

Bittersweet Migrations:
Type II Diabetes and Healing in the Hmong Diaspora

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What is research? Research in Hmong is to *tshawb nrhiav*, translated as “looking to find.” But what has been my experience of research? It is not exactly the looking and finding, but as one of my interlocutors kindly put it, “let’s help this daughter to finish her paper” so that I could finish my school. Research is not just about the discovery but also about the debt it generates. My success is because of my interlocutors’ generosity in assisting me in my schooling. Even if nothing good comes out of this dissertation, I wish to tell my interlocutors that they have had an impact on my life. Their generosity and kindness has made this dissertation possible. To them, I owe my first and biggest acknowledgement. *Ua nej tsaug tau heev. Thov kom nej muaj kev noj qab hauv huv. Thov kom nej muaj chaws sov siab thiab chaws cia siab. Vim muaj nej, kuv muaj txoj kev cia siab rau kuv tej kev kawm ntawv.*

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For my mother and father,
Kao Xiong and Kong Thao
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INTRODUCTION

The season I arrived in Xieng Khouang, Laos was the end of the winter; the air was dry, leaving children with snot-caked cheeks that cracked from the cold boisterous wind. I heard that I had missed the snow brought by the cold weather that had killed banana trees and even some livestock. While areas of Vientiane, the capital of Laos, were hot and often caked in red dirt during the winter, Xieng Khouang was slightly green during the winter season, or the break before the monsoon, with hills and mountains littered with rocks and wild grass. I rode on the two-rail truck where passengers sat paralleled to each other in the truck bed, with side railings and a roof topper to enclose the passengers. I sat across from my aunt (my father's sister-in-law), a woman I had just met that day. My family had separated from her in 1975 after the United State's Secret War in Laos, or as the Laotians remember it, the American War.¹

On our one-and-a-half-hour ride to my aunt's village at the outskirts of Phonsavan, I felt the eerie memories of war as I watched the hillsides of Xieng Khouang pass by. The landscape opened up from rocky hills to lands of agriculture behind her, her hair blowing beneath a colorful bandana similar to the ones I had worn as a child around my neck under my Hmong clothes. She had a small thin frame, and her skin was tanned

¹ In the United States, the "American War" was better known as the Vietnam War. However, the war in Vietnam spilled over into Laos and Cambodia. As Hmong-Americans and the US now commemorate the war as the Secret War, in Laos the war is remembered as the American War.

dark from working in the sun. My eyes were in awe of the beautiful rolling hills emaciated by bomb craters. Ponds, too perfectly circular, collected water from the last season's monsoons.

I felt haunted by the stories I had overheard around childhood campfires in the state parks of Wisconsin with my parents and relatives. While I always enjoyed the outdoors, mother and other women of her generation told me that they hated camping because it brought back memories of this part of their life where they had to seek shelter and refuge in the forests. Currently, areas of Xieng Khouang were being deforested for commercial and residential development. Xieng Khouang had changed and apparently moved on from the war, and yet the symbols in the social memory of Hmong-Americans remained. There remained unexploded American bombs in the dense forests. The bomb shells that have split in half are now rusted red-brown and turned into fire pits to warm the hands of little Hmong children. Rusted gasoline barrels were repurposed as water containers, used to collect the monsoon rains for later use.

I found myself here, half a world away, after interviewing Hmong-Americans with type II diabetes in Saint Paul, Minnesota about their experiences with chronic disease management and what they thought offered them healing. The interviewees became my interlocutors; they became my friends, colleagues, *cov yawm txiv* (grandfather), *cov niam tais* (grandmothers), *cov niam laus* (older sisters) and *cov tij laug* (older brothers). I use the term interlocutors to capture how they have shaped my thought and writing dialogically (Montoya 2011). Through our conversations about health and

healing, my interlocutors ultimately changed the direction of this dissertation. My initial intent was to conduct ethnographic fieldwork on Hmong-American experiences with chronic disease management in the United States. In conversation with my interlocutors, this dissertation is an engagement with what it means to live in the U.S. as displaced persons and how to imagine ways of caring for someone, and on questions of belonging for my interlocutors.

On my first day of fieldwork, I was coordinating a diabetes group visit at a clinic in St. Paul, MN. During a round of introductions, one Hmong-American man with diabetes proclaimed to the other Hmong-American diabetes group visit patients, “In Laos, there is a cure for diabetes, but it is not here [United States].” He and many of my Hmong-American interlocutors with type II diabetes mellitus, all 50 years and older, share the common belief that a return to Laos means a return to health and a cure from diabetes. This cure is only temporary and place-specific, definitely not found in the U.S. The cure is to be in the places that you once lived, seeing those you left behind after the war, and eating and living as you used to do. Those who claim to have returned to health on their trip to Laos shared with me how their bodies embodied the animacy of the land and weather; that their bodies “fit” there in Laos while being out-of-place/displaced in the US. This curative place for my interlocutors also extends to Thailand, a place of Hmong-American temporary asylum during the United States’ Secret War in Laos. I was told that as they were getting on the plane to go home, they could feel the rising of their blood

sugars as their memory returned to daily reminders of bills and a displaced life in America.

Yet paradoxically, while a return to Laos is associated with returning to health and vitality, others have told me that the only possible return to Laos is through death. Similarly, the only cure for diabetes is by the same token, via the hoe and the shovel, or *hlau thiab tuam txhob*². The parallel claims regarding death and return migration highlight the perils of such desires. By taking on the sentiments of the Hmong diaspora, sentiments of loss and desire, *Bittersweet Migration* sets up the possibility of understanding how different configurations of return (return migration and death) reimagine different ways of healing for the Hmong body and a larger Hmong body politic. This dissertation begins as a journey from the biomedical encounter (patient-provider interactions and diabetes group visits) to Hmong-Americans' experience of displacement alongside their disease. Displacement is reinforced in biomedical care as Hmong-Americans feel they do not fit the biomedical body. Displacement, a feeling of being both here and there (in Laos) at the same time, is a source of potential that fuels the desires for return migrations. However, given the complexity of the historical alliance between Hmong-Americans and the U.S. during the American War in Laos, I understand the claim to death as the ultimate cure and return to Laos, as a political claim to Hmong sovereignty that opens the doors to imagine a Hmong kingdom through death.

² The hoe and shovels are tools used to dig graves. This saying metaphorically infers death as the only cure.

Who Are the Hmong-Americans?

Hmong-Americans come from the northern region of Laos but have ancestral origins in China's provinces of Yunnan, Guizhou, Sichuan, and Hunan (Chan 1994). Called the Miao (natives/sprouts) by the Han Chinese, Hmong oral stories document years of conflict with the Han. One story details the destruction of the Hmong written script by the Han and the killing of the Hmong king³ that has perpetually left Hmong displaced and without a kingdom (Vang, C.T. 2016; Lee, M. 2015). Hmong roots in China are also reiterated in the Hmong funeral song, *Qhuab Ke* or the "Showing the Way." This song directs the deceased on a return journey, tracing back the deceased's places of residence, ultimately returning to the ancestral lands that have been claimed by scholars to be located in Southern China (Lee, G. 2007; Lee, G. and Tapp, 2005).

From 1790-1860, as China began consolidating various ethnic minority kingdoms, many Hmong and ethnic minorities rebelled. Large fractions of Hmong migrated southward to Vietnam, Burma, Thailand and Laos. The earliest Hmong migration into Laos was in 1820-1840 into Nong Het, the northern part of Laos that currently borders Vietnam and China (Stuart-Fox, 1997). Other areas that the Hmong resided in were Luang Prabang, Phongsaly, Sam Neua, and Xayaboury.

³ There are many Hmong kings but there are no records of the kings except oral accounts.

Although European powers had been present in Southeast Asia as early as the 1500s, the French arrived fairly late to colonize the region of Indochina, which included Vietnam, Cambodia, and Laos. France ruled Laos as a colony from 1893-1945 but never developed Laos “economically, socially, and culturally” (Chan, 1994:7). France was more interested in Vietnam and colonized Laos under the prerogative of looking for a river route to China. To generate revenue, the French implemented a head tax on all males from 18-60 years of age, taxing opium, alcohol, and salt, and enforcing *corvee* labor. A Hmong revolt led by Pa Chai in Dien Bien Phu resulted in the French designating Nong Het as an autonomous district for the Hmong and appointing Hmong *kiatong*, clan leaders, to collect taxes on behalf of their ethnic others. The French appointed Lobliayao⁴ as district chief. The French later appointed Lobliayao’s son-in-law Lyfoung, causing resentment in the Lo clan of Lobliayao. When Lyfoung died, an election resulted in the election of Lyfoung’s eldest son Touby, who was the first Hmong alongside his two brothers to receive formal education, and not Faydang, the second son of Lobliayao (Stuart-Fox 1997; Lee, G. 1982). The division between the Lo and Ly clans began with the French backing of this election and continued into the first Indochina War, where Japanese invasion of Laos in 1945 resulted in a formal end to French colonial rule in Laos. Faydang and the Lo clan opposed pro-French Touby and sided with the Japanese and Vietminh (Quincy 2000).

⁴ Prominent Hmong leaders’ names are written in the manner of clan name first and then given names. For example, Lo (Last name), Bliia, and Yao and Vang (last name) Pao (first name).

During the Indochina War, Japanese occupation of Laos gave way to anticolonial resentment. Because he wanted to advance an independent Laos free from the French and Vietnamese intervention, Nationalist Prince Phetsarath Rattanaongsa (the premier of the Luang Prabang kingdom) formed Lao-Issara (Free Lao) with his brother Prince Souvanna Phouma and half-brother, Prince Souphanouvong (Vang C. 2010). At the end of World War II, the Japanese were disarmed and Laos was reinstated as a French Monarchy. The French appointed Touby Lyfong as district governor in 1946 of a Xieng Khouang province that spanned from Nong Het to Xieng Khouang, north of the Plain of Jars. Members of the Ly clan followed Touby into Xieng Khouang where he opened up his office, leaving Nong Het empty of Ly clan members. This migration enabled Faydang and the Lo clan to partake in communist activities in Nong Het (Quincy 2000).

After 1954, at the height of the Cold War between the U.S. and USSR, the French, engaged in another war in Algeria and relinquished their Indochina colony. Despite signing the 1954 Geneva Accords (and later again on July 23, 1962) declaring Laos to be neutral, the U.S. and North Vietnam (the proxy of the USSR) meddled in Lao political affairs, further continuing the division within the Lao nationalist groups. Prince Souphanouvong broke away to align with the Communists, and formed *Neo Lao Issara* (Lao Freedom Front) that would later become the *Pathet Lao* (Lao Communist Party) (Chan 1994; Stuart-Fox 1997; Vang C. 2010), representing the leftist party. When the first coalition government formed in November 1957 with Prince Souvanna Phouma, the US ambassador to Laos, J. Graham Parson, was suspicious of Souvanna and believed

Souvanna was a Communist sympathizer. The U.S. was unhappy with the results, fearing that Souvanna legitimized the Pathet Lao. Souvanna was a true neutralist who made multiple attempts at forming a coalition government that would include the leftist Pathet Lao, neutralist, and the rightists that were comprised of the royal family and the military. In the supplementary election in May of 1958, the US launched a campaign and funneled money into swinging the political terrain in Laos towards the right, a government that would be pro-American. However, the results of the election swung towards the left, with the most votes for Souphanouvong. The U.S. withdrew their aid to Laos, causing an economic crisis that resulted in Souvanna resigning (Chan 1994).

After the failure of the coalition government, Kong Le, the commander of an elite paratrooper company, staged a coup in August 1960. He demanded that Souvana Phouma be restored as Prime Minister and that foreign powers stop intervening in Lao national affairs. During this junction, the U.S. became fearful of the Communist Pathet Lao's takeover of Laos. Ignoring the Geneva accords of 1964, the CIA began recruiting Hmong General Vang Pao, who was an officer of the Royal Lao Army. Vang Pao would go on to command Hmong and other ethnic minorities in guerrilla tactics against the Pathet Lao and North Vietnamese Army in the eastern region of Laos.

The historical moment when Colonel Bill Lair recruited General Vang Pao has been disputed by many, with various accounts of whether a promise was made between the Colonel Bill Lair and General Vang Pao. Colonel Bill Lair would be quoted in an interview as saying that when he recruited Vang Pao, Vang Pao declared his dislike for

the Communists and said that he would either stay to fight or flee, and chose fighting with the support of the Americans. (Hamilton-Merritt 1993, Hillmer 2010). Suschan Chan's book (1994) illustrates the complexity of these narratives, as others have said that the CIA promised that if the Americans won, the Hmong would receive their own homeland to govern. The debate about Hmong being mercenaries or "heroic homeland protectors" (Vang, C. 2010:34) continues today, yet what has been clear in the policies and the secrecy that shrouds the American War in Laos is that Laos was a political pawn for the U.S. While news surrounding the bombings in Vietnam surfaced, reporters were banned from interviewing pilots sent on bombing missions in Laos. The veil on US involvement in Laos would not be lifted for the American public until 1969, by which time the U.S. was already looking to exit the war in Southeast Asia (Chan 1994).

The Pathet Lao encroachment into the Plain of Jars forced thousands of Hmong to evacuate from their homes and eventually resettle into Long Cheng for Vang Pao's military headquarters. Displaced from the highlands, Hmong became exposed to lowland diseases and malaria. Children during this time grew up on USAID and air-dropped rice (Hillmer 2010). Vang Pao's army numbered to 20,000 and was tasked with saving downed American pilots and disrupting the North Vietnamese Army's supply chain to the south of Vietnam. 17,000 Hmong soldiers died in the war (Hamilton-Merritt 1993). To maintain the Geneva Accord, the majority of the fighting was done by Hmong and other Laotian ethnic minorities. As casualties swelled, the fighting was done through air warfare. The U.S. dropped 2 million tons of bombs in Laos alone (Chan 1991).

A cease fire ending the Vietnam War was signed at the Paris Peace Accord on January 1973. A coalition government between communists and non-communists was formed in Laos but dissolved in 1975, when the Pathet Lao took full control of the government shortly after the fall of Phom Penh and Saigon. U.S. soldiers were withdrawn from all over Southeast Asia as Saigon fell to the Communists. Vang Pao and 2,500 Hmong at Long Cheng were airlifted out of Laos, leaving many more Hmong families on their own. While those families left behind attempted to return to a semblance of life in Laos, the Pathet Lao executed reprisals against those who fought with the Americans, putting them into reeducation camps; according to oral claims, the government sought the elimination of all American sympathizers. 102,479 refugees arrived in Thailand by 1980, of which 95 percent were Hmong. (Vang C. 2010) Hmong soldiers left behind felt betrayed by the U.S. to the extent that they were “used and abandoned” by their American allies (Hamilton-Merit 1993; Lee, M. 2018). Many wanted to remain in Laos, but Laos’s political and economic situation resulted in the mass exodus of Hmong to Thailand.

Hmong, unlike the Vietnamese who were granted resettlement in April of 1975, were unknown to the State Department and Immigration and Naturalization Services (INS) due to the secrecy of the American War in Laos. The INS felt the Hmong were “far too primitive to ever be considered for resettlement in the U.S. because they were straight out of the trees.” (Hillmer 2010:198). Advocacy from Americans like CIA officer Jerry Daniels detailed the blood sacrifice (Lee, M. 2018) of the Hmong on behalf of the

Americans. Daniels argued that the U.S. was indebted to the Hmong and should resettle Hmong in the U.S. (Lee, M. 2018; Hillmer 2010) As a result, the resettlement of the Hmong began in December of 1975. Vang Pao, though, had a different desire, which was to return to Laos. In exile in Montana, Vang Pao continued to fuel Hmong hopes of returning to Laos by sending money to resistance fighters in Laos and encouraging many Hmong who qualified for resettlement to deny resettlement in the U.S. (Long 1993). It is estimated that 150,000 Hmong left Laos (Chan 1994).

Hmong sought asylum in Thailand and later according to the Geneva Conventions, were relocated to First World Nations: U.S., France, Australia, Germany, and French Guinea. In the United States, Hmong were first dispersed throughout the nation to avoid overburdening states, only to have a secondary migration, where Hmong migrated to places where their family lived to help with the cultural adjustments (Chan 1991). Hmong refugees were often illiterate⁵, as Hmong have an oral society, and by the last wave of Hmong resettlement, Hmong were predominantly younger (many were younger than 18) than other Indochinese refugees (Kelly, 1986). Because of this secondary migration, Hmong are more populous in California, Minnesota, and Wisconsin. Ban Vinai, the refugee camp in Thailand that housed the most Hmong refugees officially closed in 1992. One remaining place of refuge, Wat Tham Krabok, would resettle the last remaining Hmong to the U.S. in the 2000s.

⁵ As stated earlier, when Laos was a French colony, the French did not establish any institutions for education except for one. It is after U.S. involvement that schools were more established and girls were trained as nurses in Long Cheng.

According to the 2016 U.S. Census, there are 296,890 Hmong in the U.S. with the majority of the Hmong communities residing in California, Minnesota, and Wisconsin. 40 years have passed since the first resettlement of Hmong refugees in the U.S. and currently 61% are proficient in English, compared to 70% of the average Asian population in the U.S. 53% of all Hmong in the U.S. have a high-school level education or below and 28.3 % of all Hmong live in poverty, compared to the national average of 15.1%. Hmong in the U.S. have a median household income of \$48,000 (Pew Research Center, 2017). Asian households often have multiple family members contributing to the family income. (Chan, 1991)

Since their resettlement in the U.S., Hmong-Americans have had major achievements in both education and American politics. Chai Vang's (2010) book on Hmong in America documents great strides forward within Hmong-American communities. This progress began with the election of the first Hmong-American to the St Paul Board of the Education, Choua Lee, and culminated in the election of Mee Moua as the first Hmong-American to be elected a State Senator a decade later. Although she was the first Hmong-American to be elected to a state legislative office, she would be followed by Cy Thao, who was elected to the Minnesota House of Representatives in November 2002. Vang C. writes, "Today, the images of displaced, struggling refugees during the mid-1970's have transformed into a partially blurred image of upwardly mobile new Americans plagued by fragmented and disconnected social, economic, cultural, and political representations. In their demands for inclusion, Hmong through

American cities and towns continue to exercise significant agency in building alliances and seeking resources for their ethnic group” (156).

Disparities in Health

Type II diabetes is the seventh leading cause of death in the US (American Diabetes Association, 2017). The cost of diabetes, according to the American Diabetes Association (2013), is a total of \$176 billion - \$245 billion for direct medical costs and \$69 billion in reduced productivity. The National Diabetes Statistics Report, provided by the CDC, estimates that 22.1 million Americans were diagnosed with diabetes, and that minorities, non-Hispanic whites (7.4%), Asian Americans (8.0%), Hispanics (12.1%), non-Hispanic blacks (12.7%), and American Indians/Alaskan Natives (15.7%) were disproportionately burdened by the disease (American Diabetes Association, 2017). Ethnic minorities racially classified as Asians are often grouped under the homogenous umbrella of Asian-Americans. Ethnic specific research studies, like those on the Hmong, remain sparse and provide unreliable data on the health risks of the Hmong community given the low statistical numbers of Asians in the U.S. and a pervading myth that depicts Asian Americans as a model minority that is healthy and has competent access to health services (Esperat, Inouye, Gonzalez, Owen, & Feng, 2004; Foo 2002). Although the disaggregation of data among racial groups illustrate that fewer Asian Americans are diagnosed with type II diabetes compared to other groups, the categorization of Asian

American distorts the heterogeneity and unequal burden of the disease within the population.

What exists in the literature are community based research studies that document Hmong health disparities. According to Stewart, Dang, and Chen Jr. (2016), Hmong were more likely to have the highest age-standardized prevalence of DM than Koreans, Chinese, or Vietnamese. Chinese were more likely to have a pre-diabetes diagnosis. The literature on Hmong and their struggles with diabetes remain sparse. One study conducted in Wisconsin found that Hmong-Americans in Wisconsin are three times more likely to have type II diabetes than non-Hispanic whites, with 19.1% of Hmong adults diagnosed with the disease as compared to 7.78% of non-Hispanic white adults (Thao 2015). Her and Mundt (2005) found that 41% of Hmong-Americans in their sample at a Hmong Wisconsin festival, were potentially at risk for developing diabetes. The message is overwhelmingly clear; Hmong-Americans have a high diabetes burden compared to the general population.

The majority of literature that examines Hmong cultural perceptions and barriers around diabetes and biomedical care comes from the health sciences. Culhane-Pera, Her, and Her (2005) describe a Hmong cultural model of diabetes that is rooted in the Hmong refugee experience in the U.S. Hmong-Americans feel culturally dislocated within the U.S.: specifically they feel that their bodies do not fit with the food and the environment. In Laos and Thailand, Hmong-Americans used to have an active lifestyle, walking to and fro, and doing hard labor in their crop fields. In the U.S they are unable to sweat the

chemicals in the food out of their bodies due to sedentary habits at home and/or desk jobs. Hmong-Americans identify the lifestyle and the chemicals in food (rather than a particular diet) in the U.S. as the reason for diabetes. In Perez and Cha's (2007) work, they found that their respondents often did not know what diabetes is nor how to treat diabetes. Most importantly, in Hmong there exists no word for diabetes other than sweet blood or *ntshav qab zib*. The term sweet blood connotes the idea to Hmong people that food items that taste sweet will result in diabetes. Perez and Cha's participants also stated the need to avoid high cholesterol foods as well. Lack of medical translation can affect how one comprehends diagnoses and treatment regiments (Johnson 2002). Johnson reported, "The concept of a chronic illness that could be controlled but not cured was unknown. One man said, 'In Laos, you got sick and you either got better or you died'" (Johnson, 2002:127-128). Some of Perez and Thao's (2009) participants identified environmental challenges and barriers, such as unsafe neighborhoods, working outside of the home, and access to fast food as contributors to diabetes.⁶

These studies identify challenges directly related to Hmong-Americans' recent engagement with biomedicine starting from the time of the Secret War, and to their socioeconomic standing in the U.S. Yet, the study authors still often maintain a cultural explanation for Hmong-American's experiences with type II diabetes. Johnson (2002) references Hmong beliefs ranging from the idea of a pool of blood in the chest to beliefs about spirits and ghosts to the absences of medical terminology. Despite Johnson's

⁶ Although fast foods is mentioned as contributor to diabetes, Hmong elders often don't eat fast foods.

demonstration that Hmong had negative experiences, she continues to paint Hmong as cultural actors (Johnson 2002), while unconsciously writing medical providers as acultural (Taylor 2003a). Pinzon-Perez (2006) states that Hmong have “cultural beliefs and health utilization patterns that pose challenges for health education practitioners” (Pinzon-Perez, 2006:8). Identifying the cultural characteristics in Hmong-American health beliefs allows the development of cultural competency programs (Helsel et al 2005; Cobb, 2010) while taking for granted that medical knowledge and culture are not themselves cultural (Taylor 2003a).

Type II Diabetes and the Culture Explanation

Ferzaca (2010) argues that in the health sciences, the production of knowledge on diabetes and communities of color utilizes “culture as apparatus” in a way that has often conceptualized culture as a bounded whole, consisting of relevant traits. This approach in the study of diabetes has been “applied to Cambodian, Hmong, African American, and other marked groups, for example—designated as in need of therapeutic approaches requiring cultural competency” (Ferzacca, 2010: 420). The cultural competency argument doesn’t take into consideration that these communities live within unequal relations of power, in both the clinical setting in the U.S. and also within the realms of knowledge production. Culture becomes the explanation for the differences in diabetes associated with ethnicity. Culture then becomes synonymous with socio-economic inequality in a way that ignores the larger social/racial context of the everyday.

