

**“IS IT THE SPIRIT OR THE BODY?”:  
SYNCRETISM OF HEALTH BELIEFS AMONG  
HMONG IMMIGRANTS TO ALASKA**

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*Because of the emphasis within the Hmong folk health system on spirituality and nonphysiological etiologies, there has been a significant degree of conflict between Hmong refugees and the Western health care system since the beginning of the Hmong migration to the United States in the mid-1970s. This conflict has been well documented in the literature, but previous research on Hmong health has tended toward a totalization of Hmong health beliefs to emphasize its distinctness from Western biomedicine and subsequently advocate culturally sensitive health care. In doing so, however, researchers have overlooked the burgeoning syncretism of health beliefs among Hmong in the United States. The present study seeks to explain how and why the Hmong health system in Alaska is developing into a syncretism of the folk beliefs and elements from the Western biomedical paradigm. This syncretism has led to an intricate system of combined physical and spiritual diagnoses that significantly affects the way health care decisions are made within the Hmong community. Alaskan Hmong use contextual factors (regularity, longevity, and spiritual manifestations) as well as the course of traditional and biomedical treatments to assign and reassign spiritual or biomedical root causes to ailments. As this argument unfolds, I also address the use of “syncretism” as a theoretical construct and ultimately argue that it is the most useful concept for understanding changing health beliefs among the Hmong in Alaska, despite the pejorative historical use of the term. Understanding health seeking behaviors through a syncretic paradigm, health care professionals and anthropologists can better account for the multifaceted treatment paradigms that Hmong seek as well as account for changes between traditional and biomedical treatment regimes. Key Words: Hmong, folk health, syncretism, medicalization, hybridity*

America’s “secret war” in Laos during the late 1960s and early 1970s displaced hundreds of thousands of Hmong refugees who would, after years in Thai refugee camps, eventually resettle in various Western and Latin American countries following the communist takeover of Indochina in 1975 (for a summary of the conflict, see Robbins 1987). Even as recently as the summer of 2004, the United States granted resettlement to up to 15,000 Hmong who had been living in Wat Tham Krabok, a refugee community in Thailand, since the end of the war in Laos. By the end of this most recent program, a total of

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approximately 145,000 Hmong will have been officially resettled in the United States alone (Pam Lewis, program officer at the Bureau of Population, Refugees, and Migration at the U.S. State Department, personal communication, May 14, 2004).

In a short number of years, Hmong refugees have been displaced from their mountainous farming communities in the highlands of Laos and resettled in inner-city U.S. neighborhoods, representing perhaps the most drastic ecological and sociopolitical changes a group could undergo in such a short period of time. Consequently, they have gone from having little or no contact with Western customs to being immersed in and forced to live through a Western paradigm. Some Hmong portray this experience as progress while many others emphasize the difficulties of living in the United States and long for the time when they can return to their mountain homes in Laos and to their former way of life.

One of the most difficult aspects of displacement and resettlement for the Hmong has concerned health practices and beliefs. In their villages in Laos, the Hmong were familiar with the local spirits, had free access to shamans who were not politically limited in their curing techniques, and were not subject to an alternative, hegemonic view of health and illness such as that experienced by many Hmong in the United States. Some of the literature suggests that the Hmong, previous to intervention by American and Pathet Lao military forces, were not deeply affected by Western biomedicine merely because of the distance from their villages to the cities. While some contact was inevitable (e.g., missionization), major influences in areas such as health care were not rampant except in those communities where residents converted wholesale to Christianity and rejected the former worldview (see Beghtol 1988:12; Capps 1994:164). Thus, traditional Hmong health beliefs in Laos did not entertain many biomedical explanations for illness—the Hmong were not indoctrinated with the *Gospel of Germs* (Tomes 1998).

Having been uprooted and relocated, however, the Hmong health system has been directly challenged and influenced by Western medical practices, and many traditional practices have been questioned by the U.S. citizenry (particularly regarding animal sacrifice) and government agencies. The resulting confrontation between doctors, U.S. citizens living in communities with large Hmong populations, and the Hmong themselves have been well documented in the literature (e.g., Beghtol 1988; Cha 2003; Deinard and Dunnigan 1987; Fadiman 1997; Johnson 2002). However, as the Hmong have interacted with health care and political systems in Western countries, they have also begun to adopt aspects of Western biomedicine and scientific rationalism. This syncretism of health beliefs has been mentioned only briefly in some research on Hmong health beliefs and has gone largely untreated as to its nature, extent, and prevalence.

The present study seeks first to document how a group of Hmong refugees living in Anchorage, Alaska have integrated various Western concepts, diagnoses, and rationale with their traditional health system.<sup>1</sup> Second, this study describes how syncretism bears heavily on the manner in which health care decisions are made and how the Hmong interpret interactions with both Western health care providers and traditional healers, including negative experiences. In the process of describing the syncretism, I seek to participate in recent efforts to recast syncretism as a useful theoretical construct and argue

that it is indeed the most analytically appropriate concept for understanding the nature of Hmong health beliefs in Alaska. Finally, I briefly describe how health care professionals can better understand Hmong health care seeking behaviors through this model and, consequently, facilitate better communication and treatment for Hmong communities.

### **THE HMONG AND WESTERN MEDICINE: A LITERATURE REVIEW**

The medical and anthropological literature is well developed in terms of documenting many of the traditional beliefs of the Hmong health system and their incongruence with the Western biomedical paradigm. Researchers have described a great number of case studies in which such cultural differences have led to legal, physical, cultural, and psychological problems in medical encounters. Much of this work totalizes Hmong health beliefs in an essentialist framework that juxtaposes Hmong against the Western medical health regime. The thrust of this body of work is most often to advocate culturally sensitive health care or relativize health beliefs through an exotic description of the Hmong worldview (most particularly Beghtol 1988; Fadiman 1997). Many researchers briefly mention the syncretism of Hmong and Western medical ideologies, but only in passing, as if it were a relatively infrequent or unimportant phenomenon. However, an understanding of the present syncretism offers essential insights into health care-seeking behaviors of the Hmong that would otherwise be overlooked.

