TRADITIONAL HEALING AND WESTERN HEALTH CARE: A CASE AGAINST FORMAL INTEGRATION

V. Edward Bates

The holistic health movement has the potential for improving health care for all Americans. It also has the potential for descending upon Indian people with unexpected consequences. Traditional healing practices may become imperiled when, under the guise of holistic health, public health officials and health care workers (HCW)[1], who dominate the services and bureaucratic processes, underwrite third-party payments and training for medicine persons. These processes potentially can subvert individualized spiritual services into a standard item of health care. None of the changes or preceding movements impacting Indian health over the past 30 years has presented such a risky challenge to Native American culture.

A review of major societal changes during the past three decades may help to explain why holistic health practices, affecting Indians in particular, are becoming popularized today. Recent history that has altered public attitudes toward Indians might begin with the clinical awareness of ethnic diversity and prejudicial attitudes that were significantly heightened by Adorno (1950) and Allport (1954). Certainly health concerns were highlighted when the Indian Health Service was legislated into existence at about the same time (1955). Remedial programs to address mental health problems, however, would not come into being within IHS for another 15 years.

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[1] The abbreviated HCW is taken from the definition of the term "modern health care worker" by Joseph Westermeyer, M.D. (1977). It includes physicians, dentists, social workers, nurses, psychologists and similarly trained practitioners whose powers to treat are based on the scientific method, demonstrated knowledge and skills, licensure by the state, and certification by peer professionals.

The 1960s constituted a decade of dramatic changes that gave greater visibility to minority health issues and greater acceptance of alternative life styles. Among these ideological changes were passage of the Civil Rights Act, the "counter-culture" upheaval, deinstitutionalization, and the para-professional movement. Professional education began to move beyond the limited stance of expounding moralistic and dogmatic condemnation of inadequate cross-cultural services toward specifying the necessary skills required to serve minority people effectively.

The 1970s exploded with literature on racism in education and other institutions and on characteristics of minority clients -- presumably, so they could be better served within the prevailing service system. The literature no longer underestimated the complexity of communication and therapeutic involvement with the culturally different, and the principle of noninterference in Native American interpersonal relations was articulated (Wax and Thomas, 1961, 1976; Goodtracts, 1976). Barriers to cross-cultural counseling became more focused (Sue, 1977).

The past few years have also given visibility to the previously underground Pan-American Indian movement, reflecting a growing Indian nationalism replacing ancient tribal antagonisms (Spencer, 1977, p. 518). Government policy began to emphasize self-determination. National attention was focused upon Indians (and other minorities) and rural mental health problems through Task Panel Reports submitted to the President's Commission on Mental Health (1978). Federal/state Mental Health Manpower and Community Support Programs were initiated giving added emphasis to minority service provision. At this writing, the Mental Health Systems Act, with its specific features designed for services to Indians, has

just been signed into law.

Throughout this succession of change the predominance of Western scientific thought, in the main, remained unchallenged. Traditional systems of beliefs and healing were regarded as primitive, archaic and largely irrelevant -- except to those practitioners who were identified early with the human potential movement. This devaluation of natural providers is being reversed too, as the holistic health movement emerges with greater intensity.

"Unorthodox" theories of illness and methods of treating Indians are currently enjoying popular attention (NIHB Health Reporter, 5:1980, p. 8 ff). Indian spokesmen are calling for "methods of blending traditional and modern forms of medicine" (NIHB, 1979, p. 21). Recently practitioners of traditional Indian medicine and Indian physicians met together under the conference theme, "Traditional Indian Medicine: Bridging the Gap" (AAIP Newsletter, 9:1980).

Commendably, as these conferences bring together persons with different values and perspectives, they can only produce better understanding and improve mutual respect. However, recommendations are calling for expanded federal intervention in the recognition and training of traditional healers. It is as though everyone has forgotten the bureaucratic intrusion lessons of the past. Somehow dominant and established systems are supposed to behave differently today and government intervention is called upon solely to "bridge the gap." Little recognition is given to the unforeseen consequences that could signal a co-opted alteration at best -- or a premature end at worst -- to a delicate system of healing that is only now finding its way back into the Indian way of life with the vigor it once knew.

