the causes and appropriate treatments for diabetes and hypertension; limited physical exercise was cited by all those interviewed as the major cause of both illnesses. On the surface, there was little indication that Khmer elders underutilized American health care services and most had biomedicines in their homes “just in case” they need to take them. Most elders, however, preferred Khmer medicine, in part, because it reflected their identities as Khmers. Another component of the consensus for the primacy of Khmer medicine may have been due to the nature of the relationships of elders within the community studied. All those interviewed frequently interacted within the 180 acre community. They shared knowledge of traditional medicine, often exchanged herbs, roots, or foods, and all had stories of unpleasant encounters within the American health care system. All participated in communal meals and most regularly participated in temple celebrations and ceremonies. They also shared a common social history of escape from Cambodia and resettlement in the United States, although personal histories varied greatly. The community was in a rural area, which also may have facilitated the continuation of traditional medicine because of the availability of land for gardens. There are no simple answers to questions as to why Khmer elders in this particular community continue to rely on traditional medicines and health strategies, and use American medicine as complementary or alternative therapies. Reasons for primarily using Khmer medicine ranged from a lack of understanding on the part of American health care providers to trusting centuries-old cures.

Often a complicated dynamic exists whereby a “semantic network” (Jackson et al., 1997 p. 64) or a constellation of symptoms, words, and feelings creates systems of meanings that go far beyond linguistics and cross-cultural misunderstandings to create tension and conflict in health-seeking preferences and practices. Cultural and medical pluralism, or the blending of more than one ideology, has become the norm rather than the exception within many refugee populations (Marshall, Koenig, Griffithorst, & van

Ewijk, 1998). The Khmer elders I interviewed are no exception. There seemed to be little interest among younger Khmers to learn the often tedious tasks of tea preparation, cleaning roots and bark, or grinding herbs to make various poultices. A lack of interest by younger Khmers or pressure from adult children, such as the daughter who verifies that her father is following “doctor’s orders,” may eventually cause a shift in the medical paradigm within which this group of Khmer elders construct preferences, patterns, and beliefs surrounding health care and use Western biomedicine as complementary or alternative therapies.

Such a shift in the medical paradigm that guides use of medicines may also cause shifts in intergenerational relations that, in turn, may lead to cultural dissonance. Cultural dissonance, which includes cultural discontinuity (Smith-Hefner, 1999), cultural dislocation (Lewis, 2001; Smith-Hefner, 1999), role loss (Becker, 2002; Becker & Beyene, 1999; Detzner, 1996, 2004), and fragmentation (Detzner, 1996; Portes, 1996) are but a few of the challenges refugee elders and their families must face as they navigate new territory within unfamiliar societies. Cultural dissonance often occurs when elders attempt to teach younger immigrants traditional cultural values, beliefs and behaviors, such as use of traditional medicine, while residing in a society notably different from their homeland society (Gelfand, 1979; Kaplan, 2002; Lewis, 2001). Younger cohorts may view traditional cultural beliefs and behaviors as no longer relevant in their “new” society.

Culture is embedded within individuals, but is revealed in groups who share common traditions and customs regarding beliefs and behaviors. Individuals are “enculturated” across the generations, that is, they learn rules and norms from observations and interactions with older or more experienced members of cultures. Culture provides a way to locate one’s self within a group, or conversely, to identify who is not “of the group.” The shift toward use of Western biomedicine may lead to a devaluation of elders’ knowledge and, consequently, a reduction in their status in the community.

This study illuminates a continued reliance on traditional health practices; at the same time, it also illuminates a strong perception, by the elders, of a power differential between U.S. health care providers and elderly refugees. Health care providers should seek an increased understanding of the history of refugees; such knowledge could impart a measure of cultural awareness that would aid in providing appropriate health care to refugee families. One result of the perception of an imbalance of power between refugee elders and health care providers is the reluctance on the part of elderly refugees to ask questions of health care providers; whether those questions are for clarification or are questions of appropriateness of the treatment. By actively listening to narratives of refugees, health care providers can build rapport and trust and could create an environment where elders are comfortable describing beliefs and behaviors surrounding diabetes, hypertension, and other illnesses. Such rapport could increase refugees’ willingness to question health care providers and could, consequently, increase health care providers’ ability to address health needs of refugees.

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