Original Article

MIGRATION, RESETTLEMENT, AND REFUGEEISM: ISSUES IN MEDICAL ANTHROPOLOGY

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Migration is a characteristically human adaptive strategy. For many human groups, even the sedentary life-style made possible by the domestication of plants, the industrial revolution, and modern urbanization has been simply a pause for a generation or so in the ongoing search for a favorable environment. Throughout recorded history, the occurrence of migration as an activity has been exceeded only by its use as the subject of philosophical speculation by utopian idealists (Mumford 1962).

The philosophical dimensions of migration are far more than a matter of historical curiosity. Utopianism has always been one of the principal motives for migration and resettlement, particularly in the Western Hemisphere. The Dominican resettlements of Central America (Hanke 1935), the Jesuit reductions of South America (Morner 1953), and the Franciscan mission system of the American Southwest (Spicer 1962) were but archetypes for countless contemporary church-sponsored resettlement programs (Morrissey 1978).

As commonly used, "migration" is a generic term, applied to activities varying greatly with respect to motive, duress, planning, process, time span, place and manner of resettlement, and impact on various dimensions of social organization. By identifying distinctive features of specific migrations, authors acknowledge implicitly the existence of an underlying typology. There remains, however, considerable need for the construction of a comprehensive typology that takes into account both the structural similarities and formal differences of various types of migration.

The objective of this article is to identify and discuss the range of migration-related issues of actual or potential concern to medical anthropologists. By noting and expanding on classification schemes encountered in the literature, this article, it is hoped, will also advance the cause of typology development.

Migration and resettlement are interrelated concepts. Migration is the process by which an individual or group moves from one physical and social environment to a new one. Resettlement is the process whereby migrants become situated in and adjusted to the environment of the place of arrival. The environments of both point of origin and place of arrival are composed of highly complex assortments of physical and social variables, all of which have an impact on the outcome of the migration.

Refugeeism occurs when some aspect of the social environment of the point of origin presents such an imminent threat to survival that a population seeks refuge elsewhere. Typically, the flight is precipitous—undesired and unplanned. Typically, too, the decision to resettle elsewhere is finalized only after a place of refuge is reached. The overriding concern while in flight is simply escape. Use of the term "camp" for the place of refuge suggests that migration is not necessarily intended, and that there is even an assumption that refugees might return home. When this proves impossible or inadvisable, refugeeism becomes migration.

Dyadic Features of Migration

Many of the features that characterize migration can be reduced to dyads. Some are disjunctive, others indicate opposite extremes of a continuum. Identification of these features facilitates an understanding of the range of possibilities for theoretical and applied work in medical anthropology. This identification does not, of itself, constitute a typology, but it is an important prerequisite for the development of one.

Perhaps the most frequently encountered attribute of migration is the deceptively useful distinction between internal and external migration. The terms are disjunctive and verifiable, and they provide convenient, intelligible categories for a library's card catalog. Their presumed utility lies in the assumption that external migration involves areas of difficulty not found in internal migration, such as border crossing procedures and dealings with an unfamiliar government bureaucracy.

The experience of some countries, however, suggests that migrants who submit to border exit and entry procedures are generally well equipped to deal with them, and those who are not are highly resourceful at devising ways to bypass them. Moreover, migrants frequently originate from remote areas where they had little interaction with their national government before migration. The difficulties of dealing with the bureaucracy of a new nation are not much different from those they would face if they moved to urban areas within their own country. Undoubtedly, there are international migration situations where exit, entry, and the laws and procedures of an unfamiliar government are major sources of difficulty. This lack of a direct correlation between the complexity of a migration and its external or internal character limits significantly the utility of the internal/external distinction.

