HEALTH AND HEALTH CARE OF
SOUTHEAST ASIAN AMERICAN ELDERS:
Vietnamese, Cambodian, Hmong and Laotian Elders
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DESCRIPTION

This module introduces the learner to issues in geriatric care for elders from Vietnamese, Cambodian, Hmong, and Laotian backgrounds living in the United States. Available information on demographics and health risks are presented with emphasis on the effect of immigration and refugee experiences and traditional cultures on elders' health. Suggestions for assessment and treatment are included, along with information on barriers to care. The module is designed to be used in conjunction with the Core Curriculum in Ethnogeriatrics.

LEARNING OBJECTIVES

After completion of the module, learners should be able to:
1. Describe major differences in the four Southeast Asian populations and their traditional health beliefs.
2. List at least three health risks facing elders from the respective Southeast Asian populations.
3. Evaluate the major options for communicating with an older Southeast Asian patient who speaks a language not spoken by the provider.
4. Develop a strategy for providing culturally appropriate health screening and education for Southeast Asian elders for the conditions for which they are at high risk.
5. Describe the important issues health care providers should consider in working with elders and their families in end-of-life care.
I. Introduction and Overview

A. Demographics and Background of Southeast Asians in the United States

From 1975 to 1995, approximately 3 million people left Vietnam, Laos, and Cambodia, including 1.75 million Vietnamese. The U.S. has resettled over 1.4 million of these Indochinese refugees, and the majority of 900,000 were from Vietnam.

In order to avoid the social service burden experienced by Miami, Florida, during the Cuban refugee crisis, the federal government embarked upon a plan to widely disperse Southeast Asian refugees throughout the 50 states. This solution was temporary for the large numbers of refugees seeking asylum after the fall of Saigon in 1975, but was a failed social experiment. There followed a great secondary migration of refugees from place of first resettlement in the U.S. toward geographic locations that became magnets for Southeast Asian refugees. These included locations characterized by: presence of Southeast Asian community leaders and sponsoring relatives, tropical climates, strong socioeconomic conditions for work by non-English speaking refugees, and established social infrastructure (e.g. Asian grocery stores) by established Asian-American populations. (For more information on the immigration and refugee experience, see section III.)

While Southeast Asian refugees and immigrants have the Vietnam War, refugee experiences and acculturation issues in common, there is wide diversity within and across the ethnic groups that comprise the Southeast Asian population. These include: degree of Westernization and acculturation, education and literacy in the home country; migration history; social class and social backgrounds; English and other linguistic skills; social supports; age at immigration, and years in the United States.

In the 1990 census, a total of 955,264 individuals residing in the U.S. identified themselves as Vietnamese; the states in which the largest Vietnamese populations resided (from largest to smaller) were California, Texas, Massachusetts, Florida, Illinois, Virginia, Washington, Minnesota, Maryland, New York and Connecticut. The Hmong (195,119 in the U.S.) were settled in: California, Minnesota, Wisconsin, North Carolina, Michigan, and Colorado. The largest Cambodian American populations (176,148 in the U.S.) are located in: California, Massachusetts, Pennsylvania, Washington, Minnesota, Texas, and New York. The Laotians (135,423 in the U.S.) have settled primarily in: California, Wisconsin, Minnesota, Maryland, Virginia and Texas. The Southeast Asians were concentrated primarily in urban centers.
For numbers and characteristics of elders from each of the Southeast Asian ancestry populations, see the chart in the Introductory section of the Asian/Pacific Islander modules. In general, Southeast Asian elders are more likely to be in poverty, much more likely to be foreign born, and much more likely to be classified as "linguistically isolated" than any other ethnic minority population.

Buddhism is a common religion in Laos, Cambodia, and Vietnam. However, a large proportion of Vietnamese who immigrated to the U.S. are Catholic.

II. Patterns of Health Risk

A. Southeast Asian Elders in General

There are many cross-cutting health risks in the Southeast Asian communities. The largest amount of empirical research deals with mental health issues and acute or infectious health conditions. More recently, concerns have shifted to a discussion of chronic health concerns and risk factors for cancer, cardiovascular, cerebrovascular, and diabetes conditions. There are no national data on health status of Vietnamese, Cambodian, Hmong and Laotians in the U.S. Most of what we currently know about health status in these Asian groups comes from smaller studies, state or local statistics.

A large number of Southeast Asian refugees suffered from mental health concerns during the refugee experience, sudden and involuntary cultural transplantation to a foreign culture, spending many years in squalid refugee camps or being held in political detainee prisons in Vietnam for a decade or more (Mollica, McInnes, Pham, et al., 1998). In addition to the trials and tribulations of acculturation and adaptation to Western life, there were numerous stressors prior, during, and after refugee migration, and horrific life events during the Vietnam War and its aftermath that may lead to depression, loss, and trauma expressed as post-traumatic stress syndrome. The Southeast Asian elderly appear to be at higher risk of psychological distress than younger Southeast Asians because they have fewer buffers and coping strategies to deal with their distress (Shapiro, et al., 1999; Yee, 1997; Yee & Thu, 1987). Acculturation stress, depression and mental health issues are not often incorporated into physical health research designs for Asian and Pacific Island (API) populations. Acculturation stressors, as measured by high cortisol levels, may be risk factors for cardiovascular and cerebrovascular diseases, and cancer. (Peeke & Chrousos, 1995: Schneiderman, Antoni, Saab & Ironson, 2001). Opium or backache remedies containing opium may continued to be used by Southeast Asian elders in the U.S. to cope with acculturation stress (Smith & Nelson, 1991).
Lauderdale, Salant, Han and Tran (2001) found that Southeast Asian women may be at very high risk for osteoporosis. These authors conducted a cross-sectional study of women born in Southeast Asia and found that the reference values for post-menopausal Southeast Asian women were lower than that of White women. Several predictors of high bone mineral density were: more years of education, earlier age of menarche, lower height, and coastal birth (seafood consumption) among premenopausal women.

