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Pilot study to develop a tool to elicit Khmer beliefs about the causes of illness

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PILOT STUDY TO DEVELOP A TOOL TO ELICIT KHMER BELIEFS ABOUT THE CAUSES OF ILLNESS

by

DONNA LYNN LAZORIK

BACHELOR OF ARTS, ASSUMPTION COLLEGE, 1975
BACHELOR OF SCIENCE, WORCESTER STATE COLLEGE, 1982

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Bianca Chambers, RN, MS
Professor of Nursing

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Abstract

Since 1979, thousands of Southeast Asians have sought resettlement in the United States. The cultural framework of these people is evidenced in their health belief system. Semi-structured interviews were conducted with ten Khmer refugees in order to elicit their beliefs about the causes of symptoms they have experienced. It was found that both natural and supernatural causes were attributed to their illness. The concept of k'chall, bad air in the body, was very important in the health belief systems of the Khmer respondents.

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Chapter I

Statement of the Problem

Introduction

Between 1975 and 1983 over 600,000 Southeast Asian refugees arrived in the United States. Massachusetts alone has become the home for more than 13,000 Southeast Asians who have fled war, famine, and political upheaval in their homelands to find themselves in a new and alien culture (Office of Refugee Resettlement, 1983). Their compromised health status has put the refugees in contact with the American health care system, a system which is very foreign to them. For the American health care worker, the refugee may represent an enigma--different values, customs, and languages have led to misunderstandings and less than optimal health care for the refugees. This problem is compounded by the fact that the Southeast Asian refugees are comprised of several distinct groups--Khmer, Vietnamese, Lao and Hmong--each with its own culture and language.

This pilot study was an attempt to begin to bridge the gap between the refugees and the American health care providers; a gap which Leininger (1978) refers to as "the cultural discrepancies in health norms (p. 77). By providing a tool by which to elicit the health beliefs of one particular group of Southeast Asian refugees, it was believed that this study would contribute to a better understanding of the Khmers' own perceptions concerning the causes of illness, and thus facilitate communication and understanding

between the Khmer patient and the American health care provider.

Statement of the Problem

The purpose of this pilot study was to develop a tool to be used with Khmer refugees to elicit their beliefs concerning the causes of illness. The information can then be used to gain insight into the cultural belief systems of the Khmers through inquiry into their health belief system. This information can also be used to add to the cultural data base necessary for the planning and delivery of appropriate health care to the Khmers.

Assumptions

1. The search for understanding is a primary source of motivation (Weiner, 1979).

2. People construct causes to explain and control events that happen to themselves.

3. A community's perspective about health and illness is linked to its values, belief systems, religion and form of social organization (Fabrega, 1978).

4. Illness occurs in individuals in a social setting, and the meanings given to the illness rest on culturally specific conventions (Fabrega, 1978).

Rationale

1. Health beliefs are a major component of any cultural belief system and thus provide valuable insights into a culture. Health beliefs reflect the world view of an ethnic group (Foster, 1978; Good & Good, 1981; Kleinman, 1980; Murdock, 1980).

2. Knowledge about the health beliefs held by a client group is essential to the planning and delivery of appropriate health care to that group (Foster, 1978; Leininger, 1978).

3. Cross-cultural research contributes to the scientific basis for nursing by developing generalizable theories which allow for those phenomena common to all people (cultural universals) as well as those phenomena which vary (culturally specific phenomena) (deChesnay, 1983, p. 21).

4. Because the focus of the community health nurse is the community itself, it is imperative that the community health nurse be knowledgeable and sensitive to the cultural belief system of that community. The nurse's sensitivity to the cultural belief system will facilitate access into the community.

Conceptual Framework

The value of understanding a person's beliefs about health and illness has been addressed in the literature. Eliciting information concerning health beliefs is included in most nursing assessment guidelines in the literature on transcultural nursing (Bloch, 1983; Davies & Yoshida, 1981; Gagnon, 1983; Kubricht & Clark, 1982).

Understanding a person's beliefs about illness is important because often beliefs held by the patient and the health care provider differ, leading to divergent goals for therapy. These divergent beliefs are illustrated in the dichotomy between disease and illness. Disease is defined as abnormal or malfunctioning biological and/or psychological processes, while illness refers to the human experience of disease in the social context (Idler, 1979; Kleinman, 1980). Western professional health care providers are usually oriented toward disease and lay people are oriented toward illness. Health belief systems, including beliefs about the causation of illness, are tied to these orientations. Both orientations are culturally determined (Henderson & Primeaux, 1981). Although health care providers are disease oriented, their application of the biomedical model may reflect other cultural influences as well (Kleinman, 1980).

Good and Good (1981) suggest that the task of the health care provider is to not only interpret the data using the medical model, but also to interpret the subjective meanings of the patient's symptoms as expressions of the illness. Good and Good state their view of health care transactions in the following way:

> All clinical discourse involves mutual interpretations or translations across symbols of meaning--across medical models and idioms, across perspectives and across medical subcultures. The therapist interprets the intentions and the contexts of the patient's discourse in order to identify and construct a pathological entity. The patient interprets the therapist's discourse to construct new understandings of the illness. This mutual process of understanding and interpretation is a basic element in effective healing. (p. 178)

In order for this mutual process, and the resulting effective healing to take place, the health care provider must be sensitive to health and illness from the patient's point of view. This includes answers to questions concerning the patient's understanding of the illness. One important feature of a person's understanding of illness is their belief about what causes the illness. The basis for attribution theory is that people attempt to understand their experiences by assigning causes to them (Stoeckle & Barsky, 1981). Assigning a cause to an illness serves two functions: a) an explanation in itself can reduce anxiety, and b) the explanation for an illness provides direction in terms of what should be done to alleviate the illness. According to Stoeckle and Barsky, "causal explanations provide control because they give personal meaning to bodily discomfort as well as suggesting actions to take" (p. 225).

The theoretical framework on which this study was based is attribution theory. Attribution theory as a theory of motivation was described by Weiner (1979) to explain success and failure in the classroom. Weiner suggested three dimensions to causality of an event: 1) stability, the changeability of the cause; 2) locus of the cause, internal or external to the person; and 3) control, whether the cause could be controlled or not controlled by the individual. These dimensions of causality are thought to influence subsequent behaviors, emotions and expectations.