PURPOSE

Until recently, the well-intentioned social and medical programs imposed by federal and state agencies upon Indian people have been consistent in two respects: (1) they have been insensitive to Indian cultural values, and (2) they have undermined the traditional authority of community leadership by assuming responsibilities historically held under local control (Topper, p. 76).

The aim of this paper is to identify some administrative, service, and cultural complexities inherent in current efforts to "bridge the gap." The intent is to demonstrate that bureaucratic features appropriate and necessary to one system of health care -- performance requirements, standards, evaluation criteria, and administrative accountability -- are patently contraindicated, yet inevitable, for a system of traditional health care. Traditional healing among Indians is relatively intact precisely because the system has not been tampered with up to now.

A secondary purpose is to compare the similarities and differences between the two systems for the non-Indian provider. The aim is to initiate some thoughts about etiology, role expectations, and situational factors that are traceable to the treatment characteristics of the two cultures in question. Western trained providers generally have lacked involvement of intellectual reciprocity concerning traditional healing. The cultural meanings attached to health and illness by Indian people are insufficiently considered by those in helping professions, as they inexorably march toward equitably distributed western health care.

The intent is not to facilitate referrals and communication across systems, although this would be a worthy design. Nor is it to encourage a gaudily simulated respect for healing concepts about which most of us know very little. In-

deed, "going native" is the worst kind of patronizing (Stubbins, 1978, p. 17). Rather, it is to evidence the ways in which the freedoms of those who would heal themselves in traditional manner can be diminished in this highly-technical society, if amalgamation efforts are not linked to clearly conceptualized and articulated constraints.

TWO ORDERS OF INFORMATION

Two divergent orders of information can be compared and contrasted between the western health care system and traditional healing practices. The "curing" vs. "healing" model described below seems to be a more useful tool for contrasting the two systems than for teasing out similarities. The model oversimplifies in that it fails to take into account exceptions to the rule; it fails to reveal the complexities and interlacing nuances of each system within itself. Nevertheless, heuristic value as a mechanism for perceiving the hazardous nature of merging systems, compensates for its limitations.

TABLE 1

COMPARISON OF CAUSATION FACTORS

WESTERN HEALTH CARE "HOW"	TRADITIONAL HEALTH CARE "WHY"
1. Processual Explanations	1. Etiological Explanations
• Based on concepts of instrumental causality	• Based on concepts of ultimate causality
• Body-state imbalance (focus: the body) e.g., germ theory	• Patient out of harmony with nature, e.g., spiritual life and social disturbance
• Theory relates to effect of illness on body (illness results from a physiological disturbance of bodily processes)	• Theory relates to reason for the occurrence of illness (illness results from individuals lack of harmonious relationships)

• Focus: emperical data surrounding illness of patient	• Focus: metaphysical beliefs and strengths of patient
2. Internal Etiology	2. External Etiology
• Natural or chance causes	• Intervention of supernatural powers (other's retribution or retaliation)
• Explanations in impersonalistic, systemic terms (imbalance of basic body elements)	• Non-human (supernatural leaves little room for accident or chance
• An equilibrium model; dichotomy is health vs. illness	• Example: "Not Navajo Life": dichotomy is "good life vs. bad life."
3. Levels of Causality	3. Levels of Causality
• Instrumental or immediate cause	• Causes on a continuum (instrumental causes to ultimate causes)

Table 1 describes two aspects of every illness in which people are generally concerned: "how" did I get sick, and "why" did I get sick? * Scientifically oriented HCW typically deal with "how" kinds of questions -- symptoms and processual issues aimed at restoring body balance. People seek out professional providers to alleviate stress and pain. They expect and pay for the latest technical materials and advice to reduce or eliminate symptomatic causes for their discomfort.

When symptomatic relief is not forthcoming or, occasionally, when answers to "why is this happening to me" becomes relevant, traditional health care providers are sought by many Indian people. This process is similar to non-Indians

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*In making this distinction, the author has drawn from the concepts and ideational ordering of information about illness as described by Bill Gray Douglas, Illness and Curing in Santiago Atitlan, A Tzutujil - Maya Community in the Southwestern Highlands of Guatemala. A dissertation submitted to the Department of Anthropology, Stanford University, May, 1969.

turning to their spiritual advisors seeking personal answers to the transcendental concerns that personally touch their lives.