Southeast Asians are at excess risk of high blood pressure, high total cholesterol, cigarette smoking, and obesity (Bates, Hill, & Barrett-Conner, 1989). Overall 61% were at moderate to high risk in at least one category.

B. Vietnamese

1. Life Expectancy. It appears that the life expectancy has improved for Vietnamese living in the U.S. In 1979-1989, Merli (1998) found that the life expectancy at birth was 61.4 years for males and 63.2 for females. Hoyert and Kung (1997) report 1992 life expectancy in seven high Asian and Pacific Islander reporting states to be 78.8 at birth and 18.8 additional years if a Vietnamese American lived to 65 years of age. The authors caution that these estimates were based upon small sample sizes, therefore may limit their generalizability.

2. Cancer. Cancer is the leading cause of death for Vietnamese of both genders in the United States. (Hoyert & Kung, 1997; Shinagawa, et al., 1999). High smoking rates and exposure through passive smoking among Southeast Asian families contributes to excess cancer rates among this ethnic group. The SEER data (Miller et al., 1996) report excess cancer rates for Vietnamese males in nasopharynx, liver, and stomach cancers. The same authors report excess cancer deaths for Vietnamese women in cervical, stomach and thyroid cancers. Vietnamese women have the highest incidence of cervical cancer in the U.S. It appears that much of this can be explained by lack of Pap screening, however, other factors such as high stress levels may also contribute to the Vietnamese women’s higher incidence of this cancer.

3. Heart Disease, Stroke Hypertension, and Diabetes. The second leading cause of mortality for both Vietnamese men and women in the seven U.S. states was diseases of the heart, and another leading cause was cerebrovascular diseases (Hoyert & Kung, 1997). Among Vietnamese hypertensives over 40 years of age, essential hypertension was associated with significant increase in body mass index (BMI). However, this figure was far lower than the defined threshold of Occidental obesity. Insulin resistance was found despite very slight or no excess weight among Vietnamese hypertensives (Van Minh et al., 1997). This study suggested that thresholds established in Caucasian populations may be an inexact predictor for the Vietnamese. Related to the risk of cardiac and hypertension problems may be the high rates (35%- 42%) of smoking among Vietnamese men.
4. Other Conditions. Other leading causes of mortality for Vietnamese men included accidents and adverse effects, homicide and legal interventions; for women they included accidents and adverse effects, and pneumonia and influenza (Hoyert & Kung, 1997).

A small community study of recent Vietnamese immigrants in Boston found the following: 32% smoked (54% males, 9% females); 24% used alcohol; 17% were depressed on the Vietnamese Depression Scale, with those older than 40 having more depression; ova parasites were found in 51%, (63% of them required treatment); 70% tested positive on the TB test (39% required treatment); 83% had been exposed to hepatitis B and 14% were chronic hepatitis B carriers (Nelson, Bui, & Samet, 1997).

Environmental exposures and developmental timing (i.e., in utero, infancy, childhood, adolescence, young, middle and elderly adulthood) of such exposure need to be examined to determine how toxicity and carcinogenic substances influence health of Southeast Asian elderly, for example, dioxin levels in adipose tissue and exposure to Agent Orange in South Vietnamese (Verger, et al., 1994).

C. Cambodians

1. Life Expectancy. Life expectancy in Cambodia is around 47 years for men and 49 years for females (Heng, 1995). There is no life expectancy data for Cambodians in the United States. While the major killers in Cambodia are malaria, tuberculosis, severe anemia, undernutrition, and diarrhea, these conditions become less health compromising with acculturation and as chronic conditions take more prominence.

2. Mental Health. The Cambodians are at very high mental health risk and suffer from post-traumatic stress syndrome and depression that is exacerbated by financial stress (Blair, 2000). The majority of Cambodians in the United States have been touched by the genocide under Pol Pot and the Khmer Rouge. Up to two million Cambodians died in the killing fields from violence, starvation, and disease. Mollica, McInnes, Poole and Tor (1998) found a dose-effect relationship of trauma to symptoms of depression and post-traumatic stress disorder among Cambodian survivors of mass violence.

Handelman and Yeo (1996) found that sadness from obsessive thinking about the loss of family members or traumatic events in the killing fields were the root of the most common illnesses among 76 Cambodian elders in San Jose, California. This condition (pruit chiit/kiit chraen) produces severe headaches with dizziness. Similarly, in a study of emotional distress and violence among Cambodians in Long Beach, California, and Lowell, Massachusetts, respondents experienced headaches from "thinking too much" about the horrors of Pol Pot regime. Family violence may be the outcome of thinking too much, and the woman's solution would be to talk softly to the violent male. Only half of these
Cambodian women would call the police if necessary. Greater use of alcohol, prescription drugs, especially sleeping pills, were used to deal with the "thinking too much".

Drinnan and Marmor (1991) found that Cambodians presenting with functional visual loss may have conversion hysteria from wartime experiences and cultural issues. This explanation for the emotional causes of physical illnesses illustrates the strong holistic concept of health among Cambodians Americans. There may be a reactivation of post-traumatic stress disorder symptoms, behavioral indicators, self-reports of distress, and increases in heart rate by seeing traumatic videos one to two decades after the event (Kinzie, et al., 1998).