This has been exemplified in Anne Fadiman's book *The Spirit Catches You and You Fall Down: The Clash of Two Cultures* (1997), a story that is often taught in medical education to demonstrate the effects of culture in the biomedical encounter. Fadiman tells a story centered around the tragedy of a young Hmong girl, Lia Lee. Lia is painted as the victim of the cultural differences between Hmong culture and medical culture that leave her in a vegetative state for the rest of her life. Orienting Lia's Hmong parents as pre-determined agents of Hmong culture and history, Lia's parents are painted as stubborn, "a strain that you can find throughout Hmong history." And yet the white biomedical doctors, although actors of biomedical culture, are left to their individual quirks and differences, not exactly in the same framing of historical and cultural determinism in which Lia's parents are painted. This central text in medical education has taught medical students the very challenges of cultures and yet continues to reinscribe Hmong racially as outside of historical time, primitive, and needing to be saved from their cultural excesses. The use of culture as an explanation for health disparities racializes Hmong-Americans in the U.S. (Vang, M. 2012). Vang argues in her dissertation that the Hmong racial subject in the US is configured through US empire and the "secret war" that produces Hmong as needing the masculinist rescue of the US empire, all the while formulating Hmong as primitive, ahistorical, and embodying cultural excess. Similarly, this gendered racial configuration frames the biomedical encounter with Hmong bodies and Hmong agents as timeless tribal individuals who have yet to arrive in modernity. Hmong lack of compliance is inscribed as cultural, indicative of their backwards and pre-modern Hmong

identity. Highlighting Hmong as cultural with the implicit bias that those adhering to biomedical techniques and beliefs are non-cultural, is largely tied to a normalization of difference. As Renato Rosaldo (1986) argues, cultural visibility makes visible the Other while obscuring the “self” which is often, in this case, the author. Cultural visibility partakes in the racialization of minority communities. Health sciences literature that focuses on Hmong “health beliefs” or Hmong “traditional beliefs” about diseases and biomedicine continues to reify Hmong Culture as a significant social determinant of health. Thorburn et al (2012) captures the racialization of Hmong as cultural by their younger Hmong-American participants. These participants described the Hmong as cultural, ascribing culture onto the figure of older Hmong-Americans rather than the participants themselves. Despite the lack of personal explanations for their own mistrust of the health care systems, participants gave generalized reasons for why the Hmong did not trust Western medicine. They cited that distrust resulted from Hmong-Americans’ lack of understanding and familiarity with Western medicine, and that their distrust was rooted in culture/tradition. In so doing participants in this study racialize the Hmong community as cultural and stuck in time, with comments such as: “they're used to the old ways...they're not used to change” (Thorburn et al, 2012:825). Anthropologists Jacob Hickman (2007) and Lisa Capps (1994) have argued that Hmong engagement with biomedicine and their own cultural ideas is actually syncretic, entailing a blending and mixing of medical and cultural beliefs. Gary Yia Lee (1999), a Hmong anthropologist from Australia, urged Hmong studies scholars at a Hmong International Conference

against the static notion of culturalizing Hmong, stating that Hmong culture and identity is a continual mixing and blending, reinforcing James Clifford's (1986) notion of culture as always changing as it is situated within relations of power. The behavioral model of culture to explain noncompliance strips Hmong-Americans of their own historical and social complexity. Culture as explanation employs a simple explanation that prioritizes easily accessible information. This move assumes that the only thing that would solve the situation would be providers becoming culturally sensitive or competent or changing Hmong-American health behaviors. It turns a blind eye to the limits of biomedicine or, as Taylor (2003b) writes, the "specter of medical failure" (Taylor 2003b:172; Rouse 2010) and also the cultural project of biomedicine (Taylor 2003a).

Why Diabetes?

As mentioned earlier, diabetes heavily burdens the Hmong-American community despite the relative lack of documentation. But my reason for carrying out research on type II diabetes was a personal one: my father has type II diabetes and has had it since I was in middle school. I wanted to understand how Hmong-Americans of my father's generation experienced type II diabetes and how their experience as refugees might in some way affect and be affected by diabetes. As this dissertation will show, these two seemingly different experiences do inform one another. This dissertation draws from cultural theorist Eric Cazydn (2010) and his work on chronic disease management and the project of deferring crisis. To Cazydn, chronic disease management works not only to

divert the impending crisis of death but it structures an experience of chronic time where the present is perpetually present, and the futurity of death is deferred. What is unique in the Hmong-American case study is that as displaced persons and individuals who experience exclusions from the nation-state, chronic disease management structures not only their experience with diabetes around the logic of the fostering of biological life, but also the chronicity of their displacement, of being non-English speakers, socially isolated, and socially insignificant. For Cazydn, those who don't buy into the chronic care model hold onto the potentiality to assert a different experience. That is the case for my interlocutors in their claims that there exist promises of healing for Hmong-Americans with diabetes through return migrations.

Through everyday diabetes management in the chronic care model, the experience of the present becomes fixated in the practices of disease monitoring around the role of numbers. Left outside these practices are the sociality of a life, its instability, fluidity, and infectious potential to affect blood sugar levels. Here it is useful to consider Vigh's (2008) suggestion to examine crisis (in this case diabetes crisis) as context. Vigh writes, "In a social scientific perspective crisis is not often the result of a sudden tear within the fabric of everyday normality but rather the result of slow processes of deterioration, erosion, and negative change—of multiple traumas and friction" (Vigh, 2008:9). The scholarly task is not to understand a singular trauma of crisis but rather to see diabetes as a process, constituted by a multitude of other events, such as bodily discipline, everyday experiences, and the frictions of the structural on the body as well as past traumas and

crises. The context of crisis includes the chronic everyday that leads up to the acute symptom of crisis. Smith-Morris (2010) suggests that through ethnography, diabetes can be understood as fluid. The linearity of disease can be destabilized, by ethnographically attending to the fluidity of social and structural inequality that factor into diabetes. Taking on a critical melancholia perspective, my engagement with time and diabetes imagines a disjuncting of the perpetual present, examining how past experiences, memories, and haunting feelings of being from *tim u* (afar), shape and influence Hmong-American diabetes experiences.

Health Disparity through a Narrative Lens

The more I worked in the health sciences as a community researcher, the more I came to realize that providers and health scientists were well versed in the theory of social determinants of health to explain the high burden of disease for minority communities: that one's place in society structures his/her health, whether this place pertains to location, income, gender, or race. They articulate that patients who are best able to navigate the biomedical system are often highly educated, middle class, and white. The health scientists with whom I spoke are able to point to the structural context of their noncompliant patients, citing noncompliance as a result of the lack of transportation, poverty, non-English speaking, lack of insurance, unaffordable housing, and other socioeconomic factors.

This very understanding seems to challenge biomedical culture, asking for biomedicine to change in order to accommodate others who do not have the social and cultural means to cultivate a self that ensures medical compliance. What continues is the contradiction that providers must work through the challenges of these determinants of health for their patients' lives. This is an impossible task, a set up for failure for providers with dire consequences for patients. The focus on structural determinants of health as a theory to explain why people do not seek health care or carry out health recommendations, works as a supplemental narrative that neither addresses nor makes clear the failures of medicine to treat the complexity of the patients. It also assumes a neoliberal idea about human agency, that once barriers are removed, actors can function normally within the world of biomedicine. At the end of the day, the care offered by medical providers is indeed limited in its ability to address the structural determinants of a racialized, cultural society and this model of care continues to reinforce the idea that health ultimately lies with the patient.

Structural explanations for health disparities favor easily digestible information and readily available solutions or anecdotes. As Walter Benjamin articulates in his piece *The Storyteller*, the prioritization of information after WWII eclipsed the desire for experience that is embedded within the story and for the wisdom that storytelling conveyed. The analysis of health disparities embraces an information-centric method by valuing the extraction of lived localities, erased of their history, and plastered to theories of structure and predictors for risk. It numbs and flattens the social world that sustains it

(Taussig 2003). Information is lived momentarily; stories are capable of being retold creating a chain of repetition. To re-envision health disparities in the way Benjamin (2006[1936]) conceptualizes the storyteller, is to give way to “the profound perplexity of the living” (365). Most importantly, stories enable the appreciation for time through the craft of narrating memories. For Taussig, the diary works in a similar fashion. “Diaries record events, not non-events...Diaries record trivia, too. In doing so they fold life back on itself so we see the ordinary in new ways...” (Taussig 2003: 150). Understanding health disparities through storytelling allows for the imagination of a world that is ontologically different from the information based world. The narratives of my interlocutors, blended in my retelling, are a mode of opening up the imagination of the reader to the possibility of alternative desires and alternative ways of envisioning a world or a way of healing. Taking health disparities as a narrative emergent in the stories told by my interlocutors, structured by their hopes, desires, and experiences, allows me to illuminate how they live and experience chronic disease and how they envision healing.

This move to reconsider health disparities as narrative rather than universal explanation is in response to the ways race has become conflated with health disparities, as if race is indicative of the disease. Montoya’s book (2010) *Making the Mexican Diabetic* illustrates the procedures that make race a marker for disease while overlooking the actual lived social circumstances that produce the disease in the first place. I take on the anthropological lens of storytelling to see health disparities as part of a larger story about history, politics, gender, and even the intimate aspect of love and marriage. For me,

a narrative allows one to see what is at stake in healing, what relationships are most desired for wellbeing, and why the past is important to healing. For my interlocutors who are separated from kin in the diaspora, a narrative approach to type II diabetes and health disparities includes the ways that the social fields of transnational relationships, history, and racial politics play out in medicine, health, and healing.

Stevenson's book *Life Beside Itself* (2014), provokes me to think beyond a structural model and its ontological explanations of risks and predictors, to "listen differently to the lives and imaginations of the people who matter to us" (174) and to their "desire to belong differently to the world" (173). Under the structural explanations of health disparities, the desire for a cure for diabetes and the idea of return migration as a form of healing make no sense. There is no room for this logic; it becomes irrational, and the choice to engage in return migration rather than to seek out continual chronic disease management is then deemed as noncompliance and easily written off as another cultural explanation for that noncompliance.

Structural models around health disparities hold a worldview where the logic of care sustains biopolitics—ensuring a population's life. Stevenson's work enables the consideration for how return migrations and diabetes together ask and speak to a different way of caring for one's health and wellbeing, and in my interlocutors' case, to care for the chronic life circumstances that stem from displacement. Return migrations for health and wellbeing from diabetes reimagine a care for dislocation through social connections and the recreation of kinship ties and relationships in Laos and Thailand. Listening to the

stories told rather than attending to the ways Hmong-American patients fail or are obstructed from receiving care, signifies for me their lived experiences as displaced persons making a life in the US or as, one interlocutor put it “just living” in the US passively (see Chapter 1). In her (1990) book on selfhood in Japan, Dorrine Kondo uses the rhetorical ploy of vignettes—setting the scene, narrating events, and reflexively inserting herself in her book, to highlight “the complexity and richness, methodologically expanding what counts as theory. Experience and evocation can *become theory*, where the binary between ‘empirical’ and ‘theoretical’ is displaced and loses its force” (Kondo 1990:6-5). Like Kondo, I take theories of health and illness, life and death, and home and displacement, to be emergent in my interlocutors’ stories.

Critical Melancholia

This dissertation draws on critical melancholia as a primary theoretical orientation. Drawing on the sentiments evoked by the diaspora for Hmong-Americans, critical melancholia engages with the feelings of loss and desire within type II diabetes illness narratives as a productive potential. Attending to Hmong-Americans who feel their diabetes is caused by *kev nyuaj siab* (a distressed liver) from living in the U.S. and that return migrations are a way to cure their diabetes, even if it is temporary, points us to the objects of loss for Hmong-Americans. As I detail more fully in Chapter 3, melancholia for Sigmund Freud (1963[1957]) is the narcissistic and pathological condition caused by the ego’s inability to comprehend the loss of the love object to the extent that

the individual internalizes the lost object and the shadow of the lost object falls upon him. For Freud, a healthy individual is able to overcome their loss through the process of mourning. In the case of melancholia, the shadow of the lost object remains and the individual attempts to reincorporate the lost object. In this dissertation, the lost object is a multiplicity. It is the lost object of a social life where one is socially valued, mobile, young, and youthful. The lost object is also Laos and the once autonomous region of Nong Het where Hmong leaders emerged for a time. And lastly, the lost object is a Hmong sense of sovereignty and a Hmong Kingdom.

The lost object's shadow functions similarly to remnants (Eng and Kazanjian 2003), memories (Yoneyama 1999), and even the emergence of a ghost that embodies the trauma of the past of U.S. imperialism (Cho 2008). I draw on Avery Gordon's (2008) work on haunting to consider the shadow of the lost object as "an animate state in which a repressed or unresolved social violence is making itself known, sometimes very directly, sometimes more obliquely." (Gordon 2008:xvi). The inability to move on from repressed or unresolved violence, makes a claim about the violence of U.S. imperialism and the Secret War. For in addition, Hmong loss was not recognized. Their grief was never officially mourned, only further excluding Hmong-Americans from the nation-state as their racial positions are figured around the secrecy of U.S. violence in Southeast Asia (Butler 2004; Vang, M. 2012). The shadow of the lost object is the culmination of multiple figures and subjectivities. It embraces the feelings of being from *tim u* (afar) as discussed in Chapter 1, the displaced subjectivities as discussed in Chapters 1 and 2, and

the *plig* (spirit or soul) that remains in Laos and Thailand despite Hmong-Americans living in the U.S. Attempts to reincorporate the lost object are made through return migrations, as discussed in Chapter 3. Rather than pathologizing, critical melancholia examines the ways in which the desires of the *plig* to return home and to be in a place where one feels socially significant and where feelings of displacement are settled, are productive ways of creating and healing a displaced Hmong body politic. Drawing on discourse and practices that constitute Hmong-Americans as belonging in Laos and Thailand, I illustrate how sentiments of melancholia, of loss and desire, work to reunify Hmong in the diaspora.

As Judith Butler (2004) argues, in *Mourning and Melancholia*, Freud considered mourning as successful only if the lost object would be replaced by another. But Butler was not as optimistic about the interchangeability of objects. For her, following a later Freud, a melancholic incorporation of lost objects is inevitable, and this incorporation renders loss transformative in ways unknown to the individual. However, I maintain skepticism about the productive potential of melancholia. As melancholia is implicitly linked to Freud's work on the death drive, I engage with his work on the repetitive activity of an individual to try to incorporate the lost object. In the case of return migrations, I illustrate the ways in which incorporation of the lost object is unequal, heterogenous, and even discontinuous. As Freud writes in *The Pleasure Principle*, these repetitive actions are never really able to reincorporate the original lost object because any attempt at reincorporation blends the old with the new (Freud 1922). For Deleuze this

is also the case in repetitions, as repetitions continue to create new forms of the old (Deleuze 1994:1). This is where my dissertation's work on death as the only possible cure for diabetes and a true return to Laos enables a consideration of the dream of attaining the lost object of the Hmong kingdom. However, death, in terms of Hmong cosmological beliefs, is a return to the ancestral land that coexists within the present. My work on the claim to death as a political claim to Hmong sovereignty illustrates that a Hmong kingdom has never been lost.⁷ It is like the trauma of displacement, a metaphor of the ghost: "what has been concealed is still very much alive and present" (Gordon 2008:xvi).

Journey through the Chapters

This dissertation takes on the metaphor of a journey to understand how the everyday practices of chronic disease management and living in the U.S. as displaced persons inform the claim that return migrations (through actual return or through death) can heal the Hmong-American body. Similar to the return migrations that my interlocutors take on, this dissertation moves through multiple sites, beginning in the clinic in St. Paul, and moving on to Laos and Thailand, and then returning to an earlier time in my fieldwork at an adult daycare center in St. Paul.

⁷ Mai Na Lee shared with me that funerary practices are engagements with the Hmong State. Any debt that the deceased incurred during their time in the land of the living must be settled before they can be received into the afterlife.

Chapter 1 begins with the biomedical encounter. I analyze the experience of diabetes management and how diabetes management is structured by quality measures, in order to understand how these processes produce feelings of displacement for my interlocutors. In this chapter I argue that the biomedical encounter of diabetes management, blood glucose numbering, and quality measures around diabetes and care, leave my interlocutors feelings subjectively displaced because they do not compose the sort of population for which these medical regimes (diabetes management, education, stress, and nutrition) are designed. I define subjective displacement as the trace of their refugee excess, of always being both here and there (in Laos) at the same time.

Chapter 2 continues this line of argument by examining how the biomedical encounter further reinforces their feelings of displacement in the pedagogies of diabetes education that focuses on the biological and the present, and is informed by the white nuclear family. In this chapter, I detail the gendered aspects of type II diabetes around issues of food, performance of gender, and Hmong identity. I argue that Hmong-Americans are explicitly engaged in informing others of the limits of biomedical care as they assert their own need to care for one another through social care. I ground my definition of social care in my interlocutors' explanation of the need for tending to one's social relationships and for speaking kindly to one another. While my interlocutors in the diabetes group visits try to care for one another and make their lives and disease more bearable, I find the subjective experience of displacement as a source of potential that shapes Hmong-American desires to engage in return migrations.

Chapter 3 details the different forms of return migrations. This chapter tracks Hmong-American return migrations, the role of family and kin in shaping health and healing through discourse and rituals of *hu plig* (soul calling), the embodiment of place, and Hmong herbal medicines. Chapter 3 argues that return migrations remedy Hmong-American feelings of displacement by (re)connecting them with kin in Laos and Thailand. Return migrations not only work to heal their embodied sense of displacement but also heal a displaced Hmong body politic. Drawing on critical melancholia, I argue that the desire to heal a displaced Hmong body politic is rooted in sentiments of loss and trauma. But return migrations are bittersweet; they are complicated by historical change, the inequality of class, money, and gender, and the divergent political alliances that are embedded in the Hmong diaspora.

Although chapter 3 concludes with feelings of hope mixed with the complications of return migrations, **Chapter 4** theorizes the impossibility of return migrations through the claim that death alone can heal diabetes and is the only true return to Laos. I argue that biomedical and governmental narratives of salvation are failures as Hmong-Americans continue to be made to live biologically, while suffering a social death. The claim that death is a cure for both chronic disease and their life in the U.S. forgoes the promises of salvation and the possible promise between the U.S. and the Hmong. It forgoes the long-disputed idea that if the war was won, the Hmong would receive their own homeland or autonomous region. Return migrations can become destructive, as I will show, when they represent repetitions of a return to the first lost object, that is the

Hmong Kingdom. Therefore, I argue that the notion that the only true cure from diabetes and the only true return to Laos to Laos are through death is a political claim to Hmong sovereignty and a Hmong kingdom through death. Drawing on Hmong funerary practices, I argue that Hmong sovereignty and Hmong kingdom has never been lost. Informed by Eliade's approach to *The Myth of the Eternal Return*, the Hmong Kingdom (the land of the ancestors) exists not within the past but is everlasting present.

Method and Fieldsites

During my graduate studies, I was fortunate to meet Jessica Russel⁸ when I worked on a community research project with her at Hawthorne Clinic. Jessica was the medical director at the clinic at the time, and she often engaged in community research with her patient population. Hawthorne Clinic is a federally qualified clinic, meaning that they offer a sliding fee scale for their patients, care for uninsured patients, and receive federal funding. In the summer of 2012 I was awarded the scholarship and began my job at their clinic as a diabetes program coordinator. During this time, I did not conduct research because I was aware that it could be a conflict of interest and might make my interlocutors feel pressured to be part of my research study. Instead, I used my time as program coordinator to get a feel for their experiences with type II diabetes and chronic disease management. I coordinated the diabetes program for both Hmong and English-

⁸ All names for persons and places have been changed.

speaking groups. What soon became apparent while I was observing the groups and considering their efficiency and effectiveness was that the Hmong speaking group was often overcome with emotions. Tears streamed down Hmong-American men's faces as they related their struggles around masculinity in the U.S. and the challenges of cultural changes. Most striking was the discussion of a possible cure for type II diabetes in Southeast Asia. Returning to Laos and Thailand, to places they used to live, to eat the food they grew up eating, and to be with family members from whom they had been separated were equated with a temporary cure from diabetes. When my paid scholarship work ended, I asked participants if it was okay for me to contact them for my dissertation research. Many saw me as a daughter and were willing to help me with my "paper" so I could finish school.

I had also conducted other interviews and observations during my volunteer work at an adult daycare center for Hmong and Vietnamese-Americans. My interviews with Hmong-Americans who had type II diabetes confirmed the health science literature—Hmong-Americans often did not know what type II diabetes was until they were diagnosed, but interestingly, they cite as a causal factor for their diabetes the displacement of Hmong-American in the US.

Since chronic diabetes affects mostly the adult population, I interviewed Hmong-Americans who were 50 years and older, born in Laos and who had experienced the American War as teenagers. I call these interlocutors Hmong-Americans while I refer to those Hmong still residing in Laos and Thailand as Hmong-Lao and Hmong-Thai. It is

important to note that my interlocutors/informants in the U.S. do not call themselves Hmong-Americans when speaking about themselves abroad. They identify themselves as “Hmong.” I chose to, however, use the hyphenated designations as a means to trace the historical and cultural variations between different Hmong national groups. Scholars like Ma Vang (2012) have chosen to call Hmong-Americans, Hmong American/Refugees to highlight the historical reference of political conflict and how the refugee status of being unsettled continues despite their resettlement in the US.

The phenomenon of return migrations for health and healing that I found seemed particular to my interlocutors’ generation. Upon asking about their diabetes, I soon learned that many returned to Laos and Thailand to seek healing that is place specific and temporal. Their return migrations often coincided with the New Year festivities in Laos and Thailand that occur from November into January. This is also a time when the subtropical climates of Laos and Thailand are ideal, when it is not too hot or humid. Of course, there are some alternative views, mostly among Hmong-American women, who sometimes argued that it was Hmong-American men who returned for the purposes of romance. Louisa Schein (2004) and Nicolas Tapp (2010) write about these romantic return migrations by Hmong-American men. Jue Vang, a Hmong-Lao scholar at Chiang Mai University at the time of my fieldwork in Thailand, was also conducting qualitative research on the romantic return migrations and transnational marriages between Hmong-Americans and Hmong-Lao. I do not want to silence the nuances of these return migrations, whether for love, for health or healing, or for the purposes of seeing family.

They are folded into one another. During the time of these scholars' fieldwork, Hmong-American women were not returning. However, during my time in Laos and Thailand, Hmong-American women were starting to increase in numbers and also engaged in romantic pursuits.

Whether their return migrations were conducted under the guise of healing or otherwise, the Hmong-American women and men with diabetes that I interviewed who came into the clinic to check their prescriptions before their return migrations all agreed that these migrations helped them feel better. The biomedical researchers to whom I presented my project, who were well versed in psychosomatic disorders and the biological effects of racism - or rather how social experiences of discrimination could biologically imprint on the body, always inquired whether I had tested the blood sugars of these Hmong-Americans. Many asked if my informants ate too much rice, or if they did not get enough exercise in the U.S. This reflects the difficulties for any researcher in uncoupling diabetes from its dietary and sedentary explanations. However, the aim of my project is not biomedical research, but an anthropological project that begins with diabetes to examine the chronic not in the biological sense (i.e. diet, exercise, obesity etc.) but rather the social sense, so that I can interrogate the politics of return migration and healing for a community in diaspora.

Because of the interconnections between type II diabetes in the US and transnational relationships and lives in Laos and Thailand, my dissertation involved multi-sited fieldwork that spanned not only clinic spaces and the homes of Hmong-

Americans with type II diabetes but places that were identified by my interlocutors in my interviews. During my six months in Laos and Thailand, I conducted research with Hmong-Lao and Hmong-Thai about Hmong-American return migrations. A limitation to my research was that I was not able to interview Hmong-Americans during their return migration trips as they were often in a hurry and uninterested in my questions. On the other hand, the months I spent in the villages of Laos and Thailand allowed the locals to trust me over time and to entertain my questioning. Taking note from my interviews in the US and with local Hmong-Lao and Hmong-Thai about the places Hmong-Americans visited, I traveled to those places and observed the reception of Hmong-Americans. In Laos, I went to villages on the outskirts of Vientiane. I went to the Hmong hub of Xieng Khouang, in northeastern Laos, where even the ethnic Lao spoke Hmong. I also stayed in a village in Luang Prabang. In Thailand, I went to the provinces of Chiang Mai and Chiang Rai in the northern region of the country where the majority of Hmong-Thai and Hmong refugees from Laos lived. I stayed with a Hmong-Thai herbal healer who had treated many Hmong-Americans. I also interviewed and observed the practices of one Hmong-Thai healer who practiced Chinese medicine and acupuncture.

After my field work in Southeast Asia, I returned to the US to work in the diabetes groups as a volunteer. The returning diabetes participants who were already familiar with me through previous contact were interested in my fieldwork stories and continued to tell me more about their travels in Laos and Thailand. This time I was able to conduct participant observation during the diabetes group visits.

In this dissertation, I ask: How do Hmong-Americans experience chronic disease management? How does chronic disease management fail to address the issue of Hmong-American experiences as displaced persons? How do these return migrations serve as an alternative form of care to chronic disease management? How does the paradoxical notion of death challenge the paradigm of preventative medicine and chronic care, as well as a larger Hmong politics that stem from a complicated historical political relationships between Hmong-Americans, the U.S., and Laos? And what is made possible through these claims of life and death for a community in the diaspora?

CHAPTER 1: NUMBERING DIABETES

Soua's rental duplex in St. Paul, MN was located at a dead-end corner street that was plagued by the sounds of constant traffic. The house appeared run-down and the lawn neglected. The first floor was rented out by another Hmong man. When I arrived, Soua came to the door wearing a pink polyester shirt with shiny sequins and flower decals. She paired her brightly colored shirt with black sweat capris. She looked tired, her eyelids droopy. The middle of her eyelids had white patches of skin and her face was freckled with dark spots, perhaps from long days in the garden. Her dark tan cheeks fell past her jawline and her lips were thin, forming a small frown. She directed me towards the couch in the living room. "Thank you so much for letting me come out here. Where would you like me to sit to ask you questions?" I had asked. "Oh, there's nowhere to sit anyways," she said. She pointed to the tan love seat sofa, indented from years of use. "Just here on the sofa." The room was bare—no pictures and no clutter. Soua told me that she has a total of six children, four boys and two girls. Just past the living room area was the dining room consisting of bare walls and entrances closed off by sheets of fabric that served as curtains separating the rooms. She used to live in a Section 8 apartment but had since moved in with her youngest son.