Traditional healers work less with technique and technical healing aides than they do with spiritual power. Supernatural power is perceived as emanating from both consumate good in the world as well as consumate evil, although the latter force is never employed by Indian medicine persons. Ultimate causation of personal stress -- physical and mental illness among them -- is not attributed to instrumental reasons, e.g., germ theory, loss, and internal feeling states. Rather, causal factors are ascribed to thoughts, feelings and behaviors destructive to internal harmony (Topper and Begaye, P. 85 ff; Leighton and Leighton). Among the Navajo, for example, the dichotomy is not between mental health and mental illness, but between living "bad life" (a form of "not Navajo life") and "good" life." This underlying spiritual imbalance requires treatment focused upon restoration of "good life," not symptomatic cure.

For Indian people, the illness-health continuum is grounded in such cultural perceptions of the world. How, then, are these world views to be integrated with the precise technology of the dominant health care system? While western services have excellent descriptive categories and exact instrumentation, they are judged poor in explanatory models of causation.

TABLE 2

COMPARISON OF DIAGNOSES

WESTERN HEALTH CARE "HOW"	TRADITIONAL HEALTH CARE "WHY"
1. Diagnosis attempts to understand <u>How</u> patient became ill	1. Diagnosis aimed at understanding <u>Why</u> patient became ill
• Evidence related to picking-up signals from the body (sumptoms) - signs and symptoms, external manifestations of illness measured as deviations form normal	• Evidence related to reasons for spiritual imbalance
• Validation: degree of deviation from "normal" body functioning, observed, reported and inferred from somatic evidence	• Validation: by seer, through devination; secondary meanings inferred from situational evidence
• Diagnosis related to empirical evidence and symptomatic treatment	• Diagnosis related to etiological factors of a metaphysical order
• Diagnosis largely depends upon what patient reveals; extensive facesheet and narrative at intake; psychological tests	• Diagnosis already known (often the less said by the patient the better); traditional healers speak with the patient's spirit
• Diagnostic bias in favor of illness, e.g., what is wrong with this person (weakness)	• Diagnostic bias is on the internal/spiritual state, e.g. does patient desire to harmonize self with the Great Spirit (strength)
2. Diagnosis involves <u>labeling</u>	2. <u>No labeling</u> -- if traditional healer agrees to intervene, patient is accorded maximum respect (sincerity is recognized)
• iatrogenic illness is a risk	• protocol important
• stigma	• Three criteria: 1) faith in "supernatural" powers, ceremony, yourself, and God; 2) respect for yourself, your people, for all people; 3) love for your patient. (Stevens-Navajo)

Table 2 differentiates a few of the many ways in which two kinds of data are perceived and acted upon in arriving at diagnoses. As in causality, modern HCW look to acute and chronic pathological agents or life stresses to explain "how" disorders materialize. Traditional healers seek diagnostic criteria that have ultimate etiologies as the source, i.e., fundamental explanations of "why" the condition has occurred. Of course in actual practice, both systems are divided along more than this one diagnostic axis.

Levy-Bruhl, as quoted in Morley (1978), contrasted the fundamental diagnostic differences between traditional healers and western trained providers. He stated:

> - - - the reality in which primitives move is itself mystical. There is not a being, not an object, not a natural phenomenon that appears in their collective representations in the way that it appears to us. Almost all that we see therein escapes them, or is a matter of indifference to them. On the other hand, they see many things of which we are unaware. (p. 7)

Perhaps at no sharper intersect do the traditional Indian culture and western health care collide than in the diagnostic labeling process that takes place in offices, hospitals and clinics. The preoccupation with labeling results in socially created reality for the purpose of arriving at a prescription to treat "how" explanations of disease and disability. Goffman (1961), Szasz (1961), Laing (1970) and others have expressed interest in the ways in which western health care can be used for political purposes. To make their point, they all contrast "unreal" mental with "real" physical disease. The diagnostic measurements, anatomical and physiological testing, and experiments applied to physical sickness are replaced with the mental health practitioner's judgment as to deviancy without reference to the value system of the diagnosed person. The political dangers of

HCW diagnostic procedures are of most concern to these authors, as the status of "sickness" depends almost entirely on subjective judgements of social, ethical, and political persuasion.