Several studies have been carried out based on attribution theory applied to illness situations. Lowery, Jacobsen and Murphy

(1983) conducted a study of 55 males with rheumatoid arthritis. One aspect of the study was to look at the extent to which people with arthritis construct causes for their condition. The information for this part of the study was obtained through the use of an open-ended question: "With respect to your arthritis, have you ever thought about Why me? If so, how did you answer it? If not, please take a moment and think about this" (p. 159).

The results of this study showed that of the 55 participants interviewed, 85% indicated that they had decided upon a cause for their arthritis. When compared with those who gave a cause, the non-cause group was significantly more anxious, depressed, and hostile. Lowery et al suggested the need for further testing.

As part of a larger study of the health and health care of children, Blaxter (1983) interviewed 40 women using an unstructured ethnomedical approach. Content analysis was applied to the conversations about health and illness during which the women themselves decided which diseases they wanted to talk about. The women belonged to a group selected for its geographic and social stability, from which an identifiable subculture could be expected.

Blaxter (1983) concluded that ideas about causes "...were a very important component of the models of disease held by this social group" (p. 68). What the women believed about the causes of their disease directly affected where they went to get help. Blaxter also found many examples of the women worrying about their symptoms, consulting again and again. She suggested that this was

because, although they had been given a diagnosis, they had not been given a cause for their illness, at least not one that satisfied them.

Lau and Hartman (1983) interviewed 257 UCLA undergraduates in order to describe common representations of illness and to determine what effects those representations have on other health beliefs and behaviors. The participants were asked open-ended questions concerning the last time they were sick and why they had become sick. Of the 257 participants, 94% responded to the question about why they had become sick. The authors concluded that the reasons why an individual becomes sick, as well as how they label the illness and how they believe they become better, are important components of the individual's schema of illness.

Definition of Terms

Illness. Illness is theoretically defined by Kleinman (1980) as "the psychosocial experience and meaning of perceived disease... Illness is the shaping of disease into behavior and experience. It is created by personal, social, and cultural reactions to disease" (p. 72).

For the purpose of this study, the concept of illness was operationalized through one of its manifestations--symptoms. When people feel ill, they define their problem in terms of symptoms, and these symptoms reflect underlying theories of illness (Good & Good, 1981; Kleinman, 1980; Murdock, 1980).

Causes of Illness. Theoretically, causes of illness are those supposed agents, entities, or properties which are thought to produce illness (Fabrega, 1978). Operationally, causes of illness are defined as the individual's own explanation of the etiology of symptoms; that is, the informant's responses to questions about the causes of specific presented symptoms.

Scope

The population from which this sample was drawn is that of English-speaking adult Khmers living in the Boston area who have resided in the United States for less than five years.

It was proposed that the pilot study would result in information about Khmer theories concerning the causes of illness. The area of investigation included commonly experienced symptoms, as well as categories of their believed causes.

Limitations

1. This pilot study excluded those Khmers who:
    a) were under 25 years of age,
    b) lived in the United States more than five years, or
    c) resided outside the Boston area.
2. The sample size was small and caution must be used in generalizing the results to those Khmers who do not meet the inclusion criteria.

3. The sampling technique used resulted in a convenience sample which could not be controlled for other variables, and thus caution should be used in generalizing the results to the larger population.

4. No method was built into the study to control for the effects of time spent in the United States on the Khmer belief system.

5. Because English was the second language of the Khmer informants, it was assumed that some subtle meaning were lost in expression through the English language.

6. The validity of the method to be used may have been affected by the informants' reluctance to share beleifs not held by the researcher.

Chapter II

Review of the Literature

Southeast Asian Refugees and the American Health Care System

Since 1975, thousands of refugees from Southeast Asia have resettled in the United States. The circumstances surrounding their arrival here have made the refugees especially vulnerable to physical and emotional problems. These circumstances include almost fifty years of warfare and political turmoil in their homelands. With little or no preparation, the refugees fled their homes, often enduring perilous escapes, to find themselves in crowded refugee camps, their futures uncertain. From these camps, the refugees were dispersed to third countries where, far from familiar support networks, they encounter a strange culture, environment and language.

Perhaps one of the ways in which this cultural conflict is most apparent is at the interface between the Southeast Asian refugees and the American medical system. The western medical system is one of the first American institutions with which the refugees come into contact. This is because they arrive in this country with many medical problems. These problems include anemia, parasites, tuberculosis, malaria, skin infections and malnutrition (Ericson & Hoang, 1980; Catanzaro & Moser, 1982; Health Status, 1982). Nguyen (1982) described the mental health needs of the refugees, as well as their difficulty in making a psychosocial

adjustment to this culture.

What happens when the refugees seek health care in the United States? The fact that there are problems is attested to by the large number of articles in the professional literature which address this issue (Gallo, Edwards & Vessey, 1980; Gordon, Matousek & Lange, 1980; Hoang & Erikson, 1982; Reizen, 1980; Santopietro, 1982). The refugees may be unfamiliar with western scientific medicine as it is practiced in the United States.

The health beliefs of the Southeast Asians have evolved over thousands of years. Health beliefs are a major component of any cultural system and thus provide valuable insights into that culture. Health beliefs reflect the world view of an ethnic group (Foster, 1978; Good, 1981; Kleinman, 1980; Murdock, 1980). This is equally true for both Americans and Southeast Asians. Because the world views of these two groups are so different, it can be assumed that their health belief systems will also differ. These differences can become barriers to the refugees' access to appropriate health care.

It is the responsibility of American health care providers to plan and deliver adequate and appropriate health care to the Southeast Asian refugees. In order to do this, it is essental that health care providers develop a basic understanding of the social, cultural and medical beliefs and practices of this group (Erikson & Hoang, 1982; Leininger, 1978).

One difficulty in studying and providing care for the

Southeast Asians is that this group is comprised of several separate ethnic groups--Lao, Khmer, Vietnamese, Hmong, and other smaller tribal groups. While similar in many ways, each group has its own distinct culture and language. Each group must be studied separately before generalizations can be made about Southeast Asians as a group. Perhaps the group about which there is the least literature is the Khmers of Kampuchea.[1]

Historical Influences on the Khmer Health Belief System

In order to understand the many influences that have come to bear on what constitute Khmer beliefs about health and illness, it would be helpful to briefly review the history of Kampuchea. According to Williams (1976), Southeast Asia, because of its geographical centrality, has been a crossroads of trade and peoples. The main external influence on this region came from India, especially in the realms of government, religion and the arts. Despite the close geographical proximity of China, the role of the Chinese in Southeast Asia (Vietnam being an exception) was minor compared to that of India. This is partially due to the Sinocentrism of the Chinese. However, merchants and travelers from China did visit Southeast Asia and elements of the Chinese culture can be

[1]Approximately 85-90% of the people who live in Kampuchea are ethnic Khmer, 5% are Vietnamese, and 5% are Chinese. The remaining 2-3% consist of Cham-Malays, Europeans, Japanese, Indians, Pakistanis, Thais, Filipinos, and tribal hill people. Kampuchea was formerly known as Cambodia.

found in, among other things, the health belief systems of Southeast Asia. Although culturally dominated by India for centuries, Kampuchea, like the rest of Southeast Asia, never surrendered its autonomy.