In the prologue to a recent anthology dealing with mental health aspects of migration, Pfister-Ammende (1982) lists five types of migration and mobility. This schema identifies three additional features of migration. The elements of the schema are (1) biological mobility, related to stages in the life cycle; (2) sociological mobility, related to career advancement; (3) voluntary and planned mobility; (4) forced, planned mobility; (5) forced, unplanned mobility. The first two elements of this schema suggest a dichotomy between migration that functions as an integral part of a society's adaptive strategies and migration that serves to extricate a group from a context where existing strategies are perceived as no longer effective. The former operationalizes established adaptive strategies; the latter requires the development of new ones.

This schema also identifies planning and volition as important features of migration. Even though the concepts of "planned" versus "unplanned" and "voluntary" versus "forced" suggest dichotomies, a continuum is a more ac-

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curate model of the wide range of variation found in real life. A further distinction can be made between planning done at the departure stage and that done at the resettlement stage. Planning can also be distinguished according to source. It may be done by the migrants themselves or by outsiders, who may be countrymen, nationals of the place of resettlement, or total foreigners.

The amount of planning involved can vary widely. In the case of the refugeeism, which in the extreme might be as drastic as fleeing on a moment's notice with just the clothes on one's back, planning would be an unavailable luxury. Further along the continuum there are the small-scale migrations of individuals, families, or groups, who plan their own move and prepare in advance for resettlement in a new location. A major obstacle to planning at this level is the lack of control by groups of this sort over the variables encountered in the new environment. The term "spontaneous" is sometimes used to describe the resettlement phase of migrations of this sort.

At the other extreme is the highly planned migration, where preparations, the actual move, and eventual resettlement in new surroundings are all characterized by a high level of planning. Though it is possible for migrants to plan such moves for themselves, they are often directed by persons outside the migrating population, and sometimes by persons who are not nationals of the nations involved. The element of volition is frequently an important factor in migrations of this sort. Participation may range from the completely voluntary to forced resettlement in settings such as "strategic hamlets" or "model villages."

Volition encompasses an especially wide range of variation. Force is clearly present when one flees for one's life before a hostile armed invasion. A different kind of force, but force nevertheless, is involved when one makes a decision to migrate after observing a steady decline in the productivity of one's soil until it reaches the point where it can no longer support one's family. Volition is affected not only by factors that motivate one to leave an undesirable situation but also by the attractiveness of an alternative. Kunz (1973) distinguishes between refugees, who are "pushed" out of their homeland, and immigrants, who are "pulled" away from it. A strong enough "push" or "pull" might precipitate migration, but it is also possible that neither alone would be sufficient, while the two working in conjunction would be.

The situation of certain Mayan agriculturalists of the highlands of Guatemala illustrates this situation (Morrissey 1978). They had long experienced the two "pushes" of population pressure on the land and declining fertility of the soil. It was not until the "pull" of a reasonably sound alternative appeared in the 1960s, however, that they decided to migrate to new regions.

The case of these Maya also illustrates the distinction between permanent, or long-term migration, and seasonal migration. Before having the option of moving to new lands, they survived during periods of the year when resources at their home base were not adequate by migrating during planting and harvest seasons to work as laborers for large landowners (Appelbaum 1966). This is similar in some respects to the pattern of survival behavior followed by migrant farmworkers in the United States.

Another important distinction can be made on the basis of the social environment of the place of arrival. Although migration usually involves resettlement in an area already occupied by other human populations, there is a specialized form of resettlement called colonization, where the environmental niche at the place of arrival is unoccupied. Colonization presents both problems and opportunities not found in more conventional resettlement settings.

Time depth is another factor of major significance in the study of migration. Although the migration experience would seem to have a declining impact over time, a residual effect could conceivably survive into succeeding generations. The United States is correctly described as a nation of immigrants, but the impact of the migration experience on contemporary descendants of passengers on the *Mayflower* is substantially different from the impact of migration on Cuban, Haitian, or Vietnamese people who have migrated here during the past decade. Although it is probably not possible to identify a specific point beyond which migration is no longer a factor, it is legitimate to examine the migration history of an individual or group to determine whether or not it is a factor in adjusting to the contemporary environment.