"Do you remember when you first heard about diabetes?" I asked her. "No. I don't know. I never heard of it before my diagnosis." Her answers were short and to the point. I nervously ran through my questions and scenarios trying to extract more

information. I continued with question 2: “Are there other terms that Hmong used to describe symptoms similar to diabetes?”

“No, Hmong [people] don’t [have other terms].”

I continued to probe for more answers. “Yeah, diabetes, Hmong people don’t really know about it until they come here [the U.S.] and doctors tell them that they have diabetes.”

“Yes, you’re right. I believe that back in Laos, we probably had diabetes too. It’s just that here, they have doctors to diagnosis you. Over there you didn’t have that.”

Her brief answers made me nervous, afraid that perhaps I wouldn’t get much out of this interview. I offered my own reflections on my father and my observation of his experiences with diabetes. I told her that, as a daughter, I didn’t know if I could tell him what to eat and not to eat. “You care about him and want him to be healthy, but he doesn’t do what the doctors recommend,” I said. She opened up then to teach me about the problem of ascribing blame to the patient by referring to her personal experience. “Doctors tell you to take care of yourself and to not eat certain foods like sugar [sugar and sweet foods were the only food that she cited]. And you do as they say but your diabetes doesn’t get any better. And so, I wonder to myself what is wrong with me? What kind of person am I?”

Soua explains her feelings of social insignificance as she continues in our interview, “You listen to the doctors and you try as much as the doctors tell you to do but there is nothing that seems to help. It’s like people look at you differently now. You’re not

the same person anymore. They look at you like you're someone disgusting. You no longer seem like the old person you used to be and you've become sick and you look disgusting. How is it that you've [referring to herself] aged so ugly...people tell you these things that you no longer look like you used to. With diabetes you age differently. See, I'm only 62 but I can tell you that my body is much older. In Laos," Soua went on to say, "you could speak and talk to people. There was a purpose for you. You could go to the garden, you could talk to people, and do your work. But here, you just live here."

In sharing her story about her experience with diabetes, I understand what Soua is trying to teach me in this moment. It is not that she, or my dad, doesn't do what doctors tell them to do. But in her attempts to follow doctor's orders, the experience of the biomedical encounter and the disease itself, has a way of leaving Soua feeling inadequate and subjectively different. By examining the biomedical encounter, between Jessica and her patients and blood glucose numbering, I argue that patients like Soua are left feeling subjectively displaced. Drawing on my ethnographic fieldwork in the clinic, community-based research on quality measures, and interviews with my interlocutors, I illustrate the different forms and expressions of subjectivity that Soua and my interlocutors experience. These forms and expressions of subjectivity occur at the level of the subjectivity, population, and the experience of time and temporality. Soua and my other interlocutors feel they do not fit the mold of diabetes care (and in my work diabetes care as structured by numbers). I situate diabetes care within the project of quality measures to argue that quality measures assume a white neoliberal patient subject and population, one that has

the self-motivation to ensure its own biological life. My argument on quality measures is drawn from my community-based research work in Solahmo (Somali, Latino, and Hmong) for Health and Wellness. Solahmo is a community-driven program of West Side Health Services with community researchers from Somali, Latino, and Hmong backgrounds. As a Hmong community researcher, I and a team of researchers from Solahmo consisting of doctors and community members, conducted qualitative research on the perception of quality measures on the part of doctors who practiced at both FQHC and non-FQHC clinics.

Citing feelings of social insignificance for Soua and her nostalgic reflection of a past life or perhaps a past self, which is situated in Laos, I then understand her feelings of incongruence with diabetes management as an experience that summons forth a Hmong-American racial subject that I define as being caught in feeling *tim u* (from afar) and yet living passively in the U.S. This incongruence is produced by the biomedical encounter and the performative tensions around the use of numbers, in blood glucose testing and quality measures. I argue that Hmong-American patients may not recognize themselves in the biomedical construction of the patient for Hmong-Americans. In the treatment of the Hmong-American body, interlocutors like Soua feel their bodily difference as also the haunting reminder of their refugee subjective excess.

Glucose Numbering

I met Jessica Russel M.D. Ph.D in 2011 when I started graduate school at the University of Minnesota. My acquaintance with the Hmong-American communities in the Twin Cities of St. Paul and Minneapolis also began at this time. Jessica who is a physician, clinic medical director and trained medical anthropologist has worked with the Hmong community since 1983 and provided care to them when they first resettled in the United States. She told me that they were afraid of getting vaccinations at that time. Jessica has always maintained a persistent spirit in helping Hmong patients. Jessica is fluent in Hmong and has always called her Hmong patients by their fictive kinship titles, *niam tias* (grandmother), *yawm txiv* (grandfather), *txiv ntxwam* (uncle) etc.

My ethnographic research with Jessica began when I was awarded a community health initiative scholarship at Hawthorne, a Federally Qualified Health Center (FQHC) clinic. We worked on improving the clinic's D5 measures. D5 is a set of treatment goals that would "represent the gold standard for managing diabetes" (MN Community Measurement 2014). D5 resources were created by Minnesota Community Measurement [MNCM] to make it easier for people with diabetes to work with their health care provider to better manage the disease by setting and achieving goals. When a person achieves D5 success, they reduce their risk for complications such as heart attack, stroke and problems with their kidneys, eyes and nervous system." (MN Community Measurement, 2014). These goals consisted of: 1) control blood pressure 2) lower bad cholesterol 3) maintain blood sugar 4) be tobacco-free 5) take aspirin as recommended.

My work at Hawthorne focused on goal number 3, maintaining blood sugar level or A1c levels to that of 7 (blood glucose level over the past 3 months).

The patient population of a FQHC clinic that is seen by Jessica and other providers is complex. Federally funded, they provide health care for underserved populations and offer sliding fee scales depending on payment ability. Hawthorne's patients are often immigrant, low income, and racially diverse. The clinic is staffed with Hmong, Latinx, African American, and white medical assistants, providers, pharmacists, and front desk personnel. In other words, the staff comes close to representing the racial makeup of their patient population.

The clinic has three branches, one in a community center, one (during the time of my ethnography) that was situated in a shopping center, and another one in a predominately Latino neighborhood. My research moved between the community center and shopping center clinics. One day I went to Hawthorne's clinic at the community center in order to observe one-on-one patient-provider appointments. The provider office was straight in the back corner, following the entrance from the main office. The office had four wall desks, a fridge adorned with photos of providers, medical assistants, and their children. One desk occupied by a registered nurse (RN) was making follow up calls with patients. I greeted Jessica who was deep in conversation with the RN. As I sat down, she pulled her desk chair up to mine and directed my attention towards the patient charts. Jessica pulled up the day's patients' charts and gave me a fast summary of each one. There were two that I would be observing that day.

The first patient I would observe was John whose appointment was a follow-up. Jessica told me that he had failed to get an MRI she recommended for his head and neck pressure. She suspected that the pressure was the result of a pinched nerve.. She also suspected that he had not been taking his diabetes medications. John had been instructed to come to the clinic for a fasting blood glucose test.

Another patient, Mee, was an elderly woman; when Jessica spoke about her, she placed her palms on her chest, expressing how much she loved the woman saying in Hmong “*hlub hlub hlub*” (love love love). Jessica had provided care to Mee for many years but today she had asked Mee to come into the clinic so she could speak with her about a mass of cells found on her liver that appeared to be cancerous. Many patients with diabetes had other health conditions; in this case of Mee it was the potential prognosis of cancer. Because diabetes affects the cell’s ability to obtain sugar, diabetes, if unregulated, has the potential to exacerbate other medical conditions.

After our morning run down, I followed Jessica into the exam room. She grabbed John’s chart from the wall, pushed the black tab reading “provider read” down, and walked in to greet John in Hmong: “*Nyob zoo os* (Hello) John!” The room was cramped with only enough space for the examination bed, two chairs, and computer. I chose to awkwardly occupy the small space by the examination bed, and I couldn’t shake the feeling that I and my research were intrusive. They continued with their visit after Jessica introduced me to John and told him about my research. Asking John what he was up to, he told her that he had just returned from California to be healthier. In California where

John had stayed with a relative, he had worked to lower his blood sugar by working hard in the gardens and sweating often⁹.

During his time in California, his body felt lighter; the tingling sensation that was present in both arms had lessened to only slight tingles down his left arm. Jessica asked again, “*Koj ua dabtsi xwb?* (What have you been up to?)” John immediately answered that question as if it pertained to his diabetes. “I have been taking my insulin and I have increased my vegetables a little bit.” They went through his medical regimen. He took 38 mg of insulin daily and his glucose meter has been reporting very low blood sugar. He suggested that it must be broken since he had not experienced any shaking or weakness with the low blood sugar readings. I watched his phone ring three times on top of his sweater on the second chair.

Jessica revisited his earlier complaint of head and neck pressure asking, “Are you willing to do this for me? Do you want to get an MRI?” He replied honestly, “No.” His trip to California had made him feel better and he no longer needed the MRI to check if he had a pinched nerve. For today’s visit, he wanted Jessica to treat the rash on his inner thigh that hadn’t gone away. I had left the exam room to give John privacy and returned toward the end of the 15-minute visit.

⁹ Culhane-Pera, Her C., and Her B. (2007) found that the concept of sweating was important to their Hmong-American participants. Diet and physical activity, such as working in the garden, are important to maintaining a health bodily balance. People understood that living in the US with the lack of physical activity and food infused with chemicals reduced the chances of sweating.

Jessica was facing the computer as she went over his medical results from today's examination: "Well you have a rash. Your blood pressure is not high...." Then she exclaimed in a congratulatory manner, "...and you lost three pounds!" turning to him to report the good news and then returning to the computer. She asked if he was still continuing his medications for blood pressure, cholesterol meds, and blood sugar; he answered no to all three. We waited for Jessica's medical assistant to enter in John's A1C result into the computer from the laboratory room, which was a room away.

In a matter of seconds, Jessica said, "Oh *koj cov ntshav pem heev* (your blood is really bad), 11.9, really high. We think that 7 is best but for the last three months, your blood sugar is very high but it seems as though to you, your body has gotten better." John answered her, "I don't know since I feel better, my body is lighter." Jessica's prediction during our morning meeting was correct: John had not been taking his medication and this was reinforced not only by his answer that he had discontinued his medication but also his A1c levels. Watching his facial expression grow confused reminded me of another patient who was meticulous about her diabetes management. When she was informed that her A1c levels had gotten worse, her optimism changed to a flat confused state. The diabetes educator told her that they would have to increase her insulin.

Testing blood glucose number is central to the control of diabetes. Type II diabetes mellitus is a disease where the body is no longer able to transport the sugars in the blood stream into the body's cells. In some cases the body's cells are no longer

responsive to the insulin beta cells, produced by the pancreas, that transport the sugar in the blood to the body's cell for energy. In other cases, the pancreas does not produce enough beta cells to remove the accumulation of sugar. Either way, when blood sugar accumulates within the body, the body's response is to dilute the sugars by extracting water from other parts of the body such as the mouth, eyes, or other organs, potentially causing severe dehydration that can become life threatening if left untreated. On the other hand, if the sugar in the bloodstream decreases dangerously and does not meet the demands of the body's physical exertion, diabetic shock can set in. A mild case of shock would result in fainting, and a severe case would leave a patient in a coma.

Daily finger pricks and fasting blood glucose testing are essential in avoiding the potential bodily crisis. In 1921, Frederick Banting, who discovered that sugar in the blood could be traced to the liver and metabolism of carbohydrates, argued for a change in the treatment of symptoms to an examination of the molecular metabolism of carbohydrates within the liver. The treatment of diabetes before WWII was a diet of starvation accompanied by a poor prognosis. In 1923, Frederick Banting, Charles Best, J.J.R. Macleod, and James Collip won the Nobel Peace Prize for isolating the hormone insulin from the pancreas and demonstrating that administering insulin decreased blood sugar levels in dogs with no pancreas. The introduction of insulin prolonged the lives of diabetics, who at the time were juveniles with type I diabetes. No longer were patients dying from diabetes at a young age. However, the double-edged effects of medical innovation would result in diabetes complications that couldn't be observed in children

such as renal failure, eye disease, and neurological problems. In the early 1950s, a second form of diabetes was becoming noticeable, specifically among adults who were 40 years and older. It was often associated with being overweight. Technological and medical advances changed the treatment of diabetes to prolonged management, through life style modifications, blood sugar regulation, and insulin treatment (Greene 2007).

Green (1997) argues that in 1977 testing for A1c levels and glucose readings transformed the prognosis of diabetes to one that is no longer based in symptoms but rather in asymptotic detection. Before the introduction of these tests, diabetes diagnosis relied on symptoms of glucose in the urine that produced a sweet smell or taste in the urine. The abstraction of numbers replaced the perceptual tools of doctor and patient. A patient is no longer required to present symptoms of pathology to receive a diagnosis. “We live in an age of numerical diagnosis in which the popular imagination depicts disease as a thing reducible to a fundamental molecular logic, ideally detectable by a blood test (Greene 2007:6).” By abstracting the disease to number rather than symptoms, diabetes becomes a *thing*, able for management. But what does diabetes number do? The numbers enable the clinical gaze to be drawn into the body to cultivate a neoliberal subject that sees their health along the lines of productivity and work (Ferzacca 2010).

Glucose Care and Quality

Despite John’s efforts, feeling better, and his claims to having taken his medicines, his A1c levels told a different story. They worked to reveal his high blood

glucose levels, allowing Jessica to care for John by making the disease an object for control and John's actions tangible for modification. Lisa Stevenson (2014) argues that use of numbers is "a form of care and governance that is primarily concerned with the maintenance of life itself and is directed at populations rather than individuals" (3). In John's case, Jessica's care is concerned with the maintenance of his biological life. Jessica's efforts are to direct him towards an understanding of his diabetes as oriented around biological values such as blood glucose, diet, and exercise in order to obtain the recommended A1c level of 7. Yet A1c recommendations that Jessica imparts as her mode of care are a population-based recommendation called quality measurements. She and other physicians have challenged some of these quality measurements, including A1c, as not applicable to their diverse populations. While quality measures around A1c is supposed to be "decontextualized, homogenized, and remote from local systems of meaning" (Merry 2016:3), Jessica and other providers have argued that quality measures are produced from systems of meanings that favor middle class white populations who are often less obstructed by systemic issues such as racism and poverty in achieving health. In their critique, they challenge claims that numbers are abstract by pointing out the different registers in which numbers are used in the practices of care. Yet despite this ambivalence, numbers offer providers ontological comfort; they allow providers a measurement of their care and their patients' progress.

Stevenson's work on care is indeed helpful in this moment to understand how Jessica and other doctors provide care. She conceives of care "as a way someone comes

to matter and the corresponding ethics of attending to the other who matters. Shifting our understanding of care away from its frequent associations with either good intentions, positive outcomes, or sentimental responses to suffering allows us to nuance the discourse on care so that both the ambivalence of our desires and messiness of our attempts to care can come into view” (Stevenson 2014:3). Numbers comfort providers because they are seen as a validating tool to assess and provide care. This care is ambivalent in its creation of a lived reality insofar as it attends to disease facts while figuring the social in different terms. Here providers encounter the limits of attempting to quantify a crisis that is not quantifiable.

Numbers in quality measures are seen as testifying to the essence of healthcare processes, delivery of care, patient satisfaction, and disease outcomes. An evaluative tool, quality measures are used to evaluate and improve health care through evidence-based best practices and with the objectives of rewarding performance with pay¹⁰. Quality measures are co-created from an array of agents from health care providers to private organizations that push forward evaluative agendas on health care processes. The goals of quality measures are to “Create reliable, comparative performance information on which consumers can rely to make informed decisions about their care; ensure practitioners and provider organizations are held accountable for the quality and efficiency of their performance; and support quality improvement activities.” (National Quality Forum,

¹⁰ Not all clinics pay providers based on performance, the clinic I conducted ethnographic fieldwork at didn't while other clinics that are private, for profit clinics did. It is debated in our findings whether this pay for performance actually got to the essence of quality and what truly is quality

2018) Quality measures order diabetes care through the regulation of A1c glucose numbers, recommending an A1c level of 7 to all patient populations.

A1c quality measurements are the abstraction of diabetes numbers to the spaces of “policy, guidelines, markets, simultaneously distanced from the level of human experience by the very small (molecular diagnosis) and the very large (mass long-term population studies)” (Green, 2007:6-7). The decline in acute diseases post-WWII coincided with the development of health organizations and associations alongside the participation of insurance companies in support of advancing the research on chronic disease. Networks of agents like public health agencies, insurance, and pharmacy companies, worked together in governing populations and managing population risk for chronic disease. During President Obama’s administration, he pushed forward his program of Hospital Value-Based Purchasing (Center for Medicare and Medicaid Service, 2017), a pay for performance agenda that was better known as rewarding doctors who make their patients healthier. Under this program, hospitals and clinics that received federal dollars (FQHC’s) and treat patients with Medicare and Medicaid would be paid for their quality and not the quantity of their services. While quality measures differ in different social and cultural contexts, the attempts to reward quality care through numerical representations present numbers as not just representative of something concrete but that numbers are made to testify to the essence of quality care. For Jessica and other providers, the desire to measure quality and the reality of not being able to meet the recommendations often leave her and other providers frustrated and ambivalent about

the role of these numbers. Yet, the numbers comforted them as they too also wanted to know how to assess their practices of care.

The fixation on numbers and the belief in their testament, removes the local context and everyday practices. During my fieldwork on the diabetes group, the quality measure of A1c of 7 was created by Minnesota Community Measurement; the number, when met, is supposed to illustrate “quality care” and ensure a decrease in morbidity and complications from type II diabetes. Five years after my fieldwork on diabetes, A1c levels had changed to 8. This was a response to the assertion of providers including Jessica that an A1c level of 7 was actually more dangerous for elderly diabetics. As mentioned earlier, Jessica herself had argued for years that her Hmong-American patients have constantly told her that they felt better at an A1c level of 9. Another provider shared how even the simple act of a health provider printing an after-visit summary for their patient was a “performance” of quality. Jessica smiled as she told me how she would print these off and throw them away. I understood exactly why in this moment, as her patients, like my interlocutors, often did not read English, let alone read or write in their native language. The act of printing off an after-visit summary favored a patient subject who was able to read and have some level of medical literacy. Despite these numbers assuring some real assessment of quality, the everyday practices of what counted as quality became mute for patient populations who did not sustain the reality that quality measures structures. While quality measures like A1c seem to impart objective truth, they also create their own truth in their use and deployment (Merry, 2016).

Providers from FQHC's that cannot meet these quality measures have argued that they largely serve to support and reward already well-resourced clinics with a homogenous patient population (Weinick et al 2010). Over and over again, providers interviewed stated that quality measures were created by a panel of white males disconnected from the diverse populations in urban St. Paul and Minneapolis. They critiqued the numbers as disregarding the racial and economic differences within the deployment of health care. They felt that quality measures defined by white males would only exacerbate health disparities in care. The deployment of quality measures gloss white male gloss as neutral while effacing the qualities of inequality that is experienced by patients and providers.

Quality measures are also supposed to allow patients, who are customers in the service of health care, to compare between clinics and the clinic's quality of health care it delivered. Quality measures assume that the free market and its forces will over time ensure quality care; they actually take for granted the market's forms of exclusions by assuming not only one universal patient population but also a neoliberal patient/customer. When considering quality measures, there is a need to take into consideration the social determinants of health and their role in shaping health outcomes. In addition, when we tease apart the neoliberal market of quality measures and health care, then it is apparent that quality measures, while reified as "homogenous" spaces of objective truth, are produced out of relations of power. Those who are more likely to have experienced

historical and social injustices have little power to participate in the construction of numbers that impact their lives.

Chronic Temporality

Jessica: How's your diabetes?

Mee: I don't know. Today I was 115 last night it was 70. I didn't shake but I was hungry.

Jessica: Has there been a time that it was more than 200?

Mee: No, just 180, 160, 120 only.

Jessica: At night, is it ever beyond 200?

Mee: Sometimes when you eat a lot more then it's 300, nqaij nqaib [if you eat chicken] then its 300. When you eat meat a lot a lot. Vegetables doesn't do anything.

Glucose monitoring was a medical breakthrough that extended the lives of patients with diabetes, in turn making diabetes a chronic disease. In the case of a chronic disease the terminality of disease is removed, instead giving way to medical complications such as heart disease, stroke, loss of nerves or limbs, and potential blindness. As one doctor told me, "No one dies from diabetes anymore, but they die from the complications of it." The meticulous disciplining of the body and knowing one's number, like in the conversation as shown in the conversation quoted above between Jessica and her patient Mee, structures an experience of time as focused on the present. The chronic care model or maintenance care is fairly new, and cultural theorist Eric Cazdyn (2012) argues that this mode of medical care structures our relationship to time, death, as well as to the social, the cultural, and the political. Returning to Soua in the beginning of this chapter, not only does she experience her diabetes chronically and the

possibility of death as deferred but she, within her disease experience of diabetes, also experiences chronic social insignificance. Resolution is deferred because addressing this social insignificance as acute would seek a return to the historical specificity of Hmong-Americans in the U.S. To seek resolution would require a reexamination of the historical and political.

The chronic is a term that Cazydn defines as a structuring of temporality as a “...mode of time that cares little for terminality or acuteness but more for the undying present that remains forever sick, without the danger of sudden death” (Cazdyn, 2012:5). The chronic, then, is the displacement of death from the present moment, so that we are unable to confront the terminal nor are we able to see the acuteness of the everyday that sustains the chronic. It extends the present moment into the future despite the fact that patients with diabetes (as well as other managed terminal diseases like cancer) would have once died from diabetes at an earlier age but now live to suffer from the morbidity of the disease. Their death is deferred but will come again in the future. In this mode of time, the present becomes the limit of experience and the acute becomes irrelevant.

In the model of chronic disease management, there is a continuous method of balancing blood sugar levels through multiple disciplinary acts of exercise, diet, and blood sugar testing. The focus of life is centered on the present. Temporalities of the future and death are displaced in chronic management due to the medical focus on the acute symptoms of diabetes. Only chronic symptoms of rising blood sugars are significant enough for attention; when her social experiences of living within the U.S. are

excluded, Soua is reduced to an embodiment of her diabetic signs. Diabetics often find themselves negotiating a moral disease, in a constant balancing act to manage their blood sugar, an act that renders their bodies as “something else,” something not them. Soua is caught in her diabetes; the physicality of the disease and the management of diet are a series of transformations in which Soua is often displaced, being both subject and object to her disease. Being caught also entails the unraveling of herself, so much so that Soua is unsure of herself and her place in society. She is beset by both the perpetual management of diabetes and the perpetual feelings of social insignificance.

Soua’s experience of social insignificance is also structured by the limit of the present in that it is treated as chronic rather than acute. Stating how she “just lives” (*lam nyob*) in Hmong, has the sentiment of passive living. Soua’s passive self is reflected nostalgically onto an animated and active self that is situated in Laos. Actions and social life helped to constitute “who she used to be.” Life in the U.S. for Soua, and many of my other interlocutors who were born in Laos but left as teenagers or adults, is a numbing existence of social insignificance, especially for those who are unable to speak the language and who find the cultural changes in their children’s lives in the US too challenging to handle. In Laos and Thailand, locals often told me that Hmong-American returnees described their life in the U.S as follows: “In the U.S you are like a pig. You are always sheltered from the elements. You live in your house and when you leave your house you’re in a car. Only to leave the car to go into another house.” The expression of being locked up as a pig, speaks to the animality of such passive living. In Hmong, to

live is to *ua neej nyob* (to make a life living) in which the subject is agentive in the making of their life. However, Soua's articulation of her positionality in the U.S. leaves her as a subject devoid of any agentive abilities.

Her experience of social insignificance is chronic in that any redress is deferred and the past remains closed off in the limit of the present. However, Cazdyn poses a radical shift from chronic time by seeing "the chronic (the everyday, non-urgent crises that are internal to the stability of the patient)...as acute while to manage the symptoms (to treat them as chronic) is to terminate any possibility of significant change" (Cazdyn, 2012:36). In Soua's case, to address social insignificance as acute require a reexamination of Hmong-American U.S. politics, the historical event that structures her continual experiences of social insignificance. In order to resolve those feelings would require a reframing of the chronic to the acute and a return to past (this is addressed in chapter 4). Soua's interview points us towards this wavering past that is summoned in her feelings of incongruence with biomedical practices, as she fails to become the patient with controlled blood sugar levels.