3. Physical Health. Cambodians have high rates of hypertension, diabetes, heart disease, stroke and seizures accompanied by a variety of somatic complaints such as headaches, stomach aches, dizziness and fatigue (Baughan, White-Baughan, Pickwell, Bartlome & Wong, 1990). According to Palinkas and Pickwell (1995), the influence of acculturation on chronic disease risk needs to be examined, such as preference for and consumption of traditional foods and changes in food preparation style. While cultural preferences may remain quite traditional, use of American food substitutes, alteration of healthy food preparation styles, and lack of availability of traditional foods products may change nutrition patterns that may be damaging to the health of Southeast Asian elders.

Many older Cambodian women, primarily those over 50 years of age, chew betel nut quid, a stimulant and narcotic substance that is quite addictive, with tobacco, and red limestone paste. Chewing betel nut or its leaves puts one at possible risk for oral squamous cell cancer that is prevalent throughout Southeast Asia (Reichart, Schmidtberg & Scheifele, 1996). This is a female rite of passage into adulthood, and Cambodian older women do not view this addiction as harmful. It appears that with acculturation, younger Cambodians have not adopted this addictive and health damaging health habit.

Cambodian refugees often do not associate liver disease with Hepatitis B virus, only heavy alcohol use, according to Jackson, Rhodes, Inui, and Buchwald (1997). These authors found that about 10-15% of Asian refugees are chronic carriers of Hepatitis B virus. Liver cancer may be a possible negative outcome from this chronic infection.

D. Hmong

1. Cancer. According to Mills and Yang (1997), the Hmong have elevated rates of cancer for the following sites: nasopharynx, stomach, liver, pancreas, leukemia and non-Hodgkin's lymphoma. Cervical cancer incidence overall was elevated, and invasive cervix cancer rates were higher than expected. Hmong also experienced advanced stage and grade of disease at diagnosis for many cancer sites in addition to cervical cancer. Cultural
factors are implicated such as avoidance of Western medical care, thus leading to low rates of participation in screening programs.

2. Other Conditions In one study Hmong were found to have significantly lower mean cholesterol level than other Southeast Asian populations (Bates, et al., 1989).

E. Laotian.

No data are available of the specific health risks of elders in the U.S identified as Laotian.

III. Culturally Appropriate Geriatric Care: Fund of Knowledge

Two issues that are important background knowledge for effective care of elders from Southeast Asia are the traditional health beliefs and practices they may have, and the historical experiences of their cohort.

A. Health Beliefs and Practices

The belief and practices of Buddhism are widespread in Southeast Asia. Many Buddhists believe that human suffering and hardships provide the catalysts for change and development (Young-Eisendrath, 1998). During difficult periods of life, people will become enlightened and focus on how their suffering and hardships are brought about by their own attitudes and intentions, actions and relationships. Buddhism teaches believers that suffering is necessary to develop personal responsibility for subjective lives and awaken thoughtful compassion about human limitations. Illness as suffering has value as a catalyst for change and development. Therefore, the illness and disability journey, through pain and suffering, can provide valuable lessons in life (Miles, 1995). Delays in obtaining relief from illness may be a Buddhist stoic response to religious awakening.

Some traditional remedies practiced by many groups throughout Southeast Asia include herbal medicines, coin rubbing, cupping, therapeutic burning (moxibustion), and acupuncture (Jenkins, et al., 1996). Because coin rubbing to relieve “wind illness” produces superficial abrasions, Western providers can misinterpret them as elder abuse.

1. Vietnamese. Traditional Vietnamese believe in one or a combination of three models of health (Tung, 1980). First, the Am-Duong model is based largely upon Chinese traditional medicine and a belief that illnesses are caused by imbalances in the yin (am) and yang (duong) (Sheikh & Sheikh, 1989). Physiological imbalances can be caused by high emotional state, external influences such as sudden climatic or seasonal changes that block the circulation of vital energy (chi) or blood. Acupuncture can clear obstructions.
A second organic model sees illnesses as a function of the nervous system. For instance, neuroses are weakness of the nerves (than kinh suy nhuoc) and psychoses are turmoil of the nerves (than kinh thac loan). Verbal expressions such as weak nerves may signal minor mental disorders from anxiety, depression and mental deterioration. A nerve tonic or tranquilizer is usually prescribed to treat such conditions.

In the third model, a supernatural intervention is the most persistently held cause of mental illnesses. Tien dieties have the power to protect, and errant spirits are ancestors who have not been properly venerated by their descendants with ancestor worship ceremonies and offerings. The Vietnamese have spirit mediums, and sorcerers deal with the spirits. Buddhist priests and lay monks can provide amulets and medicines for physical ailments, as well as exorcism for spiritual ailments (Hickey, 1964).

2. Cambodian. The Cambodian people or Khmer culture is a combination of indigenous folk traditions, Indian, and French influences (Zadrozny, 1955). The majority of Cambodians adhere to Theravada Buddhism. The folk religion centers on spirits in the natural habitats such as mountains, ancestral spirits, and dangerous spirits or ghosts. Some spirits are benevolent, while others are malevolent. Western medical practices were introduced in Cambodia around 1860, however, indigenous practitioners were the first line of defense. Western doctors were seen only when the illness persisted. There were indigenous practitioners who dealt with sorcery and exorcised the evil spirits from the patient. Buddhist monks provided medical services from spiritual to Western therapy. The causes of illness were typically attributable to supernatural causes or natural causes such as humoral imbalances. Spirits cause illnesses by entering the body through the patient’s food. Practitioners of black magic can prevent or cause harm to people.

Illnesses from humoral imbalance come from Ayurvedic medicine in India and Southeast Asia and its use of five basic elements -- ether, wind, water, earth and fire to regulate bodily functions. According to Ayurvedic thought, illness occurs when the homeostatic condition of the humors is upset (Sheikh & Sheikh, 1989).