One of the most commonly cited articles in the Hmong health literature is Xoua Thao's chapter in *The Hmong in Transition* (1986). Thao is both a member and student of the Hmong American community and cultural practice. His research was carried out in the context of the aftermath of the original migration of Hmong to the United States, and his work represents one of the founding studies. Thao's main objective is to describe traditional Hmong health practices, which he does primarily to inform medical practitioners of the most significant cultural differences. Mary Jo Beghtol (1988) seeks to further facilitate this intercultural understanding between U.S. doctors and Hmong patients. Her conclusions include the assertion that "the Hmong who enters the U.S. medical system often does so only when all traditional curing methods fail. At this point, the patient is usually extremely ill, sometimes critically" (1988:12). This suggests that Western health care is treated only as a last resort to the Hmong, which is an artifact of the essentialist framework and the exoticized construction of Hmong cultural practice that characterizes much of this literature. Adopting such an assumption in the present would negate the prevalent syncretism of Western and folk health ideology in the community and underestimate the extent to which many Hmong rely on Western health care as a primary resort.

Sharon Johnson's (2002) work represents a more recent treatise of similar matters. Once again, the focus is delineating the Hmong cosmology in an attempt to suggest ways that medical professionals can better accommodate the Hmong. Rebecca Henry (1999) explains the medical metaphors used by the Hmong in describing illness, particularly its etiological development. Henry delineates the differences between the symbolic

representations of illness held by Hmong and individuals in the United States. The Hmong do speak of the natural world when talking of measles, but they attribute volition and will to that world, unlike the Western medical paradigm that does not. This description reflects the spiritual nature of the traditional Hmong system, again delineating the differences and avoiding the syncretism. Both of these articles portray the Hmong system as static and mutually exclusive to the Western system.

Dia Cha (2003) and Lisa Capps (1994) deal most directly with medical syncretism in the Hmong community. They both do so mainly from an analysis of the way Christian indoctrination has led to the wholesale rejection of traditional Hmong cosmology. On the one hand, Cha also deals with non-Christian Hmong, and she even goes as far as to list some conditions that are better treated by doctors than by shamans and vice versa (Cha 2003:60). However, this syncretism is only briefly touched on in her book-length treatise of Hmong health and remains underdeveloped. Capps's (1994) study, on the other hand, dealt solely with Christianized Hmong. Consequently, her findings dealt primarily with the way Christian doctrine nullifies the perception of beliefs, such as "soul loss," as valid causes of illness. Unfortunately, Capps did not have a non-Christian Hmong population against which she could compare her findings because of the homogeneity of religious affiliation among the Christian Hmong group in Kansas City.

The present study deviates from the course of this literature in its emphasis on the actual integration of Western concepts in the health-related worldview of Hmong Americans. Members of the community in Anchorage, Alaska have merged aspects of both perspectives and have come to develop the necessary rationale for adopting seemingly contradictory philosophies. This elucidates how the Hmong are more holistic than typical adherents of the biomedical paradigm in their medical reasoning. They do not see their traditional health system as mutually exclusive to the Western biomedical paradigm, whereas many Westerners view the two systems as just so. To delineate the changes in the folk system, I begin by framing syncretism as a theoretical construct and subsequently proceed to outline the basic nature of traditional Hmong health practices and beliefs. Subsequently, I describe how diagnoses are made and how treatments are sought in the syncretized system.

#### **PROBLEMATIZING SYNCRETISM**

Syncretism has a variegated past as both an analytical construct and a pejorative term used to devalue "impure" forms of religious practice. While a comprehensive consideration of the problematic of syncretism is beyond the scope of this paper, I must clarify the sense in which I use the term in my analysis of Hmong health beliefs and practices (for a more complete review of the theoretical issues and etymology of syncretism, see the edited volumes by Stewart and Shaw 1994 and Leopold and Jensen 2005).

Ultimately, I hope to participate in the effort called for by Charles Stewart and Rosalind Shaw (1994) to recast syncretism as an analytically useful construct and reclaim it from its historically pejorative use. "Problems with syncretism do not seem to lie with

any substantive objections to the semantics of the term—since hardly anyone would deny that different religious traditions have amalgamated in the past, and continue to interact and borrow from each other today—but with the very word itself and its historical application” (Stewart and Shaw 1994:3). In fact, I will argue that syncretism—both semantically and analytically—is the most appropriate term and concept for understanding the ethnographic data I collected on Hmong health beliefs in Alaska. Consequently, I will proceed to build up syncretism as an analytically useful construct and defend it in the arena of changing Hmong health beliefs.

### **Pejorative History**

First, the most common critique of syncretism involves its pejorative historical use in (primarily) Christianity and Islam to describe impure forms of doctrine and practice. Stewart (2005), Stewart and Shaw (1994), Anita Maria Leopold and Jeppe Sinding Jensen (2005), and others (Magowan and Gordon 2001; van der Veer 1994) describe this involved history in detail. In summary, syncretism was largely used in various historical periods to critique the indigenization of Truth, invalidating religious forms such as Maya folk Catholicism. Robin Horton found, for example, that Western Christians perceived the localized uses of Christianity in Nigeria to be incoherent and even irrational. In other words, they did not see “their” belief system as one that could be intertwined with local beliefs in a syncretized manner. “From the point of view of the Western Christian, for whom Christian and traditional ideas are incompatible, any such combination naturally appears as ‘a welter of rationales.’ From the point of view of the person concerned, however, the combination may represent a perfectly coherent synthesis” (1971:99).

In utilizing syncretism to describe changes in health beliefs, I am avoiding any previous pejorative sense of the word. In fact, as Melville Herskovits (1937) has argued, the use of syncretism can actually empower subaltern agents who seek to reconcile their traditional beliefs and practices with the hegemonic system that seeks to assimilate them. Syncretism’s contradistinction with an “assimilationist” paradigm denotes agency and empowerment of those who choose to integrate two systems into a coherent set of practices and beliefs that are yet distinct from the hegemonic system. Thus, syncretism can be a valuable construct in analyses of agency and resistance.