Medical Anthropological Issues

The domain of medical anthropology extends to all issues of health and health-related behavior, including illness, treatment, and the organization and delivery of health services. Its contribution, as a discipline, lies in its efforts, through research and applied programs, to relate cultural factors to health behavior. Kasl and Berkman (1983) point out that morbidity and mortality studies among refugees actually require studies of three distinct groups: the population at point of origin, the migrants themselves, and the host population at the place of arrival. Similarly, the application of medical anthropological methods to migration may be complicated by the need to take into account multiple populations and the interaction of their respective cultures.

Mental health issues are perhaps the best studied of migration-related health issues. Under the best of circumstances, it is stressful to uproot oneself and one's family and move to a new location. Migration rarely provides the best of circumstances. Moreover, it sets the stage for situations that might adversely affect mental health long after the actual migration is completed. Obtaining and holding employment in a strange setting can be very stressful for an adult; going to school where children and teachers talk an unfamiliar language might be more than a child can endure.

The literature on this subject has matured to a point where it not only provides extensive coverage of the field, it also warrants literature review articles. In his overview of the health and mental health situation of Indochinese refugees, Van Deusen (1982) reports that he encountered over 100 references to this topic in the literature. The bibliography accompanying his article is an excellent starting place for someone interested in becoming familiar with the field.

An important characteristic of migration-related mental health issues is that their impact is felt over a long period of time. This provides medical anthropologists with an extremely broad window for investigation, ranging from the time when a group first experiences anxiety over an impending migration, through the stress of the actual move, to the long-term process of adjustment by the migrants, and even their descendants, to a new environment. The mental health implications of long-term adjustment to a new social environment are brought out by a number of articles in the recently published proceedings of two congresses of the World Federation for Mental Health (Nann 1982), which deal with the adjustment of the children of migrants to the larger host society (Verdonk 1982; Stockfelt-Hoatson 1982; Ashworth 1982; Chud 1982). Parthun (1976) also discusses the mental health implications of adaptation to a new social environment, in the case of Italian immigrants in Canada.

An important but as yet unresolved issue arises in connection with literature dealing with health and migration: the need for a clarification of the disciplinary criteria for medical anthropology. Bibliographic materials on migration and health range widely, from epidemiology to sociology to geography to pharmacology. Although all might provide useful data, not all analyze the data in terms of cultural factors. Malzberg and Lee (Malzberg 1940; Malzberg and Lee 1956) were among the earliest contemporary authors to attempt this. Weenberg (1955) shows that factors in the broader social context can affect volition and consequently increase the stress of migration.

More recent authors have found a wealth of research material on the interaction between social environment and mental health in the situation of refugees worldwide. Cohon (1981) notes that the psychological risks are greater for involuntary refugees than for voluntary migrants. He observes, with regard to Vietnamese refugees, that psychological dysfunctions can manifest themselves in a variety of somatic complaints, resulting from, among other things, cultural beliefs about illness. Letcher (1981), studying South American refugees in Argentina, discusses the psychological impact of the uncertainty and emotional isolation that can be experienced by refugees, particularly when confined to refugee camps. Mattson and Ky (1978) observed a high level of psychosomatic complaints among Vietnamese refugees who had not yet been permanently resettled.

A sampling of other authors who have noted a relationship between the stresses of migration and mental health risks include the following: Naditch and Morrisey (1976) have studied role stress among adolescent Cuban immigrants in Miami; Canino et al. (1980) have done a similar study of stress among Puerto Rican children in New York; Reubens (1980) describes the psychological needs of immigrants from the Caribbean, particularly the Dominican Republic; Roglera (1978) reports on informal patterns of seeking help for mental illness, including schizophrenia, among Puerto Rican families in the south Bronx; Harwood (1977) develops the thesis that spiritists who serve as informal treaters of mental health problems among Puerto Rican families also serve a larger role as legitimizers of cultural behavior.