Treatments consist of ritual ceremonies to deal with the nefarious spirits and pay homage to the benevolent spirits, moxibustion, and herbal medicines.

3. Hmong. The Hmong are a very traditional people without a written language prior to coming to the United States. The Hmong formed nomadic clans who wandered in the remote and sparsely populated mountains of Laos, used shamans, and were animistic in their folk healing beliefs. The Hmong combine Chinese medicine and Protestant Christian beliefs, but spirit illness and soul loss beliefs still persist in this country (Fadiman, 1997). Temporary soul loss or soul separation is considered a factor in the majority of illnesses (Geddes, 1976). Souls can be separated by accident or by a frightening event, or may be
taken by an angered or offended spirit. A shaman is an important leader and healer who is the only person who can communicate directly with the supernatural spirits; he has clairvoyant powers in traditional Hmong culture.

Sudden Unexpected Nocturnal Death Syndrome among healthy Hmong refugees has been attributed to nightmare or attack by evil spirit that threatens to press the life out of its terrified victim (Adler, 1995).

Hmong may not make direct compliments or show great admiration for loved ones since this may attract the attention of evil spirits and arouse their envy. As a result of this envy, the evil spirits may take away the loved ones.

The Hmong perceive dementia as a natural part of aging and the lifecycle, rather than a devastating disease that robs individuals of their identity and autonomy (Olson, 1999). Wandering and combative are rare or non-existent in the Hmong community, in spite of the fact that demented relatives are cared for in their sons' homes. Nursing home placement is made for advanced dementia only when sanctioned by the entire extended family.

4. Laotians. Laotians are mostly literate and Buddhist. Many of the population of Laotians in the U.S. are from Lao Mien background. Like the Hmong, traditional Lao Mien believe that the spirit world can exert influence over the world including, health and well being of humans. The supernatural world consists of ancestral spirits and spirits of animals and plants. They can be protective; however, they can also be a major source of human affliction such as illness or accidents. The Mien have been strongly influenced by the Chinese Taoist, and healing practices of Lao-tsu and his priests. An individual’s spirit status in the spiritual world is dependent upon whether the person accumulated merits during their life. The Mien believe that health is dependent upon the status of the 12 souls that make up a person’s life force (Hwen) (Miles, 1973). These 12 souls correspond to 12 parts of the body (i.e., eyes, ears, mouth and nose, neck, arms, chest and upper back, abdomen and lower back, legs, left side of the head, right side of the head, feet and hands). Illness may be produced when malevolent ancestors express their anger by creating a loss of hwen. Illness is created in that part of the body associated with that lost soul.

The Mien have two major ways of dealing with sickness. "Dia " medicine is called upon in cases of illnesses due to hereditary factors. "Tsiang" ceremonies are carried out to address illnesses attributed to supernatural causes. In this latter case, Taoist grand master priests or other priests and spirit mediums are called to deal with these illnesses.

The Mien living in Richmond California integrated traditional healing beliefs and practices with the use of Western health services (Gilman, Justice, Saepharn & Charles, 1992).
B. Historical Experiences of the Cohort of Southeast Asian Elders

Until April 30, 1975, there were very few Vietnamese, Cambodian, Hmong or Laotians residing in the U.S. The fall of Saigon dramatically changed the landscape of the Asian American population forever. It is important for health providers to know something of the events the cohort of elders they care for are likely to have experienced.

1. Vietnamese. Over 130,000 Vietnamese left the country in 1975 in the final days of the war, half of whom were evacuated by the U.S. military. These Vietnamese military, government officials, and U.S. employees were considered high risk for imprisonment. Starting in 1977, large waves of Vietnamese refugees were created by policies pursued by the Communist revolutionary government. In late 1978, Malaysia started preventing Vietnamese boat people from landing, or if they landed were towed back out to sea. Refugee drownings and horror stories of pirate attacks created an international outcry that set the United Nation's refugee policy for the next decade. By the end of 1978, about 62,000 boat people were in refugee camps across nine countries in Southeast and East Asia. In July 1979, the United Nations established a multilateral program to help Indochinese refugees and displaced persons around the world. Vietnam cracked down on illegal departures starting in July of 1979 that reduced fleeing of boat people from 54,941 to 9,734 two months later.

The U.S. the Refugee Act of 1980 (i.e., Immigration and Nationality Act, section 207) dealt with the ongoing problems of Vietnamese boat people and other Indochinese in need of resettlement. More than 80,000 Amerasian children and accompanying family members were admitted to the U.S. through the Amerasian Homecoming Act of 1987. By late 1980s, most of the resettlement countries resettled top priority applicants. The U.S. resettled some 4,600 former U.S. government employees and another 165,000 former reeducation camp detainees and their immediate family members. After the Southeast Asian refugees of the 1970's became naturalized citizens, many petitioned for immigration of their eligible family members, including many older parents who continue to come to the U.S. as "followers of children."

Many people leaving Vietnam in the late 1980s came to the U.S. under approved immigrant petitions for admittance to this country. The United Nations sponsored a conference to establish agreements among 70 countries, known as the Comprehensive Plan of Action for Indochinese Refugees in June of 1989 to deal with the 100,000 Vietnamese boat people in camps throughout Southeast Asian and Hong Kong. In 1989, 70,000 Vietnamese boat people left Vietnam. This international policy reduced the number of disorderly refugee flights from Southeast Asia. When the Comprehensive Plan of Action for Indochinese Refugees ended in June, 1996, the Vietnamese in refugee camps throughout Southeast Asia were either approved for resettlement or given incentives to return voluntarily to
Vietnam. By 1999, about 1.75 million Vietnamese had left Vietnam and been resettled. In 2000, the U.S. included East Asian refugees in its annual refugee resettlement ceilings of 8,000 each year.