### **Anti-syncretism and the Essentialist Critique**

Charles Stewart offers one of the viable definitions for syncretism in the study of religion: “the combination of elements from two or more different religious traditions within a specified frame” (2005:282). Stewart is an advocate of recasting syncretism as a useful theoretical construct and argues that it is not invalidated by postmodern critiques of essentialist conceptions of culture—another prominent argument that has been mobilized against the concept. Even under the assumption that all religious systems are dynamic, heterogeneous, and in constant flux, Stewart (2005) argues that syncretism can be useful in understanding these dynamic processes at any given moment. Stewart and Shaw

(1994) further address the antiessentialist critique of syncretism by arguing that the concept of authenticity is often inappropriately conflated with notions of purity. “‘Authenticity’ or ‘originality’ do not necessarily depend on purity. They are claimable as ‘uniqueness,’ and both pure and mixed traditions can be unique. What makes them ‘authentic’ and valuable is a separate issue, a discursive matter involving power, rhetoric, and persuasion” (1994:7). I agree with this view of syncretism and consider my analysis a snapshot of the state of Hmong health beliefs in Alaska without relying on any assumption that either the Hmong health system or its Western counterpart are static or even homogenous. Indeed,

Part of the complexity of religious synthesis is the fact that agents within a particular cosmology may hold opposing views on the integration and synchronisation of indigenous and exogenous ritual elements to the extent that they may profess some degree of cultural purity and authenticity in their belief forms. [Magowan and Gordon 2001:255]

The notion of “authenticity,” then, is one to be studied within the context of a syncretic system of beliefs, as opposed to an a priori logical requisite of the existence of syncretism. Further, understanding syncretism as a process (not an event) leads one to consider the dynamics involved as opposed to the static characteristics of the contributing or resulting ideologies or practices.

### **Conceptual Utility of Syncretism**

In response to these positions, I would agree that a loose description of syncretism as generalized change can leave much to be desired in its theoretical utility. “This can be seen as such a broad process that indeed every religion is syncretistic, since it constantly draws upon heterogeneous elements to the extent that it is often impossible for historians to unravel what comes from where” (van der Veer 1994:208). However, I would also argue that in particular contexts, such as the Hmong health practices within the context of a U.S. medical political economy, the study of the particularities of this syncretism can be extremely helpful in not only understanding what is drawn into the health practice and ideology but also the particular politics of health that lead to particular syncretisms (i.e., of particular beliefs or practices). A high level macroperspective can be useless and too complex, but microanalyses such as the present one, I contend, are far from being theoretically or even pragmatically inconsequential. Beyond van der Veer’s analysis of syncretism within particular religious discourses, then, I would add that contexts such as colonial rule (see Comaroff and Comaroff 1997 on hybridity in South Africa) or forced migration (in the case of the Hmong) can create particularly direct cultural collisions in which syncretism becomes theoretically meaningful. Perhaps in more casual cultural encounters (e.g., the study of diffusionism), the complexity of synthesis can be less interesting and less consequential.

I believe that the term *syncretism* more accurately denotes the process of change in a belief system. *Hybridity*, a competing term and concept mobilized by other theorists (e.g., Comaroff and Comaroff 1997), connotes a totalizing view of the “final product,” as

it were, whereas syncretism is more suggestive of constant flux. While some would argue that syncretism likewise leads to an essentialist view of the two (or more) traditions from which syncretic practices and ideologies are melded, I believe that this is more a matter of convention than logical necessity, as previously argued. A tradition need not be homogenous or monolithic to contribute to or influence another tradition. Further, the changing health beliefs of Hmong in Alaska can be most adequately described as a case of syncretism and not medical pluralism. My main support for this argument is found in the coherence with which Hmong seem to integrate the two systems in a holistic treatment paradigm. It does not appear to me that Western and folk medical practices are simply juxtaposed within the community, but that they are more fundamentally integrated to complement one another and treat different aspects of illness, which I describe in more detail below.

Therefore, I define syncretism for my present purpose thus: a dynamic aggregation of elements from two or more philosophically unique systems of belief or practice, which becomes generally accepted as an integrated and unitary (although not homogenous) system. The philosophical coherence of the resulting syncretism is essential to understanding the result as syncretism *per se*, as opposed to some form of pluralism. Additionally, this conceptualization must allow for the dynamic nature of the syncretic system: it is never finalized and remains in flux. I now turn to a richer description of the Hmong health beliefs and practice in Alaska, which I will analyze through this syncretic framework.

## **METHODS**

The empirical basis for this study consists of participant observation and qualitative data collected through in-depth interviews with 24 Hmong individuals living in Anchorage, Alaska. The participants came from several different clans, including Lis, Muas, Vaj, and Yaj.<sup>2</sup> I interviewed clan leaders, specialized traditional healers, a Hmong medical professional, a Hmong medical translator, and nonspecialized individuals. The large majority of participants in this research were middle aged adults who came to the United States in late adolescence or early adulthood. Participants' occupations ranged from manual labor to professional, and I would describe the socioeconomic status of all participants' families as either lower or lower middle class. Half of the interviewees were female and half were male, and some interviews were carried out with married couples while both partners contributed to the interview simultaneously. I cross-validated information among my sample of participants as I drew conclusions, using the saturation sampling and "sufficiency redundancy" technique described by Robert Trotter and Jean Schensul (1998:704). Additionally, I observed several healing rituals (performed by shaman and "magical" healers) and interviewed U.S. medical staff who frequently work with Hmong patients.

I must note here that the arguments put forth in this paper are likely specific to the generation of refugees whom I interviewed. It is possible, even probable, that younger generations have a much stronger sense of biomedical reasoning and exert a much less frequent mobilization of traditional healing rationale. Similarly, one might also hypothesize that an

older generation may experience less of a syncretism in health beliefs and may rely more heavily on traditional methods alone, but these remain unresolved empirical questions.