Prior to its contact with Indic culture, the Khmers lived in a world of omnipresent, potentially harmful spirits (Whitiker, 1973). When introduced to Indian culture, Williams (1976) suggested that the animistic Southeast Asians were awed by the magic and mysticism of Indian religions. However, while adopting Theravada Buddhism as their religion, these people continued to practice their indigenous animism. Although the simultaneous practice of Buddhism and spiritism has been described in Burma (Spiro, 1967), Northwest Thailand (Kunstadter, 1978) and Kampuchea (Ebihara, 1966), it would seem that, on the surface at least, these two practices are contradictory.

A central concept of Buddhism is that of <u>no soul</u>--there is no supernatural. And yet animistic and ancestral spirits remain important characters in the Khmer belief system. An attempt to explain this contradiction has been made by several writers. Swearer (1981) makes a distinction between Theravada Buddhism and and popular Buddhism, defining the latter as Buddhism as commonly perceived and practiced by the average Southeast Asian. He sees Buddhism as part of a total cultural system. Besides encompassing the individual and social ideals represented by Buddha, Southeast Asian Buddhism places humans within a cosmology of various divine,

human, and demonic powers and provides a system of coping with them. Spiro (1967) addressed this issue most specifically in his discussion of Theravada Buddhism and spiritism in Burma. He concluded that the spirits represent the projection of impure impulses on the part of the Burmese while Buddhism represents their ideal impulses. Both Whitiker (1973) and Williams (1976) suggested that Buddhism provides the philosophical framework while spiritism provides the people with an explanation for the events of daily life, as well as a means of controlling these events. This is perhaps why spirits continue to play such an important role in the health belief system of the Khmers. While Buddhism offers a way, through merit, to a better existence in the next life, it does not provide a means of coping with the problems of every day in this life. Spiritism, on the other hand, can explain why a person becomes ill as well as provide a means for healing the illness.

Indigenous animism remains an important aspect of the Khmer health belief system. However, exposure to the Indian, and to a lesser extent the Chinese, medical systems has also influenced the Khmer belief system. The most recent external influence on the cultural system of Southeast Asia, and Kampuchea specifically, was that of the French beginning in the mid-ninteenth century. During the nearly one hundred years of French rule, western scientific medicine was practiced in Kampuchea by medical personnel brought over from France. It can be assumed that these personnel practiced mainly in the cities and primarily for the benefit of the

French colonials. However, some elements of western scientific medicine did become incorporated into the Khmer belief system. Jaspan (1969) suggested that the Buddhist concepts of causality and freedom from theism have contributed to the acceptance of western scientific thought and biomedicine in Southeast Asia.

The historical factors reported above have contributed to a health belief system throughout Southeast Asia which is both eclectic and syncretic in nature. According to Williams (1976), the ability of Southeast Asians to absorb without being absorbed was due to the vitality of the indigenous cultures and their ability to be receptive to enrichment while maintaining their distinctiveness.

Determining what elements of the Indian and Chinese medical systems are present in the health belief systems of the Khmers can best be accomplished by first briefly describing the medical systems of these two cultures. Earliest records from India indicate that disease was believed to be the work of punishing gods. Treatment for such diseases consisted of prayers by qualified practitioners, occasionally augmented by the use of herbal remedies. It was in the fifth or sixth century B.C. that the traditional Indian medical system as we now know it evolved. It was also at this time that social and dietary taboos developed controlling social contacts and dietary habits. The conscious connection of these taboos with public health is not known, however (Basham, 1976).

The traditional Indian system of medicine is known as

Ayurvedic--to prolong life. The purpose of this system is to cure sickness, prevent illness, and prolong life. Health is believed to depend upon the balance of three primary fluids in the body--wind, gall, and mucus. The bodily functions are controlled by five separate winds. In Ayurvedic medicine, the functioning of the body is controlled by natural law, not gods or demons. Early texts emphasized the importance of diet and physical exercise in maintaining health. The vaidya, the traditional practitioners of Ayurvedic medicine, undergo a long apprenticeship under a guru and employ a large and varied pharmacopeia in their practice (Basham, 1976).

The notion of balance is also an important element in traditional Chinese medicine. The principles of yin and yang are basic to Chinese medicine as well as to all Chinese sciences. Around the fifth century B.C., yin and yang began to represent the polar aspects of all interrelated phenomena. These principles provide the framework for both the pharmacology and acupuncture of Chinese medicine which concentrates on the present functions and actual symptoms of the patient as opposed to the underlying disease. Diagnostic methods include inspection, interrogation, auscultation, and palpation (Pokert, 1976).

Besides Indian Ayurvedic and traditional Chinese medicines, Hoang and Erikson (1982) described what they called Indochinese modern medicine. According to Hoang and Erikson, Indochinese medicine is a variant of traditional western medicine and is

deeply rooted in the concepts of ninteenth century French medicine. Using clinical findings rather than elaborate laboratory technology, Indochinese modern medicine is more pragmatic than scientific. Common therapeutic techniques include 'shotgun therapy' and the 'placebo effect'.

Khmer Health Beliefs and Practices

All the medical systems described thus far--indigenous animism, Ayurvedic medicine, traditional Chinese medicine, Indochinese modern medicine, western scientific medicine--have had their impact on the present Khmer health belief system. Illness is believed to have natural or supernatural causes, although Murdock (1980) identified spirit aggression as the primary etiology of illness in the belief systems of the Southeast Asian area. In supernaturally caused illnesses, the agent is usually a spirit who has been slighted in some way. Whitiker (1973) described six categories of spirits who inhabit the Khmer cosmology. These are:

1) neak ta--spirits of trees, stones, forests, and villages;
2) praet--demons;
3) chnaing ptheh--house guardian spirits;
4) meba--ancestral spirits;
5) mring kongvial--elves guarding certain animals; and
6) khmmaoc loong--ghosts (p. 146).