The Welfare Reform Act of 1996 created a lot of confusion and stress among the elderly Southeast Asian immigrants who were caught in this reform frenzy. Many of these Southeast Asian elders were already in poverty and had no resources with which to support themselves when welfare funds were withheld. [See Asian and Pacific Islander Health Forum (www.apiahf.org) and other websites for more information.] Several congressional remedies were enacted to address elimination of welfare and SSI support for some elderly immigrants and refugees groups. (See Social Security Administration site or www.apiahf.org/new_featured/ssi.html for more details.)

B. Hmong

The Hmong tribes had lived in the mountainous areas of China and then Laos for centuries before the outbreak of the Vietnam War. Hmong men were recruited to fight for the U.S. and became a dependable and important part of the fight against North Vietnam, incurring massive casualties. When Laos and Vietnam fell to the communists, a few Hmong officers and their families were flown to Thailand to safety, but an estimated 150,000 were forced to make the trek by foot pursued by communist soldiers. Many children and adults died or were killed before reaching the refugee campus. Some were captured and imprisoned and sent to "reeducation" camps. After sometimes years in overcrowded refugee campus in Thailand, thousands of Hmong were given refugee status and transported to the U.S. and other countries such as France, Canada, Australia, and Argentina in the late 1970s and 1980s. Because they had maintained a relatively isolated and very self-sufficient lifestyle based primarily on agriculture in rural mountainous areas, most knew nothing about urban living such as indoor toilets, kitchen appliances, or supermarkets. Their transition to the U.S. urban culture was very abrupt and traumatic. Families were traditionally very large, and some had been polygamous, so the resettlement meant that family members were often separated from loved ones. Because their language had been primarily oral rather than written, the transition to a culture based on written words made the acculturation even more difficult. For an excellent description of experiences of this population, see Fadiman, (1997).

The Hmong Veterans' Naturalization Act of 2000 eased naturalization requirements for eligible former spouses of deceased Hmong veterans who supported U.S. military during the Southeast Asian conflict.
IV. Culturally Appropriate Geriatric Care: Assessment

A. Use of Interpreters

A key component of cultural competence is linguistic competence. It is defined by the Office for Civil Rights in the U.S. Department of Health and Human Services (1999) as the "skills to communicate effectively in the native language, or dialect of the targeted population, taking into account general educational level, literacy and language preferences". The director of the Office of Civil Rights, Tom Perez, issued a guidance memorandum entitled "Title VI Prohibition against national origin discrimination--persons with limited-English proficiency" (www.hhs.gov/ocr/lep/). Poor practices include: use of family or friends as interpreters—especially children; use of untrained bilingual staff like janitors or secretaries or community volunteers; telephone interpretation; non-certified/untrained contracted interpreters; limited or low quality written materials in relevant languages or inappropriate literacy levels of translated materials. More details can be found at the web sites www.healthlaw.org and www.diversityrx.org. Jackson (1998) argues that the long term savings in financial and human costs are enormous in spite of short term costs since adequately trained interpreters can lessen common issues that arise during bilingual clinical encounters such as bad paraphrasing, impatience, lack of linguistic equivalence, interpreter beliefs, ethnocentrism and role conflicts. Medical interpretation is a civil rights issue and can be economically justified by improvement of long term health outcomes. See www.diversityrx.org for medical interpretation resources. It is very important to provide cultural and linguistic competence in aging services because more Southeast Asian elders are non-English or limited English speaking in comparison to younger Southeast Asians.

(See Section on use of interpreters in Module IV of the Core Curriculum in Ethnogeriatrics for a comparison of different modes of providing medical interpretation).

B. Standardized Measures

Research to ensure that assessment and measurement tools are culturally competent for the Southeast Asian population is just beginning. There are, however, several well established and validated translated instruments for depression:

- Vietnamese Depression Scale (Buchwald, Manson, Dinges, Keane, & Kinzie, 1993);
- Hmong Adaptation of Beck Depression Inventory (Mouanoutoua, Brown, Capelletty & Levine, 1991); and

An acculturation scale for Southeast Asians was developed by Anderson, et al., (1993). This 13 item acculturation scale included two subscales: proficiency in languages; and
language, social and food preferences. Marino, Stuart, & Minas (2000) argued that there was a degree of independence between psychological acculturation such as self identity, (the majority of acculturation instruments fall into this category) versus behavioral acculturation. In addition, most acculturation measures are heavily weighted towards English language acculturation.

C. Translation of Assessment Instruments

The science of cross-cultural equivalence of assessment tools has just begun to examine cross-cultural equivalence in translated psychological instruments among college and young adult samples. Unfortunately, very little of this preliminary research has been conducted with non-English speaking elderly. For example, Devins, Beiser, Dion, Pelletier, and Edwards (1997) examined the psychometric equivalence of Cantonese, Vietnamese and Laotian translations of the Affect Balance Scale. They found that confirmatory factor analyses indicated a good fit between the hypothesized positive and negative affect factor model. However, there was small percentage of people over 56 years of age in the sample [i.e., 1% (4) Vietnamese individuals, 3.6% (7) Laotians, and 8.5% (64) Cantonese speaking subjects].

A certain translation protocol is suggested by cross-cultural researchers (Brislin, Lonner & Thorndike, 1973). This process includes translating the instrument from English to the target language, then a new group of translators would translate the document back into English. Discrepancies between the original English version and the back-translations are resolved by consensus and clarification to produce conceptual equivalence. The caveat is that even under ideal circumstances, a translated/back translated instrument may be unable to assess concepts that have no conceptual equivalence or are culturally bound concepts (Dunnigan, McNall, Mortimer, 1993).