## **OVERVIEW OF TRADITIONAL HMONG CONCEPTS OF HEALTH AND HEALING**

The lack of a hierarchal, standardized structure of any type of religious belief or practice in Hmong society, reliance on oral tradition for learning such practices and beliefs, and the emergence of a transnational diaspora have undoubtedly led to geographical idiosyncrasies with regard to spiritual beliefs and healing practices (Cha 2003:136). Therefore, one must be careful in generalizing characteristics of one community to all Hmong. As a result, I do not intend the following description to be a homogenizing characterization of Hmong health practice everywhere, but merely to represent the salient traditional healing techniques described to me by practitioners and lay persons in the Alaskan Hmong community.

Even with regional and communal variations found in the intricacies of the Hmong worldview, typically only “old men” are expected to understand the system in great detail. Consequently, the most important considerations for the average Hmong person are the aspects of the worldview that are generally understood by most individuals as well as generally accepted as “Hmong.” In other words, idiosyncrasies in specialized practice are less important in a general analysis of the status of the folk health system because of the small sector of the population (old men, magical healers, and shamans) who maintain access to them. The average Hmong person only understands the generalities of the traditional system and is equally, if not more, exposed to modern U.S. medicine. Based on my interviews with both lay Hmong and specialized healers, I describe the more general traditional outlook of all interviewees and some of the more generalizable practices of traditional healing instead of dwelling on more nuanced and idiosyncratic beliefs.

### **Sickness through the Traditional Lens**

Animism is central to this generally accepted traditional Hmong worldview. Every person has a spirit or spirits, but the exact number varied by interviewee. The natural world consists of benevolent, malevolent, and ancestor spirits. The physical and spiritual welfare of the Hmong depends heavily on their relationships and interactions with these spirits. The spiritual root causes of illness traditionally reside in three causes: spirit loss, relationships with ancestor spirits, and interactions with menacing spirits.

First, one of the most common sources of spiritual and, consequently, physical problems concerns the loss of one’s *ntsuj plig* (soul). *Poob plig* (to lose one’s spirit or soul) most commonly results from extreme fright—such as from a car accident, as a result of offending a spirit in the environment, or from the mere malevolence of a *dab* (bad spirit) who holds the soul for ransom (*tim raug dab*). When the soul is lost or strays from the body, the victim will become physically sick.

Second, the status of one's ancestors, particularly recently deceased kin, is also intimately related to an individual's health. If one's parent or grandparent, for example, is wandering in the spiritual realm without food or money, one can become sick as a sign that the ancestors are in need of food offerings. This was described as "*cov poj koob yawm txwv yuav noj yuav haus*" (the ancestors want food and want drink). This problem can be ascertained when the sickness is accompanied by dreams in which the hungry or poor ancestor visits the sick person or is seen in a dream wandering without food or money. Alternatively, a shaman might diagnose this as the cause of the illness even in the absence of dreams or other spiritual manifestations.

Third, in addition to stealing a soul, malevolent spirits can also cause sickness from mere molestation (*raug dab*). In this case, the actual soul of the victim has not left the body, but the presence of the *dab* affects the victim, such as giving him or her a very painful headache because the sick person has offended the spirit or disrespectfully entered its domain. This is commonly described in English as "being possessed." These spirits can thus inflict physical sickness on people, but this condition is mutually exclusive from *poob plig* or *cov poj koob yawm txwv yuav noj yuav haus*, because of the differences in the spiritual causes of these conditions.

### Traditional Healing Practice

Hmong healing practice revolves around several central practices: *ua neeb* (the practice of shamanism), *khawv koob* (magical healing), *daws dab* and *xa dab* (untie or send away evil spirits), *fiv yeem* and *pauj yeem* (supplicating powerful spirits), *hu plig* (soul calling), and *tshuaj* (herbal medicine). These are qualitatively different techniques, some of which are preventative while others are curative.

*Ua neeb* is the central practice, and the term is also often used as a metonym to refer to the traditional healing system as a whole. *Ua neeb* in its specific sense is the Hmong practice of shamanism, which is performed by a *txiv neeb* (a shaman). There are as many brands of *ua neeb* as there are *txiv neeb*. This relates to the aforementioned lack of standardization and reliance on oral tradition, but also stems from the nature of *ua neeb* itself. To become a *txiv neeb*, one must first become seriously ill and find a cure through the help of another *txiv neeb* and tutelary spirit (*dab neeb*). A *txiv neeb* continues to learn the practice from an ancestor who is a *txiv neeb*, and the power skips one generation and is passed on only to a descendent of the same gender as the predecessor, according to a prominent shaman in the Anchorage community. Various practices will pass down certain lines, while other lines may teach different techniques. Additionally, the *txiv neeb* learns a large part of the practice from tutelary spirits who will accompany the shaman in his or her travels to the spiritual world during a shamanic performance. These factors inevitably lead to variability. These differences aside, however, I learned certain aspects of *ua neeb* from various interviewees, including several *txiv neeb* and respected elders, who described them as general principles on which *ua neeb* functions. This more generalizable philosophical basis provides the traditional baseline against which I juxtapose the present health syncretism of traditional and biomedical health rationales.<sup>3</sup>

*Ua neeb* is specifically selected as a method to cure *poob plig*, or soul loss. When the *txiv neeb* is called on to perform a healing ritual, he or she will enter into a trance-state in which one chants in a spirit language that is not always intelligible with vernacular Hmong. During this trance, the *txiv neeb* is communicating with a *dab neeb* (the tutelary spirit) as it retraces the footsteps of the lost soul of the victim. In doing so, the *dab neeb* encounters various spirits with whom the *txiv neeb* talks, both to gain information on the lost soul and to negotiate its recovery from the evil spirit that has taken it away from the sick person. The ultimate objective is to find out what happened to the soul of the sick person and devise a means of returning the soul to the victim's body.

There are typically two phases of the *ua neeb* ceremony. The first is diagnostic and is referred to as *ua neeb saib* ("to do spirit rites and see;" translation by Heimbach 1980:137). The *txiv neeb* is seeking to make deals with spirits and entice them to return the lost soul. After this stage, the family and the sick person wait to see if health is restored. If it is, then a second phase must be performed, the *ua neeb kho* (to do spirit rites to fix the problem). During this ceremony the *txiv neeb* pays the ransom promised to the spirits, which typically consist of the sacrifice of a pig, some chickens, fake money, or a combination of these. Should the victim not recover, the family does not carry out the ransom payment ritual (*ua neeb kho*) and will likely seek out a different *txiv neeb* and start the process over.