These spirits are unpredictable and may be either benevolent or malicious, except for the chnaing ptheh which are entirely benevolent.

Illness and other misfortunes may be attributed to the spirits' anger. Rituals are performed and offerings are made to appease the spirits and keep their good will. Illness may also be caused by a sorcerer (t'mop).

In order to influence the spirits to prevent or cure illness, the Khmer will seek the assistance of a Kru--spirit practitioner. Kru has the same linguistic origins as the Indian word guru (Heigel, 1980). The Kru have other abilities besides treating illness. These abilities include making love potions, finding lost objects, and injecting supernatural powers into protective amulets (Whitiker, 1973).

Schiller (1984) described six specialized types of Kru:

1) Kru psom tanom--practitioners who diagnose and treat naturally caused illnesses using traditional medicines made from plant and animal matter. They may also use physical techniques such as cupping, coining, and pinching.

2) Kru ahcomh--specialist in magical Pali (the mother tongue of Buddha) and Sanskrit words. They may chant special formulas while chewing betel nut. They also produce special amulets to protect their clients.

3) Kru chanou--usually women who can act as intermediaries between ancestral spirits (meba) and the living.

4) Kru t'mop--treat persons afflicted by the black magic of sorcerers (t'mop).

5) Kru snie--produce love charms to enable one person to

attract another.

6) Kru howe--male or female fortunetellers.

7) Banjoule ruup areak--intermediaries who contact the spirit world while in a trance. Through them, the demon speaks to the client who can then discern the appropriate offering to appease the demon.

Techniques employed by the Kru to determine the nature and origin of the disease being presented include questioning the patient about the signs and symptoms, feelings and antecedents to the disease, meditation, and correlation between the day of consultation and the phase of the black moon. The Kru are also very proficient in the local taxonomy (Hiegel, 1980). For example, Whitiker (1973) has identified the use of chaulmooga oil for leprosy, herb teas for intestinal ailments, and quinquina bark for malaria.

Elements of Ayurvedic and traditional Chinese medicine can be found in the Khmer concept of k'chall--wind illness. Eisenbruch (1983) identified wind illness as one of the most common complaints in Southeast Asian societies. He suggested that the etiology of wind illness lies in Buddhist, Confucian, and spirit possession beliefs. Wind illness can be caused by a variety of factors--smelling noxious odors, eating certain foods, hunger, breach of custom, and spirit possession. The pathophysiology of wind illness lies in the imbalance of wind, one of the four basic elements, in the body. The wind may rise, fall, or get stuck in the body. The

effect of the wind disturbance may be such varied symptoms as pain, dizziness, seizures, or other odd behaviors (Eisenbruch, 1983).

Muecke (1979) interviewed 178 women in Northern Thailand who had reported a history of wind illness. These women represented the full range of socioeconomic status. Wind illness was perceived to be a "non-contagious illness deriving from an identifiable array of an individual's attributes or behaviors that upset the body's humoral balance, causing a wide variety of symptoms that are emotional or neurological in nature" (p. 277). Wind illness was associated with such etiological factors as karma, macrocosmic conditions such as climate, time of day, or seasons of the year, spirit possession, and rarely, heredity. Muecke suggested that the signs and symptoms of spirit possession and wind illness among the Northern Thai are similar. She found that among the villagers and healers there was some disagreement about the relationship between wind illness and spirit possession.

Muecke concluded that wind illness is a general term for various disorders and that, for some, a self-diagnosis of wind illness changed to a biomedical diagnosis after consultation with a physician. In addressing the issue of why wind illness persists in this culture, Muecke suggested that biomedicine is costly and ineffective in a number of cases. Also, wind illness is often associated with minor symptoms related to general debilitation from stress or self-neglect, conditions for which the women in this study preferred self-treatment.

According to Muecke, wind illness serves the social functions of veiling undesirable diagnoses which might disparage or frighten the sick person because of their incurable nature, and of providing a relatively benign label for otherwise unexplainable or intractable symptoms (p. 291). Muecke also suggested that wind illness may be a manifestation of socioeconomic pressures on the poor through such symptoms as social withdrawal, nightmares, respiratory and gastro-intestinal disturbances.

In the Khmer belief system there is no clear demarcation between natural and supernatural causes of illness. Water, wind, and fire are the mediators by which the magic powers act (Heigel, 1980). In order to affect the flow of wind through the body, several physical techniques are employed by the Khmer. These techniques include cupping, coining, and pinching (Heigel, 1980; Moser, 1983; Schiller, 1984).

In the practice of cupping (chop k'chall), air is extracted from a small jar or cup by means of an open flame. The cup is then placed on a part of the body, the vacuum causing suction and a subsequent red mark. Coining (kosh k'chall) involves massaging an area of the body with a mentholated ointment such as tiger balm and then rubbing the area with a coin until an ecchymotic area develops. This is considered especially effective for such ailments as nausea, vomiting, and coughing. Pinching (chap k'chall), often used in the treatment of headaches, involves pinching the skin between the eyebrows until the area becomes reddened (Moser, 1983). Pinching

may also be used in the treatment of fever (Sargent, 1983). These methods are believed to work by releasing wind where it is stuck in the body and allowing it to flow naturally through the body.

The humoral theory of hot-cold balance is also evident in the Khmer health belief system. According to this theory, disease may disturb this necessary balance. Food and medicine are classified according to their intrinsic nature as yin (cold) and yang (hot). They are then prescribed to correct the imbalance (Sargent, 1983).

In interviews with 42 Khmer women of reproductive age who were recently resettled in Dallas, Sargent, et al (1983) found that pregnancy is considered a 'hot' condition, while the postpartum period is considered 'cold'. Accordingly, pregnant women selected food considered cold, while the postpartum women selected hot foods, in order to restore balance to the body. They also report the practice of mother roasting after the baby and the placenta have been delivered. In this practice, three pots of hot coals are placed under the bed. The mother lies on the bed, frequently changing positions to heat all sides of her body. This practice may be continued for up to a month after the delivery. Although 83% of the sample in this study did not practice roasting, most believed that a condition characterized by fatigue, weight loss, diarrhea, and reduction in breast milk would result if no substitution for roasting was obtained. The most prevalent substitute for roasting was found to be wine mixed with medicines believed to contain tiger bones. Substitutes also included other medicines, a

warm rock applied to the abdomen, and warm clothing.