Displacing Subjectivities

For Soua, these "decontextualized" regimes of care summon forth a racial subjectivity that draws on the history of displacement for her and my other interlocutors. Biomedical regimes are predicated on a particular patient subject that is not the racial Other. Engagements with biomedicine and medical intervention continue to cement their

bodily and subjective differences as they continue to experience a lack of congruence with the numbers and their lived experiences. In Soua's narrative of her constant struggle with her disease, she gestures to the haunting reminder of Laos and her participation in that society. As diabetes renders her control ineffective, Soua articulates the haunting reminder of who she used to be. For some interlocutors this unfamiliarity with the person who has the disease is often contrasted with the familiarity of who they used to be in Laos and Thailand.

Ahiwa Ong's book *Buddha is Hiding* (2003) illustrates the racial politics of medicine as enacted on refugee bodies, articulating that clinicians discipline the refugee into a citizen by "normalizing and directing refugees in the rules and aims of biomedicine and the medical bureaucracy..." (Ong, 2003:121). Yet these forms of disciplining mechanisms are not all encompassing; discipline is a very contested project, as refugees are also engaged in actively negotiating these practices. The act of territorializing refugees into citizens through the body is therefore never complete. Relying on quality measures and A1c and blood glucose numbers allows doctors to remove their and the patient's biases. But Hmong-Americans feel the use of these numbers fail insofar as their application onto Hmong-American bodies summons forth Hmong-American a racial subject.

For interlocutors who are recent refugees, their continual remembrance and articulations of displacement are deeply embedded in their experience of diabetes. The inability to control their diabetes is shadowed by the excess of the refugee subject, one

who remains unterritorialized and uncontained by biomedicine. Expressed in the experiences of bodily difference, the chronic living of displacement, and the experiences of minoritization, monolingualism, and feelings of social isolation (*kev nyuaj siab*), the culmination of these experiences sustains a flexible subjectivity that is outside of nation-state and biomedical boundaries. It expresses a form of excess that cannot be contained either within the biomedical gaze or the boundaries of the U.S. For Interlocutors often use the descriptor *tim u* to describe why the medications given to Hmong-American patients don't work. *Tim u* serves as a directional term, stating where the individual is from at the same time it locates the subject's positionality and origin as outside of the current nation-state and medical boundaries. The term *tim u* is ambiguous, enabling a potential to not only position oneself as outside of nation-state boundaries but to also territorialize places of exile by indexing them as traces in the body, which encompasses Hmong places of residence during their flight from Laos. As one participant clarified for me, *tim u* also includes Thailand, a site of asylum for Hmong refugees after the Vietnam War. This usage then blurs the geophysical and historical boundaries of Laos and Thailand; deterritorializing Laos to reterritorialize Thailand in the pursuit of a Hmong return to health. Commenting on their bodies as *tim u* indexes their birth country of Laos and also Thailand, a place of temporary asylum. Not fitting within the U.S. bodily, socially, and medically highlights moments of minoritization, isolation, and alienation within the U.S. At the same time, there is an excessive trace in the body that cannot be demarcated within the confines of the biomedical/American body. This trace is felt inwardly for my

interlocutors, as both corporeal and transcendent, a trace of both a somatic difference and a subjective excess.

The description of not “fitting” within the U.S. remains prevalent as my interlocutors often deployed comments like “We are people born *tim u*” not only as a statement of racial and immigrant status in the United States but also as a moment of indexing a Hmong-American subjective displacement. This displaced subjectivity is similar to Ma Vang's (2016) articulation of a Hmong deterritorialized subject. Vang writes, “[a] Hmong deterritorialized subjectivity is connected to the persistence of the refugee's condition of homelessness in exile.” (Vang, 2016:90) However, identifying or positioning themselves outside of the US nation-state and the medical gaze, highlights not only a homelessness but their inheritance of this past.

Such social and biological differences produce an awareness that they are “not the same person anymore” but always marked as born *tim u* [afar]. The usage of the term *tim u* to mark Hmong-American bodies as different from biomedical understandings was present in even the most compliant patient, who has their diabetes under control. It is not only a marker of difference but way to position the subject as both here and *tim u*. The subject then occupies multiple positions, spaces, and temporalities, existing both within the U.S. yet simultaneously emerging from the spaces of the past. One could argue that self-positioning is nostalgia, but I suggest instead that the articulations of this feeling during my fieldwork work to imagine that another self continues to live in Laos even as the speaker resides in the U.S.

Conclusion

In this chapter, numbers order diabetes into a manageable disease. It allows the possibility of deferring the crisis of diabetes and death. While these numbers exert a form of truth-telling to the disease within the body, they are embedded within a social context that, in its universal application, leaves people like my interlocutors to feel subjectively different from the biomedical body that these numbers treat. As this chapter has shown, the subjective difference my interlocutors experience is a trace of their refugee excess that cannot be contained within the medical treatment of chronic disease, especially when that treatment is to chronically manage their biological life. In turn, they are also to experience chronically their own displacement.

However, as this dissertation will show, I find the displaced subjectivity of my interlocutors as a site of possibility. A displaced subjectivity disjoints the limits of the present as my interlocutors' subjectivity remains haunted by the past and also by a desire to resolve their displacement. Perhaps then, it's not surprising that in my fieldwork, I have found that many Hmong-Americans who experienced war and displacement, often asserted that the cure for diabetes is to engage in return migrations to Laos and Thailand. Both Vincent and Jessica had patients who left for Laos and Thailand. Jessica told me that one woman chose to return to Laos to die there. The rest of this dissertation illustrates the processes that enable a return migration to become possible and how it becomes important for the healing of so many Hmong-Americans. Of course, not all Hmong-Americans agree that return migrations can cure you of diabetes. But it is still

worth asking how so many Hmong-American diabetics have made it a practice to live three months out of year in Laos and Thailand. What does chronic disease management pedagogy fail to address for Hmong-Americans? How do return migrations provide the care that Hmong-Americans with type II diabetes seek?

CHAPTER 2: DIABETES GROUP VISITS AND FINDING HOPE

The diabetes group visits started at eight in the morning and I had recruited eight Hmong participants to attend. The diabetes group visit is a once a month meeting that brings together a group of diabetes patients with their entire health care team to work on caring for the patient's diabetes, replacing separate appointments with individual members of their health care team (i.e., a doctor, nutritionist, pharmacist, and diabetes educator). The group visits met once a month for six months and afterwards, every other three months following each three-month A1c fasting blood glucose test. We began with each person introducing themselves by their first names and stating how long each had been a diabetic. Lor Vang stood out, wearing a Hmong patterned vest with wiry hair and beard; he stood up and tears began to fill his eyes. Lor wiped away the tears as they streamed down his face with his working hand, and continued, "I used to be an able person, but after I had my stroke I can no longer wash my own hair. This hand [lifting his nonfunctioning arm into view], I can't lift over my head. My wife took all my kids away from me and she's taught them to hate me. Sometimes I just watch my blood sugar levels go up and wait to see if I will die. I wait to see if someone will call me, to give me a reason to live." I choked back on my own tears, moving my eyes from patient to provider to staff to see if anyone was moved to tears, or if I were the only one. A patient got up from his chair to tell Lor to not think about those things, and a staff member gave Lor some tissue to clear his nose. He had slowed his tears and his breathing returned to

normal. Another patient interrupted him to console him, “This is why we need a group like this, to find ways to help each other.” And as this sentiment is repeated in other diabetes group visits, so that patients can “load our guns and barrels” especially when, “everything is the thing that will kill you (*qhov twg yog qhov yuav tua yus*).”

The metaphor of “loading and reloading one’s guns” through the diabetes group visits speaks for these patients about the real dangers and ongoing crisis of the everyday. As Lor watches his blood glucose numbers rising in moments of intense mental and emotional distress, the lack of social support and feelings of insignificance in his family are what sustains his diabetes and endangers his life. Like Lor’s poignant account of waiting for someone to give him a reason to live while waiting for diabetes to cut his life short, this chapter argues that the separation of the biological, diabetes, from the social nexus of life and social relationships is not possible for my interlocutors. To understand the “everything” that threatens to kill, this chapter draws on the phrase “walking back to the root” to understand the dangers of the lived everyday for Hmong-Americans and its effect on diabetes. Drawing on my observations of the diabetes group visits, I illustrate how Hmong-American patients work to reveal the rigidity of diabetes pedagogy by telling stories of their own personal struggles of daily life.

Diabetes group visits are set up to cultivate and motivate patients to perform self-management of the body through diet, exercise, and collaboration with health care provider expertise. Yet as Taussig writes, “The patient’s so-called model of illness differs most significantly from the clinician’s not in terms of exotic symbolization but in terms

of the anxiety to locate the social and moral meaning of the disease” (Taussig, 1980:13). This chapter argues that the moral (the question of Lor’s social significance) and the social (the chronicity of social challenges) are embedded within the patients’ experiences of diabetes. By drawing on my fieldwork observing the diabetes group visits, I illustrate that questions of morality and questions of the social arise in conversations about what it means to be a man in the US with this disease, experiences of cultural dissonance, and problems of love and marriage. I argue that despite the seemingly totalizing nature of the technologies of self that diabetic patients are supposed to cultivate, Hmong-American patients’ subjectivities remain “undisciplined” as Hmong-American testimonies around diabetes center their experiences of displacement in the diabetes group visits. Through the act of sharing their lived experiences of loss, the constraints of gender and diabetes, and questions of love and marriage, they re-envision a way to care for diabetes by performing social care, that is to tend to their social relationships with the use of kind words.

Diabetes Group Visits Structure

During my time at Hawthorne’s Family Clinic, I coordinated English- and Hmong-speaking diabetes group visits. I had been awarded a summer scholarship to work with a community organization for improving health which brought me to Hawthorne’s Clinic. As the diabetes coordinator, I recruited individuals from lists of Hmong patients that providers had previously singled out as good candidates for group education. When

selecting patients to invite, providers had to consider patient personalities and also “star” patients, the patients who had their blood sugar under control. I was the person of contact for these patients, the consistent voice that they heard on the phone reminding them of their upcoming appointments and inquiring whether they had carried out the goals they set in the group. Other times, the providers and I facilitated a discussion around the experience of coping with diabetes. With IRB approval, I also conducted focus groups with these diabetes group visits for the purposes of my own research.

As the organizer of the group visits, I also worked to improve the efficiency of the visits, making sure that all the required staff personnel were scheduled, and deciding on the topics for each visit. Sometimes topics such as diet, exercise, or general diabetes information were taught by a diabetes educator. Diabetes is a complex condition that often requires multiple sets of appointments. Structuring diabetes groups so that patients had contact with all the members of their care team during the same visit, allowed patients the ability to do “all their shopping at once.” Any concerns that were not diabetes related were then delegated to another clinic appointment. I also met with the pharmacist and providers to talk about the how to improve the group visits. Staff providers at the clinic understood that the control of diabetes consisted of more than just the regular blood sugar checkups and required a holistic examination of the patient. This holistic approach consisted of diabetes education, foot care, reviewing medications, and consulting a mental health specialist and nutritionist.

Creating the diabetes group visits allowed the clinic the chance to foster a patient-centered approach that accounted for the differing ways that people learned and provided good examples and mentors by including people whose A1c level was good. The practice of diabetes group visits within the clinic varies to a large degree. According to Tang's (2006) literature review of diabetes group visits, there exist three types of diabetes groups: empowerment groups, groups based on the needs of the patients, and community-based diabetes group. The diabetes group that we implemented utilized an empowerment pedagogy. Although there is only a slight outcome difference in group education verses individual education on diabetes management, diabetes group visits are often argued to be more cost efficient than one-on-one education from provider to patient. Yet clinics with lower resources like Hawthorne Clinic, a federally funded clinic that offers sliding fees and takes on a higher number of Medicaid patients, often face challenges and limited success in diabetes group visits. Lack of resources can choke the clinic's ability to carry on diabetes group visits if there is only one staff member involved in creating and running the group visits. At Hawthorne, for example, the Hmong diabetes educator wore many hats; she often worked as a medical assistant, checking patients into their exam room and taking blood pressure, in addition to working the front desk which entailed making reminder calls to patients. Every Thursday she saw patients to review diabetes education. My time at Hawthorne Clinic was spent initiating the group visits program; when I left, the staff told me how much they would like to have me back to run the groups. Having someone dedicated to coordinating the groups would ensure that staff

members could attend to their main duties rather than balancing additional tasks. For Hawthorne Clinic, under-resourced as a FQHC, the option of hiring a full-time diabetes coordinator is not financially feasible. FQHC's are able to supplement this lack of resources by applying for grants, or in my case, inviting in someone who has an external grant to cover their stipend. Unfortunately, these short term financial solutions do not address the long term need for diabetes education.

The Object of Health Education

The diabetes group visits structurally unsettle the clinical encounter by bringing together all of the patient health care team: provider, diabetes educator, nutritionist, and pharmacist. The duration of the groups is four hours. Most often only patients who weren't working were able to attend the long educational group visits. Learning about diabetes did not occur only between patient and provider but was structured as a collective experience where patients could share their own knowledge and experiences with diabetes, encouraging empowerment, and active learning from each other. The health provider/doctor under this new model was no longer considered the authoritarian figure in the room because the person directing the groups was also the diabetes educator, and patients were invited to voice their experiences. The provider during this time was nothing more than a gentle mentor who would support patients in their diabetes management.

Yet in the intention to make the diabetes group “patient centered” and overturn the hierarchy of provider and patient relationship, the very use of this terminology, as Michael Taussig (1980) argues, misleadingly presents patient-centeredness as seemingly instrumental and straightforward. The terminology masks the ways that health and disease are both components of larger human experience, situated within a nexus of relationships and context. Health, Taussig reminds us, is not “provided” by the provider alone, but rather is a relational interaction between provider and patient and community. Biomedical knowledge remains guided and channeled by the diabetes educator. The group’s central aim is structured around the chronic disease management of type II diabetes through self-management and discipline. Testimonies of diabetes experiences involving the challenges and successes of chronic disease management continue to reinforce the object of care as the thingness of diabetes, a biological fact that is measurable and manipulatable. Testimonies, as Vinh-Kim Nguyen (2010) writes in his work on an AIDS workshop in West Africa, partake in what Foucault describes as “technologies of the self.” For Nguyen, testimonies in the workshops around AIDS worked to fashion an “inner self that could be examined, prodded, and told...The workshops equipped participants with powerful tools by which they could transform themselves and others.” (2010:39-40) In the diabetes group visits, testimonies under the guidance of the diabetes educator, helped to orient the self around the care of diabetes. It is the process Nikolas Rose (2007) describes in his book *The Politics of Life* through which the subject is encouraged to view themselves and their risky futures alongside

expert knowledge and treat them as manipulatable through diabetes self-management technologies.

As Taussig argues, the focus of care on the biological mystifies the human relations involved, so that diseases become things-in-themselves, devoid of the social nexus that sustains them. Reifying the disease as an intrinsic thing enables, in turn, the commodification of care. In other words, the commodification of both care and disease requires that inter-human relations become obscured in order to position health and disease as the central objects in the transaction of care. Taussig continues to argue, drawing on Victor Turner's discussion of a Ndembu doctor, that sickness is a sign for a larger problem in society. Disease points us to the "communal and reciprocal inter-human considerations that are antithetical to the bases of modern social organization patterned on the necessities of capitalist and bureaucratic prerogatives" (Taussig, 1980: 13).

I remember the adrenaline running through me the mornings before group started. Would the patients show up after all the recruitment calls I had made? And would I finally get to match the patient to the voices that I became familiar with over the phone? Were there enough snacks? Did I communicate with all the staff? The medical assistants were a blessing; they handled the stream of patients who were all checking in at the same time and getting their blood drawn. At the end of each visit, I debriefed with the doctor and the medical assistant or pharmacy technicians about ways to better improve the flow of the group. I was concerned about the numbers: the numbers of patients, their retention rate, and how the program might become too costly for the clinic if recruitment numbers

fell too low. I, too, became accustomed to the biopolitical logic of a disease-centric approach—I worked for months on the flow of the group visits, making sure it was efficient and not chaotic, to ensure that the groups ran according to time, and that the topic of care that day was given the appropriate attention.

My interlocutors often complained to me about the awkward movement through the clinic, the procedure of waiting in line, blood draws, and sitting idly before the group visit began. “We’re here for groups, why are we still waiting like we do for a doctor appointment?” complained one elderly Hmong-American woman. In their view, a group visit was not supposed to be another doctor’s appointment. They were also suspicious of the commodification of care and the way in which they were expected to buy into the groups for the sake of improving their disease. My ears caught the complaints of one Hmong-American woman, who shared to the group that diabetes group visits were simply a pretext when the actual purpose was taking their Medicare or insurance money. Many Hmong-American patients qualified for medical health insurance because of their low-income status. They had the suspicion that their presence in the clinic equated to profit; in other words, the clinic could make a profit from their biological presence. Even though these groups were framed as being for their “common good” and as a way of learning from each other, at the end of the day, someone’s insurance had to be charged. Her critique pinpoints the very mystification that is essential to the commodification of disease in Taussig’s argument. If not enough patients showed up, which was a constant problem, then the time providers spent on, say, four patients would have subtracted care

from other patients who may have needed it. In other words, group visits were costing the clinic. The clinic itself operated not just on serving underserved populations but also on the practices of efficiency and cost-benefit.

Group education continues to order diabetes as the central object of care, but the patients' reflections on their feelings of displacement in the U.S. reordered care around the social. Voicing the effects of cultural dislocation and the trauma of losing loved ones, Hmong-American patients sought out social care in each other's stories and wisdom. In a debriefing meeting with Vincent Moua, a Hmong-American doctor, and the Hmong diabetes educator, I shared with them that it seemed to me that the patients seemed to attend group visits not just for the diabetes education but also to seek social care from other patients. Vincent insisted that allowing such a thing to happen would deviate from the purpose of the group, which is the biomedical care of diabetes. If diabetes groups were taken by patients to be a place for social gathering, it would cease to be what it is, a diabetes-centered group visit. Yet still, Hmong-American patients continued to remake the group visit. Ong (1995), in her work on Cambodian refugees, argues that the "biomedical gaze is not such a diffused hegemonic power but is itself generated by the complex contestation of refugee/immigrant subjects pursuing their own goals and needs" (Ong, 1995: 1244). What became clear in participants' complaints about the logic of diabetes group visits was the continual focus on the biological aspect of the disease and how to control the disease. The most important critique was something the diabetes group

failed to address: it failed to situate diabetes care within participants' social and moral questionings of their place within the world as displaced refugees.

Returning to the Root

Vincent was in charged of leading discussion on the topic of mental health. He went over his PowerPoint slides to the three Hmong-American patients attending diabetes group visit that day. Sitting to the side of the projector slide, he discussed the topic of stress and worries. He began by saying that we all experience stress, even himself. He described the body's mechanism for responding to the presence of the stress by explaining the body's fight or flight mechanism. The body, when encountering a stressful situation, is flooded with adrenaline and cortisone hormones (a stress hormone) that helps to signal to the brain a reaction to the situation, which is to flee or fight. Blood builds up within the body to enable a physical reaction but for one with diabetes, the rising glucose levels in the body cannot be easily removed. In today's society, one who experiences chronic stress usually cannot respond to these stimulants (by fighting, for instance) but continues to dwell with these stressful biological hormones. Rather than to be stressed and worried, Vincent continued, one can control their bodily reaction by isolating themselves until they feel better enough to reengage with the situation. He showed a photo of a serene lake with a pier and canoe that was surrounded by green pines as a place he associates with calming effects.

When Vincent finished his presentation, one patient, Youa, who had her blood sugar under control, instructed Vincent to cover a new topic. Youa was a medical interpreter who had received medical training in Vientiane, Laos, and took additional classes when she arrived in Minnesota in order to resume work as a medical interpreter. “Yes,” Youa affirmed Vincent’s presentation but then said, “we’ve already walked ahead and now we must come back and walk in the middle [or the root].” (*Peb twb taug tom ntej peb yuav tsum mus taug hauv npaus*). With these words she was telling the group that they had discussed the biological effect of facing stressful situations: the increase in blood sugars increase that can affect diabetes detrimentally. The education of diabetes group visits was always centered on the future, on what might happen. Returning to the root cause of diabetes would mean focusing not on what might happen, but rather examining and understanding *why* those situations arise. She continued on, “I want to talk about *qhov kev nyuaj siab* (the stress and worries). You are a doctor; can you talk more about why I am *nyuaj siab* (stressed and worried)? Is life good? I need you to come and tell me why I have diabetes. There are others who have marital problems, harassment, problems with their children; why do we have diabetes?”

All of my Hmong-American interlocutors with type II diabetes articulate that their diabetes is caused by their *kev nyuaj siab*, their stress or worries which arise from living in the US. One woman in the diabetes group visits articulated, “this is just a disease of anger.” The translation to stress and worries is a biomedicalization of *kev nyuaj siab*. In Vincent’s portrayal, stress and worries are removed from their context and become

objects for treatment and control. Yet, wanting to untangle the root is the return to the context of *kev nyuaj siab*. Many of the interlocutors that I came to know through the diabetes group visits consistently emphasized that diabetes is a disease you *will* die from. Rather than learn only about the many ways one could die from the disease and how to prevent death by the management of diabetes, they also wanted to understand the *why* of the disease.

Evans-Pritchard's (1976) classic ethnography of witchcraft and the Azande in Africa articulates the importance of the *why* in explaining misfortune. His example of the granary that falls onto a group of people sitting underneath reveals that misfortune has two explanations—or as the Azande says, two spears. They both are the causations of death. The first is that the termites ate the pillars of the granary that caused the granary to fall. The second is witchcraft, which is the reason the granary fell on top of those particular people on that particular day and not any other day. “Witchcraft explains *why* events are harmful to man and not *how* they happen... The attribution of misfortune to witchcraft does not exclude what we call its real causes but is superimposed on them and gives to social events their moral value. (Evans-Pritchard 1976:24-25)” Why is it that Lor has type II diabetes? The social context of his relationships and their relationship to increasing his blood sugar levels when in distress is the second spear. This as Evans-Pritchard articulates, allows for social intervention and can be communally addressed. In the case of Lor as well as others, the social disruption and distress that Hmong-

Americans with type II diabetes experience alongside their diabetes is a pressing concern that falls outside of the purview of biomedical care.

I understand Youa's efforts to redirect the groups focus to an examination of the root cause of diabetes as an examination instead of the social and moral context of Hmong-American displacement in the US. Youa cites *Kev nyuaj siab*, which means in translation "a difficult liver." *Kev* is a classifier as simple as the word "the." Yet, in Hmong, a classifier describes the object that it stands before, whether the object is string-like (*txoj*), flat like a sheet (*daim*), or elongated like a stick (*rab*). *Kev* as a noun translates as a path or road; as a classifier, it describes the object as a journey or a process. *Nyuaj siab* relates to conditions that "could result in a 'difficult liver' if they persist and become aggravated" (Dunnigan, McNall, and Mortimer, 1993). Unlike the English association of the heart as the seat of emotions, the liver (*siab*) "integrates the full gamut of experience, thought, emotion, and sensation as well as the processes of daily life such as talking" (Henry, 1996: 23). While in America the self is metaphorically divided into the bodily organs of the heart (emotions) and brain (mind), there is no such division in the understanding of *siab*. *Siab* can denote personality like *hnyav siab* (heavy liver/slow to do things) or, in our current case of diabetes, an emotional state. "Emotions and thoughts are not separated from other aspects of embodied experience and interpreted in terms of their relatedness to either 'the body' or 'the mind.' They are not taken as 'symptoms' of the body as a separable entity, but rather as related to events through which they were manifest and their effects on daily practice" (Henry, 1996:118-119). I understand the

articulation of diabetes as caused by *kev nyuaj siab* as an indication of the embeddedness of my interlocutors within their social and historical context. In Youa's articulation that Vincent's presentation focused on the present to defer the crisis of the future, she used the Hmong word for "walking to the root" to understand why she has diabetes. I then understand the phrase *kev nyuaj siab*, in its literalness and my metaphorical use of it, to infer a Hmong-American historical path that references their displacement in the U.S. and how displacement affects their liver as a corporeal object and a seat of emotion. *Kev nyuaj siab* is the manifestation of the social and cultural displacement in their lives. As a process or journey, it is also a movement through the world that maintains and remembers its historical root. It cites the importance of relations and the effects of displacement on social ties and relations. Hmong-American patients insist that the disease itself cannot be disentangled from the social, historical, and moral journeys of a Hmong body politic. Though Youa's question was never answered by Vincent or any of Youa's health care team, Youa's stories about diabetes, as well as those of other Hmong-American diabetic patients, are stories of envisioning an alternative form of care.

The Root of Diabetes

Youa's husband, Meng, who often frequented the diabetes group visits with Youa, continued her question of "why do we have diabetes?" by discussing the time he went with Youa to a biofeedback appointment.