As opposed to *ua neeb*, one does not need a special calling such as that endowed on a *txiv neeb* to master *khawv koob*, a supplementary healing method with its own techniques. Anyone who wishes can learn it from an established *khawv koob* practitioner. Bilingual Hmong often translate *khawv koob* as "magic," although it is not parallel to the Western conception of magic. *Khawv koob* is a mystically naturalistic method of communication (using the same spirit language as the *txiv neeb*) and healing in which the practitioner chants or speaks magical formulas on the sick person's body to effect the cure. There are no spirits involved. For example, *khawv koob* is widely believed to fix broken bones much quicker than the cast that one might get at a hospital. A *khawv koob* practitioner explained to me that if one says the right formula into a bowl of water and uses the water to wash over the area with the broken bones, for example, the latter will work themselves back together and can heal in as quickly as seven days.

*Daws dab* (to untie an evil spirit) and *xa dab* (to send away an evil spirit) are related practices in that one does not have to be called as a shaman is to learn the techniques. In essence, *daws dab* and *xa dab* consist of various methods designed to chase away (through either negotiation or intimidation) any malevolent spirit that is thought to possess or inflict sickness on an individual. In extreme cases of spiritual molestation or possession, *ua neeb* can also be performed.

*Fiv yeem* is a preventative method of spiritual contract in which various spirits or ancestors are promised certain dues in the form of animal or monetary offerings in exchange for services, such as protection. Again, any knowledgeable person can perform *fiv yeem*. Once the services are rendered (e.g., a person is protected during a surgery and recovers well or a student passes her exams), then the responsible party must follow up with *pauj yeem* (the sacrificial debt payment). *Fiv yeem* sets the terms of the agreement while *pauj yeem* settles them.



Figure 1. Causes and treatments of illness under the traditional Hmong folk health system

*Hu plig* (soul calling) is also a very common healing technique. Once again, any one who knows the method can perform a *hu plig*, but *txiv neeb* often perform it as well. I observed *hu plig* performed as a preventative measure at several happy occasions, including a one-month birthday celebration and a graduation, but interviewees also describe it as a healing method. This is typically the preliminary curing technique for *poob plig*, or soul loss (described earlier). During the *hu plig* ceremony, the soul caller may go to the spot where the soul was thought to be lost and try to retrieve it. If the soul caller finds it, then the soul is brought home and a *hu plig* is performed to welcome it home and invite it back into the body of the sick person. If the soul can be retrieved easily, *hu plig* will suffice, while in more complicated situations a *txiv neeb* must solve the problem through *ua neeb*.

Finally, the Hmong also use herbal remedies (*tshuaj*) to cure certain ailments. These remedies are usually used for stomach problems and typically involve roots and plants that were common in the mountains of Laos. Families still order them from Laos, but one must know how to cook the medicine properly to obtain the desired effect. *Kws tshuaj* (herbalists) are still practicing and are typically female (Thao 1986:366), but I never met or interviewed one during my fieldwork. *Kws tshuaj* also use Chinese herbs, and many Hmong consult Chinese herbalists. Interviewees indicated that neither brand of herbalism was superior, but both are used for different sicknesses. Additionally, the Hmong have adopted many other homeopathic practices, such as Chinese cupping. The mother and father of the family with whom I stayed during my fieldwork were sought out often to perform cupping on sick Hmong throughout the community because they received specialized training on the technique in California. Figure 1 above summarizes the main types of health issues in the traditional system along with the most common treatments, as described by participants.

#### “TUS DAB UA” AND “LUB CEV UA XWB”: HEALTH SYNCRETISM

This description of health practices serves as a traditional baseline against which I compare changes in the health beliefs of Hmong refugees in Alaska. Beghtol (1988:12) and Capps (1994:164) speak of the sudden shift from very little contact with Western medicine

before the Vietnam War—era to immersion in Western influences that the Hmong refugees experienced during resettlement in the United States. The previous lack of access to Western medicine made the traditional healing system extremely important. One female interviewee stated:

There is a lot of things that Hmong believe that like sometimes, . . . when we live in Laos, and we don't have a doctor, and all we have is *ua neeb*, and natural herbs medicine, and they don't have any doctors to tell them what is wrong with them, so they just *ua neeb* and use their own medicine.

In support of Beghtol's and Capp's assertions, many interviewees indicated that they did not believe in biomedical causes in Laos specifically because biomedicine was not available. While other types of naturalistic (i.e., nonspiritual) explanations were present, such as “the shifting of the man–nature relationship” and “the equilibrium of men and nature” (Thao 1986:370–371) nothing akin to a pathophysiological explanation was present in the traditional scheme. According to these sources, Western medical practice and biomedical rationales were completely novel to many Hmong who resettled in Thai refugee camps and subsequently migrated to the United States. Other Hmong scholars argue that Western medical influence among the Hmong in Laos stretches back to the 1950s (Gary Yia Lee, personal communication, January 2006).

Many Americans expect the Hmong, on migration, to abandon their traditional system in favor of the “more advanced” scientific medicine available in the United States, but this is clearly not the case. As they came into contact—often forcefully—with Western medical practice in the refugee camps in Laos and Thailand in the 1970s and subsequently in the United States, the Hmong have developed an integrated health system that relies heavily on the traditional cosmology and incorporates Western explanations for some sicknesses. This has led to a dual diagnostic system in which various criteria are used to assess the spiritual or physical root cause of a given health problem. While Westerners often see the Hmong system as incompatible with the scientifically based medical practice of the United States, the Hmong see the two systems as complementary.