Singer reminds us that "any discussion of therapy for the mentally ill must be concerned with the intermingling of political and therapeutic concepts . . ." (1977, p. 6). The unique implications of this argument for Indian peoples are those of (1) stimulating continued success in the perpetuation of self-fulfilling prophecies ("the drunken Indian" and other stereotypes); (2) introducing non-Indian cultural norms through inappropriate application of Anglo-western theory to Indian behaviors, (3) perpetuating a climate for low self-esteem; and (4) contributing further to tribal and cultural disintegration. If the HCW concern is ultimately with mutually-qualifying interaction between the individual and his milieu, successful therapy is more likely to occur when it is culturally syntonic rather than diagnosis-specific (Araneta, 1977, p. 69).

How, then, does one go about integrating into traditional healing world views a system of diagnosis whose iatrogenic labeling (Illich, 1976, pp. 89-90) brands the patient forever with a permanent stigma? The traditional system, in response to concerns of ultimate causation, attempts to reverse the degradation to the patient's identity by telling him he is now in harmony with life. The western system, in response to concerns of curing the observed symptoms, applies an adhesive label that renders the patient forever as an ex-offender, ex-alcoholic, and ex-mental patient. Implicit in traditional diagnosis is the expectation that the patient assume primary responsibility for cause, effect, and change of his condition; just as implicit, western diagnosis tends to replace this personal responsibility with maintenance, management, check-ups and follow-through by a professionally staffed agency.

TABLE 3

ROLE COMPARISONS

WESTERN HEALTH CARE "CURERS"	TRADITIONAL HEALTH CARE "HEALERS"
1. Primary role is that of technician (restoring "normal" body functions)	1. Primary role is that of mediator (between immediate effect and ultimate cause)
• Deals with illness condition	• Deals with illness situation
• Uses specialized knowledge	• Uses supernaturally granted power
• Is related to curing	• Is related to healing
• Is that of the "doer"	• Is that of intermediary and facilitator
2. "Curers" work with specialized knowledge and techniques	2. "Healers" broker with supernatural power primarily; also has knowledge of ritual, herbs, etc.
• Open to anyone who aspires to acquire the knowledge (self-selecting)	• Reserved for a few who are chosen to fulfill a specific purpose in life (an extra-human process; a "gift")
• High level of tolerance for cognitive dissonance required to maintain divergent roles of "curer" and scientist	• Sometimes "how" techniques are used, but their purpose is to reestablish inner harmony
• May devote life to continued learning, searching for new methods	• Must devote life to continued learning. Searching for old ways (much that was known has been lost)
3. Role focus: to reduce or eliminate pain	3. Role focus: to provide significance and meaning to pain and suffering (interprets its meaning and necessity)
• Utilizes methods of patient control to eliminate pain	• Helps person in pain or stress to take responsibility for his experience
• Basically supportive, as illness is often perceived as environmental (epidomiology), accidental, or beyond patient's personal control	• Basically confrontive (maximum support but maximum confrontation, i.e., "you did it! You choose to be this way -- you can change it"!

4. Roles formalized through credentialing and/or licensing	4. Roles sanctioned through community acceptance
• Licensure/certification demonstrates competency (professional review)	• Competency evaluated by tribal community served
• Patient goes to the "curer" -- turns trouble over to the professional	• Healer is an instrument. (turns professional paradigm around as healer puts responsibility on patient)
• Roles are standardized by bureaucratic organization	• Roles are standardized by cultural tradition
• Role requires adherence to professional codes, public law, policies to protect self and patient	• Role and personal protection is derived from following the "Indian way" completely and maintaining personal cleanliness (e.g., non-smoking, non-drinking)

Table 3 draws comparisons and distinctions between the "curing" role of HCW and the "healing" role of Indian medicine people. Similarities are noted principally at obvious levels: both are helpers; both undergo rigorous training and maintain a continuous learning stance; both rely on external resources, such as pharmaceuticals and herbal medicines; both are licensed, credentialed, or otherwise sanctioned by their communities; and both represent complex systems.