Meng: Us Hmong have always said; your eyes don't see. I went and did a biofeedback and the educator said to think of a good time. You can see the biofeedback. The way it looked like it had a laughter with it. After that, "you can see clearly" that the way you think about the good and bad [*kev xav phem los zoo*] can affect you. After this, it helped with her headaches and then she took me to a counselor. The things we can see we went to Rochester to see about this biofeedback. This is an important piece.

Biofeedback helped Youa's husband to understand the bodily materialization of *kev nyuaj siab* and the effects of thinking "about the good and the bad." For Youa's husband, Meng, his experience of witnessing the biofeedback spoke to the importance of the social context of his relationship and its effect on Youa's disease. Since then, he has followed her to all her health appointments, making an effort to learn about the disease and to speak kindly to his wife. Rather than to give a straight forward answer, Meng offered this story to impart a wisdom on what he thought was the root of the problem. In Hmong, there is a saying that words can kill. If someone is terminally ill, the words you offer the sick person could keep them alive longer or shorten their life. That phrase infers the importance of tending to social relationships (the care of the sick person) through the act of kind words. In Meng's story, he imparts his vision of social care for his wife. The moral of his story is the central need to tend to one another through the sharing of kind words.

In my view, Meng's story offers an avenue to imagining the social care he and my interlocutors envision as care for their chronic illness and chronic displacement. His story points us to the lived everyday of Hmong-Americans in the U.S. who suffer the trauma of displacement (manifested in feelings of social insignificance, lost and strained social

relationships, questions of gender) and offers a possibility of caring for that displacement through the tending of social relationships. Caring to the trauma of displacement by bringing it forth in speech does not close it off to the past as a way to “get over it” but as a way of learning how to live with the irrecoverable loss in their lives.

Diabetes, Gender, and Loss

The need to tend one’s social relationships is embedded in Hmong cultural value placed on the collective. In the U.S., maintaining strong kinship relations is strained; families no longer live patrilocally but rather live where they have access to jobs. Yet, the failure to maintain a job in the U.S. unsettles their relationship in the household. Vang, fluent in both English and Hmong, spoke about how his diabetes affected his identity as the head of the household. Vang’s diabetes made his job as a bus driver difficult because he had to urinate often. He shared with me how he had to pee into a bottle during his shift. It was embarrassing for him and he worried that eventually his disease would result in him losing his job. He feared that the loss of his job would also result in the loss of his role as head of the household. Another Hmong-American man in the diabetes group shared that he believed his diabetes was the direct result of his unemployment and the way that his unemployment compromised his ability to provide for his family and pay the bills. In Laos, he told me, they would be able to cultivate the land for survival. However, survival was based on financial means in the U.S. Another man, who was a soldier in the war, was able to receive mechanical training which eventually landed him a job making

hearing aids. As his skills advanced, he was required to know English and learn how to use computers. The compounding realization of his social incompetence to perform work duties led him to eventually leave his job. These three stories told by the men speak to how diabetes is gendered. Whether the displacement of their identity as head of household is due to the disease or vice versa, diabetes and cultural displacement are experienced together.

Traditionally, Hmong in Laos follow a patriarchal structure which traditionally consists of a multifamily household. Back in Laos, Hmong were also patrilocal, residing in villages with their clan. Knowing and tending to one's social relations within the household and clan are essential not only to the individual but also to the welfare of the household. Nancy Donnelly (1994) writes about the household as an economic unit. Men were seen as the core of the household, and they possess the ability to make choices about the welfare of the household. However, the wife affirms the decisions of the husband. If a husband and wife together both contribute to the economic wellbeing of the household, they make up a strong household. Hmong women are seen as the other half of the household. In addition, relationships are not just important to the household but also to Hmong society. In Laos, economic stability relied on labor in the fields for survival. However, here in the U.S., the commodification of labor is essential for survival. It also allowed women to join the work force, undermining the traditional hierarchy of Hmong men first and then women (Donnelly 1994).

Women define themselves in relation to others as a source of agency and power in a system that often situates men before women. Diabetes was gendered for the women in how the disease affects and is affected by the social relationships within these women's lives.

Pua: I think diabetes comes from *ib kub menyuam* (having children). The wife has so much to take care of so when she is *nyuaj siab* (stressed)...I stayed home when...I lost my job, I had no money to pay the bills and there is disputes between us two. When you're not *nyuaj siab* (stressed) then you're fine. But if you are then it [blood sugar] is high.

For Pua, the high demands of being a mother and yet having to contribute to the economic stability of her family seemed to aggravate the disease and harm her marriage.

For other women who attended the group visits, diabetes was said to be caused by the traumatic loss of relationships.

Yer: This diabetes disease, I don't know...it came from all sorts of places, I had a *kev ntxhov siab* (distressed liver) because my mother died and I cried so hard. After all of that, I was always tired. [Then] they [doctors] said I had diabetes.

Yer cried so hard for days after the loss of her mother. In the case of another woman, her husband had left her for a second wife in Laos. Shortly after he had left, she told me, she was diagnosed with diabetes. The trauma of losing close social relationships for these women are tied to their disease.

Together, men and women shared how after a bout of anger, whether at a spouse or family members, their blood sugar level on their insulin monitor was close to 300. Many offered how they coped with changing emotional states, taking time away from the

source of anger to be on their own. Chue, a Hmong man, shared the need for social care for *kev nyuaj siab* and diabetes by finding “the place that warms your liver” which is to find care in his wife’s kind words.

Chue: I want to say, you have to help yourself early. Your motivation must not be tired. You cannot just eat fat without remembering that it will make you sick. For me, I think that this disease, you will die one day. Diet or caution yourself, perhaps you may live to see tomorrow. Go to the *chaws sov siab* (place that warms your liver), which is the place of your children. I am being honest now, I love my wife. When I am upset, when my wife says one nice word, it warms your heart for a long time.

Pua: As long as I have lived, I have never known that the love of a husband and wife can be so good.

Bee: I have never heard a man say he loves his wife. Out of 7,000 Hmong men, I believe you are the only one to say that. Why is it that ours have gone to live in another country? [Laos]

Within this conversation, to be angry is normal. Unlike the biomedicalization of stress and worries, Chue presents the importance of finding a place of warmth in others. The embodiment of those social relationships through kind words were essential to health and wellbeing. Husbands at the diabetes group visits suggested that they needed to be considerate of their wife, kids, and others. This declaration of care for their spouse shocked a lot of the women within the room, especially Bee, who, although she was a star patient, had to cope with divorce. A few men, often the elderly men, expressed their care for their wives. One man said he cared for his wife by waiting for her to be home so they could eat together, sometimes peeling an apple or an orange for her to eat as well. Another one said he learned to speak more gently to his wife. Though others within the

group stated that they coped with anger by leaving the house and spending time alone, the elderly folks at the diabetes group insisted that anger should also be handled together as a couple. Despite the challenges that my interlocutors faced in their life, they offered each other places for healing, in one another.

Nutrition and Gender

Heather came into the room with her mixed salad of kale, sugar snap peas, chickpeas, and Asian sesame dressing. I had to run and get Vincent to tell him that the group had started; our provider staff was not on time while most of the patients arrived on time. Lor said in English as Heather walked out of the room, “They said be here at 8 and I was here at 8.”

As the group started, Heather seemed uncomfortable and stressed out. Through Vincent as translator, she asked them what healthy eating was and the conversation soon veered elsewhere. Tony shared the challenges as to *why* he couldn't eat in more healthy ways, while Lor and Ger nodded and grunted in agreement. “If there is no *kwv tij neej tsa* (patrilineal and matrilineal family) then my blood would be better. It is because on the weekend you have to go out, and your blood pressure goes up.” Heather tried to interject ways that he could improve his eating on these “going out” occasions but the English translation failed to communicate that these events were not for fun but encompassed important ritualistic practices such as weddings, soul callings, blessings, or funerals. Performing and engaging in these rituals are part of their roles as men and these tasks are

always in the company of food and alcohol. Mai Na Lee's (2015) historical work reveals oratorical knowledge as an important contributor to Hmong masculinity. Oratorical knowledge coincides with being able to perform ritual tasks. "At these closed events Hmong men exhibit uninhibited charisma, intelligence, and wit..." (Lee 2015:30) Drawing on Hmong folk hero Nuj Nplhaib as a symbolism of Hmong masculinity, Hmong masculinity entails

"mastery in the traditions involving funeral, marriage, and healing practices. He may be the master of the *qeej*, possessing talents in reciting marriage and funeral songs and familiarity with the rituals involved in these important life events. He may also be a shaman and have expertise in other arts of healing such as herbal medicine or reciting magical incantations (*khawv koob*). Healing and ritual knowledge, in particular, would also make him an expert in Hmong customary law (*kab lig kev cai*) and the "flowery," formal language (*paj lug*) and mannerisms used to perform and discuss such laws" (Lee, 2015:30).

Declining these invitations to partake in the performance of Hmong masculinity is in part a form of emasculation but also a refusal to tend to those social obligations. Patricia Symonds (2004) ethnography in Thailand reveal that Hmongness is often equated to maleness. Hmong men are culturally seeded with the expectations to continue the practice of Hmong culture through ritual expertise and practice.

Kou Yang's (2003) article on Hmong masculinity centered around table conversations during a ritual gathering. Yang's finding echoes the Hmong-American men in the diabetes group visits. Their role as the decision maker is displaced and their status as fathers and men are increasing devalued. However, attendance at these ritual gatherings is a way for men to reconstitute each other's masculinity. In Yang's

observation of a welcoming ritual to a brother-in-law, alcohol and food is consumed at the ritual as a way of welcoming and thanking the honored guest(s) and others. Only men are present at the table, while women refill the food. Yang's article details how conversations during this practice "centered on the keeping of proper relationships among clans members, drinking, and asking for news and information from one another... Occasions like this seem to be the only events wherein the older men are invited to sit at the head of the table; treated with respect; and, most important of all, get to be together and share news" (Yang 2003:12). Men present at these gatherings reconstituted each other's masculinity by expressing their own vulnerability and criticism in relation to the displacement of Hmong-Americans in the U.S. and its manifestations in cultural changes within the community and within their families. They were concerned about what would be required to sustain Hmong community in the future.

For Tony and Ger, having diabetes is a form of emasculation. Ger said, "If we were like children with parents to tell us what to eat then we would be better off. However, you're not, you're an adult, you are a *txiv neej* (a man)." Not only is he restricted from his ability to perform his masculinity, but he also points to the need to control his diabetes by lowering his status from a man to child.

Although men are often credited with performing Hmongness, Hmong women are just as essential for these ritual practices as they prepare, cook the appropriate Hmong food, and serve the dishes in the appropriate manner. According to Wa Vue and Cindy Wolff (2011), a woman's role around food is not only to feed their children but also to

impart a Hmong identity onto their children by cooking Hmong foods. To this I would also add, to impart Hmong identity in all of the areas in which they are obligated to cook Hmong foods. For mothers and grandmothers, living in the U.S. proves difficult when children prefer American foods that are often easy to make but highly processed. In Vue and Wolff's findings, the mothers have had to cook different dishes to accommodate this change in diet while the mothers insisted that consuming Hmong food was essential in maintaining Hmong identity. Pang, a young grandmother, finds herself wanting to try the food her grandchildren want to eat, and it worsens her diabetes.

What is healthy eating did not consider the cultural performance that food consumption played for Hmong-American men and women. Stories of their lived experiences insisted on the rigidity of the question by pointing out that education on diabetes nutrition was framed around the American nuclear family. Most often, diabetes education focused on older patients with diabetes who did not have children at home; nor was the American nuclear family bounded by rituals and Hmong cultural practices. For my interlocutors, food was not just for consumption; sharing and eating food together works to constitute relationships and at large, a Hmong body politic. To decline food symbolically meant that they would deny their roles as males and women within these social settings.

A Request for Hope

Writing this dissertation, I think about Lor constantly. I can still see his face, his unshaven beard and wiry dark black hair. Once I ran into him at Hmong Village, a building filled with Hmong vendors and stalls selling various services like travel booking to Laos and Thailand, Hmong medicine, Chinese medicine, and Hmong clothing. When I recognized him, he was taken aback, asking “How can you still remember this face of mine?” He was clean shaven and had just gotten a new haircut, but I could spot Lor out in a crowd by his small stout structure. Lor leaves a mark on my memory by his courage to share his vulnerability, constantly reminding me and others of his precarious zone of existence. He reminded us that diabetes was more than just the biological by his insistence on his daily challenges that leave him feeling powerless.

This chapter has shown that the diabetes group visits were created to provide a space for patient-centered care that allowed for a collective experience of sharing each other’s experiences with diabetes. These testimonies of diabetes experience were elicited with the pedagogical purpose of instilling knowledge about diabetes that might then spread to other more reluctant participants. Lor used these testimonial moments to tell his story and the ways his diabetes is entangled with his lived experiences. Towards the end of my time of coordinating the diabetes group visits, Lor had asked me to develop a group visit with the topic of *muaj chaw cia siab* (how to have a place to put your liver) or in the American sense of it, “how to have hope” in the face of social and physical debility. At the time of Lor’s request, we had already covered the basics of diabetes

education, including nutrition, exercise, mental health, and medication. Unfortunately, I was leaving for fieldwork in Laos and Thailand and could not provide Lor the diabetes group visit that he wanted and requested. Since that time, his request has made me think about what it means to care for diabetes under the lens of biomedicine and how its narrow focus on the biological does not enable alternative visions of healing and care. Hope in Lor's and other's speech, does not reside within the modernist sense of hope in the future nor to find hope within oneself.

In science and technology studies, hope has been represented as a central feature in the ways that patients and families imagine their engagement with a risky future and their ability, in conjunction with biomedical technologies, expert knowledge, political activism, and health (Taussig, Rapp, and Ong 2005), to manipulate the future and conceive the possible futures for themselves and upcoming generations (Rose and Novas 2007). These forms of hope enable subjects to politically effect biomedical knowledge, technologies, and research. In the diabetes group visits, the presumed homogenization of diabetes experiences to a template appropriate to middle class white older adults partakes in rendering invisible the chronic social experiences that other racial groups like Hmong-Americans face. For the generation of my interlocutors, experiences of cultural dissonance and social isolation are part and parcel of their racial experience as displaced subjects. For them, displacement and uprootedness give rise to cultural changes such as new familial expectations, generational divides, and social isolation in the US.

The emphasis on *chaws* (place) throughout this chapter infers not to a place but rather to who. Lor's request for a workshop seeks to remedy this displaced subjectivity through an optic that focuses not on the individual but on the relation to others. This question of where to place one's hope (*muaj chaws cia siab*) reinstates a sense of place that is not constituted by geography nor physical landscape, but rather by the connections and entanglements of people, by sociality.

The question of *a place* to locate your hopes emerges as a space shared within others that transcends any borders of nation-states and even the biosocial communality of disease sufferers, expert knowledge, and medical technologies. The disease may be a shared characteristic of the group, but the overwhelming concern is the sense of displacement—the root cause of the *kev nyuaj siab* that underpins their disease. Hope only in expert knowledge and changing one's somatic future is not sufficient for the futures of belonging that my interlocutors' displaced subjectivities seek, especially when their very belonging to the nation-state of the US is based on the premise of their exclusion and invisibility.

Conclusion

Hope in each other emerges organically in the group, in unintended and undisciplined ways. Although patients had their reservations about the diabetes group visits, the more they came, the more they transformed the group visits from managing

diabetes to a social support group that allowed them to narrate their lived experiences as well as offer support for others.

As I have shown in this chapter, diabetes group visit served not only as a place in which patients learned how to care for their diabetes—not just the one-shop-stop in biomedical care—but a space for them to care for each other, providing social care and social support. During my time as coordinator, many of my interlocutors told me they didn't know others with type II diabetes and would often hear through the grape vine that someone had the disease. Having this space to talk about the disease offered a new creative way of caring for one another. What emerged slowly and quietly as the diabetes group visits continued to meet was that hope was sustained and maintained through the connections with one another, through their social support in facing the challenges of the everyday as displaced persons, including challenges of love, marriage, family, and masculinity. The question of where to place your hopes, was shifted to the question: in “whom” do you place your hopes.

The diabetes group visits taught me that health care and getting better could not be accomplished in a linear movement of dispensing knowledge about diabetes to the listener, the patient. Rather, caring for patients' health was enacted through ongoing relationships that demonstrate social support, encouragement, and most importantly sharing stories of vulnerability. Being able to express and lay bare one's social isolation and lack of knowledge in the safety of others' company, and be listened to, helped to keep these patients coming back to the diabetes group visits. The process became, as Youa

said, “walking back to the root.” Unfortunately, I often think I failed them, or the medical system failed them in focusing more on the health in health care than the actual care that is involved in health care, and the ways they envisioned care. There were many things that my interlocutors who attended these diabetes group visits asked me to do that I could not do. They wanted to have a group that allowed them to have field trips for social mingling, so that they could be happier, *kaj siab*. They wanted to form a social group to remain connected with one another and to give each other the ammunition to tackle the challenges of life and the disease. However, the clinic, biomedical care, and I were unable to address this need, nor were we able to really listen to how they imagined and desired their care.

To imagine placing hope in one another and returning to the root of the disease leads this dissertation to the return migrations that my interlocutors cited as helping them return to health. Return migrations partake in the care for the displaced subjectivity that my interlocutors experienced in the chaos of family, love, marriage, and gender identity.

CHAPTER 3: HEALING A DISPLACED HMONG BODY POLITIC

“I may be here [US] but my *plig* (spirit/soul) is over there [Laos]!” said Yang Lee one of my Hmong-American male interlocutors with diabetes. He had engaged in return migrations, twice to be exact, and was already antsy for another one. He, along with other patients with type II diabetes who frequented the Hawthorne clinic in St. Paul, agreed that a return migration to Laos and Thailand could relieve them of their chronic condition even if the relief was temporary and place-specific. Others of my generation, and Hmong-American women in particular, condemned return migrations, stating that returnees were often male and returned only to pursue young Hmong-Lao women. Yet, such comments didn’t explain the movement of patients (both male and female) into the clinic to refill their prescriptions and check their vaccination records before their return migration to Laos and Thailand for the New Year festivities (November to end of January). After each visit, I asked them whether they believed it was true that returning could relieve them of their diabetes. They answer was, “Yes, the *huab cua* (weather) fits our bodies. The food is natural, grown in the countryside. There we are better, there we have no more diabetes.”

Why would Hmong-Americans who live in a developed country such as the U.S. find healing from their chronic disease in places like Laos and Thailand? As illustrated in chapter 1 and 2, my interlocutors experience their type II diabetes alongside feelings of displacement that stem from their everyday experiences of cultural and social trauma and

their own subjective experience (feeling as though they are born *tim u*). I understand Yang Lee's statement as another reference to subjective displacement as I will show in this chapter. This chapter argues that return migration restores Hmong-Americans from their feelings of displacement by returning to places of past residence, taking up an imagined "old life" in Laos and Thailand, returning to a youthful self, and embodying the environment, climate, and Hmong herbs. Here I do not ask whether return migrations would cure them biologically of their diabetes nor whether return migrations are a cover up for transnational marriages. Instead I follow the lead of Xiang Biao (2013) who suggests that scholarship focusing on a *real* return glosses over the various agents who invest and partake in the possibility of making these migrations a *type of* return. How do Hmong-Lao and Hmong-Thai partake in making return migrations a return to home for Hmong-Americans? In answering this question, Hmong-Lao and Hmong-Thai use discourses such as "Hmong-Americans have returned" and the ritual practices of *hu plig* (calling the soul to reunite with its body/hots) to interpellate Hmong-Americans as belonging in Laos and Thailand. We can begin to understand these return migrations by taking the *plig* as an ontological starting point.

In Hmong animist beliefs, the body contains 7 to 31 or more *plig*. Various *plig* perform and live different lives. The three main ones are the shadow *plig*, reincarnation *plig*, and dreaming *plig*. The shadow *plig* stays with the host its entire life and resides with the body even in death until it is disintegrated. The reincarnation *plig* leaves the body after death and is reincarnated according to a karmic system. This dissertation

draws on the dreaming *plig*. When its host sleeps, the dreaming *plig* can move about in the world, unrestricted by land or oceans to visits places and people (Culhane-Pera et al, 2003). The dreaming *plig* is sometimes called the wandering *plig*, therefore Yang's comment is not a contradiction—his body is here in the U.S. while his *plig* is in Laos. If this *plig* is spooked by events such as a car accident, the *plig* can leave its host, making the person fall ill. It is important to maintain the unity of the *plig* for the host's health and wellness. In death this *plig* returns to the spirit world, back to its ancestors, to continue living out life as it did in the land of the living. It ultimately returns to its origin, which I equate to the Hmong kingdom of the dead (this argument is teased out in chapter 4). In chapter 2, I showed how, for Hmong diabetics, diabetes is rooted in their displacement in the U.S. The search for healing by way of returning to places of exile attempts to remedy the displacement by (re)making connections to these places. I draw on my own experiences as a Hmong-American traveling in Laos and Thailand to tease out different as well as overlapping notions of return and privileged yet unequal subject positions. The overarching argument of this chapter is that return migrations attempt to heal not only the bodies of Hmong-American but also to heal a displaced Hmong body politic.

Quteb Quchaws (Old Places)

Koom niam txiv yug
Cas ho tsis tau nyob sib hlub
Ib leeg nyob rau ib sab ntuj
Ntshe txoj siab tu
Ho tsis sib cuag
Thov muab lub suab xa tuaj mus qhia kwv qhia tij

Tias kuv nco nco nej tshav ntuj nrig
Yuav nco txog hnuv lub qhov muag qi

Born of two parents
How come we can't live together, to love one another
Each other living on the other side of the earth
Perhaps when life has ended
We would still have not reached each other
Please send this voice to tell relatives [patrilineal]
That I miss you like the constant sunlight
I will miss you till the day my eyes close
-Nraug Nas, "Koom Ib Lub Mis Hlob"

Sitting in my *tij laug*'s¹¹ van as it bumped along the caked dirt country roads of Vientiane, I was spellbound by the music video that played on car video player. I listened closely to the lyrics while we drove back to his village after a day of running errands in the capital city. In the video, the young Hmong-Lao man named Nraug Nas laments the separation of two brothers torn apart by America's Secret War in Laos. One is left in Laos while the other is a world away, most likely the United States. Nraug Nas's singing in the accent and style of Lao is heart wrenching. The song implicitly addresses Hmong-Americans (as well as Hmong-Lao), reminding them of their connections to one another and the tragic separation of the Hmong communities and families due to war. With the background of hilltop cultivation and Hmong thatched houses, the camera oscillates between Nraug Nas singing in a field of green with mountain ranges behind him and a Hmong -Lao brother struggling to keep his family afloat. The video depicts the Hmong-

¹¹ *Tij laug* is translated as brother. Kinship terms are based on their relation to the person calling the person of kin. Because I was unmarried at the time, my *tij laug* is my father's brother's son (first degree cousin from father's side). Now that I am married, they are removed from my *kwvtij* (patrilineal) to my *neejtsa* (matrilineal).

Lao brother's memories of himself and his brother as small children struggling to survive and eating nothing but a small spoonful of rice and water in their tin bowls. Although the Hmong-American is never shown, the music video is like a voice message to the American brother, conveying deep sentiments of loss and the tearful separation of kin. It calls Hmong-Americans to remember their place of origin and kin and to wonder if a reunification will ever be possible in this lifetime.

Mitch Ogden (2015) argues that tapes and video media, sent from Hmong in Thailand and Laos to Hmong in the United States, work to produce a magnetic diaspora that draws on the nostalgia and melancholy of the Hmong migration, featuring images and sounds of places "once inhabited, cultivated, and claimed by the Hmong..." (Ogden 2015:19) These tapes and videos draw on and appeal to the sensory imagination to shape and render these spaces "suitable to the diasporic community" (19). Teasing apart the multiple meanings of the Hmong term *tebchaws* (homeland), Ogden argues that "homeland is not conceived in geopolitical terms but rather powerful and familiar environmental and ecological ones" (14). In addition, Aline Lo (2015), taking on a flexible understanding of citizenship, argues that in Kao Kalia Yang's book *The Latehomecomer*, citizenship is not centered around immigrant narratives or sanctioned by nation-states but rather situated in a non-geopolitical space where familial continuity can be imagined and created. Nicholas Tapp (2004) writes in his work on Hmong-Americans' return migrations to China and Thailand, "Physical reunions are experienced as embodiments of essence of a corporate community felt to be torn apart by spatial and

temporal separations” (Tapp, 2010:187). The fluidity of a Hmong *tebchaws* (from places, sounds, ecology, to family) and its sentiments of nostalgia and melancholia, I argue, lends potential to creating an imagined Hmong body politic.