### **Syncretic Diagnosis**

Throughout my fieldwork I attempted to form lists of spiritually based and physically based sicknesses. The results were fairly standard across interviewees, but all conceded that certain conditions may classify a typically physical sickness as spiritually derived, or vice versa. Therefore, these divisions are not hard-and-fast, and alternative classifications occur often. Epilepsy, chronic headaches, exhaustion, stress or shock, paleness, and any sickness where one sees *dab* (evil spirits) are typically seen as having spiritual causes. Diarrhea, cough, fever, gout, diabetes, high blood pressure, stomach ache, headache, vomiting, and (for some interviewees) exhaustion are commonly perceived as purely physical conditions. In Laos, before the Hmong gained access to Western medicine and explanations, many of these conditions would have been attributed to spiritual causes alone.

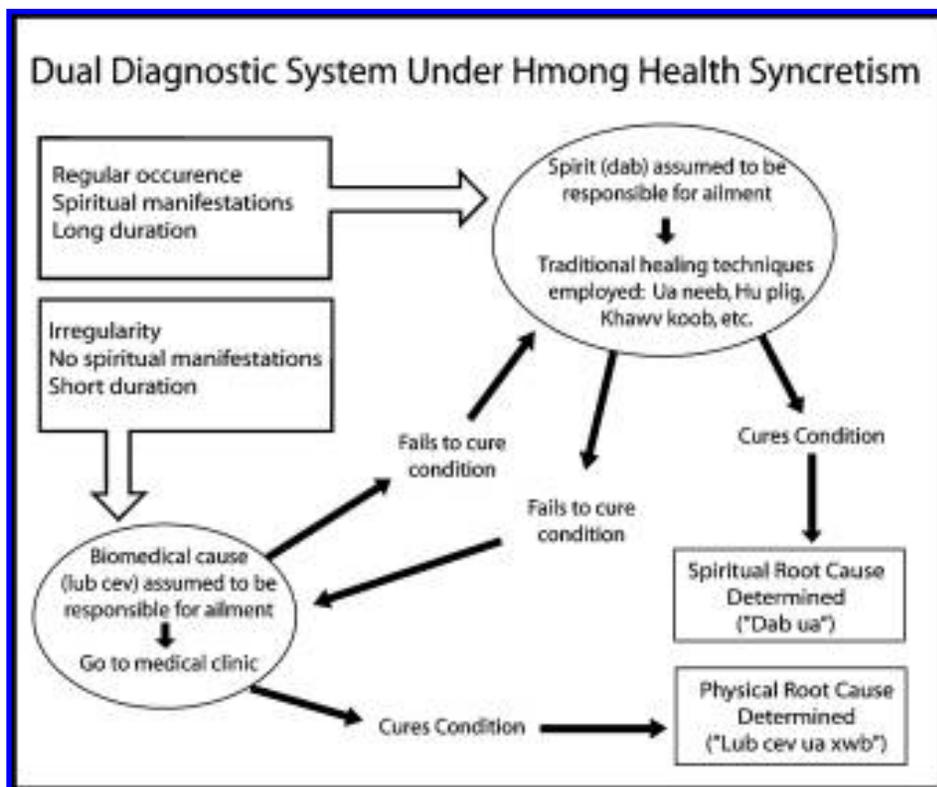


Figure 2. Diagnostic process, including contextual cues and treatments as feedback loops in diagnosis in Hmong health syncretism

Presently, headaches and exhaustion are commonly perceived as both spiritual and physical conditions. However, the context surrounding the condition is an essential consideration in making these distinctions, and may even change the status of the emic diagnosis from physical to spiritual, especially after treatments by Western medicine or traditional healers fail, which I discuss below and illustrate in Figure 2.

Three main contextual factors are able to override any spiritual or biomedical diagnosis in favor of the alternative: (1) regularity, (2) longevity, and (3) spiritual visions or manifestations. The absence on any of these indicators will likely lead to an initial biomedical diagnosis of a problem (i.e., irregularity, short duration, and no spiritual manifestations), while their presence typically indicates the spiritual basis for nearly any condition. First, if a headache, for example, occurs at the same time every day, then a *dab* is probably causing it. In the Hmong ethos, the regularity of any condition seems to communicate something from the spiritual realm. I witnessed a *daws dab* practitioner chase away the *dab* that were inflicting migraine headaches on an elderly woman. The woman explained that, because of the regularity with which her headaches appeared, it must have been *dab* wanting some offering from her. The practitioner burned ritual money and bargained with the *dab* to leave her alone. She sought *daws dab* services and consumed herbal remedies to resolve the problem specifically because of its regular

occurrence. I asked her what she would do should the traditional method fail, and she replied that she would go to a doctor to correct the problem. The contextual factor (in this case regularity) gave her a starting point for diagnosing and treating the problem.

Second, longevity of any condition is also indicative of a spiritual cause. The spirits have power to inflict sickness that physical medicine cannot resolve. Through descriptions of the powers of medical and spiritual healers, Hmong interviewees indicated that, even if the proper treatment is applied to a physical condition, it will yet persist because of the spirits causing it until their debt demand is met. Interviewees could not explain how the spirits can enact physiological changes in humans. It seems that this is an irrelevant consideration—the fact of the matter is that they can. In one case, a stroke victim was left debilitated and unable to care for himself. Interviewees clearly saw this illness (through biomedical terms) as stemming from eating habits and blood conditions, as one woman stated, “high blood pressure is caused by the things that we eat.” However, the same woman also indicated that the family (her relatives) still needed to ask a *txiv neeb* to perform an *ua neeb saib* to see the spiritual reason that his condition was so persistent—to find out what is wrong with his spirit.

Regardless of the seeming physical nature of any condition, visions of *dab* or visitations from the spirits of ancestors (usually in dreams) constitute the third indicator of a spiritual root cause. In the context of ancestor problems, sickness generally indicates their lack of food or money in the spirit world, which would necessitate an offering on their behalf (performed by a shaman). If the victim sees a *dab* while sick, then they must perform *ua neeb* or *daws dab* to scare it away or retrieve the spirit if the *dab* stole it. This last indicator is particularly powerful in overriding any initial presumption that an ailment is purely biomedical.