It is at the juncture of role dissimilarity where integration of the two systems becomes difficult, if not impossible. Prominent differences include etiology, teleology, and methodology. One system looks to poverty, improper sanitation, accidents, low self-esteem and genetics among the conditions which account for specific role prescriptions. The other designs role responses to deal with illness situations involving "sorcery or witchcraft, breach of taboo, object intrussions, soul loss, soul possession, ghost sickness and, of course, natural causes" (Joe, p. 142).

Purposes for which the "curer" and the "healer" apply their skills and knowledge is considerably divergent. The HCW is trained to restore health or maximize living potential through techniques which eliminate virus, increase body resistance, develop insight, improve diet, and alleviate stress. This training is scientifically oriented and ethnocentric, holding to Anglo-European cultural values that "must categorically deny the existence of supernatural influences," (Ruiz and Langrod, 1977, p. 93). The medicine person believes that all mankind has the purpose of living harmoniously with God, his fellow man and the natural elements. He believes that each person was born to fulfill an individual purpose as well. When illness or misfortune is experienced, through personal discord and responsibility, it becomes the "healer's" role to mediate between that person and constructive supernatural forces to restore harmony to the situation. As competence is often compared between one physician, psychotherapist, nurse or social worker and another, Indian families, too, weigh the relative merits between singer ceremonials and hand trembler diagnostics. But roles <u>across</u> systems seem not to be comparable. Different methods are employed to accomplish different purposes for different reasons.

TABLE 4

COMPARISON OF PROCESSES

WESTERN HEALTH CARE ACTIVITIES	TRADITIONAL HEALTH CARE ACTIVITIES
1. <u>Treatment</u> focused upon body or mind manipulations to establish normal mental or physical functioning • Involves concepts of ethno-anatomy, ethno-physiology, epidemiology, prevention • Activities very flexible and pragmatic (new approaches and new practices readily accepted)	1. <u>Treatment</u> aimed at marshalling of supernatural powers to intervene in spiritual situation first, then mind and body dysfunction • Involves concepts of cosmology religion, ethics, personal responsibility • Activities may include ready incorporation of modern technical knowledge to treat instrumental causes, but "life view" and historical "thoughtways" remain fixed to treat ultimate causes.

- Shared activities with supervisors, consultants, peers (inter-agency collaboration)

- Often correlates with "don'ts" Processes include doing <u>to</u> people

- Treatment requires that patients give the <u>professional</u> their trust -- necessary to "establish a relationship." Patient gives responsibility for change to the professional

- Curers tend to mystify and expropriate the power of the individual to heal himself and shape his own environment

- Task of getting well belongs to professional providers, an anonymous agency, and the insurance company

- Prevention focus requires intrusive techniques

2. <u>Methods</u> include applications of materials into or onto the body

- Intent is to reestablish normal functioning

- Form includes medication, diet, surgery, drugs, clinics

- Resources include Government funding, University systems for professional production, technological research and a vast consuming public

- Activities considered very personal by each healer. "Nobody can tell you what I do -- that's mine" (Rolling Thunder)

- Often correlates with "do's"! Process include doing <u>with</u> people

- Treatment requires that patients believe in the <u>medicine</u>; that you "put" the disease there and you have the responsibility to "take it away." Healer will not take on patient's responsibility, patient's illness, or patient's growth

- Healers contend only God can intervene and this will not happen unless patient <u>asks</u> first

- Task of getting well belongs to the sick! Hope and positive attitude are supports.

- Interference in the personal lives of others is contrary to the Indian value system

2. <u>Methods</u> include ritualized prayers and actions, healer acts as mediator between patient, his group and the supernatural world

- Intent is to reintegrate the individual into his total universe

- Form includes correct and appropriate combinations of chants, sings and ritual, often to go along with specific herbal remedies; may also include sandpaintings, incense, and sweatbaths.