This chapter draws on the literature on melancholia to see the continual sentiments of loss and displacement in Hmong-Americans as productive for shaping a Hmong body politic through the pursuit of return migration as healing. For Freud, melancholia is a destructive manner of mourning where the subject is unable to mourn its loss. The state of melancholia is the “identification of the ego with the abandoned object” and the shadow(s) of the lost object that befalls the subject/ego (Freud 1917:248). As I will discuss in more detail in chapter 4, in the Hmong-American case, the loss is Laos – it is the Hmong homeland, a way of life in Laos, and the kin relations that were disrupted by war. I understand the descriptors of bodily difference, such as *tim u* (described in chapter 1), as also the shadows of melancholia. Melancholia materializes within the inability to become the biomedical patient, and within the desire for a cure that (for my interlocutors) requires a reunification to places of familiarity. For Freud, suffering from the loss of the object leaves the individual to engage in unhealthy attempts to incorporate (achieve a return of) the lost object. Proper mourning for Freud is the ability to relegate the loss to the past. Scholarship on memory has illustrated the productive potential that melancholia produces where the past is seen as a fluid. Eng and Kazanjian argue in their book, (2003) *Loss: The Politics of Mourning*, that Freud’s pathologization of melancholia posits a fixity to the past. By focusing on what remains (survivors, ghosts, witness),

memory provides the means by which one can reengage and reimagine the past (Benjamin 1969).

The desire for the lost object, and the attempts to incorporate what is lost, make possible the transnational interpellation of Hmong-American subjecthood as that which belongs *tim u*. This assemblage is productive in creating transnational ties to Laos and Thailand and, furthermore, creates an imagined community through the act of healing the body (Castellanos, 2009; Camacho, 2006). In the following sections, I detail what constitutes return migrations to Laos and Thailand to argue that the consumption of Hmong herbs, and Hmong-Lao and Hmong-Thai reception of Hmong-Americans, create Hmong-Americans as belonging to Laos and Thailand through kinship relationships. Lastly, although I find these return migrations productive, I also retain the skeptical Freudian concern for its potential destructive nature. I reveal return migrations as bittersweet by attuning to the global frictions that emerge from the imagined desires of return migrations and by examining the complications of a return to kin.

Dreaming of a Return

Bee Thao: Xieng Khouang, Sam Neum, Nong Het, these were the *tebchaws*¹² (places) that Hmong had come to live. That is the *tebchaws* they [Hmong-Americans with illnesses] want to see, where their people died, the *tebchaws* that you [they] grew up in. They dream as they are in Laos and not in the U.S. It is not that they are actually missing Laos, but as they have always lived here.

¹² *Tebchaws* here is translated as place. Hmong words often depend on its context. *Tebchaws* can imply a Hmong Homeland but can be used to refer more generally to place.

Hmong-Americans continue to dream of visitations and taking up their old life and living with family members left behind. Bee, a Hmong-Lao who lived in a resettled village near Vientiane, had many family members in the U.S. with chronic diseases (hypertension and diabetes) who would return to visit him often. In his observations and conversations with returnees, both family and strangers, return migrations are nostalgic not only in the sense that one misses a place and time, but also that their dreaming *plig* is actually living in Laos. Bee equates the dreaming self (*plig*) with a unified notion of self, the person who is dreaming. The self is both the person witnessing the *plig* living on in Laos and the dreaming *plig*. Tapp (2010) equates the two as well and sees the self as a multiplicity rather than one unit.

“The spiritual is surely the significant... To lose one’s spirit, or self, is to be ill, in the terms of Hmong shamanism, and it must be restored to one by rituals of hypostasis which reinsert the self into a timeless and communal narrative of history. That is why Hmong Shamanism and its recognition of the multiplicity of self [*plig*], continues to be important in the Hmong diaspora, where ceaseless travels divide the community and spill the self transnationally.” (Tapp, 2010:273-274)

By referencing to *kev nyuaj siab* (in chapter 2) alongside their type II diabetes, my interlocutors allude to their displaced subjectivities (in chapter 1) as also this displacement of both self/*plig* and the body. To dream that one lives on in Laos speaks to the *plig*’s attachments to locales of familiarity but also the potentiality that dreaming enables.

The Hmong dream of reunification speaks to the desire to negate the loss of a Hmong body politic. I use the term body politic to suggest an open-endedness in the ways practices of the Hmong body and ideas of health and healing are mapped onto an imagined Hmong community. In Lee (2015)'s historical analysis, dreaming and feelings of loss fuel the aspirations for a Hmong kingdom. Documented in myths and reenacted in funeral songs, the loss of the Hmong kingdom and the dreams to retrieve it have produced two methods of legitimation: one through the recognition of powers or nation-states (like the French and American), and the other by awaiting the return of the messianic Hmong king (Lee, 2015). Dreaming and the desire to return to Laos [are practices that create?] have resulted in the creation of a Hmong transnational community and engagement in Lao politics (Vang 2010; Lee 2006). Here, to reunite with the dreaming self is an attempt to take up life pre-war through the reengagement with social life in Laos.

Returning to a Pre-diabetic Time

“We all know that they [Hmong-Americans with diabetes] are not here for medical treatment because the United States has the best of medicines in the world. They are here to be happy, to be *kaj siab* [peaceful], and to live like they did in their old country.” Seeking to be *kaj siab* returns us back to my earlier discussion of the liver (in chapter 2) as both a corporal object and a seat of emotion. Courting and even marrying Hmong-Lao locals, visiting places of past residence, eating the foods, and enjoying the

climate are all material and social embodiments that work to soothe the *nuaj siab* (difficult liver). Hmong-Americans and their relatives in Laos and Thailand explained to me that reunification with the old ways of living in Laos worked to return their blood sugar levels to normal. These practices and engagement, I argue, work together to restore a Hmong-American identity. I understand the restoration of a Hmong identity (since chronic disease is caused by displacement) as the healing that my interlocutors point to when they state “In Laos there is a cure for diabetes.” As one Hmong-Lao living in a village at the outskirts of Vientiane said, “Yes, they come and get to *tham pem* (talk for fun) and we walk and it’s like their *mob* (illness) is *kaj siab* (peaceful). Like you’re [they’re] the old person you [they] left behind and they are better.” This is illustrated in my following fieldnote:

Swiftly he moved, zipping around the broken mud road like a local with a young Hmong-Lao lady sitting behind him on his rental motorbike. I sat watching the movement and flows of the community and watched with envy, this oddity as it passed me. “That’s a Hmong-American,” I am told by my relative as we sat outside the house to bask in the sun’s warmth. They were better at discriminating Hmong-Americans than I was. They say, you can tell them by their formal attire, large video bag and camera, their plump bodies, and white complexion (lighter skin than the locals). They are often much older than the young women they take for motorbike rides. (Fieldnotes, December 2, 2013)

I remember watching this man drive past me while I sat squatted over the fire that my relatives kept going in the early morning. I was envious because he was able to operate a motorbike and move through the village, while I felt socially isolated because I could hardly count to three in Lao. My two cousins, who were seven and six years old,

while hugging me and laughing, asked me, “*Pauj* (Aunty) how come you are a *nkauj laus* (spinster) but you’re basically a baby?” One continued to rub my cheek, gesturing to my baby-like abilities. They were speaking about my limited Lao skills and my improper use of Hmong from time to time. I was envious of this Hmong-American man on a motorbike because, to me, it seemed that I had switched places with him. Whereas in America he may have struggled with broken English and the fear of the unfamiliar cultural and social terrain in the U.S., I now felt those same sentiments paralyzing my fieldwork in Laos. Of course, this is not to ignore my privilege as an academic and 1.5 generation Hmong-American who was able to travel to Laos.

Here in Laos and Thailand, I watched and observed Hmong-Americans move through the countries of Laos and Thailand almost effortlessly. I saw Hmong-Americans able to order plates of food for themselves and others while I always had to drag an interpreter with me when I went out to restaurants. I craved restaurant food but I willingly settled for the boiled chicken and boiled greens with pepper that my *nyab* (cousin’s wife) made for me in the village. In Thailand, Hmong-American returnees go back to the places where their old refugee camps once stood. As in Laos, they travel the country to see old places of familiarity, and reconnect with family relatives who resettled into Thailand. The desire for a temporary and place-specific cure is rooted in the desire to be their old youthful self that had always continued to live in Laos. This, I understand, is to return to a place where one can be socially mobile, independent, and socially significant as opposed to their life in the U.S.; this return is ultimately like rejuvenation (see chapter 1).

Return for Love

During my interviews with Hmong-Lao locals, they shared with me that Laos is like [Hmong-Americans'] first love. This metaphor echoes Louisa Schein's (2004) article that illustrated how Hmong-American men who engaged in nostalgia tourism sought out love relations in Laos as a form of homeland eroticism of Hmong-Lao women that ultimately feminizes the homeland. In my ethnographic case study, if a cure is possible through a return to a youthful self, then the desire to reclaim this first love situates return migration for health and healing as an embodiment of past love through the pursuit of young Hmong-Lao women and men. During Schein's research, Hmong-American women had not participated in this type of tourism. During a New Year celebration, under the tent of a food vendor, I ran into two older Hmong-American women, dressed youthfully with makeup and jewelry. "Hi *niam tais* (grandmother), are you both from America?" I asked. "Yes." They both replied looking off into the crowd. Because I wanted to see if I could interview them, I continued to ask why they were here in Laos. "Oh just to see family." They replied. They didn't seem interested in me or my questions, perhaps they mistook me for a Hmong-Lao since I wore a Lao skirt over my white t-shirt and Keen sandals. I would later see them in the crowd of Hmong-Lao, slipping Lao money into the pocket of a young Hmong-Lao man.

Although there were some older Hmong-American women who engaged in return migrations for love, it was not as acceptable as it was for older Hmong-American men. I overheard Hmong-Lao women and men whispering to one another, condemning

older Hmong-American women who walked around Phonsavong with a young Hmong-Lao man, hand-in-hand, saying it made their hair on their skin stand on end. Perhaps, they were less enthusiastic about these sorts of unions, not just because of the gender of the situation but also because transnational marriages made tangible the commitments of Hmong-Americans to their relatives in Laos. Hmong patriarchal society and the ways money figure these relations, I believe, informs the gendered narrative of Hmong-American returnees.

Many locals told me about Hmong-American men who were riddled with chronic disease in the US; upon arriving at the airports and accompanied by their youthful girlfriend(s) (found on the internet), they were able to ditch their walking sticks and wheelchairs.

Paj: The ones with illnesses, with diabetes, they come and travel around to see if they [their illness] are any better so they can have *av nyu*.

Mai: How do you translate *av nyu*?

Paj: *Av nyu*, is when a man comes to meet young women and to talk with them so that they forget about their illness and to see whether their illness is any better afterwards. That is what they call *av nyu*.

Paj's daughter, Chia who was a nurse in Vientiane and spoke English, clarified the word: "Happy for a long life. If you happy then you have a long life." In Thailand, a Hmong-Thai confessed to me that if he knew his dad would die at a young age, he too would have encouraged his father to go to Laos and be "happy." Happiness through talking and the pursuit of love has the potentiality of healing and even extending one's life.

In the case of Hmong-American returnees who married during their visits, the new wife would be left with family or kin in Laos or Thailand until the returnee had enough money and the paperwork sorted to sponsor their new wives to come to the U.S. Unlike many return migrants who are portrayed in the literature (Vang, 2010), Hmong-Americans did not have great socioeconomic means. Some saved their social security money to marry their Hmong-Lao wives. They often bought land, motorbikes, and houses, either under the name of their wife or a trusted paternal relative. Some, especially in the Midwest states like Minnesota and Wisconsin, would spend nine months out of the year in Laos or Thailand to avoid the winter months. Missing the winter months was essential for those who suffered from chronic diseases, where icy sidewalks made any form of physical activity inconceivable. Relatives were given money to keep a watchful eye on their wife until they returned home to their sometimes-unsuspecting spouse in the United States.

Schein (2004) pointedly states that such homogenization of the homeland to Hmong-Lao women results in the erasure of power differences between Hmong-Lao and Hmong-American. Chia continued to tell me about her discontent with these forms of return migrations, articulating the differences between Hmong-Americans and Hmong-Lao.

Chia: Hmong American and Hmong *Nplog* (Lao) are very different. There are those that come to help others. I don't like the ones that come to just have fun. It causes problems—like you have a daughter and they take your daughter and you don't like it. They come to have fun and joke around it's not really fair. And Hmong *Nplog* are really stupid, so that they get fooled.

Mai: Yes, but doesn't it seem like it's reversed as well?

Chia: Yes, now they [Hmong-Lao] are smarter! They also lie too. Here the ones even with husbands lie to others for money. They use an online account with a young Hmong girl's photo and pretend that it's them. They pretend to talk on the phone. The husband allows this! That's the one with the brains! They let their husbands talk to them so that they have more money each month! They are the best at talking, the ones with husbands! They have a lot of *txwv yim* (ideas/wisdom)! The ones without the husbands are the ones who are not good! [skilled!] They say, "When you come, I will marry you! When you come here I will go anywhere with you!" But when you arrive, they are nowhere to be found!

Hmong-American men left high and dry at the airport were featured in other stories I heard circulating in the conversations about return migration for cure. The connections to "home" have become discontinuous and unequal. Some women married these men for love, or as Hmong-Lao say it, as a bridge to the US. Older Hmong-American men and even women, who return for the pursuit of love with younger Hmong-Lao women and men, became both the perpetrators and victims of unequal relations. While social joking provided entertainment within the poverty-stricken Hmong villages in Laos and Thailand, I couldn't help wondering whether love was truly the sentiment that laced these transnational relationships. What became evident in the economies of return was that families who had Hmong-American relatives exercised their symbolic and material capital through the construction of concrete homes while utilizing their thatched houses as a cooking and resting place. Political and social welfare was nearly non-existent in this post-socialist state for Hmong-Lao, especially those without family in the U.S. Hmong-Lao feel that there is no other way to break the structure of poverty in Laos other than to seek transnational marriage as a form of capital gain. Return migration for cure was not

immune to these larger political and social problems. Yet the attempts to reunify the self and transgress the chronicity of diabetes are thwarted by the inequalities that love and money and their circulation produced.

Healing through Embodiment

There was an old man who was supposed to die within a week and he came here and drunk a lot of Hmong green herbs. Some come here for *tshuaj tshuab* (green herbs) and ask around with their relatives for herbs. It's sometimes \$100 and these are *tshuaj hav zoo* (medicine from the forest). They have to use their *tswv yim* (wisdom) when American medicine fails them.

Tshuaj tshuab and *tshauj hav zoo* are Hmong herbal medicine. When American¹³ medicine (biomedicine) fails to address their ailments, Hmong-Americans must seek out Hmong medicine, especially for diseases that are the result of living in the U.S. like diabetes. Identifying one form of medicine as Hmong and the other as American suggests the political act that consuming the herbs entails (Farquhar 1994). I argue that the consumption and embodiment of Hmong medicinal herbs partakes in the political act of restoring a displaced Hmong body politic.

The materiality and substantiality of Hmong medicine offer an essential Hmongness that can be readily obtained and imbibed. For Hmong-Americans who experience cultural changes, Hmong medicine seems to offer something solidly Hmong. It is also no coincidence that the majority of Hmong medicine shipped from Laos to the

¹³ American in Hmong is translated as *Meskas* which can also be used for white people.

Hmong-American consumers in the U.S. are from Nong Het, a historical region where Hmong momentarily had autonomy. Tracking Hmong herbal circulation out from Laos, Audrey Bochaton (2015) found that the U.S., particularly the city of Saint Paul, Minnesota, received the majority of Hmong herbal shipments. Ranking behind St. Paul are U.S. cities Fresno and Sacramento, California. The locations where these herbs are cultivated are politically and historically relevant. Herbs are gathered in Nong Het and then distributed to km 52 (a predominately Hmong village based 52 kilometers from the capital of Vientiane). Two Hmong leaders Touby Lyfong and Lo Fay Dang emerged, under French legitimation, to control Nong Het. During the Indochina War, the French appointed Touby Lyfong as district governor of Xieng Khouang which linked Touby's followers (ultimately Hmong-Americans) to Xieng Khouang. Given this historical context, Hmong herbal medicines from Nong Het are powerful not only in that they allow patients to imbibe not only a Hmong identity but also the autonomy of the Hmong political region.

Instead of seeing the consumption of traditional medicine in functionalist terms, such as fulfilling a universal need, Judith Farquhar (1994) examines the pleasures of consuming traditional medicine as a way of reinserting the body in its historical and social context. The pleasures in consuming Hmong herbs soothes the Hmong-American difficult liver (*nyuaj siab*) but also the source of that difficult liver, the displacement of Hmong-Americans, their kinship, and Hmong identity. Since the liver in Hmong is not only an organ but also a place of emotion, thought, and experience, the practice of

seeking Hmong medicine by way of family connections and the consumption of herbs can be seen as healing.

Having family members assist in the search for Hmong medicine can soothe the liver. My aunt in Xieng Khouang is both a shaman and a trained herbalist. “Selling Hmong medicine is all a business,” she said as we crouched down to examine the herbs an elderly Hmong-Lao woman brought to Phonsavan all the way from Nong Het, a three-hour two rail truck ride away. I looked up to see the Hmong woman, a *niam tais*, and was surprised to see she had on gold earrings and gold rings. “You have to know what’s good and what’s not, and sometimes it’s just a tree.” In other words, sometimes the herbs sold as medicine are not at all medicinal. The pursuit of Hmong medicine must be vetted through family. Unlike in the U.S. where Hmong-American patients see the doctor individually and are treated, seeking Hmong medicine in Laos and Thailand is a social endeavor that brings together family in hopes of healing the sick. It is also an act of love.

Family members who are knowledgeable about herbs are requested to gather large bags of herbs for their relatives with diabetes. They boil the herbs in a cauldron in such a quantity that the atmosphere seems like an herbal sauna. One Hmong-Thai herbalist laughed saying “We’re pretty much in our underwear it’s so damn hot!” The afflicted person sits in the middle and bathes in the herbs. Its medicinal properties are absorbed into the body. These are “the everyday techniques through which individuals, even if they are of modest means, comfort themselves, compensate for daily difficulties and frustrations, or build a life of reliable bodily satisfactions...” (Farquhar, 1994:481).

During my ethnography in Thailand, I visited many herbalists who had set up formal businesses which included various healing modalities such as acupuncture, teas, herbal baths, and massage. In Laos I was only able to meet one, since many herbalists were more informal and known only through kin relations. In Thailand I stayed with a Hmong man named, Xaiv Xyooj in Khun Klang. His herbal business seemed like the American equivalent of an outdoor spa, secluded (despite being within the small village) with the sound of rushing water from a stream located behind the dormitory where I slept with two other patients. There were many places for patients to sit down and enjoy the environment around Xai Xyooj's clinic. Central to these forms of healing was the embodiment of the land and climate. Its animate-like properties are said to soothe one's liver, to be *kaj siab*. The guests had dinner with their family, eating Hmong food, and drinking filtered water that came from the stream. His patients stayed for weeks to months. He told me he had treated many Hmong-Americans, showing me an album containing some of their photos. The very experience of living at his herbal clinic provided an embodiment of the climate, sights, and sounds of a Hmong village to soothe the displacement in Hmong-American lives.

One patient was a Hmong-Thai woman. She used to live in Ban Vinai Refugee Camp, the very same refugee camp in which I was born. She had asked in which section number my family lived in Ban Vinai and I told her I didn't know, since I left Ban Vinai at the age of one year. I skyped my mother and she and the woman detailed their proximity to one another and whether they could have potentially known each other. Xaiv

Xyooj's clinic brought Hmong in the diaspora together for healing. In the clinic, they can detail their potential relationship to one another and previous places of residence to create an imagined Hmong community. Together, medicinal properties of Hmong herbal medicines and Hmong familial relations work to heal the Hmong body. The consumption of Hmong herbal remedies and family participation addresses the symbolic absence of locality and kin as herbs come to be defined as inherently Hmong in nature.

Calling the Hmong-American Home

Hlob (patrilineal uncle) recounted our family kinship every time he introduced me to curious neighbors. He narrated memories of my father, the places where my father and he lived, the name of my grandfather, grandmother, and the names of mountains and villages where our kin lived. With every introduction he seemed to be trying to recover in me the history that preceded me, a history I inherited but I didn't know was mine. In detailing our kinship, *hlob's* words and memories worked to reconnect me to my kin and origin. This origin is not just Laos but also the places of past residence of kin throughout our history. These histories narrate moments of togetherness and the tragedy of separation.

The reciting and remembering of the past, I argue, crafts a Hmong body politic by drawing a Hmong-American returnee's journey back to their point of departure in Laos and Thailand. This return path is entangled in memory that is shared and summoned by their relatives in Laos and Thailand - the kin, as they say, that have been left behind.

Relatives shaped the subjective feelings of belonging for Hmong-Americans through their reception of Hmong-American returnees and the language used when greeting Hmong-Americans. One day a woman who sat holding a baby in her arms by the fire pit with me and my aunt heard a Hmong-American relative coming into the village and prepared her baby by saying, “Your uncle is here all the way from America. That is your uncle. Be good and maybe he will give us some money.” Her infant, who could not even mumble words, was being interpellated into a kinship relationship. This moment interpellated not just the infant and the mother but the uncle who was standing at a distance, not knowing what was uttered. I watched her lift up her baby and walk over to the man in the white dress shirt; she cried in his arms as others watched for his reaction. His young wife stood at his side, a Hmong-Lao from Phonsavon I was told.

My aunt in Xiengkhouang told me that when a relative from the United States returns ‘home,’ a *hu plig* ritual is usually done. This is often called in English a soul calling ritual. My aunt assured me that a *hu plig* was not done in my honor because such a religious transgression would upset my Christian mother. In my observation, *hu plig* also served as a reunion party for families that had been separated since 1975, often bringing *kwvtij neejtas* (patrilineal and matrilineal kin) together to recount histories of the time before the war as well as histories that bind kin to their ancestors. As a rite of passage or reception in these sites, the ritual enacted the return of the *plig* home. The return is twofold: the return of the wandering *plig* to the body and also the return of the Hmong-American to their homeland. As mentioned earlier, the *plig* contains its own

agency, its ability to travel and traverse place, time, and realms of both living and dead, and it can even refuse to follow the body. In this case with international travel, a *hu plig* ritual calls the *plig* to reunite with the body of its host; the *plig* then is symbolically tied to the body with white threads around the wrists, a tradition of *bac ci* that has Lao origins. It is believed that a departed spirit can leave the body vulnerable to illnesses and that the *plig* must be reunified with its home. Tapp (2010) associates the body with the notion of home, yet the body and home are unstable categories for cases of return migration. In Hmong there is no equivalent word for home other than the structure of the house. Home then is not entirely rooted in space but made into place by the social relationships within it. Calling the body home forgets the third structure of kin—the family members who must call the *plig* for a proper reunification with the body. Home, like the body, is called into being by kin, both locally and globally. Most evident in international travel, the ritual *hu plig* hails not just the *plig* to its home but also the individual engaging in return migrations to the home of her patrilineal family. This fluidity of home lends great potential to the imagined community of a transnational Hmong body politic.

Der is in her 70s and remembers the experiences of the war. Her husband had gone mad during wartime. She and her children had gone into hiding in the highlands of Xieng Khouang after the US CIA withdrew troops and thousands of Hmong fled as refugees. During Laos's resettlement efforts, Der and her family were moved to the

outskirts of Vientiane. In our interview, she spoke as if I were a messenger who would carry her message back to the U.S. about Hmong left in Laos.

Der: Well, like, those Hmong who have gone to *tebchaws Meskas* (America) when they lived in this *tebchaws Nplog* (Laos) their country was not good so they *tawg* (became displaced) and so they went to live [in America] and their country [Laos] got better and they still had people *tom qab no* (left behind) here and they still have relatives so they come and they come often, and so they *muaj siab* (have motivation) to see the country as it has gotten better. They come and go back to the US and work some more, save money, and then they come back to Laos. Those who want to they can help those relatives close to them who were left behind, to buy land to grow crops, they help buy a nice house for their relatives to live in. The one who doesn't know how to think—the ones who doesn't love the ones left behind, they do come and see the country and go back home and don't call and ask about how we are doing.

Der has two daughters living in the United States, one who married and fled with her husband during wartime and another who married a Hmong-American. In her message to Hmong-Americans she articulates the Hmong-American's country as Laos, invoking a Hmong-American place of belonging within Laos while articulating herself as belonging to the "ones left behind." This discourse, shared by many Hmong-Lao, addresses a Hmong-American history of departure and displacement, yet simultaneously names Laos as a country belonging to Hmong-Americans and works to create a homogenous community. It also conscripts Hmong-Americans as not refugees but migrants who chose to leave Hmong-Lao. This narration denies the historical specificity of the multiple motivations for Hmong-Lao who stayed in Laos. Some didn't align themselves with the Americans but rather the Pathet Lao party. Some retreated into the dense forests of Xieng

Khouang and fought as resistance fighters until surrender and were afterwards relocated by the Lao government into various areas such as Vientiane.