Another technique used by the Khmer to restore heat to the body is the practice of ovt pleung (moxibustion) used primarily for stomach disorders. In this practice, small balls of a cottony substance are ignited and placed on the abdomen. This practice leaves small round scars around the navel. The purpose of this practice is to draw out and release the cold condition causing the illness (Muecke, 1983; Sargent, 1983). Steaming, in which the postpartum woman places her face over a pot of boiling water and herbs, also restores heat while providing the added benefit of improving the woman's complexion (Sargent, 1983).

Western scientific medicines and techniques have also influenced the Khmer health belief system. A general belief is that western medicine is very powerful and cures quickly, although there may be some concern about the appropriateness of western medicine for Asian people. Part of this concern arises from the fact that according to the humoral theory of hot-cold, most western medicine is considered hot, while most traditional medicine is considered cold (Muecke, 1983). Jaspan (1969) states that there is continual interaction between western and traditional medicine. A Khmer person would probably not say that one system is better than another, but rather that one system might be more appropriate for a certain type of illness than another. Each system has areas of specialization and different categories of knowledge.

What happens then to the health beliefs and practices of the Khmers when they arrive in the United States and there is not the same support for the traditional belief system? The study done by Sargent, et al (1983) indicated that while the beliefs remain, the practices may be adapted to the conditions found here.

Methodology in Transcultural Research

Leininger (1978) defined ethnoscience as "the systematic study of the way of life of a cultural group in order to obtain an accurate account of the people's behavior and how they perceive and know their universe" (p. 76). It is based upon the principle that people classify their universe. The aim of ethnoscience is to elicit people's views about something by the way they talk about it. According to Leininger, the information obtained in this fashion has a high degree of validity and reliability.

The purpose of this approach is to obtain information in the person's own words. According to Polit and Hungler (1978), open-ended questions provide the best means for allowing subjects to respond in their own words. Analysis of responses to open-ended questions is accomplished by developing categories and then assigning the responses to those categories.

Most of the studies reviewed utilized techniques designed to elicit the participants' beliefs about the causes of illness in the participants' own words. Two of the studies used open-ended questions (Lau & Hartman, 1983; Lowery et al, 1983). An exception

to this was the study conducted by King (1982). In order to determine the participants' beliefs about the causes of high blood pressure, King used a list of 15 possible causes of high blood pressure compiled on the basis of a previous survey of patient knowledge.

deChesnay (1983) has identified the inherent subjectivity of cross-cultural research as a challenge to be met by the nurse researcher. She suggested consensual validation during the data collection process as a method of decreasing error. deChesnay has also identified that defining terms operationally is the single biggest methodological problem. The author warned against mechanisms of selective inattention, ethnocentrism, and prejudice as areas of subjectivity (p. 22).

Summary

The history of Southeast Asia has resulted in a cultural belief system which contains elements of indigenous spiritism, Buddhism, and Western influences. This eclectic belief system is reflected in the health beliefs and practices of the Southeast Asians. Upon arrival in the United States, the refugees from Southeast Asia come into contact with the American health care system. Divergent cultural beliefs may lead to miscommunication and difficulties between the refugees and the American health care providers.

It has been argued that understanding a person's health

beliefs is a basic element in the delivery of effective and appropriate health care. An important component of a person's belief system is the beliefs concerning the causes of illness. Attribution theory proposes that assigning causes to events such as illness provides a person with an explanation of, and a sense of control over, the event.

The ethnoscientific method elicits information about a cultural group's beliefs and practices from the people's own point of view. Open-ended questions are a means of obtaining information in the respondent's own words. However, the nurse researcher must build in safeguards to decrease the subjectivity inherent in cross-cultural research.

Chapter III

Methodology

Design

This study was a descriptive, exploratory survey based on semi-structured interviews using open-ended questions. This design was selected in order to elicit from the informants, in their own words, information concerning Khmer beliefs about the causes of commonly experienced symptoms. The interviews, with one exception, were conducted in the homes of the informants.

Sample

The population consisted of approximately 1,000 Kampucheans who were currently residing in Massachusetts. The inclusion criteria for the non-probability sample drawn from this population consisted of:

1. Kampucheans who considered themselves Khmer by ethnicity,
2. were 25 years of age or older,
3. had resided in the United States for less than five years, and
4. were currently residing in the Boston area.

The age and entry date criteria were chosen to limit the sample to those Khmers who were at least 20 years old before leaving Kampuchea, i.e. had spent at least some of their adult life in Kampuchea.

In order to obtain a sample meeting these criteria, the snowball technique (Polit & Hungler, 1978: p. 454) was employed. Individuals known to the researcher to meet these criteria were contacted by telephone. These individuals were invited to participate in the study and also to suggest the names of their acquaintances who also met the criteria. Those individuals were then contacted by telephone. This process was continued until a sample of ten informants was obtained. Although English-speaking Khmers were sought to participate in the study, due to the nature of the questions some of the informants found it necessary to consult with family members in order to understand and answer the questions.

The resulting sample consisted of ten informants ranging in age from 27 to 64 years (see Appendix A). The average age of the informants was 42 years. Six of the informants were female, four were male. The level of education ranged from 3 years to 14 years, with a mean of 10.5 years of education. Five of the informants were married, four were widowed, and one informant was single. The informants had resided in the United States for an average of 31.6 months, with a range of 10 months to 40 months.

The informants had held a variety of occupations in Kampuchea. Two of the women had been seamstresses. The other women had been a housewife, a high school teacher, a grade school teacher, and a nurse. The men had been a student, a soldier, a nurse, and a translator for the U. S. Embassy in Phnom Penh. It was interesting

to note that none of the informants now have occupations similar to those they held in Kampuchea (see Appendix A). Five of the informants now have jobs which directly involve them with the Southeast Asian refugee community.

Tool

The tool used to elicit information about the causes of illness was an open-ended interview schedule designed by the investigator (see Appendix B). The questions were open-ended, and employed techniques of restating and repeating as described by Spradley (1979).

The interview schedule consisted of two parts. The first section concerned the demographic characteristics of the informants, with questions regarding the age, sex, marital status, educational level, present occupation, occupation in Cambodia, and length of time in the United States.

The second section of the interview schedule consisted of twelve open-ended questions concerning symptoms recently experienced by the informants and the informants' families, as well as questions concerning the causes of the symptoms (see Appendix B). The interviews were semi-structured, and clarifying questions were asked as necessary. It was intended that by using open-ended questions, cultural biases on the part of the researcher would be minimized.

