

Shamans in a Hmong American Community

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ABSTRACT

Objective: To increase understanding of the process and meanings of shamanic care from patient complaint through diagnosis, treatment, and outcome.

Design: Information collected from 924 patient contact forms completed by 36 shamans over an 18-month period included basic demographic information on the patients, their complaints, treatments suggested by the shamans and the shamans' perceptions of the outcomes of treatment. These data were translated and entered into a computer database.

Location: A Hmong American community in California's Central Valley.

Methods: Quantitative descriptions of the sample were generated and integrated with qualitative analysis of the content of the text from the diagnostic, treatment and outcome categories was performed to systematically identify patterns in the data.

Results: Patients sought shamanic help for an array of physical, emotional, and psychologic complaints—problems that the shamans frequently diagnosed as being caused by soul loss or bad spirits.

Conclusions: The data suggest the persistence of the need for the spiritual healing provided by the shamans within this immigrant community. Shamans' rituals affirmed and strengthened connections to family, culture, and community.

INTRODUCTION

Some biomedical health care providers may not be fully aware or tolerant of traditional healing practices within immigrant communities. Many Hmong Americans, for example, continue to utilize the services of shamans. Physicians and other members of the biomedical health care community may not be comfortable when their patients seek care from shamans and may attempt to impose acceptance of and full patient compliance with biomedical diagnoses and procedures.

Shamans who care for patients in U.S. communities may also feel resentment, disrespect, and frustration for similar reasons. Confused and fearful patients are often caught in the middle of this struggle. In many cases, mutual misunderstanding and disrespect have characterized encounters between Hmong patients, their shamans, and biomedical

providers. Mutual awareness and understanding can facilitate a process that ultimately serves the needs of patients and providers.

Lao Hmong immigrants to the United States began arriving from Southeast Asia in 1975 in the wake of the Vietnam War. In their traditional villages in highland Laos, they had been farmers. Subsequent to their involvement with pro-Western forces, they lost their homeland, and many chose to relocate to the United States. Although traditional Hmong culture emphasized collectivity, Hmong immigrants to the United States were initially dispersed widely across the country (Viviano, 1986). Through secondary migration, however, the Hmong concentrated in specific areas, including California, Minnesota, and, more recently, North Carolina (Olney, 1986; Saechao, 2001). The 2000 Census reported the U.S. Hmong population has grown to 169,428, although Hmong leaders estimate that number to be closer to 300,000 (Anonymous, 2001).

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Adapting to enormous changes in their sociocultural environment has resulted in some enduring misunderstandings, including those that emerged between traditional health care beliefs and practices and those of biomedical health care. The past two decades have witnessed tragic cultural clashes over health care strategies, for example, as in the case of Lia Lee in Anne Fadiman's 1997 *The Spirit Catches You and You Fall Down*.

The traditional culture of immigrant groups is not, of course, simply replaced by that of the new homeland. As Isajiw (1996) noted; "Assimilation has been seen as largely a zero-sum phenomenon, that is, to the extent persons assimilate into dominant society, to that extent they lose their ethnic identity and vice versa, to the extent they retain ethnic identity, to that extent they fail to assimilate." But as our understanding of culture as a dynamic process emerges and grows, so has our awareness that some of the beliefs and practices that have been part of a people's lives for thousands of years persist even as they acculturate. Shamanic healers and rituals are among those that have persisted within the Hmong American community.

Traditional Hmong beliefs included several potential sources of illness, including soul loss, supernatural or spirit causes, natural causes, magical causes (spells cast on the afflicted), or the expiration of one's "life visa" or "mandate of life" (Thao, 1986). Health care strategies involved shamanism, herbal medicines, or a combination of the two. Hmong villages always had at least one shaman (Lewis and Lewis, 1984). Generally, each clan had its own shamans. Sometimes patients would go to a shaman outside their clan, but generally reported feeling more comfortable with the ways of their own clan. Shamans could be male or female, but each had been "chosen" by the spirits to be a shaman. Lemoine (1986) wrote that shamanism was not only taught, it was also inherited; the offspring of a shaman may have inherited the predisposition to become a shaman but then had to be trained by a master shaman for 2 to 3 years or more. New shamans usually learned of their calling through a long and serious illness, which was only cured when the person consented to become a shaman and started training (Lewis and Lewis, 1984).