When I asked Cua about the divergence of Hmong factions in Laos, she laughed, “My father was the one killing your father’s people! But now we all live together and get married to one another!” A Hmong-Lao man who was a student at a nearby college in Phonsavan, used the metaphor of two brothers to explain the factions. Hmong-Americans and Hmong-Lao are nothing but two brothers whose reunification is central to Hmong kinship structure. These types of discourse work to remap Hmong-Americans as always belonging in Laos despite the historical reality and even ongoing hostilities between Hmong-American and Hmong-Lao. Many Hmong-Lao feel hurt by the way Hmong-Americans perform their modernity by commenting on Hmong-Lao’s inability to meet first world standards of living. Though the narrative of brothers or kin separated by war is powerful, Hmong-American return migration is fraught with complications of capital, history, and politics.

In creating a homogenized narrative of Hmong-American belonging in Laos, these kinds of contestations are silenced. Language like Der’s “They come and they come often (*lawd los ces lawd los los*),” work to create Laos as a place of home for Hmong-Americans. *Los* and the Hmong word *tuaj* means “to come” in English. But the differentiation of the word “to come” into *los* and *tuaj* infers an important interpellation of a subject as kin or else as someone outside of the family. In Hmong, the word *los* designates that the individual has returned to a place of *home* or a place of family,

whereas the word *tuaj* means the person is visiting. Family and home are conflated within the word *los*. In Laos, whenever locals greeted me, upon finding out I was not Korean, Japanese, or even a Hmong-Lao but indeed Hmong and a Hmong from America, they would correct their greeting from “*Koi tauj los?*” (You’re visiting?) to “*Koj los lawm os?*” (You’ve returned?). These phrases are to the equivalent of the English “hello.”

To say that Hmong-Americans have *los* to Laos ignores the fact that Hmong-Lao, like Der, now live in resettled villages in Laos and participate in a lifestyle that is different from when Hmong-Americans lived in Laos. In my observation, Hmong-Americans hardly stayed in their Hmong-Lao family villages nor slept in their thatched houses. Hmong-Americans often opted to stay in hotels and ate out at Lao restaurants¹⁴. Despite all this, Hmong-Lao still work to territorialize Laos as a place of family and home for Hmong-Americans. In Thailand I experienced the reverse, where I unconsciously insisted on *los* rather than *tuaj*¹⁵. Hmong-Thai friends and family would gently continue to say “*Koi tauj los?*” as if to correct my lack of orientation in place. I brought this up with Hmong-Thai who assisted me in conducting research and traveling around Northern Thailand. His interpretation was that people used *tauj* because Thailand was only a transitional moment in Hmong-American history. The need to greet Hmong-

¹⁴ In Xieng Khouang, it is required that all foreigners stay in hotels and not in villages. I was told that if a foreigner stayed in the village with family, the foreigner’s family must vow to be responsible for any possible accident or mishap that may occur during their stay. This is often impossible because family members are often poor and cannot cover any costs of anything fatal.

¹⁵ Because I was born in Thailand, I couldn’t help but unconsciously insist that I had *los* to Thailand rather than *tuaj*.

Americans as *tuaj* also lies in the history of Hmong in Thailand. Hmong-Thai insist on identifying as Thai based on their earlier kin's migration into Thailand following the Hmong departure from China. They distinguish themselves from Hmong *suun* (the Thai word for refugee) who came Laos to the Thai refugee camps after 1975 and settled in Thailand illegally or after the refugee camps were dissolved. Returning to kin in Thailand holds the same connection of return to family but not in the same generalizing of all Hmong-American to Laos.

In this chapter, I have shown that to insist that someone *returns home* disjoints the present and past in order to create a place of belonging for Hmong-Americans in Laos and Thailand. The discourses of "being left behind" or the greetings of "*Koi los lawm os?*" reterritorializes the historical demarcations of political alliances for the sake of crafting a narrative of Hmong-American belonging. The village in which Der lives is a relocation settlement for Hmong-Lao who returned to Lao society after the war. In our interview, she began with a greeting to all Hmong-Americans, almost as if we were on the radio, encouraging the *return* of Hmong-Americans to their country, Laos. She reveals the irony that the notion of return may be tied to Laos, yet it is not fixed to places of past residence. I argue that the fluidity of *return as los* allows the act and discourse of return to be centralized in the return to kin, unbounded by place and yet tied to kin in order to territorialize Laos and Thailand as a place of belonging for Hmong-Americans. The ideology of family and kin has powerful qualities of stitching together a Hmong body politic for Hmong-Americans who experience displacement alongside their

diabetes. Hmong in the diaspora create a narrative of Hmong-American belonging to Laos and Thailand at the expense of silencing the heterogeneity and inequalities produced from the economies of return.

Risky Returns

When my time came to leave my *tij laug*'s village, my first cousin informed me that I should utter these words: “*Plig*, wake up. We are leaving. Don’t stay in this place. Come with me.” She told me I should gently call to my *plig*, coaxing it as if to persuade it. “But you are amen [Christian] so you don’t have to call your *plig*!” We broke out into uncontrollable laughter. I stared at the space that had been my bed for over a month, its rock-hard pillows and mat laid on a wooden plank. I was uncertain that being Christian really meant that I could dismiss my *plig*'s potential attachment to a place. My interlocutors were either practicing Christians or the “traditional” which was a mixture of animism, ancestral worship and shamanism. Despite this variation, the desire for a return migration and the concept of the *plig* were not conflicting religious ideas. Upon my departure back to the U.S., I was fearful that I too would begin dreaming of Laos and Thailand, especially places where I reconnected with my patrilineal family.

And why was I afraid of this? Time and distance away from fieldwork has allowed me to see that I was afraid because these places and people like *hlob* and *tij laug* made Laos home for me. Would I too suffer a feeling of loss when I returned back to the U.S? Would I then become fixated too? My *niam tias* (matrilineal aunt) told me that people get addicted to going to Laos. Yang Lee, in the beginning of my chapter, was

already itching for another return trip. If my *plig* decided to stay, I could very well become transfixed on the desire to return. In this chapter, I began with Freud's theory on melancholia as a pathological manner of mourning. While situating Freud's work in relation to others who find melancholia as actually productive, I still maintained some skepticism regarding a situation in which mania might set in. The repetitive return migrations and the addiction to it then could mean the eruption of mania. Such instances of mania that I have heard about often stemmed from transnational marriages. For example, my mother shared a story with me that an older Hmong-American man succeeded in bringing his young Hmong-Lao wife to the U.S. While he was working, she had extramarital affairs. When he discovered this, he murdered her. Another story I heard was of a Hmong-American man who became fixated on a life in Laos, neglected his own family in the U.S. and gave up all his money to his young mistress in Laos.

In Nraug Nas's singing, he questions whether the two Hmong brothers will ever be able to truly live together. "I'll miss you until the day I die." Nraug Nas sings. The Hmong brothers will no longer miss each when they die, because the true reunification is in death. I detail the impossibility of return and its connection to death in the upcoming chapter. This aligns with the paradox of return migration as stated in the introduction. As others have mentioned to me, the only true return to Laos is through death and the only cure for diabetes is *hlaub thiab thaum txhob*—a shovel and the dirt. Such speech reveals the skepticism about a true Hmong-American return to these places from which they have departed, and the paradox of return migrations implies its constant repetition.

Conclusion

Return migrations conceptualized as a cure from type II diabetes are bittersweet. It is a fleeting pursuit as blood sugars rise for my Hmong-American interlocutors with the realization that going back to the U.S. also means going back to a life plagued with *kev nyuaj siab*. Return migrations are productive; they enable the creation of an imagined community in the diaspora by reconnecting kin separated by oceans through the acts of finding Hmong medicine for their Hmong-American family member(s), creating new family ties through transnational marriages, and partaking in a life where my interlocutors are much more socially mobile. Return migrations are bittersweet because they are embedded in sentiments of loss, nostalgia, and romanticism. Yet, as a transnational project, return migrations homogenize the divergent histories of Hmong-American, Hmong-Lao, and Hmong-Thai at the cost of creating Hmong-Americans as always belonging in Laos and Thailand. It oversimplifies and neglects the issues of power and inequality in return migrations. Yet still, as this chapter has shown, return migrations as “causations for healing” (Culhane-Pera et al 2007) from diabetes are an attempt to perform a social healing of displacement that would restore the wholeness of the Hmong body politic.

CHAPTER 4: THE WAY FOR THE BODY

During the early stages of my fieldwork, I volunteered at an adult daycare that brought elderly Southeast Asian-Americans together for social gathering. Every day they were bused to the center where they were served rice porridge or congee and, at times, eggs or bananas. For most of the six hours they spent at the center, they would converse with their usual tablemates, play bingo, or go on group field trips to the park or the market. I met Txhiaj and his wife during my time at the center and became so familiar with the details of their past life and entangled in their gossip of the day that I no longer called them *niam tais* and *yawm txiv* but by their first names. They often said I worked for them when their friends would call on the phone; in one case, they said I was their friend.

Txhiaj, who fought with the U.S. CIA during the American War in Laos, often referred to the Vietnamese-American elders in the room as the communist enemy, not knowing that these Vietnamese-Americans were also refugees¹⁶. He never talked to any of them, and this perhaps encouraged the division and misunderstanding between the two ethnic groups. He seemed to be generally resentful and, despite being unable to speak English, he was well equipped with English curse words. I often observed Txhiaj, with his fragile frame and slightly hunched-over posture, pacing the gymnasium-sized room at

¹⁶ The Hmong word for communist is *Nyab Laj* which means Vietnamese. This kind of equation may have resulted in the misperception that Vietnamese are the communist other.

the adult daycare with two-pound dumbbells in hand, curling them one arm at a time as he walked back and forth. Txhij suffered from diabetes along with his wife, who told me that her husband was constantly concerned about his health and exercised when he could.

Txhij would bring to light a central question in this dissertation because of his chronic diabetes and his service in Vang Pao's army: what does it mean to assert that the only cure for diabetes and the only true return migration to Laos is through death? What kind of political claim is the claim to death? I draw on my interview with Txhij and his wife to think critically about the promises of chronic disease management in conjunction with the promises of refugee salvation. I argue that the claim to death as a true return to Laos and cure for diabetes is a political claim to Hmong sovereignty. As this chapter will show, death (and not return migration) through Hmong funerary practices enables a return to an eternal Hmong homeland, thus allowing a return to sovereignty and healing a Hmong-American displacement.

My interview with the couple began with their experiences with diabetes and how they were diagnosed. Txhij told me that on the day he was diagnosed, he had gone to the bathroom after he woke to wash his face and his vision went dark on him. He called his wife who then called their social worker since they were elderly, monolingual, and living in a public assistance apartment complex. An ambulance soon arrived to pick him up. Txhij was hooked up to an IV, and told that what he had experienced was the result of undiagnosed diabetes. Txhij told me that he didn't believe it at the time, although his wife had been diagnosed with diabetes long before he was. He finally accepted his

diagnosis after the continuous practices of monitoring of his blood sugar levels. The numbers and the everyday practice of diabetes management became representative of the disease, and slowly erased his personal doubts.

After learning about how he was diagnosed, I went on to ask Txhij what he thought would be a cure for type II diabetes. Txhij answered me under the watchful gaze of his wife.

Txhij: If I am able to really say it then the only way for the body would be to way to the heavens. And that road must only lead back to Laos. It [the road] was not supposed to be here! If I was in California, perhaps I would have driven off already but the road to the heavens ended up here.

Kiab: You want to go to the heavens then just go!

Txhij: Like General Vang Pao said, if they [Americans] were going to say we [Hmong] are to come to this country then we'd never to return to Laos...Living in this country—[you] can't return back to Laos. So you just wait for the day for whenever you can return. So when the time comes, you just "bye bye."

Txhij's wife Kiab interrupted the Txhij, reinterpreting his statements, "Oh *Yawg* (short for *txiv yawg* which means grandpa) here doesn't know what he's saying. He doesn't know how to tell you the point of his message! Here, he's basically saying that the illnesses of the body here in the U.S. are due to all the chemicals Americans put in their food." Txhij smirked while Kiab tried to reorder his illogical thoughts to something coherent for my research, making sure it matched some kind of biomedical logic.

Drawing on Evans Pritchard's (1976) work on the Azande and articulations of witchcraft and Michael Taussig (1980) work on disease illness narratives, I understand Txhij's irrational speech as pointing to the societal inequities within Hmong-American

and U.S. politics. Txhij makes a political claim to Hmong sovereignty by equating return migration and cure from diabetes as only possible through death. In this chapter I draw on Cazydn's theory of the already dead, one who has suffered social death only to die again in the future, to understand Txhij's social position as both one who suffered a social death from diabetes (a once terminal disease that is now chronic) and one who suffered a social death from displacement to the U.S. This category is useful to understand how Txhij's claim to Hmong sovereignty dismantles the narratives of biomedical and governmental salvation and the structural framework that sustains Hmong-American refugees' relations to the U.S. and Lao state.

Speaking about Death

Hmong-American elders often sat around circular tables and chatted the day away where I met Txhij and Kiab. On one of my volunteer days, I overheard three elderly Hmong-American women talking about going to Laos. Naively, I interrupted, "Really? When are you planning on going?" The women looked at each other and laughed. "We are going to Laos, but we are not flying there," is how one outspoken woman answered my ignorant question. In that moment I realized that they were not planning a trip to Laos but were instead talking about the futurity of their own death. The phrase "going to Laos" was also an idiom used for talking about death. Yang Lee had also spoken to me about death during an interview. Indeed, Yang Lee was the first interlocutor to say this to me with a laugh, "the Hmong shovel and the dirt are the only means of curing your diabetes."

In my experience, speech about death was always indirect, using idioms such as “going to Laos” or Hmong proverbs such as the Hmong shovel and the dirt. Gerdner, Yang, and Tripp-Reimer (2007) argue that it is harmful to inform dying Hmong patients of their death, and that is best to speak in terms of the abstract, such as *npuv ib puas neeg kaum xyoos* (over 120 years old). In my experiences, I was told by elders that one can never truly know when someone will pass. Therefore, as I explained in Chapter 2, it is important to speak kindly and to speak in the abstract. Ultimately, the words spoken could lengthen or shorten someone’s life. In, *Consoling Ghosts: Stories of Medicine and Mourning from Southeast Asians in Exile* (2013), Jean Langford describes how some Hmong were in favor of informing a patient of a terminal prognosis while others shared similar feelings to those I have noted, that speaking about death could be harmful.

Speaking about death in the abstract not only defers the possibility of actual death but also works as a social and political commentary. Speaking metaphorically about death differs from wishing for death; I do not take Txhij’s articulation of death as an actual wish for death. Instead, his discourse works to address the state of Hmong-American politics in the U.S. In chapter 1 I noted that Hmong-Americans experience continual feelings of displacement, of being always from *tim u* in the U.S. Txhij and others experience displacement chronically, where they live in perpetual insignificance. This experience of chronic displacement is also compounded in chronic disease management, where one is encouraged to perpetually live in the present according to chronic time. I argue that the narratives that biomedicine saves lives, and that Hmong-

Americans as refugees must be saved, actually work to render displacement (and the violence that stems from those narratives) illegible. Drawing on Cazdyn's theoretical works on chronic disease and chronic time, I argue that Txhiaj's claims to forgo chronic disease management challenge these narratives. By situating death in terms of Hmong funerary practices and Mircea Eliade's *Eternal Myth of Return*, I argue that death serves to undo Hmong displacement by returning to Hmong sovereignty and the Hmong kingdom.

Chronic Time and Deferred Death

Bee (introduced in Chapter 2) joked many times that if the other participants didn't see her attending the diabetes group visits then she could be found at Jackson, a cemetery on the East Side of St. Paul where many Hmong-Americans are buried. Others nodded at her comment and agreed that the very same could be said for them. As patients who have been diagnosed with a chronic disease that affects older patients; they continued to joke about their impending death. As noted in Chapter 2, my interlocutors were educated to understand ways of controlling diabetes through exercise, diet, and self-discipline; elders also expressed the need to maintain good marital relationships for their wellbeing. However, information on diabetes morbidity and death is never taught or discussed, with the exception of end of life directives that only attend to the moment of dying and not the context of the death.

The erasure of death from the biomedical intervention has been a project of government and biomedicine. Populations are disciplined and managed through technologies that control life and death (Foucault 1990[1978]). Fundamental to governmental power is the ability to maintain and ensure life at the level of the population. Biopower rests in “the right of the social body to ensure, maintain, or develop its life” (Foucault 1990[1978]:136). Life is the center of chronic disease management as illustrated in the maintenance of one’s chronic and biological life. However, Txhij’s insistence on going to the heavens (*mus saum ntuj*) as curing diabetes denies diabetes management and biomedical care of life. In the project of ensuring life, death is removed from the patient in such a way that death becomes unthinkable. In chronic disease management, meticulous discipline is life sustaining, embodied, and the only commonsensical way for people with diabetes to live. As illustrated in Chapter 1, prior to the development of blood glucose numbering, people died early from diabetes. However, with the miracles of biomedical intervention, no one dies from diabetes anymore but rather from the complications of the disease. Life- extending medical therapies such as chronic disease management are actually extraordinary, as Kaufman (2015) writes; therapies that did not exist before have become available, necessary, needed, and then commonsensical and ordinary. They have been made normal through a social nexus of research, politics, and insurance. In the social field of expert knowledge (doctors, policy makers, researchers) and Medicare, preventative medicines including end- of- life therapies become medically necessary, desired, and needed by patients. Therefore, to

deny treatments such as diabetes therapies goes against the ethical field that is created through these various procedures. Ordinary medicines become commonsensical in that they seem to be the only possible choice, despite the conundrum they often pose for patients who are elderly and develop even more complications from the life extending therapies (Kaufman 2015).

In the diabetes group visits, the focus is on maintaining life. As argued in Chapter 1, the chronic care model structures experiences of time and death. It works to produce a perpetually sick present in which death is deferred, so that we are unable to confront the terminal. This chronic time negates the terminal in chronic disease by eradicating our relationship to death, attending only to the life sustaining actions and removing the figure of death. But interlocutors like Txhijaj, Lor, and Bee hold onto their double future, where death enters the disease narrative again through their insistence on joking about their own deaths.

These patients are, as Cazdyn articulates in his book, the already dead (Cazdyn 2012). The already dead are the medical patients who have been diagnosed with a terminal disease, or more precisely, one that before medical technologies would have been terminal. For Cazdyn, this diagnostic condition creates the category of the already dead. The already dead are those who have experienced social death but are biologically alive and yet sure to die again in the future from their chronic disease. However, the already dead hold onto hopes of a cure. He writes,

Management and cure are usually employed to distract us from experiencing illness in a way that opens up to powerful personal and social questions...[T]he

way discourses of management and cure occupy the experience of illness and the practices of medicine foreclose a variety of other experiences and practices (Cazdyn 2012: 199).

As discussed in Chapter 1, chronic disease management structures an experience of time where the present becomes the limit of experience and the futurity of death is deferred. One of my interlocutors, Yang Lee, a soldier who fought under Vang Pao, is the one of the few soldiers who didn't die. He was hit by bullets and survived his death, only to come to the U.S. with a disease that was once terminal. Yang Lee was fired from his job because he was monolingual and did not know English. He lives both the social death of his disease and the social death of displacement. Chronic disease management's focus on the body and its maintenance of the present forecloses the possibility of engaging in larger political and social questions around what sustains Hmong-Americans' experiences of displacement and diabetes. In other words, chronic management takes away the possibility of addressing their historical trauma. Therefore, Txhij's speech about death as a cure and true return can only occupy the register of the irrational. Txhij and the already dead defy the commonsensical in order to lay claim to the failures of U.S. governmental and biomedical promises and Hmong-American chronic displacement in the U.S.

Biomedical and Governmental Promises of Salvation

Hmong-Americans entered the U.S. political imaginary as an exotic biomedical and refugee subject, illustrated most prominently in Anne Fadiman's *The Spirit Catches*

You and You Fall Down: The Clash of Two Cultures (1997). Fadiman depicts Hmong-Americans as culturally excessive and determined by their history of resisting hegemonic rule from outsiders. Hmong culture and biomedical culture are painted at odds with each other, resulting in the tragic demise of the main character, Lia Lee. Fadiman's cultural caricature of Hmong-Americans erases the ways biopolitics is violent in its preservation of life. This chapter draws on Stevenson's (2014) work to envision how biopolitics can be violent in that it ensures biological life but not necessarily desirable ways of life (Stevenson 2014). In this dissertation, I have shown that diabetes management works to preserve life through the implementation of biological control: the control of blood sugar levels, diet, and exercise. But what it does not address are the continual feelings of displacement and social insignificance that Hmong-Americans experience as shown in Chapter 2. In being made to live under biopolitics, Hmong-Americans are also made to live out their displacement chronically. The chronic displacement that Hmong-Americans experience alongside their diabetes is the manifestation of minoritization, social insignificance, monolingualism, and feelings of social isolation. Their experiences of displacement are rooted in the aftermath of governmental promises of refugee rescue for Hmong-Americans¹⁷. Glossing Hmong as cultural and determined by history, Fadiman erases the violence of U.S. imperialism to sustain the narrative of biomedicine and the U.S. as savior.

¹⁷ The promise of refugee salvation also implies assimilation which ultimately results in the dilution and disappearance of the refugee.

The secrecy of the U.S. covert operations in Laos reinforces the erasure of the U.S.'s violence in Laos. Secrecy, as Ma Vang (2012) writes in her dissertation, racializes Hmong as outside of historical time and tribal individuals who have yet to arrive in modernity (Vang, M. 2012). Ma Vang (2012) argues that the Hmong refugee subject was produced and shaped by their role as a soldier in the American War in Laos. For Vang M., the secrecy of U.S. involvement in Laos renders invisible the legibility of Hmong-American claims on the U.S. State. The category of the refugee, as an empty category (empty of history and U.S. involvement), removes any U.S. involvement and violence in the American War in favor of constructing the U.S. as benevolent through the narrative of rescue. Hmong-Americans are racially constructed as needing rescue by the biopolitical arm of the U.S. empire, when it is this very U.S. empire that is responsible for their displacement. Biomedically and politically, Hmong-Americans must be saved from themselves; biomedical intervention and political rescue brings Hmong (imagined to be pre-modern) into modernity through the act of being made to live. In being made to live chronically, death is taken from Hmong-Americans and further deferred in chronic disease management.

Yet, Bee's joke that her absence in the diabetes group would mean they could find her at Jackson Cemetery is a haunting reminder of the possibility of death and the failures of biomedicine that my interlocutors are unwilling to shake off. Death and the failure of chronic disease management to ward off death looms in the diabetes group visits as the participants narrate their blood sugar level numbers and as Lor waits for his numbers to

slowly take his life away. Anthropologist Janelle Taylor (2013b) writes about the haunting figure of medical failure in the story of Lia Lee:

On the one hand, Lia represents the necessary limits confronted by the heroic individual doctor. On the other hand, she also represents a dramatic failure of "the system," including not only the institutions of medicine but also those of the various arms of the state-welfare, immigration, and social work-with which medicine is profoundly entangled. The still, silent figure of Lia here serves as a sort of empty space where physicians struggle to discern the parameters of their own power and agency within the institutions they inhabit (Taylor 2013b:176-177).

The narrative of Hmong-Americans, existing outside historical time and needing to be saved biologically and politically from their cultural excesses overlooks the everyday material and embodied violence of the state. Racializing Hmong in these terms ignores the biomedical, political, and social failures that attended their "rescue" to the US from genocide at the hands of communists. It is within the lived experiences of my interlocutors, who narrate their disease experiences as imbricated with their experiences of political and social displacement, that we can understand Seng-Mei Ma's article on the Hmong death fugue. Ma writes, "one wonders whether refugees have indeed begun a new life...or are they dying a slow death" (Ma, 2005: 2).

The narrative of salvation and rescue has been central in racializing and making Hmong-American bodies legible to the State. Ma argues that the Hmong-American's trauma cannot be laid to rest as Hmong refugees continue through "a disorienting labyrinth, with its linguistic and cultural puzzles, their own heavy dependency on welfare and other social programs, homesickness and a gnawing sense of impotence, dissolution

of traditional lifestyle and values, American racism and discrimination, and gradual Americanization of the younger generation” (Ma, 2005:4). Hmong-Americans face a continued prolonged dislocation through loss of family, loss of status, assimilation, and cultural change, while the violence and trauma that Hmong-Americans/refugees face every day and embody remains a haunting figure within the narrative of biomedical and political salvation.