Potential informants were contacted by telephone and invited

to participate in the study. For those who agreed to participate, an appointment was scheduled to conduct the interview in the informant's home. Prior to initiating the interview, the purpose of the study was explained and a signed consent form (see Appendix C) was obtained. It was intended that by conducting the interviews in the informants' homes, they would feel more comfortable in sharing aspects of their personal belief system with the researcher.

Chapter IV

Findings

Data Analysis

A variety of symptoms or groups of symptoms were reported by the informants (see Table 1, page 32). Some of the symptoms were reported by more than one informant. The most frequent symptoms reported to have been experienced by the informants or members of their families were dizziness, fever, nausea, diarrhea, and headache. Dizziness is an example of a symptom experienced both alone and in conjunction with other symptoms such as difficulty sleeping, nausea, and body feeling cold. One informant reported having experienced fever in the evening along with being tired and a loss of weight. Another group of symptoms experienced together was moving slowly, red face, and watery eyes.

According to the informants, most of the symptoms reported could have a number of possible causes (see Table 1). Usually the causative agent was thought to be an action taken by the individual experiencing the symptom. Consistent with the influence of traditional Chinese medicine, many of the symptoms could be attributed to some type of imbalance. This is reflected in such reported causes of symptoms as thinking too much, working too hard, not eating enough food, not enough sleep, too much of a certain kind of food, doing something different, or a change in the weather. Causes of symptoms stated in this manner seem to

Table 1

Symptoms and Their Reported Causes

Dizziness - thinking about family, remembering the past, worry

Dizziness, nausea, sweaty, body feeling cold - too tired, work too hard, not eating at the right time

Dizziness, difficulty sleeping - lack of food, fatigue

Cold, dizzy - don't eat in the morning, work too hard, do something different

Fever - outside too long, in rain without protection, air not circulating properly through the body, too much travel, working in the sun and washing your face, malaria, infection

Fever in the evening, very tired, weight loss - not enough food, work too hard, mosquitos

Headache - toothache, thinking too much, not enough sleep, change in the weather, spirit anger, walking under something, somebody touching your head

Diarrhea - spoiled food, bad water, too much milk, too much fresh fruit, bad wind, eating something strange, drinking water after not eating, poisoned food

Diarrhea with blood - not enough food, eating leaves

Feeling hot, headache, runny nose - choking on water while swimming, change in weather, being tired, cold weather, malnutrition

Swollen abdomen, constipation - not enough vegetables

Tired, hard to get breath - heart

Moving slowly, red face, watery eyes - infection, playing too much, not wearing a shirt, too exposed to air

Difficulty sleeping, nightmares - thinking about things, thinking too much, remembering the past

Nausea, vomiting - not having anything to eat, having blood drawn, bad pain, riding in the bus, frustrated to be alive after death of daughter, pregnancy, bad smells, ugly sights, riding in car or plane, hepatitis, eating food you don't like, not eating at right time, too crowded

Throw up blood, black stool - working too hard, eating leaves, very upset, not enough food, eating papaya roots,ulcers, smoking a lot

Rash on skin - measles, allergy

High blood pressure - stuck neck, tight muscles

indicate a disruption of the harmony of life which can lead to illness.

The causes of symptoms reported by the informants often reflected the physical and emotional trauma brought on by their experience as refugees. Gastrointestinal symptoms were sometimes reported as being caused by not having enough to eat or having to eat such foods as leaves and papaya roots. Headache, dizziness, and difficulty sleeping were sometines attributed to thinking too much or remembering the past.

The germ theory as understood by the Western world is also familiar to the Khmers. However, it does not appear to be considered a primary cause of illness. During the interviews, fever was attributed to such causes as being outside too long, being in the rain without protection, too much travel, washing the face after working in the sun and infection or malaria. One informant who had experienced fever in the evenings, fatigue and weight loss attributed it to not enough food, working too hard and, lastly, mosquitos. Another informant reported having experienced feeling hot, headache, and a runny nose. These symptoms were attributed to choking on water while swimming or a change in the weather.

It is interesting to note that one informant who was obviously experiencing cold symptoms during the interview did not report these symptoms in response to the questions. Another informant who was known to the researcher to have been seriously ill with hepatitis a few months prior to the interview also did

not report that illness, although still another informant said that a doctor had told her that her daughter's nausea was caused by hepatitis.

One informant had a father with high blood pressure, but said she did not know what caused it. Her mother, another informant, attributed her husband's high blood pressure to tight muscles and a stuck neck. Infection, measles, malaria, hepatitis and high blood pressure were the only medical diagnoses reported by the informants as possible causes of symptoms.

Stuck neck, as an explanation for a cause of an illness, can be understood in the context of the Khmer concept of k'chall. During the course of the study, an informal conversation was carried on with a Khmer medical interpreter at one of the health clinics in Boston. (This interpreter is not the same person who participated in the study as an informant.) He reported that Khmer patients almost never report k'chall when coming to the clinic. Instead, they report symptoms similar to the ones reported in this study. Being Khmer, the interpreter recognized the symptoms as k'chall and would ask the patients if they had k'chall. According to this interpreter, the patients frequently agreed that they had k'chall.

Following the conversation with the Khmer interpreter, questions concerning k'chall were introduced into the interviews. Although only one informant reported k'chall on her own, in response to questions about k'chall it was found that just about any of the

symptoms reported could be considered k'chall. K'chall was defined as bad air or wind in the body.[2,3] It was explained by the informants that normally air flows throughout the body. Such things as not enough food, too much activity, and being upset could cause the air to become stuck or not flow properly in the body. For instance, one informant explained that when someone has a fever, the ear lobes, fingers, and toes are cold because the air in the body does not reach them.

According to the informants, k'chall is treated by coining. The process of coining consists of applying tiger balm[4] to certain parts of the body and then rubbing those areas with the edge of a coin until red streaks appear on the skin. Then tiger balm is reapplied to those same areas. Coining was said to work because the friction releases the air where it is stuck in the body and it makes one feel hot.

[2]A similar concept described among the Thai (Muecke, 1979) and the Vietnamese (Eisenbruch, 1983) has been referred to as 'wind illness.' The Khmer word kyal or kcal has been translated by Huffman (1970, p. 117) as wind. However, except for one instance, the informants in this study used the word air when referring to the concept of k'chall.