Shamans healed their patients by covering their faces with a black cloth and going into a trance so that they could communicate with the spirit world. While in the trance, he or she called out for specific animals that be sacrificed to appease the angry spirits who were responsible for the patient's illness and battled with the forces of evil. An important part of the shaman's work was searching for wandering souls; when the shaman locates and retrieves a lost soul, health is restored. This healing procedure reflects the critical importance of the group in the traditional Hmong culture. The human body is host to several souls; health is restored by restoring the integrity of the group (Conquergood and Thao, 1989). Shamanic healing restores the connectedness between patient, family and community. At the conclusion of

the ceremonies, the shaman was generally offered a meal, paid for his or her services, and given some of the meat from the sacrificed animal to take home.

METHODS

Population and sample

Data were collected at Healthy House Within a MATCH (Multidisciplinary Approach to Cross-Cultural Health) Coalition (HHWMC), a nonprofit agency in Merced County, CA. Merced, a community in California's Central Valley, is currently home to an ethnically diverse, population, including approximately 7000 Hmong Americans (Viviano, 1986). Large numbers of Hmong secondarily migrated into the area for family reunification and because of the emphasis on agriculture in the area. Most Hmong adult immigrants had listed their occupational skills as "farmer/soldier" (Rumbaut, 1989).

HHWMC provides services and programs designed to improve access to culturally sensitive health care by removing cultural and linguistic barriers. The staff trains health and mental health interpreters, provides health education classes, and offers seminars to area health care providers designed to increase cultural competency. The center has been the site of several social and cultural programs for the Hmong, including after-school tutoring programs, Hmong music and dance lessons, and women's group meetings. The data for this research emerged from the Partners in Healing Project.

Partners in Healing began with an open invitation to the shamans of Merced, issued through the clan leadership, to talk about their work, and to learn about the work of physicians. Thirty-six (36) shamans (26 men and 10 women) responded to the invitation and became the genesis of the project. The average age of the shaman participants was 57; the youngest was 37 and the oldest was 83. Twelve (12) of the participants had more than 35 years as practicing shamans; 4 shamans had less than 5 years of experience and were still being mentored by master shamans. We also generated a waiting list of 20 more shaman waiting to received the requisite training to participate. There are 20 Hmong clan names (Lewis and Lewis, 1984). Twelve (12) clans are represented in Merced County; Partners in Healing had shaman representatives for 9 of these 12.

The project provided a forum for shamans to learn about biomedical procedures. Although there are many nonbiomedical health care providers in Merced, and Hmong American patients may be utilizing those care systems, our research on this project was confined to biomedical providers.

Tours of hospital sites (surgery, obstetrics, radiology, critical care, emergency room) were accompanied by presentations by physicians, nurses, and other health care personnel. Upon completion of the program, the shamans received badges and access privileges similar to those of clergy. The

shamans were quite interested in the information presented; one participant expressed his views on the complementarity of biomedicine and shamanism by noting that “doctors can see inside of the patient and then fix what is wrong” while shamans do spiritual healing.

Instrument and ethics

The other goal of the project was to expand our knowledge of the work of the shamans. To facilitate that understanding, it was necessary to explore shamanic processes from initial consultation with the patient to resolution of the health care concern. The purpose of the research was discussed and their input on the patient contact form that would become our research instrument was solicited. The document we jointly crafted was the result of a collaboration between the shamans and the HHWMC researchers and interpreters. We asked the shamans to explain the process of spiritual healing to us, and we tried to capture that process, step-by-step, on the form we ultimately designed; the form was then translated and back-translated by the Hmong interpreters trained by HHWMC. Ultimately, the instrument we built collected information on gender, complaints, and whether the shamans used a consulting performance, a diagnostic performance, or a curing ceremony; the form concluded with space for the shaman’s diagnoses. The shamans’ input into the construction and use of the instrument was of interest: ages of participants, for example, was not something the shamans felt they were willing to collect. That was seen as too intrusive and possibly risky in terms of tempting any spirits listening in to shorten the patient’s “life visa.” The terminology used to describe the parts of the shamanic process, while suggested by the shamans, held different meanings for us; the “Diagnosis” section was used by the shamans to record what could also be seen as either “Outcomes” or “Prognosis.” Early in the data collection, we became aware that in that section, their comments included: “The outlook is good”; “Magic healing drove away the bad spirit”; “A curing was needed to extend the patient’s life spiritually; patient is now ok”; “Patient is cured, her rash disappeared.” We learned from this that shamanic healing is, indeed, a process in which diagnoses, treatments, and assessments are inextricably linked.