D. Other Issues in Assessment

For information on eliciting elders’ perception of their conditions, sometimes called “explanatory models of illness” and issues in the domains of clinical assessment, see Module IV of the Core Curriculum in Ethnogeriatrics.

Because the use of herbal remedies is widespread among traditional Southeast Asian elders, one issue that could be kept in mind is the possibility that a few of herbal remedies may contain strychnine or other harmful substances (Katz, Prescott & Woolf, 1996).
V. Culturally Appropriate Geriatric Care: Treatment Issues

Culturally competent primary health care goes beyond mere medical interpretation to hiring bilingual/bicultural outreach staff to provide case management, follow-up care and education of health professionals (Jackson-Carrol, Graham & Jackson, 1996).

A. Health Promotion

Significant increases in maintaining or adopting healthy behaviors (physical activity, nutrition, elimination of smoking, stress management), with regular preventive physician visits and screening could substantially improve the health of Southeast Asians. Smoking cessation campaigns for Southeast Asian males (i.e., 72% Laotians, 35% to 42% Vietnamese, and 29% Hmong smoke) can lessen the burden of lung and other cancers, asthma, and other respiratory conditions among all Southeast Asian family members through exposure by passive smoking, and eliminate smoking role models for younger members. It appears that acculturation and adoption of unhealthy American lifestyle habits and rejection of healthy traditional habits may be damaging the health of Southeast Asian elderly (Yee, 1999b).

A particularly important emphasis for screening needs to be Pap smears for cervical cancer, given the high risk for Southeast Asian women. Based on findings on utilization (see Section VI below), recommendations include having a female provider, spending time to establish rapport prior to health education, support groups to discuss women’s health issues, and explaining the rationale for importance of screenings and procedures and equipment involved. It seems important that female physicians/health professionals carry out exams and explain the results.

Authors have suggested that incorporation of Buddhist values and concepts into health promotion and intervention programs might increase the acceptability and impact of those programs (Barrett, 1997; Loue, Lane, Lloyd & Loh, 1999).

B. Medication

Pham, Rosenthal & Diamond (1999) found that Vietnamese believed Western medicine to be “stronger, faster, and curative” while folk medicine is “weaker, slower, but preventive”. These beliefs have major implications for adherence to medical regimens by Southeast Asian elders. Decreasing drug doses is a cultural response to their perceptions about these Western medications. To the degree that this is systematically done by older Vietnamese and other Southeast Asian patients, some medications may not be effective.
Rationales provided by Cambodian patients for not adhering to the medical schedule and
dosing requirements as prescribed by their physicians were: misunderstandings about what
the medication was for; its side effects; concerns about the powerful effects of Western
medicines; and Cambodian beliefs about pharmacokinetics (e.g., the belief that strong
stomach reactions would be produced when two medicines are taken simultaneously
(Shimada, Jackson, Goldstein, & Buchwald, 1995).

The issue of Southeast Asian ethnicity and pharmacology needs to be explored (Lin, Poland
& Nagasaki, 1993). Cross-ethnic differences in response to therapeutic agents have been
found, but specific differences among Southeast Asian populations were not explored.

C. Working with Families

Gender and age roles are important in adaptation to aging by Southeast Asian immigrants.
The Southeast Asian gender and age roles expressed in families and in the larger
community vary by acculturation levels (Yee, 1999a). These age and gender roles may
influence family decision making.

Medical decision making and intergenerational relationships vary greatly across the
Southeast Asian communities. (Yee, Huang, & Lew, 1998). Providing orientation to the
health care system and elder care services (e.g., Alzheimer’s respite, SSI, Medicare,
Medicaid), health education, and health promotion to the entire Southeast Asian family
would enhance utilization of these services for the elderly. More acculturated members
of the Southeast Asian families can traverse the complicated health care system and be
very effective advocates for their elderly relatives. The Southeast Asian elders are paid
great deference because they are titular heads of families. However more acculturated
family members will be the conduit to utilization of services by elderly family members.
Family interventions enhance the effectiveness of individually targeted interventions.

D. End-of-life Issues with Southeast Asian Families

Cultural issues abound in health care and end-of-life decision making. Typically elders are
more traditional. Braun, Pietsch & Blanchette (2000) argued that culture influences a wide
variety of death and dying attitudes and medical decisions. Southeast Asian families have
been influenced by their religious and cultural philosophies, such as Buddhist beliefs
surrounding karma and reincarnation with concern for ancestral spirits. These beliefs may
lead to an avoidance of hospitals where souls of people who died may not have a place to
rest and can create havoc upon the living. Delayed medical attention may be the result of
this avoidance of hospitals where lost souls may gather.
Organ donation would be less likely because donors would be reborn incompletely without all their vital organs in the next life. Decisions to donate organs of dying elders by family members may be viewed as a sign of disrespect and as lacking in filial piety towards the family elder/ancestor (Nakasone, 2000). This unfilial behavior may anger the family ancestor who may create mischief for the living. However, the willingness to be a live or after-death donor of organs and tissues may be increasing, especially for close relatives or friends, with the approval by other family members (Hai, et al., 1999). These authors also found that Vietnamese would be more willing to donate organs and tissue if medical care was provided to the donor’s family or if there were monetary rewards for such donations.