[3]Although spelled various ways in the literature, this spelling of the word k'chall has been chosen for use in this paper because it most closely approximates how it was pronounced by the informants in this study.

[4]Ingredients listed on samples of tiger balm obtained in Boston's Chinatown are cajeput oil, camphor, menthol, and clove oil.

Besides being therapeutic, coining can also be diagnostic. As one informant explained, if the fever was relieved by coining, then the fever was k'chall. The area of the body to be coined depends upon the symptoms being experienced. For a headache, one would coin the neck and back. If the headache was not relieved, then the chest would be coined. According to one informant,a headache could also be treated by pinching the bridge of the nose, rubbing the temples, and tugging on the hair. For a stomachache, the lower back would be coined, or if the stomachache was serious, the stomach itself would be coined.

A particularly severe form of k'chall, k'chall kor, was described by two informants. Neither of the informants had experienced k'chall kor themselves, but rather had seen other people so affected. K'chall kor was reported to be manifested by the face turning blue, convulsions, foaming at the mouth, and an inability to speak. K'chall kor was said to occur when k'chall is left untreated and may progress to cause death. One informant reported that k'chall kor could be treated by pulling on the tendons of the heels, neck, chest and groin or by tugging on the tongue.

Although the symptoms reported could be attributed to k'chall, they may also not be k'chall. Informants often reported seeing the doctor or taking aspirin or Tylenol in addition to coining in the treatment of their symptoms. One informant explained that he does not practice coining here (in the U. S.) because there are

enough doctors here. It is interesting to note that the use of cupping, which is mentioned in the literature as a treatment for k'chall, was not reported by the informants in this study.

Spirits were also mentioned as causative agents in illness.[5] Specifically, one informant reported that angry spirits could cause seizures, mental problems, stomachache, and fever. Another informant reported that his sister was severely ill with fever in Cambodia and had been treated unsuccessfully at a local hospital. The parents of the girl sought assistance from a Kru Khmer, a traditional Khmer healer, who informed them that the meba (spirits of the ancestors) and the neak ta (spirits of the village) were angry because they, the parents, had not been giving enough attention to the spirits. When the parents followed through with offerings to the spirits, the girl was cured.

It was explained by another informant that when a person gets sick, she will try two things. She will go to a hospital and she will consult a Kru Khmer or a fortuneteller who will tell her what she did to make the spirits angry. Another informant stated, "Even if they go to the clinic, they believe both and also pray."

[5]Spirit aggression is defined by Murdock (1980) as "the attribution of illness to the direct, hostile, arbitrary action of some malevolent or affronted supernatural being" (p. 20).

Sorcery, too, is believed to play a role in the cause of illness.[6] One informant described two types of sorcerers. He explained that Kru t'mop were men who can cause a knife, needle or scissors to enter the body, cut up the insides and cause pain, vomitint, and bloody stool. An arb is a woman who will cause illness when she is angry. The victim of the arb's anger will go to a Kru Khmer. When confronted by the Kru Khmer, the arb will speak through the victim and identify herself and what she wants. According to this informant, most villages in Cambodia had at least one arb.

Discussion

The symptoms reported by the informants were similar to symptoms experienced by people everywhere. However, the causes attributed to the symptoms represent the various influences on the Khmer culture and, therefore, on the Khmer health belief system. Thus, possible causes of headaches were reported by the informants to be toothache, thinking too much, a change in the weather, or spirit anger. A fever could be caused by infection in one case or by air not circulating properly in the body in another.

[6]Murdock (1980) defines sorcery as "the ascription of the impairment of health to the aggressive use of magical techniques by a human being, either independently or with the assistance of a specialized magician" (p. 22). The informant in this study used the term voodoo when discussing the actions of Kru t'mop and the arb.

The informants were generally very willing to participate in this study. Often times other family members were present during the interviews and discussion would go on among them in response to the questions. Twice, recalling past illnesses in the family brought back painful memories of events in Cambodia and the informants became tearful. In both incidences the informants expressed the desire to proceed with the interview none the less. Initiation of discussion concerning treatment of the symptoms was unsolicited by the researcher, but once begun, clarifying questions were asked.

Some of the informants were more forthcoming than others in relating beliefs which differed greatly from the Western belief system. For example, while one informant stated directly her belief in spirits, another began by stating, "I don't believe..." This same informant, however, began to use the first person in describing beliefs about spirits as the interview progressed. It is unclear if this use of the first person toward the end of the interview more clearly reflected his own beliefs or not. This ambivalence may be a result of the acculturation process and a transition between two belief systems.

Another informant suggested that while spirits can cause illness in Kampuchea, they do not cause illness in the United States. When spirits and sorcerers were discussed by the informants, it was usually in the past tense and in regard to events which occured in Cambodia. None of the informants reported consulting

a Kru Khmer since their arrival in the United States although at least one Kru Khmer is known by the researcher to be residing in Boston. From the results of this study at least, it would seem that the belief in spirits as causes of illness plays a less important role in the health belief system of the Khmers in Boston.

On the other hand, the concept of k'chall appears to remain important to the Khmer health belief system. Most of the informants stated that at least some of the symptoms they reported as being experienced by themselves or members of their families could be k'chall. Only one informant denied using coining in the treatment of symptoms since his arrival in the United States. It appears that Khmers will also seek the assistance of Western medical diagnosis and treatment in an attempt to alleviate their symptoms.

Conclusion

The health belief system of the Khmer informants in this study is complex and representative of various influences on their culture. Causes attributed to the symptoms they reported were both natural and supernatural. Natural causes included infection and imbalances of air in the body. Supernatural causes included spirit anger and sorcery. The different agents believed to be the cause of specific symptoms determines the type of treatment sought in the alleviation of those symptoms. The complexity of the belief system frequently results in the use of more than one kind

of treatment for the same symptom or group of symptoms.

The Khmer health belief system may be changing in response to exposure to life in the United States. However, the degree to which this is occuring cannot be determined by the results of this study.

Elements of the Khmer health belief system may seem strange to Western health care providers trained in the scientific method. However, it must be remembered that most American hospitals have a chapel in which both clients and providers may seek divine intervention in the treatment of illness. Complexity is a hallmark of most health belief systems.

Tool to Elicit Khmer Beliefs about the Causes of Illness

Although the original purpose of this study was to develop a tool which could be used in eliciting Khmer beliefs about the causes of illness, the results of this study indicate that the Khmer health belief system is very complex. Beliefs about the causes of symptoms, even those held by the same individual, differ from situation to situation. This complexity would make it very difficult to develop a tool specific to the Khmer culture.