- Resources include the patient's belief and the Great Spirit primarily. Reestablishing broken relationships within the group or extended family is also a considerable resource

3. Language highly technical

- Frequently increases dependence of patient on the care of an elite profession
- Jargon of multiple disciplines, as well as that of the bureaucrat, adds to confusion
- Language of prayer considered as a last resort
- System designed for financial efficiency, professional reward and bureaucratic control
- Methods are compartmentalized to treat specific body or mind ailments (reductionistic); services fragmented.
- Methods separate the individual's treatment from his social nexus

4. Place where activities are performed typically include:

   1. Hospitals
   2. Clinics
   3. Offices

- Minimal hierarchy of practitioners: example: Among the Navajo:
  1. Singers (Specialists)
  2. Diagnosticians (Shamans)
  3. Hand tremblers
  4. Laymen (e.g., every Navajo man and woman performs some ritual prayers, songs and legends (Leighton & Leighton)

3. Language involves hundreds of songs full of archaic words that must be learned perfectly

- Precise tone and way of singing songs essential
- Enormous number of rules about sequence that are extremely complex and thorough
- Expressive names for offending spirits (known to all participants
- English frequently perceived as a "contrary" language
- System organized for local effectiveness, maintenance of tradition, antonomous learning, and lay control
- Methods integrate spirit, mind, and body (holistic)
- Methods require involvement and participation of social group survival and a sense of security

4. Place where activities are performed typically include

   1. Patient's home
   2. Natural surroundings
   3. Sometimes hospital or prison setting

• Sick are isolated (waiting rooms, visiting hours, appointments, etc.	• Group involvement provides motive for increased social tolerance of the troubled
• Pharmacies dispense synthetic prescriptions of multiple colors (red, blue, black, white)	• Herbs are gathered from outdoors (one color: green)
• Practice environment conducive to urban living	• Practice environment conducive to rural life styles

Table 4 compares treatment activities associated with western and traditional healing systems. The dominant western ideology of health care focuses upon the technical mastery of disease and stress syndromes. This is practiced to such a degree that the "mysticism" associated with what the HCW does is as incomprehensible to the patient and his family as is the mysticism surrounding the ceremonial and spiritual activities of the traditional healer.

Traditional medicine persists, in part, because of the mysticism and skepticism surrounding western health care. Traditional reservation people are aware of the maldistribution of modern medieval and human service resources, which are concentrated in large urban centers. Many others are supported in returning to traditional ways by the pan-Indian movement, the holistic health movement, and the government's current policy of self-determination.

More importantly, traditional medicine survives because it is offered in the context of cultural significance to Indian people. Each culture gives unique shape to the meaning of health and to a unique conformation of attitudes about pain, suffering, and death (Illich, p. 128). The strength of traditional Indian ways of comforting people while in stress is exemplified best in two functions

that dramatically distinguish the system from modern western care. These are: 1) the ways in which it makes pain and death tolerable and even understandable, by integrating these experiences into a meaningful setting and context, and 2) the prominence it gives to extended family involvement and group cohesion and harmony.

Illich (1976) makes the distinction as follows:

> . . . medical civilization . . . tends to turn pain into a technical matter and thereby deprives suffering of its inherent personal meaning. People unlearn the acceptance of suffering as an inevitable part of their conscious coping with reality and learn to interpret every ache as an indicator of their need for padding or pampering. Traditional cultures confront pain, impairment, and death by interpreting them as challenges soliciting a response from the individual under stress . . . it makes pain tolerable by interpreting its necessity (p. 133-134).

The dominant American perspective on death and dying is to deny or avoid the topic as much as possible. In a study of major sociological significance on this subject, Glasser and Strauss (1965) demonstrate the many ways in which professionals receive training for the technical aspects of dying, but not on the ethics, social issues, moral and personal values associated with death. The standard mode "is a tendency to avoid contact with those patients who, as yet unaware of impending death, are inclined to question staff members; (to avoid) those who have not accepted their approaching deaths; and (to avoid) those whose terminality is accompanied by great pain" (Glasser and Strauss, p. 5).