A second well-studied health issue related to migration is the matter of fertility. In 1975, an entire issue of *International Migration Review* (Macisco and Myers 1975b) was devoted to this topic. Among the features included was an extensive bibliography (Myers and Macisco 1975). The reader is referred to this for background information.

Macisco and Myers (1975a) have pointed out that there is often a marked difference in reproduction rates between point of origin and place of arrival of migrating groups. Rindfuss (1976) suggests that migration generally results in a lowering of fertility. A substantial amount of literature is devoted to verifying and attempting to explain changes in fertility. Bach (1981) suggests two hypotheses to explain this: one holds that a change in fertility is attributable to the migration per se; the second points to the interaction of influences from both point of origin and point of arrival. Harbison and Baker (1981) have studied the phenomenon of decreased fertility in urban areas among Samoan migrants in Hawaii; Hiday (1978) studied it in the Philippines; and Rindfuss has studied it in the case of Puerto Rican migrants to the United States. Although the evidence shows that urban fertility is decidedly lower, a study by the Interdisciplinary Communications Program of the Smithsonian Institution (1976) maintains that "rural to urban migration is unlikely to be a major influence in lowering natural fertility." Far from contradicting the evidence, this merely supports the medical anthropological position that many forms of health-related behavior must be explained in terms of social and cultural factors rather than natural or environmental ones.

There are a number of health-related studies of migration that focus on specific epidemiological topics. Many of these are concerned with health problems that might be traced to dietary change. Hornick and Hanna (1982), who have studied coronary risk factors among migrating Samoans, point out that increases in degenerative diseases are a well-documented consequence of urbanization. They maintain, however, that adoption of a Western life-style, rather than migration as such, is the factor increasing risk. Gerber and Madhaven (1980) have compared coronary heart disease mortality rates among Chinese migrants in Hawaii and New York. They cite findings of the Centers for Disease Control as indications that coronary heart disease mortality increases after migration. Ward and Prior (1980) have studied high blood pressure among the Tokelau population and concluded that both genetic and sociological factors have contributed to an increase. A different sort of epidemiological study is found in Gordon's article (1978) on postmigration drinking behavior of Dominicans. Most of these authors provide excellent bibliographies that can serve as guides for further research. Those provided by Hornick and Hanna (1982) and by Gerber and Madhaven (1980) are particularly valuable.

At times, migration appears to precipitate unusual occurrences of known diseases; at other times it seems to give rise to new diseases, previously unknown to both migrants and contemporary scientific medicine. The bibliography accompanying the article by Kasl and Berkman (1983) is a useful reference for literature regarding the former situation. A reliable source for epidemiological data regarding more unusual diseases such as AIDS among Haitian refugees in the United States and the sudden death syndrome among H'Moung refugees in Thailand and in the United States is

the Centers for Disease Control. Occasional reports also appear in journals such as *Migration Today* (1982) and *American Medical News* (1983). Recently, there have been reports of similar occurrences among Mayan refugees from Guatemala, who die suddenly and inexplicably shortly after reaching refuge in Chiapas, Mexico.

Curing behavior can be affected by migration in a number of ways. A migrating population can be separated from its traditional healers and be unable to obtain medical help because of its unfamiliarity with, or distrust of, the curing practices of the people of the new social environment. On the other hand, traditional healers might be available, but the new natural environment might not provide the herbs or other elements needed to exercise their art; or the rules of the new social environment might not allow them to practice medicine; or perceived changes in the spiritual environment might prevent them from engaging this dimension of their curative powers.

In addition to issues relating to migrating populations as patients, there are a number of other issues of interest to medical anthropologists, including a consideration of migrating health practitioners. An issue of major importance is the matter of the migration of health providers from their homelands. Pernia (1976) and Stevens, Goodman, and Mick (1978) are among the authors who have studied this "brain drain."