Heroic medical interventions, such as organ transplants or cardiac resuscitation, with hospital strangers surrounding the dying person, may be regarded as disturbing the natural ebb of life and a sign of a "Bad death" with a great deal of negative emotions. Withdrawal of life supports may be viewed by Southeast Asians as causing or speeding the demise of their family elder. Palliative care with its comforting, peaceful, and family supportive dimensions may be more acceptable for Buddhists and other Southeast Asians. Many Vietnamese have been influenced by Catholic, Taoist and Buddhist beliefs regarding life and death (Ta and Chung, 1990). For instance, Vietnamese women may not want the dying person to be told that he/she was dying (Calhoun, 1985). There are cultural differences in death and dying truth telling (Crow, Matheson & Steed, 2000; Muller & Desmond, 1992). Many Southeast Asian families do not want or allow the physician to inform dying family members of their terminal prognosis because it would cause them to lose hope. Some do not want to upset the loved one, others don’t want to because this may bring death sooner, or truth telling about dying may show a lack of respect for the soon-to-be ancestor.

The issue of advanced directives among Southeast Asian elders needs to be examined. Vaughn, Kiyasu & McCormick (2000) found that the majority of Chinese, Japanese, Korean, Filipino and Southeast Asian nursing home residents were listed as "no code" on their resident charts. Age and higher comorbidity was related to having no code indicated on their resident charts.
VI. Access and Utilization

Southeast Asians appear to access health care services to a lesser degree than their Caucasian or English speaking counterparts. For instance, Kuo and Porter (1997) found in the 1992-1994 Health Interview Survey that, in spite of fair or poor health self reports, the Vietnamese respondents did not see a physician as often as Caucasians. There were a greater number of Vietnamese who knew nothing or very little about diseases such as AIDS (Kuo and Porter, 1997) or cervical cancer (Schulmeister & Lifsey, 1999; Yee, 1997) and preventive behaviors/tests such as Pap smears. For instance, Jenkins, McPhee, Bird, and Bonilla (1990) found that health knowledge regarding cancer risks, unhealthy lifestyle behaviors, and cancer prevention practices need to be improved among the Vietnamese. The Association of Asian Pacific Community Health Organizations (1996) spelled out recommendations for providing health services in API communities. The most common reason for lack of health care access is the lack of linguistically and culturally competent health services. According to Cox (1986) a unique predictor of physician use among Vietnamese elderly was satisfaction with their medical care, a finding that was not found among Portuguese or Hispanic elders.

Health beliefs and misconceptions of disease and illness may impede recognition of early warning signs and delay access to medical treatment. For instance, newly arrived Vietnamese felt that tuberculosis was an infectious lung disease with cough, weakness and weight loss as symptoms (Carey, et al., 1997). Hard manual labor, smoking, alcohol consumptions and poor nutrition were believed to be risk factors. Many Vietnamese respondents incorrectly believed that asymptomatic latent TB infection was not possible and that TB infection always leads to disease. Nearly all respondents in this study felt that having TB would adversely impact their work, family and relationships, and community activities. Focus groups conducted in Vietnam found that four types of tuberculosis were identified (Long, Johansson, Diwan & Winkvist, 1999): 1)Lao truyen or inherited TB that was handed down from older generations to younger through family blood; 2) Lao luc or physical TB caused by hard work with more of the men affected; 3) Lao tam or mental TB that is caused by too much worrying with more women being affected by this type; and 4) Lao phoi or lung TB that is dangerous and caused by the TB germs by transmission through the respiratory system with men more affected by this TB. These traditional TB beliefs contribute to long delays in TB diagnosis, increased social stigma, and social isolation due to erroneous beliefs in transmission routes.

The Commonwealth Fund (1995) conducted a national survey comparing the health experiences of 1,048 African Americans, 1,001 Hispanic, 205 Chinese, 201 Korean, 201 Vietnamese and 1,114 white adults in the U.S. This study found that Hispanic and Chinese, Korean and Vietnamese adults said lack of insurance, health care costs, not having a regular doctor, and less satisfaction with health care services were associated with less care. Compared to 25% of white adults, 47% of the Vietnamese group who had visited the
doctor in the last year did not receive preventive care services such as blood pressure tests, Pap smears or cholesterol. Lack and lapse of insurance were bigger problems for minority Americans and was associated with consequences, such as not taking expensive medicines, or not taking or delaying needed medical tests. Southeast Asians feared using medical services during welfare reform because of potential threat of being deported. Minority adults also had little or no choices in where they obtained health care, a condition particularly acute among Asian and Hispanic Americans. Barriers to care were high costs of health care, long waits, poor access to specialty care with language and cultural barriers. Ethnic minorities were less likely to be satisfied with their care. Vietnamese, Mexican and Puerto Rican adults received less preventive care such as blood pressure tests, Pap smears, or cholesterol readings, compared to their white counterparts.

Southeast Asian women participate in health screening less than their American counterparts (Phipps, Cohen, Sorn and Braitman (1999). The Vietnamese and Cambodian women had poor cancer knowledge and were unable to identify cancer prevention strategies. Greater knowledge was associated with employment outside the home, more years of education, and age, but not with length of time in the United States. This study implies that limited English-speaking and traditional Southeast Asian women are not exposed to cancer information that appears in the English media and society. Lesjack, Hua and Ward (1999) found that female practitioners, free screening, and more health information improved recruitment of Vietnamese women for cervical cancer screening.