In contrast, traditional healing has emphasized physical endurance and spiritual growth to the extent that the capacity for suffering could even be understood as a possible symptom of health among Indian people. Formal procedures for integrating this cultural world view into that of the technically managed and pain-killing viewpoint of western care, creates the risk of replacing those unique cultural

meanings of dignified suffering with the artificially prolonged and depersonalized maintenance characteristic of the dominant system.

The psychological significance of group values among Indians has not been lost to modern historians. John Bryde (1971) writes, "Indian people have a sense of togetherness, a sense of being Indian together that most racial groups don't have" (p. 57). Among most tribes, the kinship system is the primary identification link determining social relationship and responsibilities. The functional abilities of a person within these clan and familial structures seems essential to personal identity. ". . . If someone should get ill or become disabled, everyone is affected" (Joe, p. 143). Consequently, the ceremonials and religious lore surrounding traditional healing have an important influence on the entire household. Leighton and Leighton describe the therapeutic value of multiple participants:

> The crowd is not just a crowd; it is usually composed of all the persons who have been of importance in the patient's life--his relatives, his respected elders, the human guide-posts who have formed his orientation in the world . . . . All these people are gathered, their attention focused on the patient, bringing their influence and expectation to bear on his illness, their very presence inferring that powerful forces are working for his well being (Leighton and Leighton, p. 12).

People learn by observing the healer; they incorporate the legends with their own lives; and they use this knowledge to maintain their own harmony, taking care of their own health and contributing to the health of others. These activities have use and value to the individual and to cultural and group maintenance. They are undertaken with the competence of generational development and enjoyed for their own sake.

How does one go about integrating this group system of care into the individual process of modern health care? The western system separates the "primary patient" from others about him, places the patient in isolation wards, and often restricts child visitors. It replaces family strength and responsibility with professional expertise and bureaucratic control. Finally, it replaces autonomous activity and spiritual belief with consumer products to be purchased, competing professional skills in the market place, and a belief in scientism.

IMPLICATIONS FOR HEALTH CARE POLICY AND SERVICE DELIVERY

In arguing against integration of the two systems of health care, differences have been emphasized. This contrast is not to suggest that the two systems are necessarily competitive. To the contrary, they are complementary. Less technically sophisticated cultures historically have incorporated empirically validated techniques and integrated new knowledge into their healing practices (Morley, p. 16). Certainly from the patient's point of view, the two orders of explanation are complementary rather than alternative approaches to his treatment as he seeks relief from both curer and healer.

Asking Indian people to choose between the two systems is irrelevant. They will continue to utilize both. Assuring the Indian patient of his historical right to understand his plaintive "why did this happen to me?" in his unique spiritual and cultural realm is not irrelevant.

Lowie appropriately sums up the essence of the religious factor:

> Science has achieved remarkable results, both practical and theoretical, but it has not made man a superman; so long as the enormous chasm yawns between man's rational control of nature and his biologico-psychological drives, there will still be room for belief in a Providence that grants not mere comfort,

but security--not mere probability, but uncertainty. Religion and science thus perform different functions in the life of man, and it is not necessary that either should interfere with the other (Lowie, 1963, p. 542).

The critical factor, from this perspective, becomes a matter of how and to what extent the two systems will be merged. Arguments against a centrally directed bureaucratic system being a suitable organizational form for financing, monitoring, and evaluating this fusion of systems, are concentrated within major areas of concern:

Professional and Personal Bias

The administrator of health care is not served by the uncritical adoption of the stereotyped perspective of orthodox practitioners. Although holistic health advocates have made stries toward acceptance of traditional healing concepts, the general perception of what a "medicine man" does is still closer to the pejorative image of the movie cliche than to that of a true spiritual healer. Local decisions on how a traditional healer's services might be utilized should not be determined by the scientific viewpoint alone. Nor should policy inquiry be rushed into with premature acceptance of every "fringe" and "marginal" practitioner who presents himself as a traditional healer.