A more pressing issue has to do with efforts on the part of the receiving society, or concerned third parties, to provide migrants with health care. The United Nations High Commission on Refugees has taken on a larger role in coordinating the efforts of all involved (Cuny 1981). The administration of health services for migrants and refugees remains difficult, encompassing several matters of direct relevance to medical anthropologists. Among the difficulties are such matters as language differences, failure to understand the culture of the migrants, difficulties in gaining access to the migrants (particularly in circumstances where they are refugees, or considered to be "illegal" in their new environment), the logistics of transportation of personnel and supplies, as well as higher-level administrative issues involving relief organizations, political considerations, international agreements, financing, planning, evaluation, etc.

Literature on the subject of providing health services to migrants is beginning to reflect the recognition of the critical need for effective administration of health services. Recent articles dealing with this issue include the following. *Migration Today* (1980) describes the seriousness of the problem of health administration among refugees in Somalia; Arnold (1979) and Chavez (1983) discuss the difficulties, in the United States, of establishing an effective policy for providing health services to migrants; Zimmerman (1981) points out the difficulties of administering health services for migratory workers.

Summary

Migration comprises a wide variety of activities, each posing its own unique problems with respect to health and health care. Medical anthropology can contribute to the resolution of these problems in both an analytic and an applied way. By analyzing health-related factors of the place of origin—status, beliefs, practices, practitioners, expectations, etc.—and comparing them with similar traits of the new society, the medical anthropologist can facilitate the process of communication needed for diagnosis, patient education, and treatment. Alternatively, by analyzing the structure and organization of the health delivery systems available to migrants, the medical anthropologist can contribute to the design and implementation of modes of health services delivery that are intelligible and acceptable to the persons they are intended to serve. Cohon (1981) points out that worldwide refugees number about 16,000,000. Both the numbers involved and the complexity of the cultures they represent pose a major challenge to medical anthropologists.

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Medicine after the Demise of "The Placebo"

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tionship in which the efficacy of that medication takes place. From the biomedical viewpoint, the placebo mocks the physician's wish to cure the patient. It introduces uncertainty; it fosters ambiguity over *who* is in control. Even when the placebo "works," it attests to the physician's impotence. The *symbolic* efficacy of placebos threatens the physician's illusion of and wish for depersonalized control. Since "symbolic" connotes "personal," it is little wonder that the dichotomy "real medicine"/"placebo" is so rigid.

Physicians view the efficacy of the placebo as lying outside their conscious power or control. Tricking patients is hardly as satisfying as controlling them (hence the emphasis on "compliance"). In a field—and culture—in which military, sports, and technological metaphors predominate (battle strategy, win, lose, team, conquer), the motive "to be pleasing" is far less appealing than the more masculine virtues. Thus, to understand the meaning of such terms as "specificity," "inert," and "placebo," it is essential to understand the cultural framework in which they are used.

The relationship between "medicine" and "placebo" can be shown to obey a cultural logic, as will be evidenced from the following cultural formula: "medicine" is to "placebo" as "disease" is to "illness"; and further, as "entity" is to "experience," "objective" is to "subjective," and "impersonal" is to "personal." What falls taxonomically under the "placebo" and "illness" rubrics is often held by physicians to be "not interesting," to be "soft" as opposed to "hard," and to interfere with control and cure of disease.

All too often, the potency ascribed to placebo is experienced by the practitioner as his or her own impotence in healing, for the wish to please or placate lies fathoms below the wish to control and to cure. While nearly three decades ago Michael Balint persuasively argued (1957) that the doctor is himself a potent drug, the potency of the clinical relationship has long ideologically played second fiddle, so to speak, to the efficacy of various chemical agents and procedures that the physician (and perhaps the patient too) regarded as somehow distinct from the relationship. Could it be that our *societal* view of medicines, placebos, and procedures as circumscribed "things" serves as a depersonalizing defense against the intimacy of the clinical relationship and the subjectivity of the illness experience itself? Might it further serve as an obsessional defense by which one hopes to gain magical control over the human body?

Discussing physician attitudes toward placebo phenom-

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