Schulmeister and Lifsey (1999) found that Vietnamese women believed that their risk of cervical cancer was low. Barriers to screening were not having a gynecologist, cost and fear of the test. Other studies found the significant barriers for breast and cervical cancer screening among Southeast Asian women were: embarrassment and shyness during the physical examination in a well woman’s checkup; cultural barriers concerning being touched by a stranger and a male physician; a belief that cancer cannot be treated; and a fear of large medical facilities and the equipment such as used in mammography (Kelley, et al., 1996; Mahlock, et al., 1999; Tu, et al., 2000; Yi, & Prows, 1996). It appears that successful programs that serve the needs of Southeast Asian elders include the following characteristics: 1) use of cultural lay health worker/interpreters, peer health educators, and family/community interventions to bridge language and cultural gaps; 2) decrease of cultural health barriers such fear of surgery and preference for female physicians to conduct health examination or improvement of health knowledge for chronic disease conditions and preventive health strategies by ethnic specific videos or health fairs; 3) use of after hours access, community based and “one stop” integrated services (e.g., medical, mental health, social services); 4) decrease of financial and medical coverage barriers and logistical barriers such as transportation; 5) significant improvements in health education targeted at Southeast Asian consumers (Cory, 1995; Free, White, Shipman & Dale, 1999; Lesjak, Hua & Ward, 1999; Mahlock, et al., 1999; Nelson, Bui & Samet, 1997; Pham, Rosenthal & Diamond, 1999; Siganga & Huynh, 1997; Stuer, 1998).
INSTRUCTIONAL STRATEGIES

Case Studies

Case of Mr. N.

Mr. N. is a 71 year old Vietnamese former lieutenant colonel who was imprisoned for 12 years by the Socialist Republic of Vietnam. He was physically and emotionally tortured with stories of family members being killed or imprisoned in other re-education camps. Mr. N. felt lucky to be alive since 165,000 people died in Vietnam’s re-education camps since 1975. He came to U.S. in 1989 and had nightmares every night for the first couple of years. He feels estranged from his family since he was imprisoned for 12 years and his family became American strangers to him. His doctor said that he suffered from Post-Traumatic Stress Syndrome from his long imprisonment and torture. Now he has nightmares only when he feels stressed out. He deals with this stress by smoking 4 packs of cigarettes a day and drinking beer. He has a hoarse cough and sometimes coughs up blood. His family brought him to see a physician because his herbal medicines did not work on his cough anymore and he cannot get to sleep at night.

Case of Mrs. K.

Mrs. K. is a 76 year old Cambodian woman who has seen a physician twice since coming to the United States in 1978. She had tuberculosis in 1978 and was successfully treated for TB at the County Health Clinic. Mrs. K. has not seen a physician since 1979. She is brought in to see a male physician at the County Health Clinics with complaints of severe headaches with dizziness, accompanied by her English speaking son who provides the English translation during the medical visit. The physician notes that its difficult to figure out what the problems may be. Notes indicate that she talks about “thinking too much” about how many relatives she lost under Pol Pot and the Khmer Rouge. Her medical records are incomplete and include only a history of her TB treatment. Mrs. K. is embarrassed to tell the male doctors, via her son, about some vaginal blood she noticed over the last 6 months. She believes that she is now “polluted again”. She stopped menstruating about 20 years ago. She has never had a well woman check up. In her physical exam, the physician noted that Mrs. K. had dark stained teeth and appears to have oral lesions in her mouth.
**Case of Mrs. V.**

Mrs. V is 62 year old wife of a Hmong war veteran who helped the CIA during the Vietnam war. They have been on welfare since coming to the United States, but were dropped from the welfare rolls during welfare reform. Mr. V. was a chain smoker and recently died from lung cancer. He provided the only financial source of support for Mrs. V. While Mr. V. was being treated for his cancer in the hospital, the nurses wanted Mrs. V. to sign some Advanced Directives papers she couldn’t read. Mrs. V. did not come to see her husband everyday. Her children claim that she didn’t want to because there are many lost souls at the hospital, and they might create problems for her. After a week, Mrs. V. brought someone from the Hmong mutual aid society to help with the translations. The translator provided the translation to Mrs. V. about the advanced directive. She still didn’t understand, but signed anyway. One day, Mrs. V. came to visit her husband, and the doctors and nurses were pounding upon Mr. Vang chest to resuscitate him. Mr. V. died, and Mrs. V. considered this to be a “bad death”. Mrs. V. said that Mr. V. may be angry with her because he died in a violent way. Mrs. V. complains to her children that she has terrible headaches and backaches since this happened. The physicians advise her to make ibuprofen to relieve pains. Mrs. V. says that these medicines have not worked because the ancestor spirit of Mr. V. was creating an illness in her head and back by removing these two body souls. She sees a spiritual medium to do the ceremonies to appease Mr. V.’s angered ancestor spirit.

**Questions for Discussion or Written Assignment**

For one or all of the cases above, consider the following questions.

1. What would a health provider's problem list include for the cases above?

2. How could an understanding of the cultural health beliefs and/or cohort experiences assist the health care provider in giving effective care?

3. What kind of treatment, management, or referrals might the health care provider consider?
STUDENT EVALUATION

Essay Questions:

1. The large majority of Southeast Asian elders were refugees fleeing Southeast Asia after the Fall of Saigon in 1975. How would the refugee experience influence their adaptation and aging in the U.S.?

2. While the majority of Southeast Asians share the refugee experience, what differences should be noted between Vietnamese, Cambodian, Hmong and Laotian populations that may lead to varying degrees of adaptive aging?

3. What are the major health threats for Southeast Asian elders?

4. What are some cultural health beliefs and lifestyle practices of Southeast Asian elders? How would they influence access and utilization of health services?

5. What are some strategies to improve the cultural competence of our geriatric services for Southeast Asian elders?

6. What are some best practice guidelines for use of language translators?

7. What are some key issues to consider when using assessment tools to evaluate Southeast Asian elders?

8. What are some end-of-life issues for Southeast Asian elders and their families?

9. What are some important issues to consider in developing a screening program for cervical cancer for older Southeast Asian women?
REFERENCES AND RESOURCES

REFERENCES


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**ADDITIONAL READINGS**


INTERNET RESOURCES