In clinical settings, it is important that health care providers establish a clear understanding of the client's perceptions of the specific illness episode the client presents with. Kleinman (1980) distinguished between general beliefs about illness, which are socially and culturally influenced, and

a client's explanation of a particular illness episode, which is influenced by the individual's unique characteristics and the situation in which the illness occurs. This distinction is reflected in the results of this study which demonstrated that specific symptoms could be attributed to different causes by members of the same culture and by the same individual in different situations.

Kleinman (1980) lists eight questions which can be used in eliciting an individual's beliefs about a specific illness episode. These questions are:

1. What do you call your problem? What name does it have?
2. What do you think caused your problem?
3. Why do you think it started when it did?
4. What does your sickness do to you? How does it work?
5. How severe is it? Will it have a short or long course?
6. What do you fear most about your sickness?
7. What are the chief problems that your sickness has caused for you?
8. What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment? (p. 106)

To these eight questions could be added the question, What have you done so far to treat your sickness? The answer to this question would provide information concerning the type and extent of the client's self-treatment and use of other practitioners.

These questions taken together could be an effective tool for eliciting an individual's beliefs about a specific illness episode.

However, familiarity with the client's cultural belief system would be necessary to place the client's responses to these questions into context and would increase the provider's understanding of the client's perspective. Understanding the client's perspective facilitates the communication essential to a therapeutic relationship.

Chapter V

Recommendations

Implications for Nursing

The data from this study suggest several implications for nursing. The nurse must recognize that traditional health beliefs serve the important function of explaining to individuals the reasons for the symptoms they are experiencing. The health belief system of the Khmers has evolved and survived for generations because it has in some way worked for them. The health belief system of the Khmer client will differ in some aspects from that of the nurse. It is the nurse's responsibility to determine the client's beliefs about their illness. Questions asked in a non-judgemental manner will demonstrate to the client the nurse's recognition of and respect for different beliefs.

The nurse can expect that Khmer clients may utilize traditional treatments, along with Western medical treatments, in attending to their symptoms. In some cases, traditional methods may be utilized instead of Western methods. The community health nurse can observe for the physical signs of traditional treatments, recognize that these signs indicate the presence of symptoms, and investigate with the client the nature of those symptoms. The nurse can also utilize the Khmer belief in the relationship between balance and health to reinforce her own health promotion teaching regarding diet and exercise.

Recommendations for Further Research

Although the results of this study indicate that the concept of k'chall is important to the Khmer belief system, very little is known about this concept. Further study in this area could increase our understanding of this concept and, therefore, of the Khmer belief system. The use of semi-structured interviews limited the content brought out in this study. Participant observation and unstructured interviews are methods which might yield Khmer concepts about the causes of illness other than k'chall, which were not revealed in this study.

A similar study using semi-structured interviews to elicit Khmer perceptions about the concept of health and how it is maintained would provide valuable information for community health nurses in their attempts to promote health and prevent disease. A better understanding of another culture's concept of health may also broaden our own perception of the same concept. Finally, a prospective study with a similar sample would provide information about how the Khmer belief system is affected over time by exposure to western culture.

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Appendices

Appendix A

Demographic Characteristics of Informants

	I_1	I_2	I_3	I_4	I_5	I_6	I_7	I_8	I_9	I_{10}
Age	29	64	40	35	50	37	44	64	27	31
Sex	M	F	F	M	M	F	F	F	M	F
Marital Status	S	W	W	M	M	W	W	M	M	M
Level of Education	14 yrs	3 yrs	6 yrs	14 yrs	12 yrs	13 yrs	14 yrs	6 yrs	11 yrs	12 yrs
Occupation in Kampuchea	Student	Seamstress	Housewife	Nurse	English Translator	HS Teacher	Teacher	Dressmaker	Soldier	Nurse
Present Occupation	HS Teacher	Unemployed	Dishwasher	Refugee Caseworker	Social Service Interviewer	Resettlement Worker	File Clerk	Unemployed	Medical Interpreter	Film Printer
Length of Residence in U.S.	30 mos	18 mos	36 mos	40 mos	36 mos	36 mos	37 mos	37 mos	10 mos	36 mos

Appendix B

Interview Schedule

Demographic Data

Age _____ Sex _____ Marital Status _____

Level of Education _____

Current Occupation _____

Occupation in Cambodia _____

Length of Residence in the U.S. _____

Interview

1. Most people feel sick at one time or another. The last time you were sick, how did you know that you were sick?

2. What are some of the possible causes of (reported symptom)?

3. Is there anything else besides (previous answer) which might cause (symptom)?

4. What else have you experienced recently which let you know that you were sick?

5. What are some of the possible causes of _____?

6. Is there anything else besides _____ which might cause _____?

7. The last time that someone in your family was sick, how did they know that they were sick?

8. What are some of the possible causes of _____?

9. Is there anything else besides _____ which might cause _____?

10. What else has someone in your family experienced which let them know that they were sick?

11. What are some of the possible causes of _____?

12. Is there anything else besides _____ which might cause _____?

Appendix C

BOSTON UNIVERSITY SCHOOL OF NURSING
Community Health Program
635 Commonwealth Avenue
Boston, Massachusetts 02215
(617) 353-4067

Study of Khmer Beliefs About Illness

INFORMED CONSENT

There are some differences between Khmer and American beliefs about illness. In order for American health care workers to better help Khmers, it is necessary for them to understand Khmer beliefs about illness. The purpose of this study is to ask Khmers about their beliefs about illness.

An acquaintance has given your name to me. If you agree to participate in this study, I will visit with you in your home and ask you some questions about when you have been sick. While we are talking, I will be writing some notes to help me to remember what is being said. You are free to end the interview any time you wish. The interview will take approximately one to one and a half hours. You are also free to refuse to answer any specific questions. I will answer any questions that you may have about the study. There are no known risks or benefits to you if you participate in this study.

The information that you share with me will remain confidential. Your name will appear nowhere except on this consent form, which will be destroyed when this study is completed. The data collected during this study will be kept in a locked file.

I have read the above information, understand it fully, and agree to participate in this study.

Date _____

Signature _____

Principal Investigator

Donna Lazorik, RN
90 Nonantum Street
Brighton, MA 02135
(617) 254-0425

Faculty Advisor

Bianca Chambers, RN, MS
635 Commonwealth Avenue
Boston, MA 02215
(617) 353-4067