Biases of a different order are cogently articulated by Singer (1977) who posits three basic reasons against the use and promotion of traditional healers. While one may disagree with his premises (and this writer does), it is clear that his views stand as forceful arguments against integration. First, he considers the promotion of traditional healers as nothing more than continued socio-economic exploitation of the "natives of colonialism." His second concern is that scientific clinical base lines are replaced with cultural relativity, low-paid paraprofessionals, and "normative propositions concealing value judgements." Finally, he

would resist integration on the grounds that it violates the "progress idea." This latter argument he supports with the belief that a progressive culture (Western) is advanced to the extent in which it can disengage itself from the primitive belief systems, magic, and superstitions of the traditional healer.

The Money Trap

The infusion of money to expand the traditional care system across hundreds of tribes will be matched eventually by a corresponding control over that system by the money suppliers. Good intentions notwithstanding, significant amounts of money can only corrupt this fragile system and restrict the options of a self-chosen way of life. The dominance of bureaucratic regimen will eventually prevail, and the professional colonization of Indian health and service delivery will be complete.

The formal arrangement of national health care dollars provided to incorporate the traditional "healing" system into the dominant "curing" system has two interrelated and ultimately destructive aspects:

1. It compounds a basic problem of enforced dependency upon Indian people. Further indoctrination to become consumers of external supports becomes encouraged, rather than the recognition of frail but tangible evidence of self-reliance in meeting their own health and spiritual needs.
2. It contributes, perhaps fatally, to further withering of the traditional way of consoling, caring and comforting people.

Manpower Dilemmas

Major effort to tamper with educating and training of traditional healers is, perhaps, the biggest folly of all. Training presumes, in the first place, that western education can provide the means whereby traditional healers can

become better at that which they are already the experts!

Secondly, it presumes that organized training programs will limit themselves to "development" aspects of manpower concerns, and not encroach upon selection, utilization, and retention criteria. Yet, each of these issues is as related to education/training as manpower concerns are related to the amdinistration of health care.

Taken collectively, the following quotes from contemporary traditional healers reveal something about the way in which expanded formal training programs might be measured and accepted:

> . . . we are now living in a time of young people. We will learn your education--learn it well--and use it for the good of the people. Yet many educated Indians go a different way . . .
> . . . give us a chance to rehabilitate our people--not with AA but with our spiritual way of life.
>
> Archie Fire Lame Deer (Sioux)

> The more the traditional ways are understood as being related to life and cultural beginnings, the more Navajo way will be preserved and healthy bodies will walk in the path of sacred corn . . .
> . . . There is some power yet among some medicine men if they use the power properly . . . but my medicine I can't give to anybody, it's mine.
>
> Fred Stevens (Navajo)

> My medicine is a gift I was born with. You don't learn it in six months, one year or two years. You young doctors--you learn from the book. You are a professional. Yet, people are still looking for something.
>
> Soloho (Hopi)

> What do I do? Nobody can tell you that. That's mine . . . There's nothing to buy--no amount of money can buy this . . . offering money is an insult . . . I have nothing to sell!
> . . . If I follow the Indian views completely, then I'm going to be protected.
>
> Rolling Thunder (Shoshone)

CLOSURE

Throughout this paper, the message has been consistent: system-tampering, well-intentioned or not, can only damage the culture of Indian people. The argument is neither against holistic health, nor against federal support in meeting Indian health problems. The argument is against encroachment upon traditional healing practices in ways that will replace them with modern social services and medical procedures.

Instead of puzzling over which of the two systems is appropriate to Indian people -- or how a pay-system and training regimen for traditional healers could be formalized -- public health administrators and modern HCW might puzzle over the neglected social and economic conditions which prompts Indian people to require so much attention from the public health sector beyond their own coping resources.

Numerous concrete strategies that are "culture-building" are more worthy of public expenditure than attempts to formally establish a pay-system and training regimen for traditional healers on a national scale. Among these strategies are adequate funding to fully implement the intent of legislation such as the Indian Health Care Improvement Act (PL 94-437) and the Mental Health Systems Act (PL 96-398) as well as tribal-specific and self-determined health plans; health-maintenance programs rather than sick-care; elimination of restrictions on the use of health manpower; utilization of the hospital system to incorporate "healing" services along side the "curing" apparatus; and additional tribal supports to restore the coping skills inherent in native traditions and religion.

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