The shamans were instructed on patient confidentiality and informed consent issues by the research staff at HHWMC; each consented to the procedures. From September 1, 2000 through June 30, 2002, a total of 924 forms were returned to HHWMC to be entered into the database by one bilingual, computer-proficient Hmong cultural liaison employed by HHWMC. The practicing shamans informed their patients that case information without names would be used to teach others about the work of shamans. Each patient contact form was numbered as it was entered into our database, and that number became the only case identifier.

Initially, the HHWMC liaison called each shaman every week or so and received an oral report on each patient contact which he transcribed onto the patient contact form, but by January 1, 2001, the shamans (at their request), were given the forms to complete by themselves (forms were available in Hmong and English) and returned them personally. The liaison, however, continued to call the few illiterate shamans and complete their contact reports by phone. The shamans have noted that they perceive of the written forms they submit as a way to get credibility in America. They embraced the process of documentation of their work enthusiastically, reporting to researchers that their participation conferred an increased acknowledgment and acceptance of their status within their own communities. Hmong shamans were highly respected individuals in their villages, a status that they are painfully aware has been diminished in the United States in the shadow of biomedicine.*

Data analysis

Qualitative analysis in the form of grounded theory was utilized to analyze the shamans’ patient contact records. Grounded theory enables an understanding of the perceptions of the respondents themselves through a careful analysis of the concepts and categories that emerge from the text (Strauss and Corbin, 1986). In an exploratory foray into a phenomenon about which the researchers’ understanding is limited, qualitative research techniques offers unique insights into the intricacies of the participants’ perspectives, laying the groundwork for future research by clarifying dimensions and directions.

RESULTS

Approximately 50% of the shamans interventions were on males; 30% were for females and 20% were listed as a family group. Family contacts were generally made by males on behalf of their families; traditionally, men directed family spiritual events and were responsible for the family’s general welfare (Rumbaut and Weeks).

The patients’ most frequent complaints included tiredness, weakness, headaches, body aches, loss of appetite, anxiety, and bad dreams. For the most obvious somatic injuries (gunshot wound, broken leg, broken nose, severe bruising) the shamans usually reported that they performed magic healing but the majority of diagnoses involved the effects caused by a wandering soul, lost soul, sad soul, evil spirits or of a “life visa” that was expiring and needed extension by the patients’ ancestors.

*Ensign J. Traditional healing in the Hmong refugee community of the California Central Valley [dissertation]. Fresno, CA: California School of Professional Psychology; 1994.

Many shamans described the patients as not having intact souls, noting that they needed to be restored. Souls had wandered off and needed to find their way back to the body for health to be restored. One shaman noted that his patient had “witnessed a car accident that involved a death, so his soul had wandered.” In some cases, the shamans would suggest building a “soul bridge” to show the soul the way home; other times they would simply call the soul back. Strings around the wrist, ankle or neck, metal bracelets, anklets or neck rings, or even safety pins on clothing may be used to secure the soul.

Sometimes the souls of ancestors were communicating displeasure and needed a feast or other action taken by those in the land of the living to quiet the restlessness that was resulting in the patient’s illness. In one instance, the ancestor missed being worshipped regularly. In another case, the deceased father did not want his son to take the clan name of his widow’s new husband; the son’s neck pain went away as soon as his father’s soul was promised that would not happen. One man’s illness was interpreted to be the direct result of his deceased wife trying to take his soul away to join her. The eye pain of another patient had been caused, the shaman wrote, because he had converted to Christianity and offended several ancestors. Another patient was having trouble with headaches and fainting because, his shaman wrote, he had promised his ancestors a feast but had failed to provide it.