### **Diagnosis and Treatment**

While these three criteria positively indicate the spiritual causes of illness, treatment is another essential consideration in making the ultimate determination of the root cause of an illness. If one of the aforementioned criteria is present but the spiritual healer is unable to fix the problem, the family will consult a Western doctor. On the other hand, if the sickness is determined to be physical but the doctor manifests doubt in his or her diagnosis or the treatment regimen is ineffective in the short run, the victim’s family will likely deem it a spiritual sickness. Thus, treatment plays a practical role in determining the nature of any condition. This practice requires the assumption that a cure will be found in one of the available treatments, whether Hmong or American, but this assumption does not seem to pose a problem to the Hmong who believe it.

As they have integrated Western concepts of health, many Hmong have developed a sense of scientific rationalism. This is narrower than the average Westerner’s view of science in that there is no blind faith that science will eventually solve all medical problems. If there is no cure available, the Hmong are less likely to expect one to emerge—they will rather attribute a spiritual etiology to the condition. In the same vein, if a surgeon feels that surgery is the best course of action to correct a health problem, most Hmong require empirical evidence that there is a physical problem and how the surgery would correct it.

This is often requested in the form of an X-ray or some sort of visual portrayal that proves the condition.

The Hmong do not, however, completely discard traditional beliefs in favor of a purely Western medical paradigm. Instead, the hegemony of the overarching system has inculcated Western concepts into the folk system, resulting in the present syncretism: the Hmong maintain the philosophical foundation of the traditional worldview while contemporaneously adopting the scientific–rationalistic foundation of the Western biomedical paradigm. The diagnostic system described here is a direct result of this interaction.

### **Health Care Decisions: Implications for Medical Professionals**

Thao (1986:372) and Beghtol (1988:12) state that the Hmong will exhaust all traditional healing techniques before consulting a Western physician. Nearly all Hmong I interviewed suggested that such was not the case. On the contrary, some indicated that they more commonly consult a doctor before performing *ua neeb* or *khawv koob*. Most commonly, however, these decisions are based on the aforementioned diagnostic system (i.e., contextual indicators). Thao's and Beghtol's assertions, while they may have been true more immediately after the initial resettlement in the late 1970s, can be misleading to medical professionals who work with Hmong patients presently. It is important to note that some Hmong do not consult Western medical treatment until the condition is more critical, which perplexes medical professionals and seems to validate Thao's and Beghtol's claims, but this by no means characterizes the health seeking behaviors of all or even most Hmong. These assertions are based on a totalizing and essentialist view of Hmong health beliefs that necessarily overlooks their reasoning through biomedical terms. Syncretism in health beliefs provides an alternative framework for understanding Hmong health seeking behaviors that, if understood by medical professionals, could be utilized to better understand health care interactions and overcome misunderstandings in the future.

Figure 2 summarizes the process of diagnosing a core physical or spiritual cause to any illness. The Hmong have no reservations about trying various healing methods that are based on different healing philosophies. The common perception is that if one method does not work, perhaps another will, and the successful method reveals or confirms the root cause. Understanding this point through the framework of syncretism, medical professionals need to understand that Hmong may frequently switch diagnoses from spiritually to physically based, or vice versa. Changing the diagnosis also guides changes in health seeking behaviors. For instance, many of the U.S. medical professionals whom I interviewed indicated that they were often confused to find that their Hmong patients suddenly stop taking medications without telling them (medical staff typically find this out some time later). Hmong interviewees, on the other hand, indicated that if they do not notice a significant immediate change in their condition, then they are likely to switch their diagnosis to a spiritually based cause and, consequently, stop taking prescribed medications and seek a traditional cure. Therefore, if a doctor prescribes a medication that has a long initial onset or adjustment period, they need to thoroughly

explain the expected etiology of the treatment regimen, because Hmong tend to switch diagnosis away from a biomedical cause if no immediate effect is felt. Understanding that some medications have longer onset periods than others is essential in this case to overcome a change in the emic diagnosis that would cause them to stop taking medication before its effect is felt.

One could also fruitfully generalize this recommendation to health care workers beyond the use and prescription of medications. Awareness of the dynamic nature of treatment and diagnosis in Hmong health syncretism allows one to understand the multiple health-seeking behaviors in which many Hmong engage, and that tend to perplex their Western health care providers. Medical professionals can overcome misunderstandings and confrontations by effectively communicating their rationales for switching treatment regimens (in medications or procedures) and general timeframes for expected outcomes. Failure to do so will most likely lead to a change in the emic diagnosis away from biomedical root causes, and a subsequent cessation of biomedical consultation.

While this is true for many Hmong who are not strictly Protestant, those who convert to orthodox Protestantism will leave behind all traditional healing practices as worldly and unholy. It is interesting, however, that these Christian Hmong tend not to negate the underlying philosophy of the traditional Hmong healing practice, but they prefer prayer as a better, or more righteous, means of healing. They see *ua neeb* and *khawv koob* as sinful without negating the fact that they are real practices based on a philosophically valid view of the physical and spiritual world. For example, one of the leaders of the Hmong community in Alaska sought out a traditional healer, Mormon missionaries, and Western medical practitioners to resolve the same physical ailment. None of them were able to heal his condition, but this did not negate the underlying philosophy of any of the systems he consulted.

The health system described to me by Alaskan Hmong forms, in their minds, a coherent system of belief. I contend that syncretism is the most useful theoretical framework for understanding this system because the *Gospel of Germs* (Tomes 1998) is seeping into Hmong rationalization of health and healing and was not present in their remote locations in the Laotian highlands. After resettling in refugee camps and later in the United States, however, the Hmong have become ensconced in Western health practice, even as a requisite for coming to the United States (e.g., through immigration vaccinations and health exams). The result is that the Hmong rationale of health and illness has integrated concepts of germs, viruses, blood pressure, etc., but these concepts take on somewhat different meanings than those they carried in a Western medical context (e.g., Culhane-Pera et al. in press). Additionally, the Hmong I interviewed have developed a contextual diagnostic system for recognizing whether a given health problem is based in spiritual or biomedical root causes, and the subsequent dynamics of diagnosis and treatment can change between or bridge across these perceived causes. The framework of syncretism that I have described above most adequately captures these characteristics.