Rescue and salvation continue to lace research on Hmong and health disparities while these literatures forget the historical and political context of Hmong in the U.S. For Vang M. (2012), it is more important to highlight the historical context that produces Hmong as refugee by challenging an ahistorical political category of the refugee. My dissertation, in remembering this historical trauma as part and parcel of the construction of the Hmong-American refugee subject, shows how displacement is legible as biopolitical violence. Rather than being seen as refugees that needed to be saved like the Vietnamese in 1975, Hmong were seen by the State Department and Immigration and Naturalization Services as far too primitive for the U.S. (Hillmer 2010). This assumption overlooked the fact that the U.S. trained and equipped many Hmong in warfare technologies and trained Hmong nurses to treat the injured (Hillmer 2010). Hmong and other U.S. CIA personnel, like Jerry Daniels and General Aderholt who worked with Hmong, insisted that the U.S. government recognize the blood sacrifices that the Hmong made on behalf of the U.S. (Lee, M. 2018). Ultimately, Hmong were used and abandoned instead of being saved as refugees (Hamilton-Merit 1993). Mai Na Lee’s (2017) talk *The*

Origin and Creation of Hmong-American Memories of Blood Sacrifice on Behalf of the United States During the Secret War given at the University of Wisconsin-Madison argues that the contradiction of having to appeal to the U.S. to recognize their debt to the Hmong-Americans for Hmong blood sacrifices on behalf of the U.S. only refigures Hmong-Americans as foreign, always having to justify their citizenship and “right to be on this land” (Lee, 2018). Narratives of blood sacrifice also forget, as Txhiaj states, that Hmong-Americans did not want to come to the U.S. Lee points out that Vang Pao resisted being labeled a Special Guerrilla Unit soldier who fought for the Americans but instead, saw himself as a servant of the Lao kingdom and the Lao king. For Vang Pao and Txhiaj, exile in the U.S. was seen as only temporary (Lee, M. 2018).

My interview with Txhiaj was conducted 6 months after Vang Pao’s death in January 6, 2011. Still, Txhaij’s apartment was adorned with photos of Vang Pao and photos of a younger Txhiaj in his U.S. military outfit. Vang Pao’s death marked a critical turning point in thinking about Hmong politics in Laos. His death seemed to finally close the chapter on Hmong-Americans’ dream of a Hmong homeland. Vang Pao was symbolic, embodying the Hmong-American plight and struggle for a homeland. His death in other ways opened the door for Hmong-Americans to engage in return migrations without instigating Lao anxieties around Hmong-American political agendas. I believe his death has enabled multiple ways to claim a Hmong body politic, through (re)connecting with kin and through death.

The interlocutors discussed in chapter 3 insist on a cure from type II diabetes, but rather than demanding a change to the social order, they seek a temporary cure through personal return migrations. Return migrations work to reimagine alternative forms of care from both the sickness of diabetes and the sickness of being in the U.S. Return migrations addresses their feelings of displacement by (re)creating familial kinships through marriage and reconnecting with disrupted kinship relationships. They attempt to treat their feelings of social insignificant by engaging in a habitus that is familiar, becoming not only their pre-diabetic self but a youthful self with social and cultural mobility.

In contrast, Txhij takes issue with this optimistic idea of healing when he states that a return to Laos is impossible. While he is also the already dead, he does not seek to remake the system nor find ways to live within it. Rather, he departs from that line of thought by forgoing the very promises of the U.S. and biopolitics, but most controversially, the desire to return ever to Laos. He believed that the choice to come to the U.S. foreclosed the possibility that he would ever return. As I will show in this chapter, return migrations are attempts to retrieve the first lost object, the Hmong kingdom and Hmong sovereignty; the desire to reunite with it structures Hmong-Americans' continual experience of loss. From my understanding, the lost object, for Txhij, has never been lost. This concept will be explored later along with Hmong funerary practices and Eliade's *Myth of Eternal Return*; first, I want to explain why a return to Laos is never possible even through return migrations.

Impossibility of a Return to Laos

I ended Chapter 3 with Freud's notion of melancholia and the fixation on the lost object of a Hmong homeland—constituted through locality and kin. While I found melancholia to be productive where the desire to be with the lost object enabled the creation of a transnational Hmong imagined community, I was also convinced that melancholia could turn into a type of mania where Hmong-Americans return migrations become repetitive. The repetition compulsion in mania derives from Freud's theory of the death drive, which is the instinct towards a "*tendency innate in living organic matter impelling it towards the reinstatement of an earlier condition, one which it had to abandon under the influence of external disturbing forces*" (Freud 1922: 44, italicized in original text). In conversation with Gilles Deleuze's (1994) work *Difference and Repetition*, return migration (even if it is the first return migration) is a repetition. Deleuze argues that repetition is not a repeat of the original but rather a resemblance of the original, or as he says, "They [repetitions] do not add a second and a third time to the first but carry the first time to the 'nth' power" (Deleuze 1994:1). Hmong-Americans have a long history of displacement, from China to Laos, from the autonomous region of Nong Het to Long Cheng, from Laos to Thailand, and from there to the U.S. Hmong may seek to return to these places and to reclaim belonging to these territorial places, but as Txhij alludes, they truly are seeking to reclaim the first lost object, Hmong sovereignty and a Hmong kingdom.

The repetitions of return migrations are not caused by the repression of Hmong lost sovereignty and kingdom. Deleuze makes clear that repetition becomes a means in which each one can live within their own particular everyday experiences. This brings back my earlier argument in Chapters 1 and 2 concerning chronic diabetes and chronic displacement. The repetition of return migrations are the attempts to live under life conditions in the U.S. and also a political situation in which Hmong-Americans can never claim place to sovereignty. They can only claim belonging in the transnational relationships cultivated across oceans that are not located within a geopolitical space.

Txhij discusses the impossibility of ever returning to Laos in the present, “Living in this country—[you] can’t return back to Laos.” Exiled from Laos because of their alliance with the U.S., Hmong-Americans have an ambivalent relationship with Laos. Some Hmong-Americans have always wanted to return back to Laos, beginning as early as the time when the Hmong lived in the refugee camps (Long 1992). The hope in returning at that time was also the hope of reclaiming a region of Hmong autonomy in Laos, even for Hmong General Vang Pao (Lee, M. 2015). But upon Hmong resettlement in the U.S., experiences of racism and nativism further continued Hmong-Americans’ desire and dreams to return. Engaged in transnational politics, Hmong-Americans appealed to the U.S. government to change the political situation in Laos in order to make it more welcoming to a Hmong-American return migration (Vang, C. 2010).

The Hmong-American and Hmong-Lao are like two brothers, said a young Hmong-Lao man. I was intrigued by the phrase I heard in Laos about Hmong who sided

with the Pathet Lao as Hmong with *pob txhas Nyab Laj* (bones of communist). That discourse points to the notion that on the outside, the brother is Hmong but within him lies Communist ideologies. This discourse also references a historically deep seeded division beginning in Nong Het and the division of Faydang and Touby that has evolved into the separation of the Hmong-American and Hmong-Lao¹⁸. A young Hmong-Lao man in Xieng Khouang told me the story today was different. Today, the two brothers were caught in political demarcations that decided their fate. Given such political complications embedded in Hmong kinship and history, I understand Txhiaj's claim that Hmong-Americans can never return back to a Laos that is informed by these tensions.

The desire to return back to Laos does not map onto the lived reality of Hmong-Americans' actual return to present day Laos. As I have already noted in Chapter 3, Hmong-Americans often stayed in hotels upon returning back to Laos, dined in restaurants, and complained about the way of life of their relatives in Laos. I overheard the word Hmong *mas es* (lamb) used by Hmong-Lao to label the mass of Hmong-Americans who took up all the hotel reservations near a Hmong New Year celebration in a village two hours outside of Vientiane. These return migrations can never truly be a *return* as Hmong-Americans imagine them to be. No matter how many repetitions, return migrations incorporate a sense of the old with something new that no longer is truly like

¹⁸ Mai Na Lee (2015) in her book *Dreaming of the Hmong Kingdom*, she points the contradiction in Hmong patrilineal society, that is clan based, as a way of undermining a unified Hmong kingdom. That is why marriage alliances were important in unifying people under General Vang Pao. Marrying women of different clans created alliances outside of the Vang clan.

the original. When Txhij points to the historical context of Hmong-Americans in the U.S. and the impossibility of Hmong-Americans to truly return, he illustrates the paradox of return migrations as returns both to life and death by bringing Hmong to the actual first lost object, the Hmong Kingdom. Following Hmong funerary practices and beliefs about death, we will find that the Hmong Kingdom and Hmong sovereignty has never actually been lost.

Death and Return

Death in biomedicine is often thought of as a finality, the end of a life. However, Jean Langford (2013) writes that death for Hmong (among others) is more open ended. Death is a communal process involving both the living and the deceased as the deceased's *plig* enters the realm of the spirits and ancestors. The realm of the spirit and ancestors does not exist in closed-off worlds such as the Christian context of heaven and earth. In death the *plig* must journey back to the ancestral land, and on the way, return to every place the deceased once lived to thank the land and the spirits for their time in that place. Returning to the "unseen world" may seem like a return to the past when it is said to arrive at the place of the ancestors; the *plig* continues living as it would in Laos, cultivating the lands and raising livestock. However, the unseen world in which spirits and ancestors reside also co-exists with the living and present time. In Southeast Asian religions, and in Hmong animism and shamanism, the dead are very much a part of the

community of the living. Equating Laos and heaven, Txhiaj points us to the continuous existence of a Hmong Kingdom to which one would return in death.

In Eliade's work *The Myth of Eternal Return*, this cosmological conception of death as a return to an ancestral place is not an engagement with a modern conception of time in which ancestral return signifies a return to the past, but rather a creation of the mythical present. The real is not the present in the modern sense of time but the real is the eternal. Rituals, particularly the Hmong funeral, serve not only to send the *plig* to the ancestral land but are also an engagement with mythical time. In Hmong funerary practices, especially in the case of elderly individuals who have elaborate funeral rites that enact the mythical times of Hmong origin, the replaying of the songs of the creation of the world confirms Eliade's argument. As he writes, "they perform the acts at the same mythical instant of the beginning; through the paradox of rite, profane time and duration are suspended" (Eliade, 1954:35).

Through imitation/rites/rituals/human acts man is projected into the mythical epoch in which the archetypes were first revealed. Death and funeral rites work to creatively recreate the individual to confront his Real self. It is a transformation to achieving an eternal self that is both an extension of the self and an amalgamation of multiple selves that are tied to an eternal Hmong community. In *Showing the Way* (1983), Lemoine's following passage illustrates the multiplicity of the self:

Now, ah, your ghost, my brother richly dressed
Appears on the other side—tall like you, your spitting image
Is it you or not? Cock your ears, turn your head
Look; that man, the stranger, he sings you a spirit song

Your ghost takes you by the hand, you cross your arms, you cross your legs
You rise up with the ghosts, is that not so, Neng Chu?
You have glided into the Beyond, you can talk with spirits—
Let your feet glide and follow the spirits (Lemoine 1983, 11-12).

In Lemoine's translation of the funeral of Neng Chu, the deceased exists as a multiplicity of spirits. "Your ghost...appears on the other side—tall like you, your spitting image." Here the return to the eternal self is at both one and multiple, the spitting image but a ghost. Yet, this passage not only illustrates the multiplicity of the self but also the uncertainty of the self in death. For Langford (2103) the phrase, "Is it you or not?" indicates that death may not be a return to a true self but potentially the undoing of the self. Similarly, Eliade writes, "the man of a traditional culture sees himself as real only to the extent that he ceases to be himself (for a modern observer) and is satisfied with imitating and repeating the gestures of another. In other words, he sees himself as real, i.e., as 'truly himself,' only, and precisely, insofar as he ceases to be so" (Eliade, 1954:34). Hmong funerary practices are a repetition but not in the Deleuzian sense of repetition, but rather in Eliade's definition of repetition of the "same mythical instant of the beginning." (Eliade 1954: 35). Hmong funeral practices are the reenactments of the mythic—the cosmos and society. The mythical Hmong kingdom coincides with the ritual repetition of the funeral. In its enactment, where the deceased is to be reinserted into mythical time and return to the Hmong kingdom, the self also ceases to be him/herself.

For Eliade (1954), death is the repetition of the individual's life as it moves from the present to the past, and to mythical time. In tracing one's footsteps back to the

mythical, the funeral rite of passage undoes the displacement of the Hmong-American. Hmong funeral rites serve as the means to guide the deceased in a return migration through the places in which the person lived, moving from Minnesota to the refugee camps, to their birth place in Laos, to China, and lastly to the ancestral land.

Morrison (1998) writes that the *qeej* provides guidance and solace to the departing spirit and the living community. It creates a pathway for the spirit as it accompanies the spirit along a journey that links the temporal and the eternal. It helps to bring the “personal life story of the deceased into the right relationship with all that is and ever has been” (Morrison, 1998:11). Although Morrison does not elaborate on what “the right relationship with all that is and ever has been” I take this open-ended interpretation to mean that the deceased’s spirits are placed within the right relationship to an eternal Hmong body politic, as the proper rites and rituals enable the admittance of the deceased to the “unseen world.”

The *qeej* is a reed instrument that, when played, communicates to the deceased and guides the *plig* to the ancestral lands. It is also played with the *txiv xaiv*, an individual who chants unrhymed lines of standard Hmong speech. They alternate their speaking parts as the *qeej* communicates with the dead and the *txiv xaiv* communicates with the family and friends. Playing the *qeej* for elders like Txhiaj is the most difficult as the songs for such elders enact the creation of the world.

It [the *qeej*] speaks of the creation of the first man and wife, the first seeds and crops, the creation of the animals, the creation of the heavens, and the proliferation of human life. It also tells why there is sickness and why

people are born and die. It speaks of *Saub*, the good god, and *Ntxwg Nyooog*, the evil god. The cyclical nature of life and death is described. Both spirits and humans are reminded that the life and passing of the deceased is part of the whole drama. Not just the drama of the living but also the drama of the spirits and the ancestors—the endless rejoining and separating of reincarnation. (Morrison, 1998:13).

The *qeej* and its musical language, which specifically invokes the foreignness of the world of the dead and yet also the possibility of communication with that world, joins past, present, and future generations, affirms clan and lineage membership, and reiterates remembered history and shared understandings about the world.

This final return is a return to an eternal community, the Hmong Kingdom where family and kin exist and, at the same time, the final return remembers the historical route and displacement of Hmong within the world of the living. Abandoning the idea of a cure and the desire for reparation for the continual displacement that Hmong-Americans face, Txhiaj's claim to death is a political claim to an eternal Hmong body politic. For my diabetic interlocutors, death lets go of the social death within the "lands of gold" in order to claim sovereignty for themselves. Conceptualizing homeland through interconnectedness beyond nation-state boundaries allows us to see the Hmong homeland/Kingdom as infused with "notion of the family and clan," and as cultural and psychological (Lee, M. 2015). The Hmong homeland is then eternal and boundless, while rooted within family and clan. The ultimate cure for the displaced Hmong body is death in which the return reunifies the Hmong who were displaced in diaspora.

Conclusion

While the desire for a return to a Hmong homeland continues, a return in this life is not possible. Txhiaj's statement that "the only way for the body would be the way to the heavens" opens up a conversation about healing, both for the body and a Hmong body politic that is contained neither within biomedical conventions nor within the US nation-state. This chapter has shown that Txhiaj's claim to death (by letting go of the desire for reparation, for a Hmong country, and for life, and letting go of the fear of death) challenge the structural frameworks of biopolitics and Hmong-American subject position in the U.S. His speech brings attention to an alternative view of the world and a Hmong social order that is eternal. Death is a cure for both the diseased body and it is a cure for the Hmong body politic, a community in diaspora.

Managed care attends to the deferment of crisis and sudden death, and my Hmong-American interlocutors are made to live with both chronic diabetes and chronic displacement. The reinforcement of the Hmong as racially outside of historical time, culturally excessive, and in need of governmental and biomedical rescue addresses the imagined crisis of Hmong racial position in the U.S. while ignoring the social context of the Hmong in the U.S. and the ramifications of displacement in Hmong experience. The limits of Hmong legibility are marked by the frames of this perpetually invisible racial subject which is shrouded in US secrets. Txhiaj's linking of the diseased body and US imperialism unshackles the frames of the present, bringing back the memories of the initial crisis of alliance with the US and the failures of US democracy and promises.

For Cazdyn, our experience of medicine and medical treatment structures our relationship with other political, cultural, and social aspects of our lives, whether it involves embracing a utopian cure or acceding to managed care. In Cazdyn's frame, Txhij is the already dead, who is aware of his death that is deferred with chronic care but demands death on his own terms and embraces the idea of cure. Death and cure allows him to see a dismantling of the current social structure, to see that his right to die allows him to reclaim a utopian idea of a Hmong state that forgoes the need for the U.S. to recognize it politically.

CONCLUSION

My grandmother was always interested in hearing about my fieldwork experiences such as meeting Hmong people in places that are now distant lands to her. As her health deteriorated, she was placed in a nursing home. I often visited her when I would return to my parents' home in Wisconsin. On one occasion, the nurse requested that I tell her that her diabetes will cause her to lose her limbs if she doesn't eat enough protein. She looked up at me with startled eyes, scared and fearful of this place she was put into with no way to communicate her pain, fear, and desires.

The day before she fell into a coma, my mother, aunt, husband and I brought my firstborn child, Evelyn, to see her. Unfortunately, my grandmother was sick that day, so my husband sat outside with Evelyn who was asleep in her car seat. When my mother showed her a photo of Evelyn on my cellphone, she asked, "That's Mai See's baby? How is it that Mai See is able to give birth to such a chubby baby?" Grandma, with a blue cloth napkin tied around her neck, hunched over the Tupperware filled with food that my aunt had prepared for her. Her shirt was almost falling off her frail frame. As she stared into the Tupperware, she said to my mother, "I want to go home. I haven't told your father yet, but I want to go home." My mother didn't correct my grandmother that my grandfather had passed away a long time ago in Thailand; instead, she asked, "You haven't told my father?" "I haven't told your father. I want to go home. The *daum* here take care of me but I want to go home." She called the white and black nurses that took

care of her Lao, *Mab Daum*. My mother and aunt played along with her calling the nurses the ethnic identifiers from Laos.

In the last conversations with my grandmother, past times and places melded into the present moment. Her end of life brought the world in which she used to live into the present. She was “losing her marbles” as I often said over the years to others as a way to describe her body and mind’s slow deterioration. Although my family and I could not inhabit her world, we observed how it formed for my grandmother. She was exhausted, and my mother didn’t want to hassle her much longer. As we were set to leave, my grandmother fiddled with the antibiotic IV attached to her arm, saying, “I want to go home.” She was trying to remove the medical technologies that gave a remaining fragile life to her, but we had to tell her that we couldn’t take her home until she got better, a hope that we knew was impossible. She asked us to stay and talk with her, even it was to just watch us.

I look back at my memory of my grandmother and her comment about informing my grandfather that she is going home as a way to close this dissertation. While she was alive, I often asked how she was doing and what her life was like when I visited from college and later graduate school. She would say similar things as my interlocutors, “I’m just sitting here watching the traffic. I’m just living (*lam nyob*).” She would ask me what was there for her to do, other than to exist and watch the world move by. She was meticulous about her diabetes management – she *caiv ncauj* (watched what she ate) and had the physical stamina of a young person. She lived a long life but would fall into a

coma the day after she informed us about going home. My family failed to come to a consensus about whether to keep her alive as long as possible, or to let her pass away naturally. It was love, my uncle would say, for a son to do everything to keep his mother alive. It was only commonsensical for him to choose life. Eventually the doctors intervened to say that she was suffering, but my uncle insisted that she feared death more than anything. As this dissertation has argued, chronic disease management defers the crisis of death only for death to come again in the future. It also structures our inability to experience and confront death. It has not only structured my grandmother's fear of death but also my uncle's inability to come to terms with her impending death.

The Hmong-American experience of diabetes may not seem all that special apart from the fact that Hmong-Americans have a high diabetes burden. However, as I have argued in this dissertation, chronic disease management not only structures the experience of diabetes but also the chronicity of displacement and the feeling of social insignificance, of "just live." It is no wonder that Hmong-Americans claim that their diabetes is caused by *kev nyuaj siab* (distressed liver) as this statement points us towards understanding their experience of chronicity as displaced persons. In chronic disease management the object - biological life - is fostered without necessarily attending to different ways of life. At the same time Hmong-Americans are made to biologically live, they are also made to live chronically in a state of perpetual insignificance. This biopolitical intervention structures experience around chronic time, where the limit of the present is removed, thus allowing patients to experiencing their present state of

insignificance and diabetes perpetually. Under the logic of chronic disease management, Hmong-Americans may no longer fear the crisis of diabetes, but also they may no longer fear the crisis of fighting for a region to claim as their own. Now they, with their diabetes, must live biologically and foster their life at all costs, even if that means feeling displaced, alone, and a stranger in “the land of gold.”

My dissertation comes at an interesting point in the health profile of the Hmong-American community. While there are no well documented statistics other than community driven studies on the health disparities the Hmong-American experiences, I have experienced and witnessed the changing health profile from the start of my dissertation to the end of my graduate studies when I worked as a research intern for Tetyana Shippee’s project on racial disparities in nursing homes. When I started graduate school, my memory of asking a group of young Hmong-American men if they knew someone with type II diabetes, and seeing all their hands go up in the air, remains with me today. And at the end of writing my dissertation, while working for Tetyana, I would witness half of the Hmong-American residents at the high Medicaid servicing nursing home suffering from a stroke, a medical complication from their chronic disease. These nursing home residents were much younger than most, around the age of 50. Their complaints about the nursing home were similar to the complaints of my interlocutors, only this time, the nursing home experience seemed more like the earlier Hmong-American experiences of the refugee camps, but far more isolating. How might these people with complications from chronic disease reimagine social care in these spaces?

How does chronic care as it is applied within the institution of nursing home, where the family is even more removed, structure a different experience of perpetual insignificance for Hmong-Americans? My dissertation is a way to think about the experiences of chronic disease and how it can structure one's experience of life but also to politically reconsider an alternative way of living for people who may seem to have been made vulnerable and powerless. My interlocutors are the already dead. They are socially dead, from a once terminal disease and from the social death they experience as displaced persons in the U.S. They seek to reimagine an alternative way to live with their life in the U.S. through return migrations.

Claim to Displacement

This dissertation theorizes displacement as a source of productive potential. I find that subjective displacement, where one feels both here (in the U.S.) and there (in Laos), fuels the melancholic desires of reuniting the displaced self. Displacement seems like a victimization of Hmong-Americans but in this dissertation, I show how it is a site of potential for my interlocutors. Through return migrations, Hmong-Americans seek to remedy their feelings of displacement by (re)connecting with kin in Laos and Thailand. They, within their kinship network, seek healing through the embodiment of Laos and Thailand's climate, food, and Hmong herbal medicines. They not only work to heal their embodied sense of displacement but also seek to heal a displaced Hmong body politic

through these practices. Sentiments of melancholia, of loss and desire, lace Hmong-American attempts to heal the Hmong body politic.

Claim to Death

The death of Hmong General Vang Pao has been a turning point in the political imagination of a Hmong Homeland. His death further displaces the dream of ever truly having a place to claim as home. However, as this dissertation has shown, Hmong people have never really needed a place to claim as home precisely because the Hmong people constitute home through kin, as demonstrated by return migrations. Yet, taking seriously the Freudian notion of melancholia's potential destructive nature, this dissertation also considers the claim that return migrations to Laos are not possible and can become destructive. To make sense of the impossibility of return migrations and the claim that only through death can one be cured from diabetes and truly return home, I argue that these claims of healing the Hmong body make a larger political claim about healing the Hmong body politic. Return migrations are not so much returns to Laos but instead the repetitions of a true return to the first lost object that is the Hmong Kingdom. Drawing on Hmong funerary practice of *Qhuab Ke* (Showing the Way), I argue that Hmong sovereignty and the Hmong kingdom have never actually been lost. Informed by Eliade's approach to the myth of the eternal return, the Hmong Kingdom (the land of the ancestors) exists not within the past but is the everlasting present.

In her desire to return home, while not wanting to tell my deceased grandfather of her return, my grandmother almost seemed to refer to her impending death as a final return to the ancestral land. In the present moment, Laos and the U.S. melded into one in the present moment, by use of old ethnic identifiers I had never heard before. What became apparent to me in the days leading up to her death, was that returning home to my grandfather was just as much present as it was past. It was a return to an eternal Hmong Kingdom.

Chaws Cia Siab (A Place for Hope)

For a long time, I felt that I had failed my interlocutors because I could not carry out their requests for a diabetes group visit around the topic of *chaws cia siab*. But it has become clear to me that there is hope in loss. Loss is needed for a desire to return, to reclaim and make anew a Hmong community. Loss is a productive source of power, coming from a place of absence. Perhaps Hmong-Americans will always feel a sense of loss because it is deeply embedded in their history, not only from the U.S.'s American War in Laos but all the way back to their displacement from China. The trauma of loss will always haunt my interlocutors because, through its wavering presence, the possibilities of demanding and claiming their past inheritance become visible.

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