Some patients sought shamanic healing, they reported, because their physician was unable to diagnose their problem: “Patient is ill; doctor can’t diagnose”; “Unexplainable illness that doctor doesn’t know what is going on.” In some of these cases of unexplained, prolonged illness, the shamans predicted that the patient “could become a shaman in the future.” In other cases, the shamans’ patients listed their biomedical diagnoses or condition as their complaints: “dialysis patient”; “stroke”; “diabetes and urinary tract infection (UTI)”; “asthma and diabetes.” For these patients, involved shamans sometimes diagnosed a spiritual problem for which they suggested a healing while in other instances they said that there was no spiritual problem with which they could help.

There were also other instances wherein the shaman did not feel the problem was within his or her area of expertise. In one case, the shaman described the patient’s complaint of a sore throat but said he could “see no problem spiritually.” In other instances, the shamans felt it was too late to intervene. One said that the soul of the patient (diagnosed with a stroke by a physician) was lost, and it was too late to chase and catch his soul. Another simply noted that the patient’s “life visa” had already expired.

Diagnoses in a few cases eloquently expressed the enormous impact of recent Hmong historical events on the shaman’s beliefs and practices. In one case a bird had flown into the home of a shaman’s family indicating to him that there was war in the ancestor’s world; this, he warned, could be both prolonged and devastating for those in both worlds. In another case, the shaman concluded that the patient had

suffered foot pain for more than 2 years because someone had destroyed the grave of his grandfather in Laos.

There were many examples of using shamanic care for prophylaxis. The annual curing ceremonies for families, soul calling, and naming ceremonies for infants or ceremonies prior to and after hospitalization for surgery are examples of such prophylaxis. Pregnant women go to shamans for “soul-splitting” ceremonies so that their souls and the souls of their unborn children are separate and, if one dies, the other will live. In one case, the shaman noted that the patient came to him because she was “getting old” and “requesting a visa extension.”

In these data, we also saw evidence of the emergence of new shamans. Shamans, as noted earlier, generally learn of their calling during a long illness, and several patient contacts noted that “the patient will be a shaman” or “the spirits have chosen him to be a shaman.” Once this diagnosis was made, these individuals entered training with an older, more experienced master shaman to begin the process of training under his/her guidance.

It was of interest that the shamans generally used the term “soul” in reference to the noncorporeal parts of humans (patients or ancestors) but used the word “spirit” in reference to the nonhuman parts of various locations or items. In this data, that included house spirits, fireplace spirits, spirits of the city of Merced, and even a world spirit. While souls could be lost, spirits generally needed appeasing with sacrifices. One female patient presented with neck pain; the shaman asked if she had caused an animal suffering by hurting its neck. She indicated that she had twisted the neck of a rat; the animal’s spirit was causing her pain. In another case, the world spirit was causing a patient to become violent. Another woman had a “sickness the doctor can’t diagnose”; the shaman concluded her problem was evil spirits. One respondent came to the shaman because a snake had entered her house; the shaman noted that her ancestors were trying to warn her that an evil spirit had entered her house. The Hmong believe that the ancestral world, the human world, and the spiritual world, while distinct, overlap.

DISCUSSION AND IMPLICATIONS

Conquergood and Thao (1989) wrote that it is a misconception to presume that individuals from diverse ethnic and cultural backgrounds will, once they encounter biomedicine, simply reject the traditional health practices that have served them for centuries. A 1997 study of Hmong healing practices in the San Joaquin Valley by Nuttal and Flores confirmed that the Hmong were more likely to use shamanism, herbal medicine, or talismans than biomedical health care providers and, in fact, only used biomedicine as a last resort (Nuttal and Flores, 1997). Plotnikoff et al. (2002) from the University of Minnesota described shamanism in the large Hmong population in Minnesota and noted that “many

Hmong who see physicians also rely on shamans for restoring health and balance to their body and soul.”

In his work on ethnicity and health care, Lee[†] noted that in some cases, as members of ethnic communities become more familiar with biomedical care, they become disillusioned when their expectations are not met. Some of the shamans' patients' complaints in our data included references to conditions that physicians had not been able to diagnose or cure. Some of these, as noted earlier, involved chronic illnesses. The management of diabetes, hypertension and other chronic conditions does not seem to be well understood by many Hmong Americans. The idea of medical control or maintenance has not historically been one with which they were familiar; one is either sick or not. If one is sick, and if one finds the right shaman, s/he will be healed.