Jean Comaroff and John Comaroff's (1997) integration of the dialectic process into hybridization in colonial South Africa is also useful in my analysis of syncretic Hmong health practice and beliefs. They define the dialectic as a "process of reciprocal determinations;

a process of material, social and cultural articulation—involving sentient human beings rather than abstract forces or structures—whose interdependent destinies cannot be assumed to follow a straightforward, linear path” (1997:28).

Two particular aspects of this dialectic are valuable in the present analysis. First, the use of “reciprocal determinations” offers an alternative to the simplistic unidirectional syncretism that is critiqued by so many opponents of syncretism as an anthropological construct. As opposed to merely integrating Western concepts and health beliefs into the traditional health model, Hmong interactions with Western health care provide reciprocal influence. This influence, in the case of the Hmong, is not just nominal as one might think. In fact, the cultural collisions of a Hmong family in Merced, California with Western medical providers have come to influence readers and medical students across the United States as a paragon of the necessity of cultural perspectives on health care. Anne Fadiman’s *The Spirit Catches You and You Fall Down* (1997), while critiqued by some anthropologists as essentializing, totalizing, and exoticizing Hmong culture, was a *New York Times* bestseller and is a common required text in “cultural competency” courses in medical schools across the United States. Other significant articles and books have been written using the Hmong as a gateway for discussion on culturally sensitive health care (Beghtol 1988; Capps 1994; Johnson 2002). For being the 11th Asian minority group in the United States and numbering only 186,000 on the 2000 Census (Barnes and Bennett 2002), one might argue that this is a profound relative influence on U.S. health care.<sup>4</sup>

Second, Comaroff and Comaroff’s lack of teleology in their concept of the dialectic is also useful in the Hmong context. As opposed to a Hegelian or Marxian dialectic, the outcome of the social process is not possibly discerned before it actually unfolds. Thus, there is no final status of Hmong health beliefs or of the localization of Christian practices in South Africa. Instead, the forced migration and colonial contexts (respectively) lead to perpetual theses, antitheses, and syntheses that play out on their own terms, not according to analytical teleologies—they “are neither self-evident nor prefigured” (1997:28–29). This emphasis on nonteleological reciprocal determinations allows one to focus more directly on the actions of individual actors and, after Stewart and Shaw, “attend to the workings of power and agency” (1994:7) in the study of the process of syncretism.

## CONCLUSION

Throughout this paper I have shown how Hmong refugee health ideology has been adapted to include biomedical concepts of etiology and pathology, while retaining the core aspects of the traditional folk health system. This has led to a diagnostic system that must account for social, spiritual, and physical contexts, as well as changes and constancies in the course of the sickness or condition. Consequently, it is often difficult to assign an appropriate treatment to an illness, and the efficacy of the healing technique reveals additional information about the source of the problem. The integration of spiritual and biological causes constitutes a diverse, holistic medical perspective in the Hmong

community, leading the Hmong to seek both “traditional” and “modern” medical practitioners as primary health care providers.

Further, I have attempted to address the major arguments against the use of syncretism and cast it as a theoretically useful construct for understanding Hmong health beliefs in Alaska. While it is important to consider the etymology and historical uses of the term, the pejorative history does not preclude the usefulness of the concept. The semantic usefulness of understanding a system of belief or practice as perpetually dynamic in melding multiple traditions supersedes, in my view, the concerns of how the word has been mobilized in the past. Additionally, syncretism can be used as an empowering description of cultural beliefs and practices that do not merely succumb to hegemonic pressures of assimilation. While syncretism surely is not the most appropriate construct in many contexts, Hmong health beliefs are most adequately understood under this framework.

Ultimately, recognition of this syncretism, the resulting health care seeking behaviors, and the commonly held perceptions of health care all contribute to an awareness that is essential to health care providers who work with the Hmong. Understanding the syncretic emic diagnosis will aid medical professionals in understanding why Hmong do not behave like their American counterparts in their interactions with health care institutions. Further, this knowledge facilitates a cultural understanding of the Hmong community that accounts for the dynamic nature of their concepts of health and healing.

## NOTES

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1. I use the terms ‘refugee’ and immigrant interchangeably in this paper to recognize both that nearly all Hmong in the United States came as political refugees of the Secret War in Laos as well as the fact that many Hmong resent the connotations and images of destitution and poverty conjured up by the label ‘refugee.’

2. A note on Hmong orthography: All Hmong words are written using the Romanized Popular Alphabet (RPA), which is the most widely used system for writing Hmong in the West and in many parts of Asia. Hmong is a tonal, monosyllabic language in which all words consist of at least a vowel–tone combination and usually a beginning consonant. ‘w’ is a vowel in the Hmong RPA, and ‘b,’ ‘m,’ ‘j,’ ‘v,’ ‘s,’ ‘g,’ and ‘d’ are indicative of the tone (and are therefore not pronounced) when found at the end of the word. If a word does not end in any of these tone markers, the tone of the word is neutral (in total there are 7 distinct tones and one neutral tone). Hmong consists of 57 consonants (17 simple and 40 complex), which consist of anywhere from 1 to 4 roman letters. There are 13 vowels (6 simple vowels and 7 complex vowels), which are either indicated by a single or double vowel (a, e, i, o, u, w). All words transcribed in this paper are White Hmong (*Hmoob Dawb*), as all of my research participants self-identify as and speak White Hmong (among the Hmong in the United States, the large majority speak White Hmong).

3. I have been told by various interviewees that particular beliefs and healing practices, particularly as they relate to *ua neeb*, can even vary significantly from one clan to another. A shaman in the Yaj clan, for example, may have different methods of curing, divination, and traveling through the spiritual realm than a shaman from the Lis clan. However, these differences do not negate the efficacy of the shaman's work to any Hmong person from any clan. Some shaman gain reputations for being particularly good and are sought out from people in all clans.

4. These figures and rankings include ethnic classifications as Hmong or Asian alone or in any combination with other Asian groups or other non-Asian ethnicities, the far right column of the table on page 9 of the 2002 Census publication. In other words, these figures take into consideration all Asians and all Hmong, whether or not they professed mixed ethnicity. I tabulated the ranking from the data in this table.

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