Traditionally, several health care strategies were utilized simultaneously or sequentially. Paul and Elaine Lewis (1984), describing tribal life in Southeast Asia, wrote in *Peoples of the Golden Triangle*,

In their quest for health, Hmong do not become discouraged if one ritual does not result in a cure, but try one after another until the right one is found. . . . Curing is not limited to such ceremonies. Many Hmong men and women have a knowledge of herbal medicines widely used for common ailments. Increasingly they are also turning to modern medicine. In many cases they first perform ritual healing ceremonies, then seek the help of modern medical practitioners.

This plan of action closely resembles concurrent utilization by patients in the general population of complementary and alternative medical providers along with biomedical providers; Cockerham (2004) notes that “the majority of patients who use chiropractic services do not depend entirely on this method of care . . . they use chiropractors and physicians in a complementary manner.” Many of the Hmong American patients in our study appeared to use shamans and physicians in this way.

Jacques Lemoine (1986) described the traditional obligation of the Hmong shaman to help patients “recover psychic balance” or “restore the self.” This was done in the framework of the familiar shamanic rituals that clarified the links between the worlds of humans, ancestors and spirits. The need for these services, he noted, certainly persisted amid the stresses, fears and uncertainties that accompanied the Hmong's arrival in their new homeland. In such a setting, he wrote, the shaman was not competing with the medical doctor but providing an alternative form of care that could complement biomedicine.

The Hmong American community continues to experience the effects of their geographic and cultural displacement. Hmong Americans, for example, are at an increased risk for noninsulin dependent diabetes mellitus (NIDDM) and complications including hypertension and renal failure (Diringer et al., 1996).[‡] Freund et al. (2003) noted that a combination of factors in the way of life in industrialized countries may be implicated in the disease since groups immigrating into industrialized societies from agricultural communities are at increased risk for NIDDM. Scheder (1988) asserted that increased rates of NIDDM are also found in groups with high levels of stress, disrupted social networks, social marginality, feelings of hopelessness and helplessness, and poverty. Virtually every aspect of Hmong lives has been disrupted; the task of helping them restore and maintain health may well be best served by the contributions of both shamanic care and biomedicine.

Now, almost three decades since they began arriving in the United States, Hmong Americans continue to craft and recraft a culture-in-transition. There are, of course, as many health care options within the Hmong American culture as there are in the general population; Hmong patients in Merced, for example, can seek the services of a number of care providers, including a Hmong American physician and/or shamans as well as a number of other complementary and alternative medical providers. As noted earlier, acculturation is not a zero-sum phenomenon; some traditional beliefs and practices may persist even as a group acquires others. Hmong immigrants from a traditionally familistic and group-oriented culture have become part of a culture described by Bellah et al. (1985) as individualistic and competitive. But as Conquergood and Thao (1989) noted, the Hmong world view perceived of a “sick society” as being one that is highly individualistic. In their recently adopted homeland, Hmong Americans may feel the need to seek out shamans to restore the sense of connection into their group, their culture and their family that helps them feel whole and healthy. Decreasing these patients' sense of isolation through familiar, communal shamanic activities may help to achieve the elusive comfort that they seek. This connectedness may also serve to ease the sadness of some of the losses they have sustained as a group and as individuals. The “restless spirits” of dead parents, spouses, and children left behind in Laos were frequently identified by shamans as sources of illness; this interpretation may be part of a cultural expression of the pain of their losses and their ongoing uncertainty that coming to America was the best thing for them, their families and their culture. Many Hmong Americans apparently share the sentiments expressed by one who noted: “Laos still remains, deep inside me.”[§]

[†]Lee P. Health care systems utilized by the Hmong of California: A case study in Stanislaus County [thesis]. Turlock, CA: California State University, Stanislaus; 1989.

[‡]Johnson, S. Diabetes in the Hmong refugee population [dissertation]. San Francisco (CA): University of California; 1996.

[§]Helsel D. Here there is much more and much less: Hmong American families, culture and childbearing the land of giants [dissertation]. San Francisco (CA): University of California; 1993.

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